



**Transforming care:
A national response to
Winterbourne View Hospital**

*Department of Health Review:
Final Report*

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Transforming care: A National response to Winterbourne View Hospital

Department of Health Review: Final Report

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Ministerial Foreword

The scandal that unfolded at Winterbourne View is devastating.

Like many, I have felt shock, anger, dismay and deep regret that vulnerable people were able to be treated in such an unacceptable way, and that the serious concerns raised by their families were ignored by the authorities for so long.

This in-depth review, set up in the immediate aftermath of the Panorama programme in May 2011, is about the lessons we must learn and the actions we must take to prevent abuse from happening again.

It is also about promoting a culture and a way of working that actively challenges poor practice and promotes compassionate care across the system.

First and foremost, where serious abuse happens, there should be serious consequences for those responsible.

At Winterbourne View, the staff had committed criminal acts, and six were imprisoned as a result. However, the Serious Case Review showed a wider catalogue of failings at all levels, both from the operating company and across the wider system.

When failure occurs, repercussions should be felt at all levels of an organisation. Through proposed changes to the regulatory framework, we will send a clear message to owners, Directors and Board members: the care and welfare of residents is your active responsibility, so expect to be held to account if abuse or neglect takes place.

Yet Winterbourne View also exposed some wider issues in the care system.

There are far too many people with learning disabilities or autism staying too long in hospital or residential homes, and even though many are receiving good care in these settings, many should not be there and could lead happier lives elsewhere. This practice must end.

We should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment. That is why I am asking councils and clinical commissioning groups to put this right as a matter of urgency.

Equally, we should remember that not everything will be solved through action driven from the centre. Stories of poor care are a betrayal of the thousands of care workers doing extraordinary things to support and improve people's lives.

And while stronger regulation and inspection, quality information and clearer accountability are vital, so too is developing a supportive, open and positive culture in our care system.

I want staff to feel able to speak out when they see poor care taking place as well as getting the training and support they need to deal with the complex and challenging dilemmas they often face.

For me, this is the bigger leadership and cultural challenge that this scandal has exposed – and answering it will mean listening and involving people with learning disabilities and their families more than ever before.

As much as Winterbourne View fills us all with sorrow and anger, it should also fire us up to pursue real change and improvement in the future. It is a national imperative that there is a fundamental culture change so that those with learning disabilities or autism have exactly the same rights as anyone else to the best possible care and support. This Review is a key part of making that happen.

A handwritten signature in black ink, appearing to read 'Norman Lamb', with a horizontal line underneath.

NORMAN LAMB
Minister of State for Care and Support

Joint Foreword

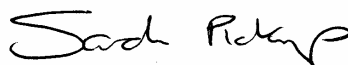
This report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. Our shared objective is to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs, and working together to commission the range of services and support which will enable them to lead fulfilling and safe lives in their communities.

The Concordat which accompanies this report sets out our commitment to work together, with individuals and families, and with the groups which represent them, to deliver real change, improve quality of care and ensure better outcomes. Together we will set the strategic direction and measure progress. This requires real system leadership across all sectors, including elected councillors as well as across health and care to reduce inequalities.

The new health and care system brings a greater opportunity for people to work together more creatively to develop local innovative solutions. We commit to doing this.



Sir David Nicholson KCB CBE
Chief Executive
NHS Commissioning Board



Sarah Pickup
President
**Association of Directors of
Adult Social Services**



Councillor David Rogers
Chair, Community Wellbeing
Board
Local Government Association

Executive summary

1. The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its 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. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.
2. This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.
3. The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.
4. CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years.
5. The review has 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 for the very high cost of places at Winterbourne View and other hospitals.
6. For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.
7. This is the wider scandal that Winterbourne View revealed. We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.

8. Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.
9. The Department of Health review drew on:
 - a criminal investigation with 11 individuals prosecuted and sentenced;
 - the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;
 - the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;
 - an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and
 - the 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.
10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11. This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for 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.
12. The Government's Mandate to the NHS Commissioning Board¹ says:

“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.” (para 4.5)
13. We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:
 - all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
 - by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

¹ <http://www.dh.gov.uk/health/2012/11/nhs-mandate/>

disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at **Annex A**;

- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
 - a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
 - we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
 - 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; and
 - with the improvement team we will monitor and report on progress nationally.
14. A full account of these actions, together with a range of further actions to support improvement of services – including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements – is set out in Parts 4-8. A timeline of the detailed actions is at **Annex B**.
15. Alongside this report, we are publishing a **Concordat** agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.
16. This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can – and should be – done for all.

Part 1: Introduction

- 1.1 This Department of Health review responds to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. It is equally concerned with the care and support experienced by all children, young people and adults with learning disabilities or autism who also have mental health conditions or behave in ways that are often described as challenging. For the purposes of this report, we describe this vulnerable group of people as “people with challenging behaviour”.
- 1.2 There are currently an estimated 3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are in assessment and treatment units (usually known as A&T units)².
- 1.3 This report builds on the evidence and issues set out in the interim report published in June 2012³.
- 1.4 The picture from investigations and reviews, and from people who use services, their families, and the groups which represent them⁴ is of good services in some places, but too often they fall short. Too many people do not receive good quality care. The review found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice⁵, and failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.
- 1.5 Starting now and by June 2014, we must – and we will – transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with challenging behaviour.
- 1.6 This is not easy. Developing the right range of services locally to build up necessary expertise is a complex task – though that will be made easier with pooled budgets. But there is clear – and readily available – guidance and evidence for what works⁶. That guidance has been available for years. There are no excuses for local health and care

² There is poor quality data about the numbers of people with challenging behaviour. In the interim report we focused on the 1,200 beds in A&T units in the CQC Count me in Census 2010. In this report we have used the larger estimate of 3,400 people in NHS funded inpatient beds (from the same census). This is because some people may be in rehabilitation or other types of unit which provide A&T services and we also want to avoid inpatient services simply re-badging themselves.

³ *Department of Health Review: Winterbourne View Hospital: Interim Report Interim Report:* (June 2012)
<http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

⁴ see summaries of engagement with people with learning disabilities and families published alongside this report at www.dh.gov.uk/learningdisabilities

⁵ see *Services for People with Learning disability and challenging behaviour or mental health needs* 2007, Prof Jim Mansell.

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/dh_080129

⁶ see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129
Examples of good practice are published at <http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

commissioners failing to come together to commission and design the services which will enable most people to live safely with support in their communities and prevent unnecessary admissions to hospital. There are no excuses for continuing to commission the wrong model of care.

- 1.7 The programme for change described below draws on actions in the interim report⁷ to which external delivery partners have already committed. A more detailed action plan will be agreed and monitored by the national Learning Disability Programme Board chaired by the Minister of State for Care and Support. The Board will measure progress against milestones, monitor risks to delivery, and challenge partners, to ensure all of these commitments are delivered.
- 1.8 In addition to this monitoring, the Department of Health will publish a progress report in one year, and again as soon as possible following 1 June 2014, to ensure that the steps set out in this report are achieved.

⁷ <http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

Part 2: Winterbourne View hospital

- 2.1 When the interim report of this review was published in June, we were unable to comment on what happened in Winterbourne View hospital as criminal proceedings against former members of staff had not completed. Subsequently, all 11 individuals charged have pleaded guilty to all charges and have been sentenced (with custodial sentences for six former staff). The Crown Prosecution Service treated these offences as disability hate crimes, crimes based on ignorance, prejudice and hate, and brought this aggravating factor to the attention of the court in sentencing.
- 2.2 We now have a very detailed and compelling picture of the serious abuse suffered by patients at Winterbourne View hospital and the systematic way in which staff abused patients and misused restraint as punishment for what staff saw as bad behaviour.
- 2.3 The Serious Case Review (SCR) commissioned by South Gloucestershire Council Adult Safeguarding Board published on 7 August 2012 gives a compelling and comprehensive chronology of events at the hospital and we do not intend to duplicate that here.⁸
- 2.4 But now we have that picture, along with other reports shared as evidence to the SCR including reports from the police, the CQC, and the review by NHS South of England of commissioning of services at Winterbourne View hospital, we are able to draw firm conclusions about what went wrong.
- 2.5 Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients in two separate wards and was registered as a hospital with the stated purpose of providing assessment and treatment and rehabilitation for people with learning disabilities. By the time the hospital was closed in June 2011, the majority of patients (73%) had been admitted to the hospital under Mental Health Act powers. Although thirteen were informal patients at admission, six of these were then detained under Mental Health Act powers after admission. On average, it cost £3,500 per week to place a patient in Winterbourne View.
- 2.6 Forty-eight patients had been referred to Winterbourne View by 14 different English NHS commissioners (there had also been a few placements from Wales); meaning that there was no one commissioner with a lead or strong relationship with the hospital. Similarly, South Gloucestershire Council, in whose area the hospital was located, was not party to the majority of referrals to Winterbourne View hospital.

