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To PCT Chief Executives
PCT Cluster Chief Executives
Local Authority Chief Executives
Directors of Adult Social Services
Directors of Children Services

Cc: SHA Chief Executives
SHA LD leads
DRDs for social care

Date: 26 June 2012

Gateway Reference number: 17822

Dear colleague

DH REVIEW - WINTERBOURNE VIEW: INTERIM REPORT

On 25th June 2012 the Department of Health (DH) published an interim report of the review into the events at Winterbourne View hospital. The Minister for Care Services, Paul Burstow, set up the review to establish the facts and bring forward actions to improve care and outcomes of people with learning disabilities or autism and behaviours that challenge. This letter is to highlight action to be taken forward by NHS bodies and local authorities as set out in that report.

Background

The letters of 21 September 2011 (Gateway reference **16651**) and 2 February (Gateway reference **17155)** set out the background to the DH Review following the events at Winterbourne View[1]. The Written Ministerial Statements published on 31st October 2011, 8th December 2011, 21st March and 15th May 2012 provide further details on the different elements of the review.[2]

[1] http://www.dh.gov.uk/health/2011/09/the-week-issue-215/#1pol; http://www.dh.gov.uk/health/2012/02/the-week-issue-233/

[2] http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111208/wmstext/111208m0001.htm#11120856000010
http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111031/wmstext/111031m0001.htm#110311000005
http://www.parliament.uk/documents/commons-vote-office/March_2012/21-03-12/5.Health-Update-on-Winterbourne-View-Hospital.pdf

The interim report does not cover what happened at Winterbourne View itself. There will be a further report on that in the autumn once current criminal proceedings against former staff at the hospital are completed and all the evidence is published in the Serious Case Review being conducted by South Gloucestershire Council.

CQC review

CQC published their national summary report of their focused inspection programme of 150 hospitals and care homes for people with learning disabilities on 25th June. Whilst the inspections did not find abuse on the scale of Winterbourne View, the CQC report highlights concerns about the poor quality of care provided to people with learning disabilities. The report can be found at http://www.cqc.org.uk/public/our-action-winterbourne-view/review-learning-disability-services.

Interim report

The interim report looks at the quality of the health and care support provided to the approximately 15,000 people in England with learning disabilities or autism who have mental health conditions or behaviour which challenges, and the quality of health and care services they receive. It draws on the reports of the Care Quality Commission's focussed inspection of 150 hospitals and care homes for people with learning disabilities, widespread engagement with people with learning disabilities, people with autism, family carers, voluntary groups, health and care commissioners, providers and professionals, as well as the regulators, and other evidence submitted to the review team.

The main findings set out in the interim report are that:

i. there are too many people in in-patient services for assessment and treatment and they are staying there for too long. This model of care has no place in the 21st century.
ii. Best practice is for people to have access to the support and services they need locally to enable them to live fulfilling lives integrated within the community.
iii. In too many services there is robust 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.
iv. All parts of the system– commissioners, providers, workforce, regulators and government – must play their part in driving up standards of care and demonstrating zero tolerance of abuse. This includes acting immediately where poor practice or sub-standard care is suspected.

The key objectives are to:

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http://www.parliament.uk/documents/commons-vote-office/May_2012/15-05-12/5.Health-Update-on-Winterbourne-View-hospital.pdf

- improve commissioning across health and care services for people with behaviour which challenges with the aim of reducing the number of people using inpatient assessment and treatment services;
- clarify roles and responsibilities across the system and support better integration between health and care;
- improve the quality of services to give people with learning disabilities and their families choice and control;
- promote innovation and positive behavioural support and reduce the use of restraint; and
- establish the right information to enable local commissioners to benchmark progress in commissioning services which meet individuals' needs, improve the quality of care, and reduce the numbers of people in in-patient services for assessment and treatment.

The report sets out clear actions at a national level to support local improvement and ensure that we are able to deliver these key objectives.

Local action

The report highlights the importance of health and care working in partnership at both a national and a local level to improve outcomes for people with learning disabilities or autism and behaviour which challenges.

The shared objective is to see the health and care system get to grips with past failings in meeting the needs of this group of people and working together to commission the range of services and support which will enable them to lead fulfilling and safe lives in their communities.

This requires real system leadership across all sectors, including elected councillors as well as across health and care to reduce inequalities for those people with behaviour which challenges.

It is encouraging to see how well many health and care bodies are already working together to respond so positively to the issues raised by the CQC inspections. This needs to continue.

The new health and care system brings a greater opportunity for people to work together more creatively to develop local innovative solutions. Healthwatch and health and well-being boards will ensure that the voice of people with learning disabilities and autism and their families has its proper place within that.

Local action needed

The letter of the 2 February reminded health bodies and local authorities of the minimum action we expect them to take to drive up standards at a local level – in particular:

- to appoint a lead commissioner to coordinate the work of all commissioners of patients/residents for any facility where CQC advise that regulatory action may be taken, to ensure the welfare of the individual residents.
- to ensure that there are effective communication links between commissioners, care coordinators and safeguarding teams in reviewing placements.
- to ensure a clear multi-agency approach to safeguarding is in place so that all commissioners and providers across health and social care within a locality understand how to respond to any safeguarding concerns that have been identified and
- to work together collaboratively across PCTs and emerging Clinical Commissioning Groups and jointly with local authorities to ensure that there are joint strategies for commissioning individualised services for people with learning disabilities or autism and with behaviour which challenges.

The review report also highlights the additional action that would be needed at a local level to implement the best practice model of care that the review sets out for people with learning disabilities and behaviour which challenges.

It includes examples of good practice where the focus is on providing intensive community support as far as possible with only limited use of in-patient services.

Conclusion

People with learning disabilities continue to face real health inequalities and it remains a priority for the NHS to work to improve health outcomes for this excluded group.

The concerns raised by Winterbourne View and the CQC inspections relate to issues that the whole health and social care system needs to consider. No health care and social care system is without risk and we must continue to be vigilant in quickly identifying and dealing with any cases of abuse in all settings.

PCTs and local authorities need to work together to assure themselves that they are continuing to take all action needed to improve outcomes for people with learning disabilities in preparation for the outcomes of the final report into the events at Winterbourne View in the autumn.

Yours sincerely

Sir David Nicholson
Chief Executive of the
NHS Commissioning
Board Authority

David Behan
Director- General
Social Care, Local Government
and Care Partnerships