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

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

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

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

This must stop"

Department of Health Final Report, December 2012

Winterbourne View – Key Findings, Recommendations and Actions

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

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

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

A British Sign Language version of the same programme can be accessed using the following link **http://tinyurl.com/c2oe6gj**

A checklist is provided below of the key findings and recommendations taken across all of the report

Key Findings

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

Key Recommendations

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

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

Key Actions

- ☑ Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014
- ☑ Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour that accords with the model of good care
- ☑ There will be national leadership and support for local change
- ☑ Planning will start from childhood improving the quality and safety of care
- ☑ Accountability and corporate responsibility for the quality of care will be strengthened
- ☑ Regulation and inspection of providers will be tightened
- ☑ Progress in transforming care and redesigning services will be monitored and reported

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Care Quality Commission – Learning Disability Review

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

CQC inspected all the services against two outcomes which were:

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

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

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

Findings

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

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

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

Conclusion relating to commissioners

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

Recommendations for commissioners

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

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

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

Conclusions relating to providers

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

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

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

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

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

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

Recommendations for providers

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

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

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

Recommendations for providers, commissioners and CQC

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

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

Recommendation for CQC

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

Summary

The report commented that since Winterbourne View ...

- CQC has inspected all of Castlebeck's 23 registered locations. Three of the services, including Winterbourne View, were closed as a result of CQC's actions.
- Inspectors have made unannounced inspections of 150 hospitals and homes for people with learning disabilities and where they found concerns, they have already taken action.
- Inspectors have continued to monitor the safety and quality of care for the former patients of Winterbourne View, with follow up inspections at 12 locations which took them after the hospital closed.
- CQC set up a dedicated team to deal with whistleblowers and to ensure that all calls are followed up.
- CQC has introduced a new inspection regime, which recognises that hospitals like Winterbourne View are high risk institutions.
- The Department of Health allowed CQC to appoint another 250 inspectors, which means that most hospitals, care homes and home care services can now be inspected at least once a year.

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

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

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

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

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

Recommendation 1

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

Recommendation 2

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

Recommendation 3

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

Recommendation 4

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

Recommendation 5

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

Recommendation 6

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

Recommendation 7

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

Recommendation 8

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

Recommendation 9

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

Recommendation 10

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

because of a focus on location level information.

Recommendation 11

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

Recommendation 12

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

Recommendation 13

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

Department of Health Review Winterbourne View Hospital

Interim Report

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

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

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

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

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

The Department of Health's report was based on :

- Reports of the Care Quality Commission's (CQC) focussed inspection of 150 hospitals and care homes for people with learning disabilities and the national summary report, published alongside this report,
- Widespread engagement with people with learning disabilities, people with autism, family carers voluntary groups, with health and care commissioners, providers and professionals, as well as the regulators; and
- Other evidence submitted to the review team.

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

The reports Initial findings

- Too many people are placed in in-patient services for assessment and treatment (A&T) and are staying there for too long.
- This model of care goes against government policy and has no place in the 21st century. People should have access to the support and services they need locally near to family and friends – so they can live fulfilling lives within the community
- Winterbourne View was an extreme example of abuse, but they found evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people.
- All parts of the system – those who commission care, those who provide care and individual staff, the regulators and government – had a duty to drive up standards. There should be zero tolerance of abuse
- DoH found examples of good practice - such as Tower Hamlets, Salford and Cambridgeshire – with good local services which mean very few people use in patient services for assessment and treatment.

For People

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

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

For Services

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

Outcomes

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

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

Background and Context

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

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

Voice of people with learning disabilities and their families:

Action

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

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

Personalisation

Action

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

Providers and ensuring quality of care

Actions

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

providers action to develop a voluntary accreditation scheme.

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

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

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

Commissioning & Contracting

Actions

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

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

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

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

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

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

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

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

Workforce

Actions

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

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

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

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

Regulators

Actions

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

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

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

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

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

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South Gloucestershire Council - Serious Case Review

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

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

The recommendations of the serious case review were as follows:

Overview

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

The principle of investing in and promoting

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

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

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

  (a) direct patient related costs

  (b) their service costs

  (c) the specific rehabilitation gains of individual patients

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

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

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

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

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

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

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

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

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

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

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

  (b) absconding,

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

  (d) criminal investigations,

  (e) safeguarding investigations, and

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

A commissioning challenge is required.

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

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

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

The circumstances and management of the whistle blowing notification

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

  (i) the Chief Executives and Boards of hospitals,

  (ii) the regulator.