⁸ South Gloucestershire Safeguarding Adults Board *Winterbourne View Hospital: A Serious Case Review* by Margaret Flynn (2012) <http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx>

- 2.7 This also meant that although a significant minority of patients were local to the hospital **almost half of the patients at Winterbourne View were placed far away from their homes**. Of 48 patients:
- 13 were referred by commissioners located within 20 miles;
 - a further 12 patients were referred by commissioners between 20 and 40 miles away;
 - 14 patients were referred by commissioners between 40 and 120 miles away; and
 - 9 patients were referred by commissioners more than 120 miles away.
- 2.8 For just under half of the people in Winterbourne View, the main reason for referral was management of a crisis – suggesting a real lack of planning for crises or local responsive services for people with this type of support need.
- 2.9 **People were staying at Winterbourne View hospital for lengthy periods**. The average length of stay at Winterbourne View was around 19 months but some patients had been there more than three years when the hospital closed – and this in a hospital which was open for less than five years.
- 2.10 There is little evidence of urgency in considering discharge and move-on plans for Winterbourne View patients. It is worth noting for instance that 10 patients detained under Mental Health Act powers remained in Winterbourne View after their period of detention ended – in one case for a further 18 months.
- 2.11 One of the most striking issues is the **very high number of recorded physical interventions** at Winterbourne View (ie of patients being physically held to prevent danger to themselves or others). The Serious Case Review notes that Castlebeck Care Ltd recorded a total of 558 physical interventions between 2010 and the first quarter of 2011, an average of over 1.2 physical interventions per day. One family provided evidence that their son was restrained 45 times in 5 months, and on one occasion was restrained “on and off” all day. It is very difficult to see how such high numbers of interventions could possibly be seen as normal.
- 2.12 Opportunities to pick up poor quality of care were repeatedly missed by multiple agencies. For instance:
- Winterbourne View patients attended NHS Accident and Emergency services on 78 occasions while Winterbourne View was open but there was no process in place for linking these so that an overall picture emerged;
 - Between January 2008 and May 2011 police were involved in 29 incidents concerning Winterbourne View patients;
 - Between January 2008 and May 2011, 40 safeguarding alerts were made to South Gloucestershire Council but these were treated as separate incidents. 27 were allegations of staff to patient assaults, 10 were patient on patient assaults and three were family related incidents.
- 2.13 The Serious Case Review provides evidence **of poor quality healthcare**, with routine healthcare needs not being attended to – for instance there were widespread dental problems and “most patients were plagued by constipation”. Many patients were being given anti-psychotic and anti-depressant drugs without a consistent prescribing policy.

- 2.14 The Serious Case Review also sets out very clearly that for a substantial portion of the time in which Winterbourne View operated, families and other visitors were not allowed access to the wards or individual patients' bedrooms. This meant there was very little opportunity for outsiders to observe daily living in the hospital and enabled a **closed and punitive culture to develop on the top floor of the hospital**. Patients had limited access to advocacy and complaints were not dealt with.
- 2.15 There is strong and compelling evidence of **real management failure at the hospital**. The Serious Case Review says that on paper Castlebeck's policies, procedures, operational practices and clinical governance were impressive. The reality was very different:
- for much of the period in which Winterbourne View operated, there was **no Registered Manager** (even though that is a registration requirement);
 - approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital;
 - there is little evidence of staff training in anything other than in restraint practices;
 - although structurally a learning disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses; and
 - there was very high staff turnover and sickness absence among the staff employed at the hospital.
- 2.16 All this suggests **that managers at the hospital and the parent company, as well as commissioners, regulators and adult safeguarding, had a number of opportunities to pick up indications that there were real problems at Winterbourne View, but failed to do so**.
- 2.17 The very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff – all could have been followed up by the **hospital itself or by Castlebeck Care Ltd**, but were not to any meaningful extent. This failure by the provider to focus on clinical governance or key quality markers is striking, and a sign of an unacceptable breakdown in management and oversight within the company.
- 2.18 Equally it is striking that **adult safeguarding** systems failed to link together the information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts – some commissioners were aware of concerns – and failures to follow up concerns when commissioners became aware of them.
- 2.19 Despite the high cost of places at Winterbourne View (on average £3,500 per week) **commissioners** do not seem to have focused much on quality, or on monitoring how the hospital was providing services in line with its registered purpose – ie. assessing the needs of individuals and promoting their rehabilitation back home. The lack of any substantial evidence that people had meaningful activity to do in the day, the way in which access by outsiders to wards was restricted, reports of safeguarding alerts (where

these were shared with commissioners) should have been followed up rigorously, but were not. **This amounts to a serious failure of commissioning.**

- 2.20 The **CQC** acknowledged that they did not respond to the Winterbourne View hospital whistleblower and that neither they nor their predecessor organisations followed up on the outcomes of statutory notifications – and clearly failed to enforce the requirement for there to be a registered manager.
- 2.21 The **Mental Health Act Commissioner** was notified on more than one occasion of incidents, and in its annual report in May 2008 referenced the need for action to improve – but it was not followed up.
- 2.22 The **Police** have acknowledged that they took explanations from staff at face value. Avon and Somerset Constabulary police were involved in 29 incidents concerning Winterbourne View patients. Eight of the reported incidents were associated with staff using physical restraint on patients. The Police secured the successful prosecution of one member of staff prior to the Panorama programme.

What happened to people at Winterbourne View

- 2.23 Patients at Winterbourne View hospital were subject to horrific and sustained abuse, ill-treatment and neglect. The Serious Case Review has thrown down a challenge to health and social care commissioners to ensure that the individual patients and their families get the support they need to recover from their experience. The Department of Health supports that challenge.

Out of Sight: Stopping the abuse of people with a learning disability provides an update on what happened to Simon, one of the patients at Winterbourne View.

Simon's Mum said:

Simon is now back living near us, and he is loving every minute of his life. He is at the same residential care home he was in before he was sent away, but the service has been adapted so that it meets his needs. They have done this by developing a flat for him adjoining the care home, where he lives with his support team. It is his own space, an oasis of quiet and calm.'

Simon's package of care now costs about half as much as it did for him to be in Winterbourne View. The staff he has now have been wonderful and are truly dedicated. I know that not only is Simon happy, he is safe."

- 2.24 But we know that not every one who was at Winterbourne View has had the same experience as Simon. Indeed, the second Panorama programme broadcast on 29 October 2012 showed that some others who had suffered abuse have continued to be moved to hospitals far from home.
- 2.25 DH asked NHS South of England to coordinate follow up on what happened to the 48 English NHS patients who had been in Winterbourne View hospital. In March 2012:
- 26 former patients had moved into a range of social care supported arrangements and 22 patients were in various inpatient facilities;
 - 19 had been subject to a safeguarding alert in their new location;

- 27 people had required support related to the trauma experienced at Winterbourne View hospital.
- 2.26 This exercise was repeated in September 2012. At that point:
- Additional hospital discharges had taken place with 32 former patients in a range of social care settings and 16 patients in inpatient setting.
 - there were initial safeguarding alerts or active safeguarding procedures for six people at the time of the exercise.
- 2.27 Whilst one cannot generalise from such a small group of patients, the fact that two thirds of those in Winterbourne View are now in social care supported arrangements gives a strong indication of what is possible.
- 2.28 DH will continue to seek assurance about what has happened to this group of people.

Part 3: The picture beyond Winterbourne View

- 3.1 The events at Winterbourne View triggered a wider review of care across England for people with challenging behaviour. This included a programme of CQC inspections of nearly 150 learning disability services⁹ together with engagement by the Department of Health to seek the experiences and views of people with learning disabilities and people with autism – some of whom had experienced care in hospital settings – as well as families, organisations who represent the interests of this group of people, professionals and providers.
- 3.2 The interim report of the Department of Health review published in June 2012¹⁰ set out the findings:
- too many people were placed in hospitals for assessment and treatment and staying there for too long;
 - they were experiencing a model of care which went against published Government guidance that people should have access to the support and services they need locally, near to family and friends;
 - there was widespread poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people; and
 - all parts of the system have a part to play in driving up standards.
- 3.3 The interim report identified concerns about the quality of person centred planning, involvement of people and families in developing their care plan, and in ensuring personalised care and support.
- 3.4 In addition, the interim report summarised published good practice guidance including the 1993 Mansell report, updated and revised in 2007¹¹, which emphasise:
- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
 - a focus on personalisation and prevention in social care;
 - that commissioners should ensure services can deliver a high level of support and care to people with complex needs or challenging behaviour; and
 - that services/support should be provided locally where possible.

