Winterbourne View - A Compendium of Key Findings, Recommendations and Actions

"The abuse of patients at Winterbourne View hospital was appalling, and those directly responsible have rightly been dealt with by the Courts. This report into the events at Winterbourne View shows clearly that there have also been many faults in the wider care system.

Children and adults with learning disabilities or autism and who have mental health conditions or behaviour regarded as challenging have too often received poor quality and inappropriate care.

We know there are examples of good practice around the country, but we also know that too many people are admitted to hospital unnecessarily in hospital and they are staying there for too long.

This must stop"

Department of Health Final Report, December 2012

Winterbourne View – Key Findings, Recommendations and Actions

This document is intended to provide a collation of the key findings, recommendations and actions resulting from the investigations of the Care Quality Commission, Department of Health and South Gloucestershire Councils Serious Case Review carried out into Winterbourne View and includes the Care Quality Commissions Internal Management review.

This document also includes the key findings and actions from the Department of Health's Final report into Winterbourne View and the Concordat which sets out the Programme of Action that includes the key actions for a range of agencies across Government, providers of health and social care, local authorities and regulators.

The various reviews into Winterbourne View followed the broadcast of the BBC's Panorama programme Undercover Care: the Abuse Exposed back in May 2011 and the follow up programme The Hospital that Stopped Caring in October 2012 which you can watch on the BBC's I-Player service by following **http://tinyurl.com/bpo8t6m**

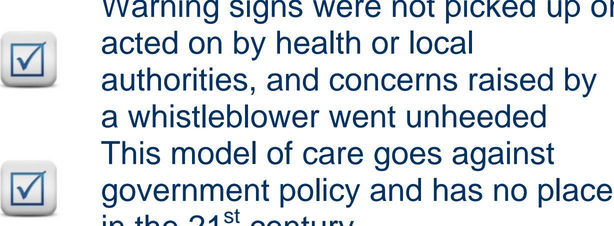
A British Sign Language version of the same programme can be accessed using the following link **http://tinyurl.com/c2oe6gj**
.
A checklist is provided below of the key findings and recommendations taken across all of the report

Key Findings

- ☑ The abuse at Winterbourne View hospital was criminal and management allowed a culture of abuse to flourish.
- ☑ Too many people are placed in in-patient services for assessment and treatment (A&T) and are staying there for too long.
- ☑ Aside from the poor care and abuse, many of the people being treated there should not have been there in the first place
- ☑ Far too many are sent a long way from their home and families and many hospitals and care homes are not offering the quality of care that people have a right to expect.
- ☑ Winterbourne View was an extreme example of abuse, but found evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people
- ☑ 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.

Key Recommendations

- ☑ Commission the right model of care to focus on the needs of individual people, looking to avoid the factors which might distress people and make behaviours more challenging, building positive relationships in current care settings;
- ☑ Listen to people with learning disabilities and their family carers in developing person-centred approaches across commissioning and care
- ☑ Only local action can guarantee good practice, stop abuse and transform local services
- ☑ Build understanding of the reasonable adjustments needed for people with learning disabilities who have a mental health problem so that they can make use of local generic mental health beds;
- ☑ Focus on early detection, prevention, crisis support and specialist long term support to minimise the numbers of people reaching a crisis which could mean going into hospitals;
- ☑ Work together to plan carefully and commission services for the care of children as they approach adulthood to avoid crises; and Commission flexible, community-based services.



- Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded
- This model of care goes against government policy and has no place in the 21st century.

Key Actions

- 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
- 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
- There will be national leadership and support for local change
- Planning will start from childhood improving the quality and safety of care
- Accountability and corporate responsibility for the quality of care will be strengthened
- Regulation and inspection of providers will be tightened
- Progress in transforming care and redesigning services will be monitored and reported

Andrea Pope-Smith
Director, Adults Community and Housing Services
Dudley Metropolitan Borough Council
Joint Chair, ADASS LD Policy Network &
National ADASS Lead - Winterbourne Review

Care Quality Commission – Learning Disability Review

In June 2011 the CQC published a review of learning disability services from within the NHS, private care and social care services where inspectors carried out 150 unannounced inspections

CQC inspected all the services against two outcomes which were:

1. Care and welfare of people who use services (outcome 4).

2. Safeguarding people who use services from abuse (outcome 7).

The key findings and conclusions from this report are provided below:

Findings

Five of the 150 inspections were pilots and were not included in the overall analysis. Therefore, of 145 inspections:

- 35 met both standards.
- 41 met both standards with minor concerns.
- 69 failed to meet one or both standards.

Many failings were a direct result of care that was not centred on the individual or tailored to their needs.

Conclusion relating to commissioners

Overall the inspections revealed that assessment and treatment services admit people for disproportionately long spells of time and that discharge arrangements took too long to arrange. People were more likely to have longer spells of care in independent healthcare service assessment and treatment services and secure services than in comparable NHS services. This raises important questions about the patterns of commissioning behaviour and practices across England.

Recommendations for commissioners

Commissioners needed to urgently review the care plans for people in treatment and assessment services and identify and plan move on arrangements to the next appropriate service and care programme.