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

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

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

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

The volume and characteristics of safeguarding referrals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Department of Health Review Winterbourne View Hospital

Full Report and Concordat

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

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

The report is prefaced by a Joint forward which states:

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

This must stop"

Key Findings

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

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

- Inspections of similar establishments around the country revealed a similar story
- There were excellent examples of high quality services keeping people safe and help them lead the lives they want to lead.
- All too often, people were being wrongly placed in hospital settings and there was a failure to design commission and provide services which give people the support they need, and which are in line with well established best practice.
- Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals
- The result is that far too many people are in hospital when they should not be, and they are staying there for too long – in many cases for years.
- Far too many are sent a long way from their home and families.
- Many Hospitals and care homes are not offering the quality of care that people have a right to expect.
- Even where hospitals are run to the highest standards, they are still, for many people, the wrong place, offering the wrong sort of care.
- People with learning disabilities or autism may sometimes need hospital care; but hospitals are not where people should live.
- This is a wider scandal, on a national scale, that Winterbourne View revealed, and it is unacceptable.
- We should no more tolerate that people with learning disabilities or autism are being given the wrong care- against best practise that has been established for many years – that we would accept the wrong treatment being given for cancer.
- People with challenging behaviours can be, and have a right to be, offered the support and care that they need in a community-based setting, as near as possible to family and other connections.
- Closed institutions, with people far from home and family members, not only deny people the right care but present the risk of a culture of poor care and abuse.

Governmental Mandate

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

"The NHS Commissioning Board's objective is to ensure that CCG's work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people"

The Concordat – Programme of Action

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

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

Programme of Actions

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

These are as follows:

1. Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014

2. Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour that accords with the model of good care.

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

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

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

6. Regulation and inspection of providers will be tightened

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

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

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

Appendix 1 – Prompts for Practitioners & Board Members:

Health and Well Being Boards

- How are the needs of people with a Learning Disability represented to the Health & Well Being Board?
- Does the Board understand the key issues resulting from Winterbourne View and is there an appropriate local improvement plan and what consideration is being given to any potential resource implications?
- How is the Winterbourne View improvement plan being monitored?
- How does the Health and Well Being Board wish to receive update/progress reports?

Commissioning

- Are robust joint commissioning arrangements in place for services for people with learning disabilities and autism, mental health problems or behaviours described as challenging? Do these plans include a strategy for the development of community based services as an alternative to inpatient Treatment & Assessment/Complex services?
- What are the overarching trends regarding needs for these complex services and are timely and adequate responses being made?
- Are there any specific cases / issues of significant concern and how are they being managed?
- Are the Learning Disability Partnership Board and Safeguarding Adults Board showing leadership for the Winterbourne View Local Improvement Plan and are they monitoring and scrutinising any relevant commissioning and delivery issues?
- Are there any issues / concerns which need to be addressed regionally or nationally where the Health and Well Being Board can make representation?
- What links does the Board have with the Safeguarding Boards for Children's & Adults Services?