⁹ The summary CQC report was published in June 2012. <http://www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services>

¹⁰ <http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

¹¹ *Services for people with learning disabilities and challenging behaviour or mental health needs* October 2007, Professor Jim Mansell – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

- 3.5 Three examples of good practice – Salford, Tower Hamlets and Cambridgeshire – were published alongside the interim report.¹²
- 3.6 As a first step to driving redesign, the interim report set out the model of care which practice demonstrates will give the best quality of life and support and improve outcomes. This is summarised in here and set out in detail at **Annex A**.
- 3.7 In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings¹³. Best practice is for children, young people and adults to live in small local community-based settings.
- 3.8 Where children, young people and adults need specialist support the default position should be to put this support into the person's home through specialist community teams and services, including crisis support.
- the individual and her/his family must be at the centre of all support - services designed around them and with their involvement, highly individualised and person-centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
 - people's homes should be in the community, supported by local services;
 - people need holistic care throughout their life, starting in childhood;
 - when someone needs additional support it should be provided as locally as possible; and
 - when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.
- 3.9 This means that people with challenging behaviour should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making. Where an individual lacks capacity and does not have a family to support them, the procedures of the Mental Capacity Act 2005 should be followed to ensure that decisions made are in her/his best interest and, if appropriate, an Independent Mental Capacity Advocate appointed.
- 3.10 Where someone is admitted to hospital the priority from the start should be rehabilitation and returning home. This requires a strong and continuing relationship between local commissioners and service providers and the hospital, focused on the individual patient's care plan, and a real effort to maintain links with their family and the home community. It also means for example, maintaining the person's tenancy of their home where relevant unless and until a more appropriate home in the community is found. Most of all, it is vital that families are involved in decision-making.

¹² <http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

¹³ NICE clinical guidelines for autism recommend that if residential care is needed for adults with autism it should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation).

- 3.11 Sending people out of area into hospital or large residential settings can cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community. It can damage continuity of care. It can also mean putting people into settings which they find stressful or frightening. This can damage mental health or increase the likelihood of challenging behaviour. There should always be clear and compelling reasons for sending any individual out of area. The individual and their family should always be involved and told these reasons. When this does happen, commissioners and the community team from the home area must keep in close contact with the individual and their family as well as the commissioner for the area where the individual is placed to assess progress and plan for their return to their own community.

Good Practice

The **Association of Supported Living** members contributed to a study on good commissioning in which they describe the ingredients to the successful outcomes they had achieved in moving people who at some point have been contained in institutions. Now everyone has a better life in community services which cost less. Prior to changes, costs ranged from £91,000 to £520,000 (for a private secure unit) per annum, following a move to supported living, high end costs reduced from £520,000 to £104,000 per annum.

- 3.12 The Government's Mandate to the NHS Commissioning Board makes clear that the presumption should always be that services are local and that people remain in their communities.
- 3.13 This model is achievable. It has been tried and tested and it works. The good practice examples published alongside the Interim Report are community-based and multidisciplinary. They can respond when someone presents with challenging behaviour, responding to that individual, their family, and care and support providers to seek explanations for the behaviour. That enables services working in partnership to develop interventions and support based on an understanding of the individual and their environment. Multidisciplinary approaches are essential because of the complexity of need and the way in which different perspectives contribute to agreeing appropriate interventions.

Part 4: The right care in the right place

- 4.1 A central part of our plan for action is to ensure that people with challenging behaviour only go into hospital if hospital care is genuinely the best option, and only stay in hospital for as long as it remains the best option. Our plan requires health and care partners to:
- a. review all current placements, and support everyone inappropriately in hospital to move to community-based support;
 - b. in parallel, put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accord with the right model of care from childhood onwards; and
 - c. give national leadership and support for local change.
- 4.2 The patients at Winterbourne View were not listened to or believed when they told people about abuse. Their families were often not involved in decisions about where they were sent, parents and siblings found it increasingly difficult to visit and families' concerns and complaints often were not acted on. This failure to listen to people with challenging behaviour and their families is sadly a common experience and totally unacceptable. It leaves people feeling powerless.
- 4.3 We expect all actions in this programme to be appropriately informed by the views and needs of people with challenging behaviour and families in line with the NHS Constitution – which can mean providing appropriate advice, information and support. This will happen at all levels, locally and nationally:
- people with learning disabilities and families will be members of the Learning Disability Programme Board;
 - CQC will involve self-advocates and families in inspections and in their stakeholder group;
 - the NHSCB, LGA, and ADASS will involve them in planning and supporting changes in the way care is developed.
- 4.4 Changing attitudes to people with challenging behaviour is vital. Tackling disability hate crime is an issue the Department of Health takes very seriously. The Department is already taking steps to improve its understanding of disability hate crime and to deliver better outcomes for patients including those with learning disabilities.

4.a REVIEW ALL CURRENT PLACEMENTS AND SUPPORT EVERYONE INAPPROPRIATELY IN HOSPITAL TO MOVE TO COMMUNITY BASED SUPPORT

- 4.5 By 1 June 2014 we expect to see a rapid reduction in the number of people with challenging behaviour in hospitals or in large scale residential care - particularly those away from their home area. By that date, no-one should be inappropriately living in a hospital setting. This is a three stage process which involves:
- commissioners making sure they know who is in hospital and who is responsible for them;
 - health and care commissioners working together and with partners to review the care people are receiving;
 - commissioners working with individuals to agree personal care plans and bringing home or to appropriate community settings all those in hospital¹⁴.
- 4.6 DH will closely monitor progress in bringing these numbers down. The Government's Mandate to the NHSCB emphasises the expectation for a substantial reduction in reliance on inpatient care for these groups of people.
- 4.7 Progress in this area will be dependent on developing the range of responsive local services which can prevent admissions to hospital or other large institutional settings and allow any existing patients to be moved to better settings, closer to home. This may involve better use of existing Mental Health services with the right reasonable adjustments, or the commissioning of new, smaller and more local inpatient units where they are needed. But the emphasis should be on designing community services in line with the best practice model. We would expect to see a dramatic and sustained reduction in the number of assessment and treatment units and beds as a result of this shift.

Agreeing who should be reviewed and who is responsible for them

- 4.8 Commissioners need to make sure they know who is in hospital and who is responsible for them.

Key Actions:

The NHS Commissioning Board will:

- ensure by 1 April 2013 that all Primary Care Trusts develop local registers of all people with challenging behaviour in NHS-funded care;
- make clear to Clinical Commissioning Groups 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, including identifying who should be the first point of contact for each individual.

¹⁴ For a very small number of people with complex needs, this can be a lengthy process. However, we expect this process to be carried out as quickly as possible. If, by this time, there are a very small number of cases where plans are agreed but not yet fully implemented, progress will be closely monitored.

Reviewing care and agreeing personal care plans

- 4.9 People should have the right care and support package to meet their individual needs. The care plans of all inpatients with challenging behaviour will be reviewed individually. Commissioners will assess whether they can create a better, community-based support package tailored as far as possible to each individual's needs.
- 4.10 People with challenging behaviours and their families will have the support they need to ensure they can take an active part in these reviews - being provided with information, advice and independent advocacy, including peer advocacy.
- 4.11 Personal care plans should be enacted swiftly and safely. In many instances this will require the development of more personalised services in different settings so that individuals can be better supported at home or in the community. Although doing this can take time, the Department of Health expects it to be carried out with pace and a sense of urgency – whilst always putting the interest of the individual first.
- 4.12 Where responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement.

Key Actions

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

Plans should be put into action as soon as possible, and all individuals should be receiving personalised care and support in the appropriate community settings no later than 1 June 2014.

4b. LOCALLY AGREED PLANS TO ENSURE HIGH QUALITY CARE AND SUPPORT SERVICES WHICH ACCORD WITH THE MODEL OF GOOD CARE

- 4.13 In parallel with the actions for people currently in hospital, every local area will put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.

Commissioning the right model of care and challenging poor practice

- 4.14 We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves:
- better joint working between health and care; and
 - using the evidence on good practice.
- 4.15 Health and care commissioners are accountable for commissioning services to meet identified needs. It is essential that they work together to develop specific plans for improving health and care services for this particular group of people. This goes wider than health and adult social care; in particular, a strategic plan must also include children's services and specialist housing.

Gloucestershire County Council and NHS Gloucestershire have a (joint) strategic commissioning plan which includes bringing people back into the county. *“For at least two years we have had a joint LA & NHS Learning Disability commissioning team (Gloucestershire CC and NHS Gloucestershire). We work from a common plan and as lead commissioner I head up the team of 8 people. We have commissioners from both health and social care. Health team members are directly engaged with complex people including people 100% funded by health and both LA and NHS colleagues work with people placed out of county”.*

Referrals for anyone needing additional assessment or treatment also go through this team to a specialist Learning Disability NHS service whose aim is to prevent admission for assessment and treatment. Social care commissioning colleagues in the team also access the NHS A&T service this way. This also means that if anyone's current services need additional resources to avoid breakdown, before the resources are allocated, the specialist NHS Learning Disability service would ensure this is necessary and value for money.