Emerging Clinical Commissioning Groups and the NHS Commissioning Board, as well as Local Authorities in England need to work together to deliver innovative commissioning at the local level to establish person-centred services. This is much more likely to lead to people being able to stay in their local communities and so maintain important relationships.

Commissioners also need to review the quality of advocacy services being provided, particularly in those locations where we identified non-compliance with the standards.

Conclusions relating to providers

For many of the locations in the sample of 150 this was their first inspection against the Health and Social Care Act 2008 regulations.

CQC were unable to compare at location level against previous inspections under the previous regulations. However, whenever possible, they made comparisons of their overall findings with the Healthcare Commission 2007 report, A life like no other:

A national audit of specialist in patient healthcare services for people with learning difficulties in England which audited both NHS and independent healthcare services.

The report indicated that since the audit there had been improvement in the development of some policies and procedures, but there still remained a significant weakness in relation to person-centred planning and care and the use of restraint.

- Restraint was not well understood in terms of what constituted restraint, the monitoring of the use of restraint or learning lessons following incidents of restraint and analysis of these.
- The use of seclusion was not always recognised as a form of restraint.

- The use of deprivation of liberties and the safeguards needed are not well understood, reported and lessons learned.

Recommendations for providers

Providers must ensure that people using services are routinely involved and 'own' their care planning and activities. These must be available in appropriate formats and must be accessible.

There are still lessons to be learned by providers about the use of restraint. There is an urgent need to reduce the use restraint, together with training in the appropriate techniques for restraint when it is unavoidable. There also needs to be systematic monitoring about the use of restraint and ongoing analysis so that lessons can be learned and patterns of use better understood which should all lead to less use of restraint. The use of seclusion needs to be recorded as a form of restraint.

Providers must ensure that staff understand and can apply the deprivation of liberty safeguards.

Recommendations for providers, commissioners and CQC

Providers and commissioners should ensure that there are appropriate quality assurance systems in place. This includes having appropriate complaints procedures, access to and use of advocates, welcoming approaches to visitors and a fundamentally sound and appropriate support and supervision structure for all staff.

CQC should determine when it is most appropriate to visit and inspect services at weekends and evenings, rather than Monday to Friday between 09.00 and 17.00. Visits at these times can sometimes provide the additional evidence needed to assess visitor access, and judge the quality of care, staff, support and supervision.

Recommendation for CQC

CQC acknowledged that the sample of learning disability providers inspected outside the thematic programme (52) was small by comparison. However, the differences in judgments about compliance and non-compliance warranted further evaluation, to help understand and explain the differences.

Summary

The report commented that since Winterbourne View …

- CQC has inspected all of Castlebeck's 23 registered locations. Three of the services, including Winterbourne View, were closed as a result of CQC's actions.

- Inspectors have made unannounced inspections of 150 hospitals and homes for people with learning disabilities and where they found concerns, they have already taken action.

- Inspectors have continued to monitor the safety and quality of care for the former patients of Winterbourne View, with follow up inspections at 12 locations which took them after the hospital closed.

- CQC set up a dedicated team to deal with whistleblowers and to ensure that all calls are followed up.

- CQC has introduced a new inspection regime, which recognises that hospitals like Winterbourne View are high risk institutions.

- The Department of Health allowed CQC to appoint another 250 inspectors, which means that most hospitals, care homes and home care services can now be inspected at least once a year.

Further details of this report can be found at the link below:

http://www.cqc.org.uk/sites/default/files/media/documents/cqc_ld_review_national_overview.pdf

Care Quality Commissions Internal Management Review of the regulation of Winterbourne View

Following the publication of the CQC's review of learning disability services an Internal Management Review of the regulation of Winterbourne View was released in July 2011

The full text of this management review can be found using the following link http://www.cqc.org.uk/sites/default/files/media/documents/20120730_wv_imr_final_report.pdf however the recommendations were as follows:

Recommendation 1

The Care Quality Commission should highlight in our quality and risk profiles (QRP) that services defined as providing regulated activities in residential institutions for people with learning disability, challenging behaviours and mental health needs are inherently higher risk institutions. This is consistent with the DH guidance on models of service delivery for this group of patients. This higher risk status will act as an alert system to our staff when looking at data and information and when carrying out inspections of these institutions. This change should be implemented immediately.

Recommendation 2

The Care Quality Commission should take account of the inherent risk of different types of service provision and the different characteristics of the people using those services throughout its work. This will include collated intelligence about corporate providers as well as individual locations which will help to identify risks across a provider group as well as at individual location level.

Recommendation 3

Compliance inspectors should record the outcome of the investigations from safeguarding alerts and compliance managers should sign off the agreed actions from those investigations. Where CQC cannot agree the outcomes from the investigation this should be communicated back to the Safeguarding Adult Team and if necessary to the Adult Safeguarding Board.

Recommendation 4

Although the Care Quality Commission now has a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.

