

## TRANSFORMING CARE: A NATIONAL RESPONSE TO WINTERBOURNE VIEW HOSPITAL, DEPARTMENT OF HEALTH REVIEW: FINAL REPORT

### 1. Introduction

In December 2012 the Department of Health published their report, '*Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report*'.

The review set up following the exposure of the abuse that occurred at Winterbourne View Hospital in May 2011 reviews the lessons to be learned and actions that should be taken to prevent abuse from reoccurring.

The report lays out clear, timetabled actions for Health and Local Authority Commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.

In order to carry out the review, the Department of Health review drew on:

- The criminal investigation of staff identified as perpetrators of abuse at Winterbourne Hospital.
- The Care Quality Commission (CQC) review of all services operated by the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes, including Rhymers Court in Rotherham and Sapphire Lodge in Doncaster.
- The NHS South of England review of serious untoward incident reports and the commissioning of places at Winterbourne View hospital.
- The independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012.
- Experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

The review also highlighted a widespread failure to design, commission and provide services which give people the support they need close to home, 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.

The report sets out steps to respond to the identified failings, including tightening up the accountability of management and corporate **Boards** within organisations.

The report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals, are provided with care that is in line with best practice based on their individual needs and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

## 2. Key Themes and Actions

The key themes are:

1. The right care in the right place
2. Strengthening accountability and corporate responsibility
3. Tightening the regulation and inspection of providers
4. Improving quality and safety
5. Monitoring and reporting on progress

The themes with actions are presented below:

### 2.1 The right care in the right place

- The NHS Commissioning Board will:
  - Ensure that all Primary Care Trusts develop local registers of all people with challenging behaviour in NHS-funded care.
  - Clarify expectations for Clinical Commissioning Groups.
  - Ensure all Health and Care Commissioners review the care of all people in learning disability or autism inpatient beds.
- Clinical Commissioning Groups (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.
- NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability, and quality standards and clinical guidelines on mental health and learning disability.
- The Department of Health will work with the Department of Education (DfE) to introduce a new single assessment process for children and young people with challenging behaviour.
- The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally.
- At a national level, the cross-government Learning Disability Programme Board will lead delivery of the programme of change.
- The NHS Commissioning Board (NHSCB) and Association of Directors of Adult Social Services (ADASS) will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour.

### 2.2 Strengthening accountability and corporate responsibility for quality of care

- Directors, management and leaders of organisations providing NHS or Local Authority-funded services must ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.
- The CQC will take steps to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.
- The Department of Health will immediately examine how corporate bodies, their **Boards of Directors** and financiers can be held to account for the

provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps.

- The Department of Health will assess whether a fit and proper persons test could be introduced for **Board** members.
- **Boards** should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care.

### **2.3 Tightening the regulation and inspection of providers**

- The CQC will use existing powers to seek assurance that providers have regard to national guidance and good practice.
- The CQC will take action to ensure the identified model of care is included as part of inspection and registration of relevant services from 2013.
- The CQC will include reference to the model in their revised guidance about compliance.
- The CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care.

### **2.4 Improving quality and safety**

- The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
- The CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
- The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.
- Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour.
- Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers.
- The Department of Health will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View. In particular:
  - Safeguarding Adults Boards will be put on a statutory footing, subject to parliamentary approval of the Care and Support Bill;
  - 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 Safeguarding Adults Board core membership will consist of the LA, NHS and Police organisations, convened by the LA.
- The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards (DOLS) provisions.
- The Department of Health will update the Mental Health Act Code of Practice.

- The Department of Health will, together with the CQC, consider what further action may be needed to check how providers record and monitor restraint. The Department of Health will publish guidance on best practice on positive behaviour support so that physical restraint is only ever used as a last resort.
- The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and the Association of Directors of Children's Services (ADCS) to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour.
- The Department of Health will work with independent advocacy organisations to:
  - Identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals.
  - Drive up the quality of independent advocacy.

## **2.5 Monitoring and reporting on progress**

- The Department of Health will commission an audit of current services for people with challenging behaviour. The audit will be repeated one year on to assess progress.
- The Department of Health, the Information Centre for Health and Social Care and the NHSCB will develop measures and key performance indicators to support Commissioners in monitoring their progress.
- The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments.

## **3. Conclusion**

Following the publication of the independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board on 7 August 2012, the Learning Disability Business Division conducted a review of their services against the recommendations. The outcomes of the review were presented to the Safeguarding Forum and the Business Division has been engaging with Commissioners to take forward the recommendations.

The Trust will work in partnership with Local Authorities and NHS Commissioners to respond to the key themes and actions contained in the report.

The Learning Disability Business Division will undertake a review of their services against known guidance. The findings of the report will be reported to the February 2013 Clinical Governance Group.

A position statement on the Trust Learning Disability Services together with a systems update will be reported to the March 2013 Board of Directors.

**Deborah Wildgoose**  
**Deputy Director of Nursing**  
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