- 4.16 Local health and care commissioners and services should be commissioning integrated care – care co-ordinated and personalised around the needs of individuals with a presumption that care should be local and that people should stay in their communities. This is more likely to happen if:
- Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) take account of the health and care needs of people with challenging behaviour; and
 - health and care commissioners pool budgets.
- 4.17 Pooled budgets with shared accountabilities are likely to facilitate the development of more integrated care. They may help overcome the lack of strong financial incentives on a single commissioner to invest in community services (eg where the cost of investment in supported living in local communities falls to councils while savings from reduced reliance on hospital services go to NHS commissioners). There should be a clear presumption that budgets should be pooled and that health and wellbeing boards should promote collaborative working and the use of pooled budgets.
- 4.18 Commissioners need to work with providers of specialist services to ensure that community learning disability teams have the additional, intensive support they need to keep people out of hospital – including in crises. They will also need to have access to local inpatient mental health services where these are genuinely required. This will reduce the need for hospital admissions out of area.
- 4.19 Finally, there is consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. It is our clear expectation that commissioners should not place people in large hospitals. There may be a few people who need inpatient care, but this should be provided in smaller units and as close to home as possible. Any new, small specialist hospitals should only be built where JSNAs show a genuine unmet local need for such provision in a way which is consistent with good models of care. Local commissioners should have oversight of the services available in their areas and take the lead in discussing future need and what additional facilities are required. In addition, CQC will take account of the model of care in its revised guidance about compliance and in the registration and inspection of providers, as part of its new regulatory model.

Key Actions:

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 could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.

The strong presumption will be in favour of 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.

Evidence on best practice

- 4.20 Commissioning needs to draw on the evidence of what is best practice in the care of people with challenging behaviour. The Model of Care set out in this report is based on well established evidence. To strengthen the evidence base, NICE is developing further standards and guidelines for this group of people, to go alongside the standards already published on autism clinical pathways.

Key Actions:

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.

- 4.21 NICE will also develop new quality standards on child maltreatment. They will focus on the recognition and response to concerns about abuse and neglect and effective interventions. These will support the use of the Government's statutory guidance, *Working Together to Safeguard Children*.¹⁵

Prioritising children and young people's services

- 4.22 Children and young people with challenging behaviour can face particular difficulties and crises as they move from child to adult services. Integrating care and support around their needs and ensuring that they have access to the services identified in their agreed care plan is vital.
- 4.23 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. This means:
- integrated planning around the needs of individual children; and
 - identifying best outcomes and measuring progress.
- 4.24 Local health and care commissioners need to plan strategically to develop local services that properly meet the needs of children and young people in the area where they live.

Good practice:

Ealing services for children with additional needs set up "The Intensive Therapeutic & Short Break Service (ITSBS). The service provides a viable model for significantly reducing challenging behaviour and securing home placement stability for a small but significant number of children and young people whose challenging behaviour would otherwise most likely result in a

¹⁵ <https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf>

move to residential placements. Residential placement was avoided for all five young people who had been offered the service between 2008 and 2010. Residential placement has also been avoided for six out of the seven young people who were first offered the service between 2010 and 2011.

Key Actions:

The Department of Health will work with the Department of Education (DfE) to introduce from 2014 a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.

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

4.25 Children and young people and their families need to be involved in this work.

4c. NATIONAL LEADERSHIP SUPPORTING LOCAL CHANGE

- 4.26 While changes to people's lives require action at a local level, with local commissioners and providers working together, change of this scale, ambition and pace requires **national leadership**. To provide leadership and support to the transformation of services locally, the LGA and the NHSCB will develop an improvement programme led by a senior sector manager. This will be in addition to the cross-government programme board.

Key Actions:

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. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this 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, regularly publishing updates.

- 4.27 Social care and health commissioners will be accountable to local populations and will be expected to demonstrate that they have involved users of care and their families in planning and commissioning appropriate local services to meet the needs of people with challenging behaviour. Families and self advocates have an important role to play in challenging local agencies to ensure that people have local services and the optimum model of care. There is a clear need both to challenge localities for failing to redesign services, and to provide practical support to help them do so.

Good Practice

There are many examples of good local practice in this area.

In **Salford**, in the last 5 years 16 people with a learning disability and behaviour that challenges living out of area have returned to their communities.

Beyond Limits have been commissioned by NHS Plymouth (now Devon CCG) to develop local personalised commissioning/provider processes and tailor-made services for people who have experienced long term, multiple placements and institutionalised living because their behaviours have challenged existing services. They are piloting this through facilitating planning for 20 people currently in out of area Specialist Assessment & Treatment Units and then providing support using personal Health Budgets.

- 4.28 Providers have a key role to play in redesigning service, working closely with commissioners, people who use services and families. The national market development forum within the Think Local Act Personal (TLAP) partnership will work with DH to identify barriers to reducing the need for specialist hospitals and by April 2013 will publish solutions for providing effective local services.
- 4.29 The Developing Care Markets for Quality and Choice programme will support local authorities to identify local needs for care services and produce market position statements, including for learning disability services.
- 4.30 The NHSCB will also work with ADASS to develop by April 2013 practical resources for commissioners of services for people with learning disabilities,¹⁶ including:
- model service specifications;
 - new NHS contract schedules for specialist learning disability services;
 - models for rewarding best practice through the NHS Commissioning for Quality and Innovation (CQUIN) framework; and
 - a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.

Key Action:

By March 2013 the NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A.

- 4.31 DH will ensure health and wellbeing boards have guidance and information to support them to understand the complex needs of people with challenging behaviour.

¹⁶ This will build on the guidance published in October 2012, *Improving the health and wellbeing of people with learning disabilities: an evidence-based commissioning guide for clinical commissioning groups*.
[http://www.improvinghealthandlives.org.uk/publications/1134/Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups](http://www.improvinghealthandlives.org.uk/publications/1134/Improving%20the%20Health%20and%20Wellbeing%20of%20People%20with%20Learning%20Disabilities%20-%20An%20Evidence-Based%20Commissioning%20Guide%20for%20Clinical%20Commissioning%20Groups)

Part 5: Strengthening accountability and corporate responsibility for quality of care

- 5.1 Although 11 former members of staff at Winterbourne View have been sentenced in connection with the abuse of patients, this review has identified weaknesses in the system of accountability where leaders of organisations are not fully held to account for poor quality or for creating a culture where neglect and even abuse can happen.

Quality of care

- 5.2 **The primary responsibility for the quality of care rests with the providers of that care. Owners, Boards of Directors and Senior managers of organisations which provide care must take responsibility for ensuring the quality and safety of their services.** The requirements set out in law include:
- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
 - providing appropriate training for staff on how to support people with challenging behaviour;
 - providing good management and right supervision;
 - providing leadership in developing the right values and cultures in the organisation;
 - having good governance systems in place; and
 - providing good information to support people making choices about care and support, including the views of people who use services about their experience.
- 5.3 We also expect boards to demonstrate good practice and comply with further legal requirements, which include:
- 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 to themselves, service users, families, local Healthwatch and the public that essential requirements are being met and that they deliver high quality and appropriate care;
 - the Boards of care providers should understand the quality of the care and support services they deliver; and
 - organisations must identify a senior manager or, where appropriate a Director, to ensure that the organisation pays proper regard to quality, safety, and clinical governance for that organisation.

Key Action:

We expect Directors, management and leaders of organisations providing NHS or local authority-funded services to 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.

Sanctions to hold Boards to account when the quality of care is unacceptable:

- 5.4 There must be robust consequences for senior managers or Boards of Directors of services where through neglect the organisations they lead provide poor quality of care or where people experience neglect or abuse.

CQC's enforcement powers

- 5.5 CQC will take steps to strengthen the way it uses its existing powers to hold organisations to account for failure to meet legal obligations to service users. CQC registers providers at an organisational level. However, its inspections take place at the level at which services are delivered. As a result CQC has not always held organisations to account at a corporate level, but rather at the level of the regulated service. This needs to be addressed.
- 5.6 While most organisations providing care put in place governance arrangements that support safety and quality, some do not pay sufficient attention to this area. Where the leadership of an organisation allows a culture to develop that does not foster safety and quality in care, the people providing that leadership have to be held to account for the service failings. In the words of the serious case review, "Castlebeck Ltd's appreciation of events... was limited, not least because they took the financial rewards without any apparent accountability."
- 5.7 This is an unacceptable situation and must change. CQC already has powers to take action:
- CQC is able to take tough enforcement action against organisations that do not meet the registration requirements, including stopping them from providing specific services or operating from specific locations. In the most extreme cases CQC can cancel a provider's registration, stopping it from providing any health or adult social care;
 - it is already an offence under the Health and Social Care Act 2008 not to meet the essential levels of safety and quality. This would include, for example, not making suitable arrangements to ensure that service users are safeguarded against the risk of abuse. As well as prosecuting the corporate provider for a failure to meet the registration requirements, CQC can prosecute individual directors or managers where the offence can be proven to have been committed by, or with the consent or connivance of, or attributable to any neglect on the part of that individual.
- 5.8 It is important that CQC makes full use of its existing powers to hold the corporate body to account. CQC will meet with executives of provider organisations when there are serious concerns about quality and safety issues to discuss their plans to deliver safe

and effective care. Since summer 2012, CQC has appointed corporate compliance managers to assess the quality and safety of care of large providers who operate across a large area.