Recommendation 5

The Care Quality Commission should build new protocols about working with local Safeguarding Adults Teams and Safeguarding Adult Boards to ensure there is timely investigation and intervention of relevant safeguarding alerts, and to ensure that all relevant parties are involved in the investigation of the incident(s) leading to the alert(s).

Recommendation 6

The Care Quality Commission should develop its analysis of safeguarding alerts to look at particular trends at individual locations, and across service providers. This is particularly important in looking at concerns across chains of providers which cross the Care Quality Commission's geographical boundaries.

Recommendation 7

The Care Quality Commission should evaluate and embed the process it has commenced of integrated, routine and on going exchanges of information between the Compliance Inspectors and Mental Health Act Commissioners and, where appropriate, for joint inspections to take place. This needs to be managed through the supervisory arrangements between the Compliance Managers and their inspectors and the Mental Health Act Commissioner Managers and their Commissioners.

Recommendation 8

The information and intelligence that the Second Opinion Appointed Doctors may capture regarding concerns that they have for patient safety as part of their statutory remit should be systematically and routinely recorded and made available as part of the intelligence and risk information used by CQC in its work. CQC should review the mechanisms by which SOADs receive pre-visit relevant information and how they feed back to CQC on concerns observed during the discharge of their statutory function.

Recommendation 9

When the Care Quality Commission Mental Health Act Commissioners set out their comments and suggestions for the provider following a visit these should be monitored through an action plan submitted to the Care Quality Commission, and linked with the QRP for the location. There should be follow up to ensure that the agreed actions are being implemented as agreed. Where there is failure to do so the Adult Safeguarding Team should be notified.

Recommendation 10

The Care Quality Commission should review how it collates information and looks at risk at provider level as well as at location level. This is particularly important for chains of providers where systemic issues could be overlooked

because of a focus on location level information.

Recommendation 11

The Care Quality Commission's Board should receive a report on the whistle blowing arrangements that are in place on a six-monthly basis. This should be a public report setting out in detail the scope, volume and actions taken by the Care Quality Commission in response to the concerns raised by whistleblowers.

Recommendation 12

The Care Quality Commission should audit, on an annual basis, the effectiveness of the case management arrangements in place to ensure that supervision is systematically considering the services with the most serious concerns as part of a quality assurance process. The outcomes of this audit should be reported to the Board, and the report should be made public.

Recommendation 13

The Care Quality Commission should now develop a protocol about the way in which we will work with the Safeguarding Adult Boards and Teams across England. The protocol should take account of what the proposed legislation may set out and also take account of what has worked effectively in Children's Safeguarding Boards.

Department of Health Review Winterbourne View Hospital

Interim Report

The Department of Health's Interim report stated that at any one time around 15,000 people in England have learning disabilities or autism and behaviour that challenges.

Most of these people are supported by their family carers or live independently in the community, often with complex packages of support. But at any one time, around 1,200 of these people may be in hospital services for assessment and treatment.

The Department of Health's review was about the quality of health and care services that these people receive. The report did not cover what happened at Winterbourne View hospital as criminal proceedings were and still are ongoing. The Department intended to publish a full report, including what happened at Winterbourne View, when criminal proceedings had concluded. This full report is included later in this compendium

The report states that strong evidence was found that the health and care system is not meeting the needs of people with learning disabilities or autism and behaviour that challenges.

There is a vast gap between policy and practice. This report sets out the actions that the Department would be taking to address the serious issues they identified.

The Department of Health's report was based on :

- Reports of the Care Quality Commission's (CQC) focussed inspection of 150 hospitals and care homes for people with learning disabilities and the national summary report, published alongside this report,

- Widespread engagement with people with learning disabilities, people with autism, family carers voluntary groups, with health and care commissioners, providers and professionals, as well as the regulators; and

- Other evidence submitted to the review team.

In the report the Department of Health felt that whilst it was only local action that would bring best practice, this report identified 14 actions that they were to take at a national level so that the focus was on improving the lives of people with learning disabilities or autism and behaviour which challenges.

The reports Initial findings

- Too many people are placed in in-patient services for assessment and treatment (A&T) and are staying there for too long.
- 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 they found evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people.
- All parts of the system – those who commission care, those who provide care and individual staff, the regulators and government – had a duty to drive up standards. There should be zero tolerance of abuse
- DoH found examples of good practice - such as Tower Hamlets, Salford and Cambridgeshire – with good local services which mean very few people use in patient services for assessment and treatment.

For People

- I and my family are at the centre of all support – services designed around me, highly individualised and person-centred.

- My home is in the community – the aim is 100% of people living in the community, supported by local services.
- I am treated as a whole person.
- Where I need additional support, this is provided as locally as possible.

For Services

- Services are for all, including those individuals presenting the greatest level of challenge.
- Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning.
- Services are provided locally.
- Services focus on improving quality of care and quality of life.
- Services focus on individual dignity and human rights.
- Services are provided by skilled workers.
- Services are integrated including good access to physical and mental health services as well as social care.
- Services provide good value for money.
- Where in-patient services are needed, planning to move back to community services starts from day one of admission.