Safeguarding Adults Boards

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

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

Assessment and Treatment Units & Complex Service provision

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

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

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

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

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

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

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

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

Commissioning and Safeguarding

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

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

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

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

Restraints and controls

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

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

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

- **Learning Disability Partnership Boards**

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

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

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

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

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

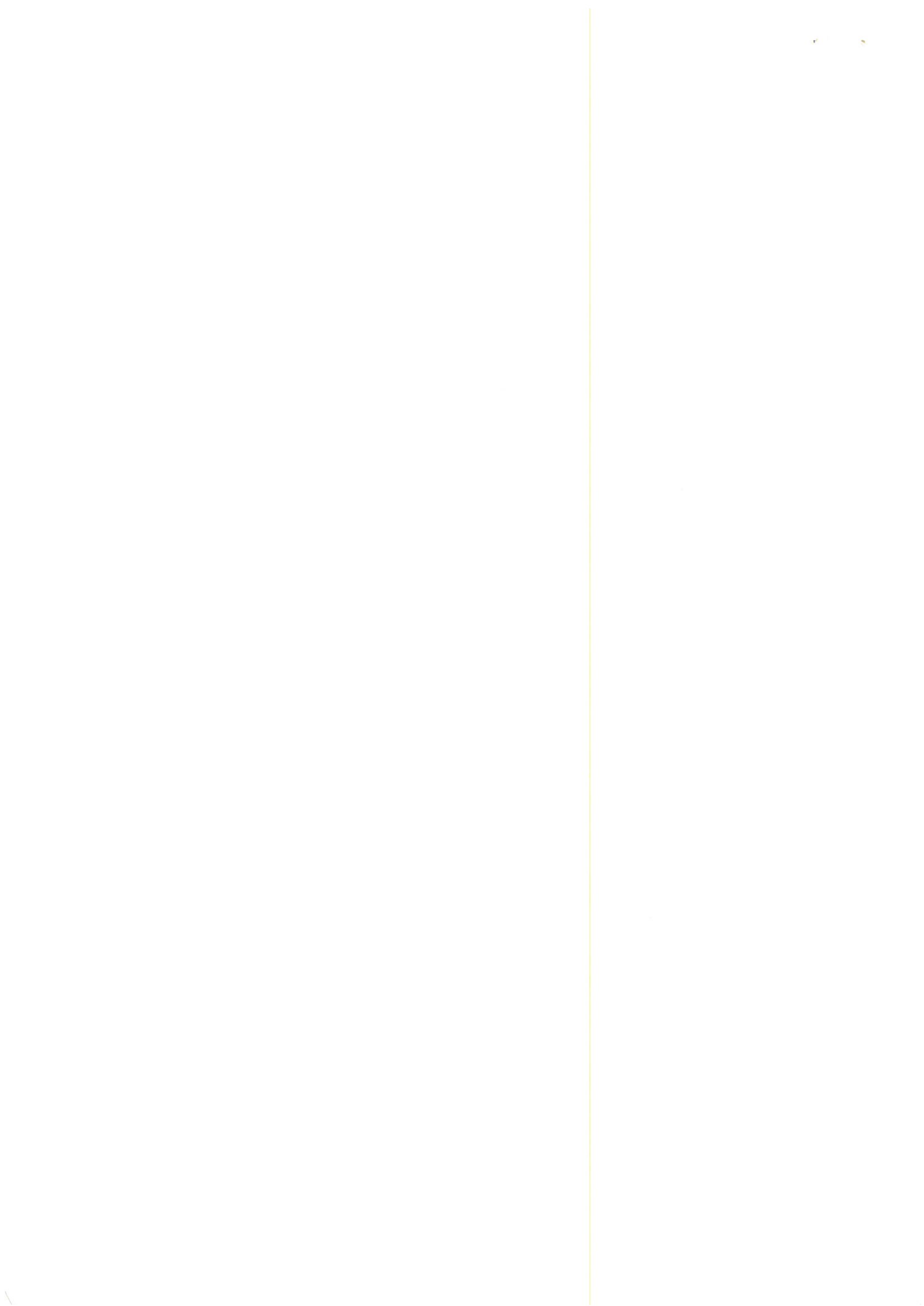
  - Are placements being reviewed and are the people using those services and family carers involved? Are people visible?

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

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

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

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



Transforming care:

A national response to Winterbourne View Hospital

Department of Health Review: Final Report

Easy Read version

What will you read about?

Message from the Minister, Norman Lamb 04

Part 1: Why did the review take place? 05

Part 2: What happened at Winterbourne View hospital? 09

Part 3: What happened to the patients who were at Winterbourne View hospital? 14

Part 4: How are people with learning disabilities and autism supported in England? 17

Part 5: The Big Goal: What needs to happen? 19

Part 6: How will we make change happen? 21

Words shown in **blue** will be explained in the 'Difficult words used' section at the end

Please see the Easy Read Concordat (or Agreement) for all the actions that will happen.

Message from the Minister

What happened at Winterbourne View hospital was horrifying for both the patients and their families.

Like many people who watched the BBC Panorama Programme, I was shocked, angry and disappointed by the way people with learning disabilities or autism and who have mental health conditions or behaviour that challenges were treated. It was unacceptable.

This review was set up immediately after the Panorama Programme in May 2011. It learns from what happened at Winterbourne View hospital and sets out action to stop such abuse from happening again.

What happened at Winterbourne View hospital was criminal. Six former members of staff at Winterbourne View hospital were jailed for the terrible crimes they committed.

There was a clear failure by the hospital, but the Serious Case Review showed that there was a wider failure across the whole system.

When such failures happen, there should be consequences for everyone involved. The plans to change the law (or regulatory framework) will mean that Boards, Directors and Managers who run hospitals where abuse happens will face consequences. This will send out a strong message to Boards, Directors and Managers that the care and wellbeing of people they care for is their responsibility.