Key Action:

CQC will take steps now 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.

Fit and proper person test

- 5.9 CQC will also consider whether it is able to use its existing powers to carry out a fit and proper person test of Board members as part of the registration of providers. One option for this could be to require providers to nominate an individual Board member with responsibility for quality who would be accountable to CQC for the quality of care. If this person did not meet the fit and proper person test, CQC could insist that another Board member is nominated. CQC could not use its existing powers to bar an individual from being a member of the Board, since Directors are not required to register with CQC.
- 5.10 DH will explore how a stronger fit and proper person test for board members of health and social care providers can be introduced to make it comparable to fit persons' tests in other sectors. This will include looking at:
- the tests applied by the Financial Services Authority, the Premier League and the Charity Commission, which look at an individual's past performance with regards to other regulatory systems;
 - prior involvement with other companies which may have had their licences revoked, withdrawn or terminated; and
 - if they or any business associated with them, has been suspended or criticised by a regulatory or professional body. Where individuals fail to meet these tests, regulators can deem them to be unsuitable to hold certain positions and organisations face regulatory action or risk being refused registration, where such persons are appointed. DH will examine if a similar approach could be applied to board members of health and social care providers.

Holding corporate bodies to account for poor care

- 5.11 There can be no excuse for Directors or managers allowing bullying or the sort of abusive culture seen in Winterbourne View. Individuals should not profit from others' misery.
- 5.12 DH will examine how corporate bodies, their Boards of Directors and financiers can currently be held to account under law for the provision of poor care and the harm experienced by people using those services.
- 5.13 There are a number of potential criminal offences for which a Board Director or Manager could be prosecuted:

- there are offences under general criminal law. For example, in cases where it is proved that an individual board member or manager has committed an offence against a person or aided and abetted the commission of any offence (such as an assault), then such individuals could also be prosecuted in accordance with general criminal law;
- organisations can be prosecuted for offences under the Corporate Manslaughter and Corporate Homicide Act 2007 if the service provider's organisation is managed in such a way that it caused a person's death. The track record of prosecution in such cases – despite new legislation being introduced expressly to address corporate failure – is thin.

Key Action:

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.

We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.

Developing leadership in Boards

- 5.14 Boards should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care. DH will explore with the National Skills Academy and the NHS Leadership Academy options to develop proposals on Board leadership development by March 2013.

Part 6: Tightening the regulation and inspection of providers

6.1 What happened at Winterbourne View raised profound questions about how regulation and inspection was working. As a result of Winterbourne View, and learning from their programme of inspecting nearly 150 learning disability hospitals, CQC is seeking to improve the way it regulates and inspects providers. In particular, CQC is committed to delivering on the recommendations set out in their Internal Management Review¹⁷, the findings of the Serious Case Review, the evaluation of their inspection of nearly 150 learning disability services¹⁸, and any relevant matters from the consultation on their strategy for 2013-16¹⁹ to ensure that its regulation of providers is robust.

6.2 This means:

- checking how services fit with national guidance;
- improving inspection; and
- improving information sharing.

6.3 Providers are already required to have regard to national guidance, as one of the requirements of regulation monitored by CQC. The model of care at Annex A sets out an agreed framework for best practice in this area. CQC will take action to ensure this model of care is considered as part of inspection and registration of relevant services in their new regulatory model which will be implemented in 2013. CQC will also include reference to the model of care in their revised guidance about compliance, which will also be published in 2013. Where services are not provided in line with this model of care, CQC will seek assurance that the provider's approach still delivers care in line with national guidance and legal requirements.

Key Action:

CQC will use existing powers to seek assurance that providers have regard to national guidance and the good practice set out in the model of care at Annex A.

6.4 In addition, CQC will:

- share the information, data and details they have about prospective providers with the relevant CCGs and local authorities through their existing arrangements, who will, in turn, take account of the information and data shared by CQC when making decisions to commission care from the proposed service provider;

¹⁷ CQC Internal Management Review of the regulation of Winterbourne View (October 2011)
http://www.cqc.org.uk/sites/default/files/media/documents/20120730_wv_imr_final_report.pdf

¹⁸ CQC Review of Learning Disability Services (June 2012)
http://www.cqc.org.uk/search/apachesolr_search/evaluation%20of%20learning%20disability%20services

¹⁹ CQC, The next phase: Our consultation on our strategy for 2013 to 2016
http://www.cqc.org.uk/sites/default/files/media/documents/cqc_strategy_consultation_2013-2016_tagged.pdf

- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;
- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, particularly in relation to length of stay and to whether treatment is being offered. Where it is not, CQC will take the necessary action (including, if necessary, enforcement action) to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place;
- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place. Evidence of effective recruitment can include a provider showing it has requested criminal records checks for eligible employees (including any staff who regularly provide care or treatment) alongside checking references and qualifications. Where a provider has not requested criminal records checks on eligible employees, it will have to assure CQC that its recruitment procedures are still effective and that it can be evidenced that it is reasonable for the check not to have been made. Providers also commit an offence if they knowingly engage a person who is barred in activities such as providing healthcare or personal care. From 2014 the government will commence an explicit duty to check that a person is not barred before engaging them in these activities;
- continue to run the stakeholder group that helped to shape the inspection of 150 learning disability services. It will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;
- continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team;
- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups (subject to the outcome of consultation on its new strategy);
- review, as part of its new strategy, the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act which include wide powers to review the way in which the Act's functions and safeguards are working and investigating complaints by any person detained under the Act.

Key Actions:

CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.

CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to the registration process in respect of models of care for learning disability services in 2013.

- 6.5 From 2013 arrangements for checking criminal records will become quicker and simpler with the introduction of a new service that will make criminal records certificates more portable. When the new service is running, the Department of Health will review the regulatory requirements about criminal records checks and consider whether providers should routinely request a criminal record certificate on recruitment.
- 6.6 Monitor will begin licensing non-foundation trust providers of NHS funded services from April 2014. Monitor will consider strengthening Board-level governance by including internal reporting requirements in the licensing conditions. This is in line with the recommendations from the Serious Case Review. Monitor and CQC are required to co-operate with each other and share information.
- 6.7 In its recent consultation document on licence conditions, Monitor proposed two requirements for providers to meet before they could obtain a licence:
- a requirement for them to hold CQC registration; and
 - to confirm that their governors and directors, or equivalent people, are fit and proper persons.
- 6.8 The proposal is that these requirements would also appear in the licence conditions, making them on-going obligations which providers would have to continue to meet in order to continue to hold a licence. Monitor and CQC will be under a legal duty to seek to ensure that the conditions are consistent.
- 6.9 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 from June 2013. This approach, which is currently being piloted, will focus on the effectiveness of local authority and partners' services for children who may be at risk of harm, including the effectiveness of early identification and early help. The inspectorates intend to publish the arrangements for the inspections by April 2013.

6.10 Ofsted is responsible for inspecting children's homes, as well as boarding and residential provision in schools. Under new inspection frameworks published in September 2012 they will make judgements on the overall effectiveness, outcomes for children and young people, quality of care, safeguarding as well as leadership and management. Under the framework inspectors are expected to consider residents views on the service, to observe interactions between staff and children and young people and to obtain the views of relevant parties including social workers and the authorities responsible for placements.

Part 7: Improving quality and safety

- 7.1 Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective will tackle many of the systemic problems revealed by Winterbourne View. However, the Serious Case Review and the other evidence we have received make it clear that the programme of change must go wider.
- 7.2 The actions we have described so far are primarily for the Department of Health, commissioners and regulators to lead. However, this wider programme lays much greater weight on the responsibility of providers, professional bodies and others to lead. It covers:
- making best practice normal;
 - improving the capacity of the workforce;
 - whistleblowing;
 - the Mental Health Act and Mental Capacity Act;
 - physical restraint;
 - medication; and
 - improving advocacy.

Making best practice normal

- 7.3 The fundamental responsibility for providing good quality care rests with providers. Representatives of provider organisations fully accept this. They have agreed to work together to develop options for improving quality, including bringing forward a pledge or code model based on shared principles along the lines of the TLAP Making it Real principles for learning disability providers.
- 7.4 Providers should involve people with learning disabilities and people with autism and their families in checking the quality of services.

Good Practice

Dimensions is a large social care provider that has made stringent efforts to monitor and improve quality and performance. It made a conscious decision to create a Compliance audit team separate from the operational management of services, believing that this tension would enable more objective and rigorous monitoring. The Dimensions Compliance team, together with a team of four Experts by Experience, work across each of the organisation's regions conducting service audits. The audits look at every aspect of the service from regulatory requirements, finance, health and safety and for evidence of better practice, including a two hour observation of staff interacting with the people they are supporting as well as on-going observation throughout the visit. The audit process gives a clear picture of what is happening in individual services and across the organisation, and forms part of the reporting of risk management up through its governance

structure, including the people it supports. The new systems are contributing to significant advances in quality and improved outcomes. Dimensions' intention is to promote best practice, ensure that it exceeds compliance requirements and demonstrate robust and rigorous processes of internal scrutiny in line with its vision and values.