Outcomes

A high quality service means that people with learning disabilities or autism and behaviour which challenges will be able to say:

- I am safe.
- I am treated with compassion, dignity and respect.
- I am involved in decisions about my care
- I am protected from avoidable harm, but also have my own freedom to take risks
- I am helped to keep in touch with my family and friends.
- Those around me and looking after me are well supported.
- I am supported to make choices in my daily life.
- I get the right treatment and medication for my condition.
- I get good quality general healthcare.
- I am supported to live safely in the community.
- Where I have additional care needs, I get the support I need in the most appropriate setting.
- My care is regularly reviewed to see if I should be moving on.

Background and Context

The Department pledged to work with the Information Centre and the NHS Commissioning Board Authority to agree what information and data was needed to be collected to measure progress – whether that was how long people stay in assessment units, how far they are from home, the experience of people who use care and support and their carers or other information that supported commissioners and providers to benchmark their activities.

Key actions were then established against key themes these are as follows:

Voice of people with learning disabilities and their families:

Action

The Department is establishing HealthWatch both locally and nationally. It will act as a champion for those who use services and for family carers, ensuring that the interests of people with learning disabilities are heard and understood by commissioners and providers of services across health and social care.

Providers need to actively promote open access for families and visitors, including advocates and visiting professionals. This is about increasing transparency.

Personalisation

Action

The Department of Health stated that they expected the NHS and local authorities to demonstrate that they have taken action to assure themselves, and the public, that they ensure personalised care and support with choice and control in all settings – including hospitals.

Providers and ensuring quality of care

Actions

- The Department expected providers to deliver high quality services. The Department would also discuss with

providers action to develop a voluntary accreditation scheme.

- DH is working with the *Think Local, Act Personal* group and providers to identify the barriers in the housing market to increasing the availability of different housing options for people with learning disabilities with behaviour which challenges and to encourage and facilitate local solutions. The project should be completed by April 2013.

- The National Quality Board was to publish in late summer a report setting out how the new system architecture will identify and take action to correct potential or actual serious failure.

  This will provide clarity on the distinct roles and responsibilities of different parts of the system in relation to quality failure, and emphasise the importance of all parts of the system operating within a culture of open and honest transparency and working together in the best interests of patients and service users.

Commissioning & Contracting

Actions

- DH was to provide statutory guidance to support health and well-being boards to develop joint health and well-being strategies, and would revise statutory guidance for the JSNA to reflect the needs and circumstances of the new system.

- The Department was to work with the NHS Commissioning Board Authority and ADASS to develop a model service specification by March 2013.

- NICE is developing Quality Standards on learning disabilities and the autism Quality guidelines were due to be published in July 2012.

- The NHS Commissioning Board would support CCGs to work together collaboratively in commissioning services for people with learning disabilities and behaviour which challenges.

- Health and care commissioners need to work together to review funding arrangements for people with behaviour which challenges and develop local action plans to deliver the best support to meet individuals' needs.

- The Department was to work with the NHS Commissioning Board Authority to agree by January 2013 how best to embed Quality of Health Principles in the system using NHS contracting and guidance. These principles will set out the expectations of service users in relation to their experience

- The Department also undertook to work with the Towards Excellence in Adult Social Care (TEASC) to agree how similar Quality of Life principles should also be adopted in social care contracts to drive up standards.

- Local authority commissioners were to review existing contracts to ensure they include an appropriate specification to meet the needs of the individual and appropriate information requirements to ensure the commissioner is able to monitor the care being provided.

Workforce

Actions

- The Royal Colleges and Learning Disability Clinical Senate were to carry out a refresh of Challenging Behaviour: A Unified Approach (http://www.rcpsych.ac.uk/files/pdfversion/cr144.pdf) to support clinicians in community learning disability teams to develop effective local pathways by December 2012

- The Academy of Royal Colleges and the professional bodies that make up the Learning Disability Professional Senate would work to develop core principles on a statement of ethics which will reflect wider responsibilities in the new health and care architecture.

- The Department would work with the other three UK health departments and key partners to establish a steering committee to consider and take forward the recommendations in Strengthening the Commitment the report of the UK Modernising Learning Disabilities Nursing Review.

- The Department would work with DfE, CQC and other partners to drive up standards and promote best practice by the end of 2013 for those working in therapeutic or supportive roles to promote use of positive behavioural support and avoid use of restrictive physical interventions, except as a last resort.

Regulators

Actions

- The Department supported CQC's suggestion that inspections of services should take place outside of normal office hours, and that weekend and evening visits could reveal additional information about the quality of care provided. The Department of Health encouraged CQC to take a flexible approach to the timing of inspections.

- The Department alongside CQC to consider options for revising the regulations that define the scope and requirements for providers' registration with CQC in order to drive up quality of provision.

- CQC would review their on-going inspection of learning disability services, including the 150 hospitals and care homes recently inspected.

For further information please access a copy of the Department of Health Interim Report at the following link

http://www.dh.gov.uk/health/files/2012/06/Department-of-Health-Review-Winterbourne-View-Hospital-Interim-Report1.pdf

---

South Gloucestershire Council - Serious Case Review

After the transmission of the BBC Panorama Undercover Care: the Abuse Exposed in May 2011, which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adults with Learning disabilities and autism, South Gloucestershire’s Adult Safeguarding Board commissioned a Serious Case Review.