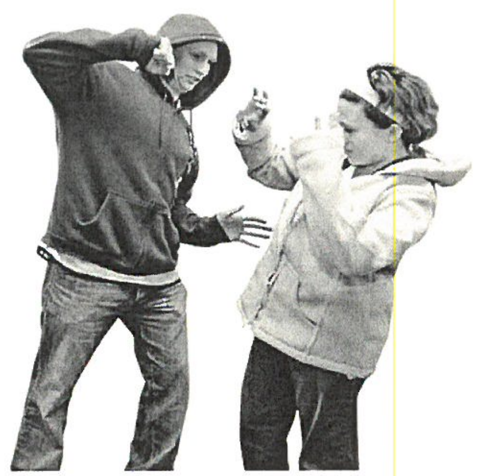
What happened at Winterbourne View hospital was terrible, but we must use it to push for change. This review is a key part of making that change happen.

NORMAN LAMB

Part 1: Why did the review take place?

On 31st May 2011, a BBC Panorama television programme showed people with challenging behaviour being abused by staff at a private hospital called Winterbourne View.

This hospital is now closed.



The abuse that took place at Winterbourne View was criminal. The staff whose jobs were to care and help patients were shown to be abusing them.

- The patients experienced physical abuse. For example - they were pushed around.
- The patients also experienced emotional abuse. For example - they were shouted at.

Paul Burstow was the Minister of State for Care Services at the time that the programme was shown.

Paul Burstow asked Department of Health (DH) officials to carry out a full review into what happened at Winterbourne View hospital.

The aim of the review was to look into what happened at Winterbourne View hospital so that lessons can be learned.

AND

To look into how people with challenging behaviour are supported all over England.

As part of the review, Department of Health officials looked at reports and evidence from other reviews.

What reports and evidence did the Department of Health look at?

1. Evidence from the criminal proceedings.

2. The Castlebeck Ltd report

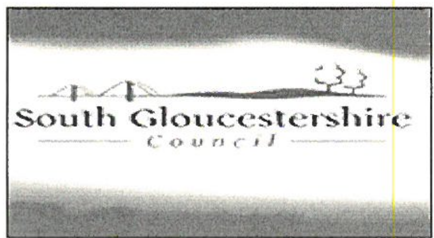
   Castlebeck Ltd was the owner of Winterbourne View hospital.

3. The Care Quality Commission's (CQC) review.

   The CQC inspected 150 hospitals and care homes that provide services for people with learning disabilities.

4. The **NHS** report.

   This report looked into how people from Winterbourne View hospital came to be placed there.



5. The Serious Case Review by South Gloucestershire Council

   The review gave a detailed picture of what happened at Winterbourne View hospital.

DH officials also spoke to different people to hear their views about how people with challenging behaviour are supported all over England. These people included:

- People with learning disabilities
- People with autism
- Families of people with learning disabilities/autism
- Commissioners
- Providers
- Workers

national forum of people with learning disabilities

DH Review

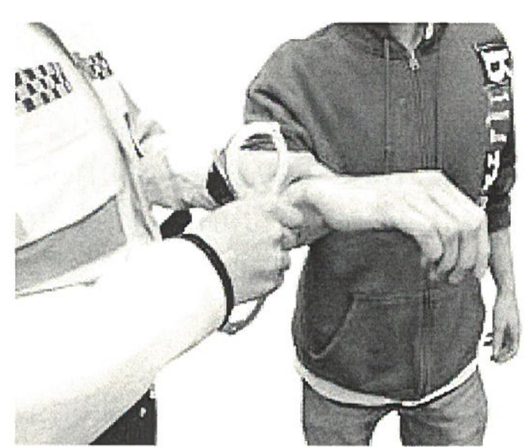
Winterbourne View Interim Report

In June 2012, the Department of Health published an interim report.

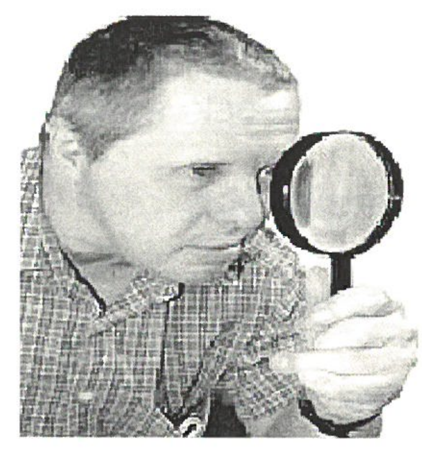
In that report, we explained that we could not say anything about what happened at Winterbourne View hospital until after the criminal proceedings.