- 7.5 Good practice guidance for the care of adults is well established²⁰. And there will be new statutory guidance in relation to children in long-term residential care.

Key Action:

The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care (s85 and s86 of the Children Act 1989) in 2013.

Improving the capability of the workforce

- 7.6 Recruiting, training and managing the workforce is the responsibility of providers. The events at Winterbourne View highlighted that there are too many front-line staff who have not had the right training and support to enable them to care properly for people with challenging behaviour. This is a theme which has been reinforced by many of the families we have heard from.
- 7.7 It is crucial that staff who work with people with challenging behaviour are properly trained in essential skills. CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. Better skills and training are an important part of raising standards overall and we expect providers to ensure the people they employ are properly trained. However, the Department of Health, commissioners and other organisations will play an important role in setting expectations, creating standards and offering advice.
- 7.8 We expect commissioners to assure themselves that providers are meeting proper training standards. Contracts with learning disability and autism hospitals should be dependent on assurances that staff are signed up to the proposed Code of Conduct which the Department of Health has commissioned from Skills for Health and Skills for care, and minimum induction and training standards for unregistered health and social care assistants are being met.
- 7.9 From April 2013 Health Education England (HEE) will have a duty to ensure we have an education and training system fit to supply a highly trained and high quality workforce. HEE will work with the Department of Health, providers, clinical leaders, and other partners to improve the skills and capability of the workforce to respond to the needs of people with challenging behaviour and will examine ways to ensure that skills include knowing when and how to raise concerns, (in other words 'whistleblow') including on disability hate crime.

²⁰ see *Services for People with Learning Disability and challenging behaviour or mental health needs 2007*, Prof. Jim Mansell, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

- 7.10 HEE will expect that all new entrants are tested for their values and interpersonal skills, and will reach out into schools and colleges to ensure that young people with the right values consider a career in healthcare. HEE will ensure the values set out in the NHS Constitution lie at the heart of all it does.
- 7.11 It is crucial that staff who work with people with challenging behaviour should be properly trained in essential skills. HEE are committed to ensuring that non-professional members of the workforce (ie bands 1-4) receive continuing development and training to provide a skilled and highly motivated workforce.
- 7.12 It is not sufficient to have a well-trained workforce. There also needs to be good clinical and managerial leadership. The National Skills Academy for Social Care, on behalf of the Department of Health, published a Leadership Qualities Framework for Adult Social Care in October 2012. This builds on the principle that leaders that demonstrate the right values and behaviours at every level of the sector provide the best foundation for transforming social care.
- 7.13 There will be concerted effort across the system over the next year to ensure health and care professionals understand and are guided in achieving minimum standards, and aspire to best practice.

Key Actions

CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.

By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach*²¹ to support clinicians in community learning disability teams to deliver actions that provide better integrated services.

By April 2013 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 by February 2013 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 by January 2013 national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.

²¹ The Royal College of Psychiatrists and British Psychological Society and Royal College of Speech and Language Therapists: *A Unified Approach* (2007)

By end 2013 there will be a progress report on actions to implement the recommendations in *Strengthening the Commitment*, the report of the UK Modernising Learning Disability Nursing Review²².

Confidence in Whistleblowing

- 7.14 When things go badly wrong, and local management is reluctant to change, members of staff must feel it is safe for them to raise their concerns more widely and that they will be listened to. The interim report of this review set out action already taken to encourage whistleblowing²³. It also clarified roles within the system:
- **Government:** in ensuring that the legislative framework in the Public Interest Disclosure Act is adequate;
 - **Employers:** in supporting staff to raise concerns by having a clear policy in place which makes it clear that staff who raise concerns will be supported and which provides ways to by-pass the immediate line management chain where necessary;
 - **CQC:** in monitoring concerns about patient safety raised with it and ensuring that timely referrals are made to the professional regulators where necessary; and
 - **Professionals and other health and care workers:** in raising concerns promptly.
- 7.15 CQC has strengthened its arrangements for responding to concerns that are raised with it by whistleblowers. Whistleblowing concerns are now monitored to ensure they are followed up and thoroughly investigated until completion and the information provided is included in regional risk registers, which list providers where 'major concerns' have been identified.
- 7.16 The Department of Health funds a free, confidential whistleblowing helpline for NHS and care staff and employers who need advice about raising concerns and for employers on best practice. The service, provided by Mencap, was extended for the first time to staff and employers in the social care sector. Mencap will shortly be announcing a campaign which aims to reduce the gap between those staff who know how to whistleblow and those who would feel comfortable in doing so.
- 7.17 In March 2012, we revised the NHS Constitution to include an expectation that staff will raise concerns, a pledge that concerns will be acted upon and an undertaking to give clarity around the existing legal rights to raise concerns. It is important that workers know to whom they can raise concerns and all employers should have a clear whistleblowing policy in place.
- 7.18 Where a doctor has good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, s/he has a duty to put the matter right if possible. Similar duties are laid on other professionals through their codes of conduct. In all cases, professionals must consider the wider implications of failing to report such concerns and the risks to patient safety.
- 7.19 The Department of Health has asked the LGA and NHSCB to take account of the recommendations of the Serious Case Review on whistleblowing. **Commissioners**

²² *Strengthening the Commitment* <http://www.scotland.gov.uk/Publications/2012/04/6465/downloads>

²³ <http://www.dh.gov.uk/health/2012/06/interimwinterbourne/>

should ensure that organisations contracting with the NHS or a local authority include a condition of employment on its workers to report concerns where:

- a criminal offence has been, is being or is likely to be committed;
- a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- a miscarriage of justice has occurred, is occurring or is likely to occur;
- the health or safety of any individual has been, is being or is likely to be endangered;
- the environment has been, is being or is likely to be damaged; or
- information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

Improving safeguarding

7.20 Following consultation, **DfE is revising *Working Together to Safeguard Children*, statutory guidance on how organisations, agencies and individuals working with children should work together to safeguard and promote their welfare.** The guidance will be published in due course.

7.21 Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements. The Serious Case Review shows that adult safeguarding systems failed to link information. NHS South of England's 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. The Department of Health has already announced its intention to put Safeguarding Adults Boards on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. By strengthening the safeguarding adults boards arrangements and placing health, NHS and the police as core partners on the boards we will help ensure better accountability, information sharing and a framework for action by all partners to protect adults from abuse.

Key Action:

The Department of Health will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View, to be completed in time for the implementation of the Care and Support Bill (subject to parliamentary approval). 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; and**
- **the Safeguarding Adults Board core membership will consist of the LA, NHS and Police organisations, convened by the LA. Individual boards will be able to appoint other members in line with local need.**

7.22 Local authorities should ensure that everyone involved in safeguarding is clear about their roles and responsibilities. All local authorities and their local safeguarding partners should ensure they have robust safeguarding boards and arrangements and have the

right information-sharing processes in place across health and care to identify and deal with safeguarding alerts. This requires a multi-agency approach including all partners. In recognition of the critical role of information sharing and multi-agency working in delivering successful outcomes for adults and children at risk, the Home Office is working in partnership with the Association of Chief Police Officers (ACPO), the Department of Health and the Department for Education to improve our understanding of the different local multi-agency models in place to support information sharing around safeguarding responses for vulnerable people.

- 7.23 **Local areas need to work in partnership, including, where necessary with police and criminal justice agencies, to ensure that people returning to communities are supported adequately. This may include working with integrated offender management teams where appropriate.**
- 7.24 NHS Accident and Emergency (A&E) staff need to be alert to adult safeguarding issues and have a clear understanding of what to do with any safeguarding concerns. The Department of Health will highlight to A&E departments the importance of detecting incidences of re-attendance from the same location /individual in their annual review of Clinical Quality Indicators.
- 7.25 ACPO recognise the importance of working together with statutory agencies, local authorities and safeguarding partners to enhance the service provided to vulnerable adults. ACPO has reviewed the overall learning from Winterbourne View and will ensure the following:
- the one direct recommendation relating to the police regarding the early identification of trends and patterns of abuse has been fully recognised by Avon & Somerset Police. A specific workstream has been created by the force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally; and
 - all associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.

Applying protections of the Mental Health Act and the Mental Capacity Act

- 7.26 Nearly three-quarters of people at Winterbourne View hospital (73%) were detained under the Mental Health Act 1983. But it is clear that the principles and safeguards of the Mental Health Act were not properly applied. This was also true for some of the people who were informal patients, who also had their freedom and movement constrained. Some of the people we met said they and their families were given little say in where they were sent. This does not fit with the principles of personalisation in the NHS Constitution or the principles of the Mental Health Act 1983 and Mental Capacity Act 2005.

Key Actions:

The Department of Health will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014.