The Review was based on information provided by Castlebeck Care (Teeside) Ltd, the NHS South of England, NHS South Gloucestershire PCT (Commissioning), South Gloucestershire Council Adult Safeguarding, Avon and Somerset Constabulary and the Care Quality Commission; correspondence with agency managers; contact with some former patients and their relatives; and discussions with a Serious Case Review Panel which was made up of representatives from the NHS, South Gloucestershire Council, Avon and Somerset Constabulary and the Care Quality Commission.

The recommendations of the serious case review were as follows:

Overview

- Clinical Commissioning Groups, local authorities and the NHS Commissioning Board should be commissioning services with regard to the needs identified in the Joint Strategic Needs Assessment, the priorities agreed in Joint Health and Wellbeing Strategies and where appropriate, the health aspects of the National Planning Policy Framework. The presumption should be to address the needs of the whole population within the geography of the local area, with the aim of reducing the number of people using in—patient assessment and treatment services in line with the policy set out in the Department of Health (2012) Interim Report.

The principle of investing in and promoting

good quality, local services…providing intensive community support ***with only limited use of in—patient services*** (Department of Health 2012) should be adopted and monitored by Clinical Commissioning Groups and the NHS Commissioning Board.

- Clinical Commissioning Groups should require generic mental health services, as part of their annual contract monitoring, to identify the steps taken to enable citizens with learning disabilities and autism to be supported in their own communities and familiar localities.

- In its direct commissioning responsibilities and perhaps as part of contractual arrangements, the NHS Commissioning Board should take appropriate steps to require hospitals and assessment and treatment units for adults with learning disabilities and autism to publish information concerning

  (a) direct patient related costs

  (b) their service costs

  (c) the specific rehabilitation gains of individual patients

  (d) the detention status of patients at the point of discharge, and whether or not discharge is to a within-service transfer to a facility owned by the same company, an associated company or an NHS Trust.

The guidance associated with the legislative framework for placing Safeguarding Adults Boards on a statutory footing, and any subsequent review of safeguarding guidance, should reflect the findings of all the reviews associated with Winterbourne View Hospital.

The role of commissioning organisations in initiating patient admissions to Winterbourne View Hospital

- Adults with learning disabilities and autism, who are not subject to the provisions of the Mental Health Act 1983, should not, by law, be the subject of restrictions in the same way as with patients who are subject to the provisions of mental health legislation.

- Commissioners should commission the model of care as set out in the Department of Health (2012) *Interim Report,* to ensure that people only go into in-patient services for assessment and treatment where they cannot get the support that they need in the community. Local authorities should only commission such services where they are the lead commissioner and there are valued services and pooled budgets in place.

- The Department of Health should take steps to ensure there is clarity across the health and social care spectrum about commissioning responsibilities for hospital based care for people with learning disabilities.

- Adults with learning disabilities and autism, who are currently placed in assessment and treatment units, should have the full protection of the Mental Capacity Act 2005.

- The Department of Health should assure itself that CQC's current legal responsibility to monitor and report on the use of Deprivation of Liberty Safeguards provides sufficient scrutiny of the use of DoLS

- The NHS Commissioning Board should seek ongoing assurance that the practice of commissioning of NHS services for adults with learning disabilities, autism, behaviour which challenges and mental health problems is explicitly attentive to reducing inequalities.

- Commissioners funding placements should ensure that they have up to date knowledge of services e.g.

  (a) adverse incidents/serious untoward incidents, including the injuries of patients and staff,

  (b) absconding,

  (c) police attendances in the interests of patient safety,

  (d) criminal investigations,

  (e) safeguarding investigations, and

  (f) the occurrence of Deprivation of Liberty Safeguards applications and renewals.

A commissioning challenge is required.

There are 51 former patients of Winterbourne View Hospital, some of whom have transferred to other hospitals and secure settings.

Commissioners ought to use their best endeavours in relation to ex-patients transferred to hospitals (who are not detained under the Mental Health Act 1983) to return them home or to suitable placements within their local communities. The treatment of those who are detained under the Mental Health Act 1983 should be focused on recovery and support with a view to returning them to their local communities.

This will require more than keeping tabs on where they are now - political support, the engagement of generic mental health services, as well as the First Tier Tribunal – Mental Health, and capable managers and staff are essential if competent and humane forms of local provision are to develop.

The circumstances and management of the whistle blowing notification

- There should be a condition of employment on all health and social care practitioners (registered and unregistered) to report operational concerns to

  (i) the Chief Executives and Boards of hospitals,

  (ii) the regulator.

- All registered health and social care employers should be required to advise their employees in their contracts to whom they can whistle blow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. This should include information about provision in the Employment Rights Act 1996 which gives protection to those making disclosures in the public interest.

