

Department of Health Review: Interim Report Winterbourne View



Easy Read version

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Background



BBC Panorama programme on 31st May 2011 showed abuse of people with learning disabilities and autism in Winterbourne View hospital.

The hospital has now closed.



The Minister for Care Services, Paul Burstow, asked **Department of Health (DH)** officials for a full review into what happened at Winterbourne View hospital.



This report is called an **interim report**.

It sets out some of the findings from the review so far.



This interim report **does not** cover what happened at Winterbourne View itself.

We will look at this in the final report.



The full review report will be published in the autumn.



It will look at all the evidence from the Serious Case Review by South Gloucestershire Council.

This will be once the court case has finished.

Who is this report about?



The interim report is about people in England with learning disabilities or autism and behaviour which challenges.

There are about 15,000 people.



People with challenging behaviour may at times put themselves or others at risk.

This may prevent them from using ordinary community facilities or having a normal home life.

What does the report cover?

The report covers information the Department has received so far. These include:



1. The **Care Quality Commission's (CQC)** inspection of 150 hospitals and care homes for people with learning disabilities.

The CQC have published a summary report about this.



2. Feedback from:
 - People with learning disabilities
 - People with autism
 - Families
 - Commissioners
 - Providers
 - The workforce



3. Other information from people and organisations.

What are the findings from the review so far?



1. There are too many people with learning disabilities or autism in hospital in **assessment and treatment** and they are staying for too long.

This is not good.



2. People should receive the support and services they need within their local community as far as possible.



3. In many hospitals and care homes CQC found:

- Poor quality of care
- Poor care planning
- Some people were not able to take part in meaningful activities
- Too much use of restraint



4. Things will only change if people and organisations play their role and make the change happen.

This includes:

- Commissioners - the people who buy services
- Providers – the hospitals and care homes
- Workforce – including psychiatrists, nurses and care assistants
- Regulators – like the Care Quality Commission

What needs to happen?

The report sets out the model of care people should get.



1. People should receive personalised services that meet their needs.



2. People should only go to hospital for **assessment and treatment** if it is really necessary and they can't get the help they need where they live.



3. People that do have to go into hospital for assessment and treatment should receive a good quality of care as near to home as possible.



4. People should be moved on as quickly as possible –either back home or on to other support.

What needs to happen locally?

Local health and care services need to:



1. Listen to the voices of people with learning disabilities and their family carers.

This is important when making person-centred plans.



2. Make sure there are good local services in the community that employ people with the right skills to support people with challenging behaviour.



3. Work together across health and social care.



4. Plan early - starting from childhood



5. Provide services that are based in the community.

What needs to happen nationally

National bodies such as the Department of Health and the NHS Commissioning Board need to:



1. Support local bodies in playing their role



2. Measure progress to see whether change is happening



3. They should make sure that everyone knows what their roles and responsibilities are.

Actions



1. The Department and the NHS Commissioning Board will look at how to include Quality of Health Principles in the NHS, using NHS contracts and guidance.



2. We will work with the NHS Commissioning Board Authority and the Association of Director of Adult Social Care to develop a model for commissioning services by March 2013.

3. NICE is developing quality standards on learning disability.



The autism quality guidelines will be published in July. 2012.



4. The NHS Commissioning Board Authority will work with clinical commissioning groups on how to commission good quality services for people with learning disabilities.



5. Healthwatch will make sure that the voices of people with learning disabilities and autism and their families are heard by local services.



6. DH expects the NHS and local authorities to make sure that **personalisation** happens everywhere, including in hospitals.



7. DH expects providers to show they are taking action to prevent abuse and improve the quality of services they provide.



8. The National Quality Board will report in the in the autumn about how the new health and care system will identify and take action to correct quality failures.



9. CQC will consider how they follow up their review of hospitals and care homes for people with learning disabilities

Challenging behaviours: a unified approach

10. The Royal Colleges and the Learning Disabilities Professional Senate will update their guidance -*Challenging Behaviours: A Unified Approach*.



11. The Royal Colleges will work to develop a statement which set out the responsibilities of professionals in supporting people with learning disabilities better.



12. DH will work with the Department for Education and the CQC and other partners to promote use of positive behavioural support and avoid use of restraint except as a last resort.



13. DH will work with the NHS Commissioning Board Authority to get the right information so that commissioners can check how well they are meeting the needs of people with learning disabilities.



14. DH is working with national partners to deliver better outcomes for people with learning disabilities or autism and behaviour which challenges.



The partners we are working with include:

- the National Forum of People with Learning Difficulties
- the National Valuing Families Forum
- the National Autistic Society
- The Challenging Behaviour Foundation
- Mencap



We are also working with other organisations such as:

- the Association of Directors of Adult Social Services
- the Local Government Association
- the Association of Supported Living
- the NHS Confederation
- Royal Colleges and professional bodies
- Skills for Care
- and other organisations.



The Department will publish the final report in the autumn.

We will publish a follow up report one year later to make sure progress has been made.

Difficult words used:

Assessment and treatment unit	<p>An Assessment and Treatment unit is like a small hospital.</p> <p>People who are upset or disturbed and who behave in challenging ways may go there.</p> <p>Sometimes people go to assessment and treatment units when there is a crisis and they are in danger of hurting themselves or other people.</p> <p>People who work there included nurses, doctors, psychologists and therapists.</p> <p>They have special skills in helping to understand a person's problems.</p> <p>They spend time finding out why someone is unhappy, disturbed and challenging and they work with others to find ways of making this better.</p>
NICE	<p>NICE is the National Institute for Health and Clinical Excellence</p>
Personalisation	<p>This means people have choice and control over the health and care they receive.</p>



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