During 2014 the Department of Health will update the Mental Health Act Code of Practice and this will take account of findings from this review.

Raising understanding of good practice and reducing the use of physical restraint

- 7.27 Physical restraint should only ever be used as a last resort and never used to punish or humiliate.
- 7.28 The CQC inspections revealed widespread uncertainty on the use of restraint, with some providers over-reliant on physical restraint rather than positive behaviour support and managing the environment to remove or contain the triggers which could cause someone to behave in a way which could be seen as challenging. In Winterbourne View, bullying, punishment and humiliation were disguised as restraint.
- 7.29 We need both to take enforcement action where restraint is used improperly or illegally and to clarify and spread better understanding on how to use restraint properly. Where CQC finds evidence of inappropriate or illegal use of restraint it will take enforcement action.

Key Actions:

The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.

With external partners, the Department of Health will publish by the end of 2013 guidance on best practice on positive behaviour support so that the physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.

- 7.30 This will include:
- a set of agreed values to promote change and raise standards to minimise the use of physical intervention;
 - looking at different methods of restraint;
 - a training framework for commissioners to enhance the skills of the workforce; and
 - identification of information and data needs.
- This work will look more widely than people with challenging behaviour and apply to anyone in the health and social care systems who may be subject to physical intervention.

Addressing the use of Medication

- 7.31 **We have heard deep concerns about over-use of antipsychotic and anti-depressant medicines.** Health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient, taking into account the views of the person if possible and their family and/or carer. Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management, involving pharmacists, doctors and nurses.

Key Actions:

The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and 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. This should include a focus on the safe and appropriate use of antipsychotics and anti-depressants.

The Department of Health will explore with the Royal College of Psychiatrists and others whether and how to commission an audit of use of medication for this group. As the first stage of this we will commission, by summer 2013, a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.

Improving information, advice and advocacy

- 7.32 Good information and advice, including advocacy, is important to help people with challenging behaviour and their families to understand the care available to them and make informed choices. But it is clear that there is a very wide variety in the quality and accessibility of information, advice and advocacy, including peer advocacy and support to self-advocate.

Good Practice

In Dudley the local authority is working with independent advocacy organisations and commissioners to develop a quality framework which we hope will be widely adopted.

Key Actions:

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 so that people in hospital get good access to information, advice and advocacy that supports their particular needs; and**
- **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.**

- 7.33 It is vital that people who make complaints about their care, or the care of a family member are listened to and are given the support (including advocacy as appropriate) and advice they need to make that complaint. This includes complaints about abuse and disability hate crime.
- 7.34 The Care and Support White Paper²⁴ states that all providers are required, by law, to have a clear and effective complaints system, and this is monitored by the CQC. If a provider or local authority does not resolve a complaint to the satisfaction of the user, that person can ask the Local Government Ombudsman to investigate. The Ombudsman will be clearly signposted through the new national information website for care and support.
- 7.35 The Department of Health accepted the recommendations made by the Equality and Human Rights Commission, which includes putting in place robust and accessible systems so that residents living in institutions can be confident of reporting harassment by staff or other residents.
- 7.36 The Department for Health is strengthening the ways in which people can give feedback on their care and support. This Government supports the development of websites which allow those who use services and their family or carers, to give feedback to providers and commissioners about any poor, or indeed good practice.
- 7.37 The Department of Health will work with the LGA and Healthwatch England on involving people with learning disabilities and their families in local Healthwatch organisations. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards, and, for children and young people, Parent Carer Forums. LINKs (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.

²⁴ *Caring for our Future: reforming care and support*,
<http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/>

Part 8: Monitoring and reporting on progress

- 8.1 How will government, the public, people with challenging behaviour and families know we are making progress? Transparency of information and robust monitoring are critical for delivering transformed care and support. This involves:
- auditing current provision;
 - developing better information for the future; and
 - national monitoring through the Learning Disability Programme Board, including service user and family representation.

Auditing current provision

- 8.2 In pursuing this review, it became clear that there is a lack of clarity on the number of people with challenging behaviour in hospital settings or who is responsible for them. There have been improvements, but much more needs to be done to establish a baseline.

Key Action:

By March 2013 the Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.

Developing better information systems

- 8.3 The Department of Health intends to establish key performance indicators (on, for example, numbers of people in hospital, length of stay, incidents of restraint, and number of safeguarding alerts) which will enable the Learning Disability Programme Board and local services to monitor progress.

Action:

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 from April 2013.

The Department of Health will develop a new learning disability minimum data set to be collected through the Information Centre from 2014/15.

The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.

Monitoring and transparency

- 8.4** We will monitor progress through the Learning Disability Programme Board. It will also be essential for the process to be transparent and open to scrutiny.

Key Actions:

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 (Annex B). CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.

Regular updates to the Programme Board will be published on the Department of Health website, with all other papers and minutes for that Board.

The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013 and repeat this by December 2014.

Part 9: Conclusion

- 9.1 For too long, people with challenging behaviour have – as highlighted by Mencap and the Challenging Behaviour Foundation – been too much out of sight. Although there is ample authoritative guidance across health and care, and examples of good practice around the country, in too many places the needs of this highly vulnerable group of people are not being addressed. It is easy to see why families and groups who support people with challenging behaviour are sceptical about what will happen this time to deliver the transformation of care which people deserve.
- 9.2 But we believe that the package of timetabled actions set out in this report and the accompanying Concordat, together with the commitment by national and local leaders to monitor and report on delivery against these will deliver real change. And this will be enabled by the reforms to health and care systems which give greater power to individuals and local communities to develop services which genuinely respond to local needs.

Annex A: The model of care

There are too many people challenging behaviour living in inpatient services for assessment and treatment and they are staying there for too long.

The closure of most long-stay hospitals in the 1980s and 1990s, and the recent closure of NHS campuses, means most people with learning disabilities, including those with behaviours that challenge now live in the community with support. But some still live (for short or longer periods) in NHS funded settings. Assessment and treatment units emerged as the most likely solution to meeting the needs of people with learning disabilities and complex mental health/behavioural issues post-institutional closure. However, there were opposing views between 'building based' services and increasing support to people in their natural communities as the preferred option.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge includes the 1993 Mansell report, updated and revised in 2007. Both emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour; and
- that services/support should be provided locally where possible.

Evidence shows that community-based housing enables greater independence, inclusion and choice and that challenging behaviour lessens with the right support. The Association of Supported Living's report *There is an Alternative* describes how 10 people with learning disabilities and challenging behaviour moved from institutional settings to community services providing better lives and savings of around £900,000 a year in total.

The CQC *Count me in* 2010 census showed only 2 learning disabled patients on Community Treatment Orders compared to over 3,000 mental health patients – suggesting a greater reliance on inpatient solutions for people with learning disabilities than for other people needing mental health support.

CQC found some people were staying many years in assessment and treatment units. Annex B estimates that, in March 2010, at least 660 people were in A&T in Learning Disability wards for more than 6 months.

This report sets out how the model of care set out in the Mansell reports fits with the new health and care system architecture focusing on key principles, desired outcomes for individuals, and a description of how the model should work in practice.

Key principles

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out below:

For people:

1. I and my family are at the centre of all support – services designed around me, highly individualised and person-centred;
2. My home is in the community – the aim is 100% of people living in the community, supported by local services;
3. I am treated as a whole person;
4. Where I need additional support, this is provided as locally as possible.

For services:

5. Services are for all, including those individuals presenting the greatest level of challenge;
6. Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning;
7. Services are provided locally;
8. Services focus on improving quality of care and quality of life;
9. Services focus on individual dignity and human rights;
10. Services are provided by skilled workers;
11. Services are integrated including good access to physical and mental health services as well as social care;
12. Services provide good value for money;
13. Where inpatient 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:

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

This is about personalisation, starting with the individual at the centre, living in the community. The first level of support for that individual includes the people, activities and support all people need in their every day lives – family, friends, circles of support, housing, employment and leisure.

Most people with learning disabilities or autism will need more support from a range of sources: their GP or other primary care services, advocacy, a care manager or support worker and could include short breaks. That support may change as needs change, and this will involve assessments of physical or mental health needs or environmental needs (such as loss of a parent, a relationship breakdown, unemployment) to identify what support should be provided.

For people who need further support – including where they have behaviour which challenges – the intensity of support should increase to match need. That should include intensive support services in the community, assessment and treatment services (which could be provided in a safe community setting), and, where appropriate, secure services. But the aim should always be to look to improvement, recovery, and returning a person to their home setting wherever possible.

Responsibility for safety and quality of care depends on all parts of the system working together:

- i. **providers** have a duty of care to each individual they are responsible for, ensuring that services meet their individual needs and putting systems and processes in place to provide effective, efficient and high quality care;
- ii. **commissioners** (NHS and local authorities) are responsible for planning for local needs, purchasing care that meets people's needs and building into contracts clear requirements about the quality and effectiveness of that care;
- iii. **workforce**, including health and care professional and staff who have a duty of care to each individual they are responsible for; and
- iv. **system and professional regulators** who are responsible for assuring the quality of care through the discharge of their duties and functions.