The multi-agency response to the safeguarding referrals from Winterbourne View Hospital

- Council Safeguarding Adults personnel must ensure that hospital patients, subject to Deprivation of Liberty Safeguards and Mental Health Act detention, who are restrained and/or make a complaint, have opportunities to access, in private, independent professionals such as social workers, local authority Deprivation of Liberty Safeguards assessors, Independent Mental Capacity Advocates or Independent Mental Health Advocates and Mental Health Act Commissioners for those detained under the Mental Health Act 1983.

- When a hospital fails to produce a credible safeguarding investigation report within an agreed timeframe, the host Safeguarding Adults Board should consult with the relevant commissioners and the regulator to identify remedies.

The volume and characteristics of safeguarding referrals

- The National Quality Board should devise a mechanism for aggregating pertinent safeguarding information for NHS patients with learning disabilities and autism as part of its consideration of actions to correct actual or serious failure (Department of Health, 2012).

- The Department of Health should consult the National Quality Board about how to rationalise the notifications which hospitals providing services to adults with learning disabilities and autism should make, and confirm which agency should "hold" this information.

The existence and treatment of other forms of alert that might cause concern

- Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures - in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009

- The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units. An investment comparable to the banning of the corporal punishment of children is

required. The use of restrictive physical intervention “as a last resort” characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.

- Clinical Commissioning Groups should explore how Accident and Emergency can detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A&E departments, including it in their annual review of Clinical Quality Indicators.

- Commissioners responsible for funding placements should be proactive in ensuring that patients are safe. If responsibility for monitoring a placement or the ongoing coordination of care is delegated to nurses or social workers, then commissioners should ensure that they are informed about safeguarding concerns and alerts. Decisions about funding placements should be based on outcome data. Arrangements should be in place to share information about safeguarding incidents and alerts between those responsible for monitoring patient safety, the provider and commissioners and this should be routinely monitored through contacts.

The role of the Care Quality Commission as the regulator of in-patient care at Winterbourne View Hospital

- Local Adult Safeguarding Boards, CQC and all stakeholders should regard hospitals for adults with learning disabilities and autism as high risk services i.e. services where patients are at risk of receiving abusive and restrictive practices within indefinite timeframes. Such services require more than the standard approach to inspection and regulation. They require frequent, more thorough, unannounced inspections, more probing criminal investigations and exacting safeguarding investigations.

- Monitor, as the sector regulator of all providers of NHS-funded services, should consider the inclusion of internal reporting requirements for the Boards of registered provider services in their provider licence conditions.

- The mental health arm of CQC should have characteristics akin to HM Inspectorate of Prisons in terms of standards. The hospital managers as defined by the Mental Health Act 1983 have the primary responsibility for ensuring that all requirements of the Act, including all the safeguards to ensure detention is necessary in the first place (3 independent professional assessments) and needs to continue. CQC and the First Tier Tribunal should ensure that these responsibilities are discharged for all detained patients. All decisions taken on the use of the Mental Health Act 1983 must be guided by that Act's guiding principles, including the purpose principle and the least restriction principle.

- The requirements concerning a service’s *Statement of Purpose* and the supporting guidance should be strengthened to aid clarity. The CQC, through its Mental Health Act monitoring responsibilities, should consider giving particular focus to

  (i) the way in which hospital managers (as defined in the MHA 1983) discharge their responsibilities, and

  (ii) evidence that hospitals are engaged in the activities they are registered to provide.

- There is a compelling case for mandatory visits by the Nominated Individual/Board Member reported and brought together in an annual report accompanying the accounts. The Department of Health should consider amending registration requirements to require such mandatory visits and public reporting.

- The Care Quality Commission should collaborate with the Health (and Care) Professionals Council, plus the Sector Skills Councils for both Health and Care, in providing advice and guidance on the qualifications and continuing professional development requirements for Registered Managers and for the practitioners they supervise. It is of concern that managers, registered to operate services across residential, nursing home, hospital and home care, are not required to be distinct registered professionals individually accountable through a governing body and code of ethics.

- The Care Quality Commission should take appropriate enforcement action where registered managers are not in place.

- Inspection is a term that the public understands and expects to be in place for an establishment such as Winterbourne View Hospital. The Care Quality Commission's Compliance Inspectors did not identify the abuse. CQC should ensure that inspections are carried out by sector specialists and experts by experience so that warning signs may be identified earlier (i.e. the approach effectively implemented for the inspection of 150 services for adults with learning disabilities in England). Inspectors should be qualified and competent to carry out inspections, and demonstrate that they have sufficient knowledge about

  (i) the services that they inspect and
  (ii) the abuse of vulnerable adults, including the crime of assault.

- The CQC must encourage whistleblowers to raise the alarm and then securely receive, log and take action when concerns are raised. They should report on actions arising from whistle blowing notifications in its annual *State of Care* report.

- The CQC and the commissioners should ensure that a service is providing care which is consistent with its *Statement of Purpose*, i.e. in the case of Winterbourne View Hospital, assessment and treatment, and rehabilitation.

The policy, procedures, operational practices and clinical governance of Castlebeck Ltd in respect of operating Winterbourne View as a independent hospital.

