**Appendix 1**

## Winterbourne View Final report and recommendations

## 1 Summary

The physical and verbal abuse of patients with learning disabilities at Winterbourne View has been extensively reported on previously, following the original Panorama broadcast on 31st May 2011.

This paper provides an update following the publication in December 2012 of the Department of Health Review Final Report: **Transforming care: A national response to Winterbourne View Hospital**

This report follows earlier publications which have been previously been reported:

- DH Review; Winterbourne View Hospital – Interim report
- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

## 2 Key Findings – beyond Winterbourne View

The collated findings of all reports as highlighted in these reports is summarised below:-

- All too often, people were being wrongly placed in hospital settings and there was a failure to design, commission and provide services which give people the support they need, and which are in line with well established best practice.

- Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals. There was a lack of focus of promoting rehabilitation back to a home setting. The DH Final report notes this as a **serious failure of commissioning.**

- The result is that far too many people are in hospital when they should not be, and they are staying there for too long – in many cases for years.

- Many people are sent a long way from their home and families.

- Many Hospitals and care homes are not offering the quality of care that people have a right to expect.

- This model of care goes against government policy and has no place in the 21st century.

- People should have access to the support and services they need locally – near to family and friends – so they can live fulfilling lives within the community.

- Winterbourne View was an extreme example of abuse, but multiple examples were found of poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people.

- Adult safeguarding systems failed to link together the information (from Winterbourne View). The NHS South of England review highlighted the absence of processes for commissioners to be told about safeguarding alerts, and failures to follow up concerns when commissioners became aware of them

- All parts of the system – those who commission care, those who provide care and individual staff, the regulators and government – have a duty to drive up standards. There should be zero tolerance of abuse.

- People with challenging behaviours can be, and have a right to be, offered the support and care that they need in a community-based setting, as near as possible to family and other connections.

## 3 Next steps – Concordat: Programme of Action

To accompany the final report the DH has published a Concordat; Programme of Action, that commits to a 'programme of change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities and autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them':

And further states that;

'we will safeguard people's dignity and rights through a commitment to the development of personalised, local, high quality services alongside the closure of large scale inpatient services and by ensuring that failures when they do occur are dealt with quickly and decisively through improved safeguarding arrangements.

The Government's Mandate to the NHS Commissioning Board sets out that

"The NHS Commissioning Board's objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people'

The key actions from the Final Report and the Concordat; Programme of Action are:

**i). Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:**

- The NHS Commissioning Board (NHSCB) will: Ensure that all Primary Care Trusts develop registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible and certainly no later than 1 April 2013;

- Make clear to Clinical Commissioning Groups (CCGs) in their handover and legacy arrangements what is expected of them, including:
    - Maintaining the local register from 1 April 2013; and
    - Reviewing individuals' care with the Local Authority and identifying who should be the first point of contact for each individual.

**ii). Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:**

Health and Care Commissioners will:

- By 1 June 2013, working together and with service providers, people who use services and families, review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual, based on their and their families' needs and agreed outcomes;

- Put these plans into action as soon as possible, so that all individuals receive personalised care and support in appropriate community settings no later than 1 June 2014;

- Ensure that all individuals have the information, advice and advocacy support they need to understand and have the opportunity to express their views. This support will include self-advocacy and independent advocacy where appropriate for the person and their family.

**iii). Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care.**

- By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.
- This joint plan will be part of the Joint Health and Well-Being Strategy and Joint Strategic Needs Assessment
- The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements

**iv). Evidence best practice**

- By Summer 2015 NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability

- By Summer 2016 NICE will publish quality standards and clinical guidelines on mental health and learning disability

**v). Prioritising children and young people's services**

For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education.

- DH will work with the Department for Education (DfE) through the Children and Families Bill to introduce from 2014, a new single assessment process for every child and young person up to age 25 with special education needs or a disability, with an Education, Health and Care Plan (subject to parliamentary approval).

- DH and DfE will work with the independent experts on the Children and Young People's Health Outcomes Forum to consider how to prioritise improvement outcomes for children and young people with challenging behaviour and how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013.

- From June 2013 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England

### vi). National Leadership Supporting Local Change

To provide national leadership and support to the transformation of services locally, the Local Government Association and NHSCB will develop an improvement programme.

- This will involve key partners including the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS) and the Care Quality Commission (CQC) and will closely involve service providers, people with learning disabilities and autism and their families in their work

- At a national level, from December 2012, the cross-government Learning Disability Programme Board chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery, and challenging external delivery partners to deliver to plan, publishing regular updates.

- By March 2012 the NHSCB and ADASS will develop service specifications to support CCG's in commissioning specialist services for children, young people and adults with challenging behaviour.

- The Department of Health will publish a follow-up report one year on by December 2013 and again as soon as possible following 1 June 2014, to ensure that the steps, set out in the Concordat, are achieved.

### vii). Improving quality and safety

Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective, underpins many of the systemic problems revealed by Winterbourne View. However, the Programme of Action also places emphasis on strengthening safeguarding adults board arrangements, applying protections of the Mental Health Act and the Mental Capacity Act, addressing the use of medication and improving access to advice and advocacy services.

- Safeguarding Adults Boards will be put on a statutory footing; local authorities will be empowered to make safeguarding enquiries, and Boards will have a responsibility to carry out safeguarding adults reviews

- The Safeguarding Adults Board will publish an annual report on the exercise of its functions and its success in achieving its strategic plan

- The DH will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions and will report by Spring 2014

- During 2014 the DH will update the Mental Health Act Code of Practice taking account of findings form the DH review

- The DH will publish by the end of 2013 guidance on best practice on positive behaviour support to minimise the use of physical restraint and never use to punish or humiliate

- The DH and Royal College of Psychiatrists will commission, by Summer 2013, a review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour

- The DH will drive up the quality of independent advocacy through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.

## 4 Bath and North East Somerset – Local response and action plan

The NHS Bath and North East Somerset/NHS Wiltshire Cluster has appointed an independent Project Manager on a short term contract to develop a local action plan to address the findings and recommendations of all of the reports identified above on behalf of both PCT's. This is attached as Appendix 1 to this report.

It is accepted that the organisational structures and current commissioning arrangements differ between NHS Wiltshire and NHS BANES, and the respective local authorities. Therefore the draft action plan has been modified in two ways

i) To reflect B&NES own circumstances
ii) To incorporate the additional actions published in the DH Final Report

## 5 Recommendations

The Wellbeing Policy Development and Scrutiny Panel is recommended to note the content of this report and to receive an update on the implementation of the action plan within twelve months

**Mike MacCallam**
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