To achieve these outcomes a revised model of care as set out below needs to be delivered.

Roles and responsibilities

Good services meeting the needs of everybody must include:

Information

- **Councils, elected councillors, health bodies and all care providers, whether from the public, for-profit or not-for-profit sectors** should provide good quality, transparent, information, advice and advocacy support for individuals, families and carers.

Community based support

- **Councils and health commissioners** should ensure that general services (GPs, hospitals, libraries, leisure centres etc) are user-friendly and accessible to people with learning disabilities/autism so they can access what everyone else can access.

- **Community based mental health services** for this group should offer assertive outreach, 24-hour crisis resolution, a temporary place to go in crisis and general support to deal with the majority of additional support needs at home.
- **Housing** authorities should include a wide range of community housing options - shared, individual, extra care, shared lives scheme, domiciliary care, keyring, respite.
- **Social care commissioners** should ensure the availability of small-scale residential care for those who would benefit from it (eg because they have profound and multiple disabilities).
- **Councils and employment services** should offer support into employment.
- **Councils and providers of services** should enable a range of daytime activities.
- **Councils** should roll out personal budgets for all those who are eligible for care and support including those with profound and multiple disabilities and/or behaviours seen as challenging.
- Where appropriate, **health commissioners** should fund continuing health care.
- **Health and social care commissioners** should focus on early intervention and preventive support to seek to avoid crises (eg behavioural strategies). Where crises occur, they should have rapid response and crisis support on which they can call quickly.

Commissioning, assessment and care planning

- **Health and social care commissioners** should develop personalised services that meet people's needs. Key factors include;
 - involving individuals - with support where needed - and families at all stages;
 - planning for the whole life course, from birth to old age, starting with children's services;
 - developing expertise in challenging behaviour;
 - developing partnerships and pooling resources to work together on joint planning and support with integrated services – including:
 - multi-disciplinary teams to perform assessments, care planning, care assessment, care management and review,
 - joint commissioning – ideally with pooled budgets, and
 - shared risk management;
- **Health and social care commissioners** should use all available information from joint strategic needs assessments (JSNAs) and local health and wellbeing strategies to commission strategically **for innovation** and to develop person-centred community based services;
- **Health and social care commissioners** should commission personalised services tailored to the needs of individuals, ensuring a focus on improving that individual's health and well-being and agreed outcomes. Progress towards delivering outcomes should be regularly reviewed;
- **Health and social care commissioners** should start to plan from day one of admission to inpatient services for the move back to community;
- **Health and social care commissioners** should ensure close coordination between the commissioning of specialised services including secure services, and other health and care services;

- **Social care bodies** have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, including working with all partners to develop and work towards delivering a discharge plan;
- **Health and social care commissioners** should audit provision to assess which services are good at supporting people with challenging behaviour (the Health Self Assessment Framework is an effective way to monitor outcomes);
- **Health and social care commissioners** should develop effective links with children's services to ensure early planning at transition and joint services. The SEND Green Paper proposal for an integrated health, education and care plan from 0-25 will also help to ensure that children's services are similarly thinking about a young person's transition to adult services at an early stage.

Service Providers

- **All service providers** (community, residential, health, care, housing – public, for-profit and not-for-profit providers) have a duty of care to the individuals for whom they provide services and a legal duty to refer. This includes ensuring that:
 - people are safe and protected from harm;
 - their health and well-being are supported;
 - their care needs are met;
 - people are supported to make decisions about their daily lives;
 - people are supported to maintain friendships and family links.

Providers should:

- provide effective and appropriate leadership, management, mentoring and supervision. Good leadership is essential in setting the culture and values;
- have a whole organisation approach to Positive Behaviour Support training;
- recruit for values and ensure that staff have training for skills - mandatory training which can include training on value bases when working with people with learning disabilities, positive behaviour support, types of communication including non-verbal communication, active support and engaging in meaningful activities and Mental Capacity requirements. Best practice includes involving people with learning disabilities and families in the training;
- operate good clinical governance arrangements;
- monitor quality and safety of care;
- Work with commissioners to promote innovation – new and different ideas, especially for the most challenging.

Assessment and treatment services

- **Health and care commissioners** are responsible for commissioning assessment and treatment services where these are needed. The focus should be on services (which can be community based) rather than units. Where a person is at risk (or is putting others at risk) in a way that community support cannot help and needs to be moved to a safe place, **commissioners** should focus on this being provided close to home.
- **Health and care commissioners** should look to review any placement in assessment and treatment services regularly, and focus on moving the individual on into more appropriate community based services as soon as it is safe for the individual to do so.

- **Social care services** should be closely involved in decisions to admit to assessment and treatment services.
- All **assessment and treatment services providers** must comply with statutory guidance on the use of physical restraint.

Prisons and secure services

- **Social care services** should work closely with prison and secure services to ensure person centred planning and health action planning and to plan for appropriate provision when people move on from prison or secure services.
- **Offender management processes** should include health screening programmes that identify an offender's learning disability and any physical and/or mental health issues.

Workforce should demonstrate that they are providing quality care and support which includes:

- personal and professional accountability;
- training in working with people with complex needs and behaviour which challenges;
- developing good communication and involving advocates and families'
- monitoring an individual's progress and reviewing plans; and
- good understanding of the legislative framework and human rights;
- Taking action to report any concerns identified.

System and professional regulators

As a regulator, the Care Quality Commission (CQC) should:

- monitor whether services are meeting essential standards;
- take enforcement action if a provider is not compliant;
- monitor the operation of the Mental Health Act 1983.

Professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), have a role to play to protect and promote public safety. They do this by:

- setting and maintaining professional standards;and
- investigating and taking appropriate action where concerns are raised about registrants, which can include the registrant being removed from the register and where appropriate being referred to the Independent Safeguarding Authority (ISA).

The professional regulators have produced a leaflet to help the public to ensure that they receive the care and treatment from professionals who meet the right standards.

Annex B: Timetable of Actions

This Report sets out a range of national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging.

The Department of Health is committed to working with partners to monitor progress, hold all players to account for delivery, and ensure better experiences and improved outcomes for this very vulnerable group of people.

No.	Date	Action
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
4.	From November 2012	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. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.
5.	From December 2012	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 provisions to protect individuals and their human rights and will report by Spring 2014.
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.
7.	From December 2012	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 so that people in hospital get good access to information, advice and advocacy that supports their particular needs.
8.	From December 2012	The Department of Health will work with independent advocacy organisations to 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.
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,

No.	Date	Action
		including Authorised Professional Practice.
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.
13.	By end of December 2012	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. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh <i>Challenging Behaviour: A Unified Approach</i> to support clinicians in community learning disability teams to deliver actions that provide better integrated services.
15.	By January 2013	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. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.
18.	By March 2013	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: <ul style="list-style-type: none"> ▪ model service specifications; ▪ new NHS contract schedules for specialist learning disability services; ▪ models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and ▪ a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and

No.	Date	Action
		adults with challenging behaviour built around the model of care in Annex A.
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.
22.	By 1 April 2013	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.
23.	By 1 April 2013	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.
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.
25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.
26.	From 1 April 2013	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.
27.	From April 2013	The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint

No.	Date	Action
		commissioning arrangements.
34.	From April 2013	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to 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.
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.
38.	From April 2013	The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.
39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINKs (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.
40.	By 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. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.
41.	From Spring 2013	CQC will take steps now 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.
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)

No.	Date	Action
		Making it Real principles.
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.
50.	In 2013	The Department for Education will revise the statutory guidance <i>Working together to safeguard Children</i> .
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and 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. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.
54.	By end 2013	There will be a progress report on actions to implement the recommendations in <i>Strengthening the Commitment</i> the report of the UK Modernising learning disability Nursing Review.
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about

No.	Date	Action
		the proposed changes to our registration process about models of care for learning disability services in 2013.
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.
57.	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 could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.
60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.

Glossary

ACPO	Association of Chief Police Officers
A & E	Accident and Emergency
A & T	Assessment and Treatment
A4A	Action for advocacy
ADASS	Association of Directors for Adult Social Services
ADCS	Association of Directors of Children's Services
BBC	British Broadcasting Corporation
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DfE	Department for Education
DH	Department of Health
DOLS	Deprivation of Liberty Safeguards
EOF	Education Outcomes Framework
GP	General Practitioner
HEE	Health Education England
JHWSs	Joint Health and Wellbeing Strategies
JSNAs	Joint Strategic Needs Assessments
LA	Local Authorities
LD	Learning Disability
LGA	Local Government Association
LINKS	Local involvement networks
NHS	National Health Service
NHSCB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NQB	National Quality Board
Ofsted	Office for Standards in Education, Children's Services and Skills
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SAB	Safeguarding Adults Boards
SCR	Serious Case Review
TLAP	Think Local Act Personal