- To meet their statutory obligations all providers of residential, nursing home and hospital care should require that their registered managers' normal place of work is one where they can become known to patients/service users and are routinely visible and accessible for the staff who are working 365 day rotas

- The Care Quality Commission through its Mental Health Act monitoring responsibilities should consider giving particular focus to the way in which hospital managers (as defined in the Mental Health Act 1983) discharge their responsibilities.

- The CQC, in discharging its responsibilities to monitor the use of the Mental Health Act, should ensure that all the requirements of the Act are applied when a patient moves from being an informal patient to being detained under the Act in the same hospital.

- The CQC and Health Professions Council should work together to describe in guidance what effective systems of clinical supervision look like in hospitals for people with learning disabilities and autism. The guidance should identify the roles of registered managers and nominated individuals in developing such systems in practice.

- Organisations providing NHS funded care should be required to demonstrate accountability for effective governance to commissioners and Council Adult Safeguarding.

- Commissioners should encourage hospitals and assessment and treatment units for adults with learning disabilities and autism to ensure that their employees are signed up to the proposed *Code of Conduct and minimum induction/ training standards* for unregistered health and social care assistants commissioned by the Department of Health.

- Reducing the use of anti-psychotic medication with adults with learning disabilities and autism requires attention. An outcome of the National Dementia Strategy (Department of Health, 2009) was an investment in reducing anti-psychotic medication for patients with dementia (Banerjee, 2009). Adults with learning disabilities require no less.

- Commissioners of assessment and treatment services should ensure that there are pharmacist led medicines reviews both for individual patients and for the service as a whole.

- The Care Quality Commission should consider including pharmacist led medication reviews in future inspections.

- In the light of the harm sustained by former Winterbourne View Hospital patients, Castlebeck Ltd should consider funding

  (i) independent psychotherapeutic provision for all former Winterbourne View Hospital patients – in negotiation with each person and their families; and an evaluation of the effectiveness of this intervention, and

  (ii) the costs associated with this Serious Case Review.

For further information please access a copy of the Serious Case Review report at the following link
http://hosted.southglos.gov.uk/wv/report.pdf
and a copy of the Executive Summary can be accessed here :
http://hosted.southglos.gov.uk/wv/summary.pdf

Department of Health Review Winterbourne View Hospital

DH Department of Health

Full Report and Concordat

The Department of Health's Full Report was delayed until Criminal proceedings against those implicated in the Winterbourne View scandal had been completed. As a result of these criminal proceedings 11 individuals were prosecuted leading to convictions and sentencing on the 26th of October 2012

The Final Report is supported by a detailed "Programme of Action" which is contained within the Concordat signed by a range of agencies within the health and social care sphere as well as Government Departments and regulators.

The report is prefaced by a Joint forward which states:

"The abuse of patients at Winterbourne View hospital was appalling, and those directly responsible have rightly been dealt with by the Courts. This report into the events at Winterbourne View shows clearly that there have also been many faults in the wider care system. Children and adults with learning disabilities or autism and who have mental health conditions or behaviour regarded as challenging have too often received poor quality and inappropriate care. We know there are examples of good practice around the country, but we also know that too many people are admitted to hospital unnecessarily in hospital and they are staying there for too long.

This must stop"

Key Findings

- The abuse at Winterbourne View hospital was criminal
- Management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded
- Steps have been taken to respond to these failings – and further steps are set out in the report notably to tighten up the accountability of management and corporate boards for what goes on in their organisations.
- The abuse was only the beginning of the story - many of the actions in the report cover the wider issue of how as a country we care for people with learning disabilities or autism, who have what is often described as challenging behaviour.
- Aside from the poor care and abuse, many of the people being treated there should not have been there in the first place. They had been sent there – to a closed hospital setting – for what should have

been short-term assessment, but some had been left there for much longer

- Inspections of similar establishments around the country revealed a similar story
- There were excellent examples of high quality services keeping people safe and help them lead the lives they want to lead.
- 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
- 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.
- Far too many 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.
- Even where hospitals are run to the highest standards, they are still, for many people, the wrong place, offering the wrong sort of care.
- People with learning disabilities or autism may sometimes need hospital care; but hospitals are not where people should live.
- This is a wider scandal, on a national scale, that Winterbourne View revealed, and it is unacceptable.
- We should no more tolerate that people with learning disabilities or autism are being given the wrong care- against best practise that has been established for many years – that we would accept the wrong treatment being given for cancer.
- 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.
- Closed institutions, with people far from home and family members, not only deny people the right care but present the risk of a culture of poor care and abuse.

Governmental Mandate

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

"The NHS Commissioning Board's objective is to ensure that CCG's 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 Concordat – Programme of Action

The Department of Health report sets out a plan of action, contained within the Concordat, to ensure that we move urgently to a position where people are no longer inappropriately treated in hospitals but are cared for in line with best practice;

- Where there is clear accountability for ensuring people get the right care, and for the quality of that care wherever it may be
- Where the needs and wishes of people who need support, and their families and carers, are listened to and are at the heart of the planning and delivery of care

Programme of Actions

The Concordat contains 7 Key actions for a range of partners across Government and Health & Social Care Providers and Regulators

These are as follows:

1. 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

2. 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.

3. There will be national leadership and support for local change.

4. Planning will start from childhood improving the quality and safety of care

5. Accountability and corporate responsibility for the quality of care will be strengthened

6. Regulation and inspection of providers will be tightened

7. Progress in transforming care and redesigning services will be monitored and reported:

For further information on the actions outlined in the Concordat or for a copy of the Full Department of Health report please see the following link

http://www.dh.gov.uk/health/2012/12/final-winterbourne/

Appendix 1 – Prompts for Practitioners & Board Members:

Health and Well Being Boards

- How are the needs of people with a Learning Disability represented to the Health & Well Being Board?

- Does the Board understand the key issues resulting from Winterbourne View and is there an appropriate local improvement plan and what consideration is being given to any potential resource implications?

- How is the Winterbourne View improvement plan being monitored?

- How does the Health and Well Being Board wish to receive update/progress reports?

Commissioning

- Are robust joint commissioning arrangements in place for services for people with learning disabilities and autism, mental health problems or behaviours described as challenging? Do these plans include a strategy for the development of community based services as an alternative to inpatient Treatment & Assessment/Complex services?

- What are the overarching trends regarding needs for these complex services and are timely and adequate responses being made?

- Are there any specific cases / issues of significant concern and how are they being managed?

- Are the Learning Disability Partnership Board and Safeguarding Adults Board showing leadership for the Winterbourne View Local Improvement Plan and are they monitoring and scrutinising any relevant commissioning and delivery issues?

- Are there any issues / concerns which need to be addressed regionally or nationally where the Health and Well Being Board can make representation?

- What links does the Board have with the Safeguarding Boards for Children's & Adults Services?

Safeguarding Adults Boards

- Has the Safeguarding Adults Board formally considered the Winterbourne View reports, carried out an audit of Learning Disability /Mental Health units (including Assessment and Treatment Units, residential and nursing care services) and agreed an action plan in response to it in your area?

- Do you have an agreed protocol for regular reporting to the Board on the follow-up actions from your local response to the Winterbourne View reports?

Assessment and Treatment Units & Complex Service provision

- Are there any patterns of safeguarding issues linked to Assessment and Treatment Units (and similar types of closed/inpatient provision) in your local area?

- How are people with a learning disability & family carers involved in the safeguarding process and how are their concerns and desired outcomes considered and addressed?

- How are these trends being monitored, investigated and responded to?

- Is there a robust information sharing and response partnership in place with CQC?

- Do you have a means of assuring the quality and safety of Assessment and Treatment Units, and that these take into account the views of service users, their families, professionals and other visitors

- Is there a mechanism for determining if staff within Treatment and Assessment Units / similar services are competent to deliver the complex care and support required? (Training / development / supervision) and a means of reporting this to the Safeguarding Adults Board?

- Is there the means and resources available to swiftly follow up any concerns about these units?

- If there are no Treatment & Assessment/Complex Service provision within your area, how are you monitoring and responding to the range of issues relating to Learning Disability Services?

Commissioning and Safeguarding

- Are issues resulting from contract monitoring inspections and client reviews being collated, linked to safeguarding referrals, and patterns reported to the Safeguarding Adults Board?

- Can the commissioners (both local and external to your area) of the services for people with learning disabilities and autism, mental health problems or behaviours described as challenging assure you that they properly monitor them?

- Are Independent Advocacy providers identifying and reporting key issues / trends in safeguarding issues in your area to the Safeguarding Adults Board?

- What links/accountability does the Board have to the Health & Well Being Board?

Restraints and controls

- Are you aware of which methods of restraint are being used in local services, how this is recorded and identified in the context of any safeguarding referrals? Is this reported to the Safeguarding Adults Board?

- Is the use of the Mental Health Act and its application in these complex cases being monitored and trends identified / reported to the Safeguarding Adults Board?

- Are the Deprivation of Liberty Standards being applied appropriately across Learning Disabilities and Mental Health Services and is this being regularly reported to the Safeguarding Adults Board?

- **Learning Disability Partnership Boards**

  - Who is leading on the Local Improvement Plan following the Winterbourne View Reports, and providing reports to the Learning Disability Partnership Board?

  - What joint commissioning arrangements are in place across health and social care for learning disability services and what consideration is being given to any potential resource implications for required improvements?

  - What arrangements are in place for the joint commissioning of services for people with a learning disability and complex needs / behaviours described as challenging?

  - What placements have been made in your local area, by whom and why? This includes those care settings that local authorities do not use.

  - Are placements being monitored? (By whom, and frequency.)

  - Are placements being reviewed and are the people using those services and family carers involved? Are people visible?

  - What are the models of care and support available within your locality as alternatives to Assessment and Treatment Centres and similar type services? How are these being developed?

    - Do people have access to good quality independent advocacy and is it adequately promoted?

  - How are you collating, validating & benchmarking local good practice in your area?

  - What links does the Board have with the Safeguarding Adults Board and the Health & Well Being Board?