The criminal proceedings are now over.

This final report builds on the evidence set out in the interim report.



The 11 members of staff who abused patients at Winterbourne View have been sentenced for the criminal acts.



As the criminal proceedings are now over, this final report can now set out what we found. The report sets out:

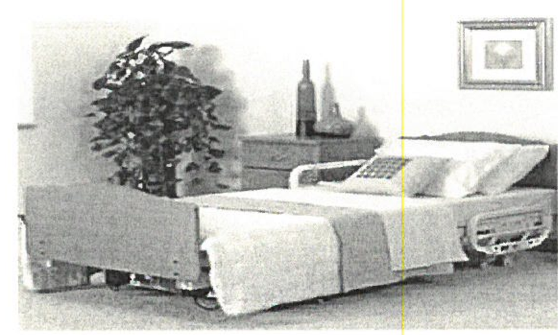
- the facts about Winterbourne View;
- What happened to people who were at Winterbourne View;
- What needs to be changed in the system;
- Learn lessons for the future; and
- Look at what the Government needs to do.

Part 2: Winterbourne View hospital

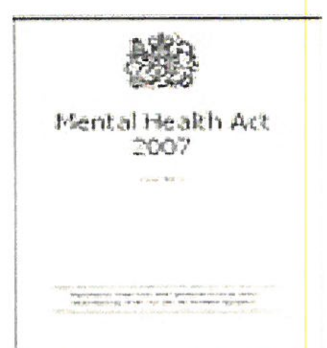
Winterbourne View hospital was a private hospital. It was owned by Castlebeck Care Limited.

It was opened in December 2006.

The hospital was registered to provide assessment and treatment and rehabilitation for people with learning disabilities.



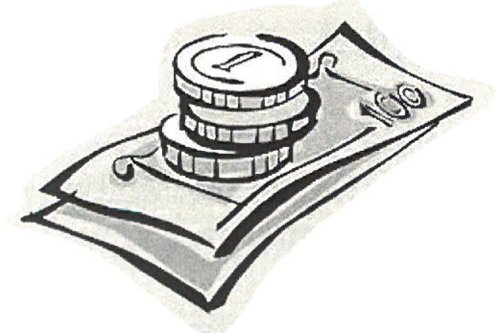
The hospital had enough beds for 24 patients with learning disabilities.



Most of the patients in Winterbourne View hospital had been placed at the hospital under the Mental Health Act.

A total of 48 patients had been placed at Winterbourne View hospital.

The patients in Winterbourne View hospital were placed there by different commissioners from all over England.



On average, it cost £3,500 per week to place a patient at Winterbourne View.

Almost half of the patients at Winterbourne View were placed far away from their homes.

One of the main reasons they were placed in Winterbourne View was to manage a crisis.

This suggests a lack of local services to support people with challenging behaviour.

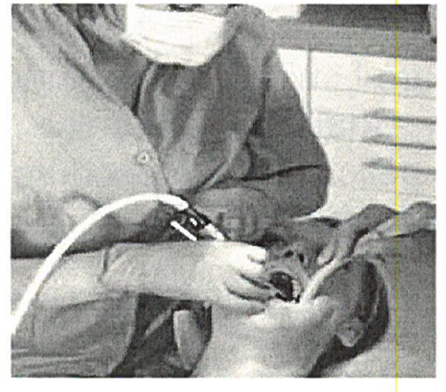
Also, the patients placed at Winterbourne View hospital were there for a very long time.

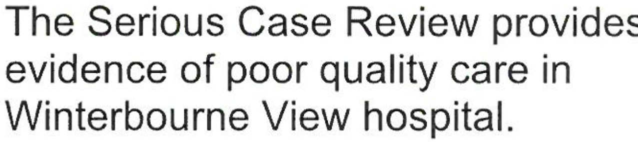
Some patients were there for more than 3 years.

From the evidence, it does not appear that there was much hurry to move patients on from Winterbourne View.

The number of times patients were restrained by staff at Winterbourne View hospital was very high and unacceptable.

For example - a family provided evidence that their son was restrained 45 times in 5 months.





The Serious Case Review provides evidence of poor quality care in Winterbourne View hospital.

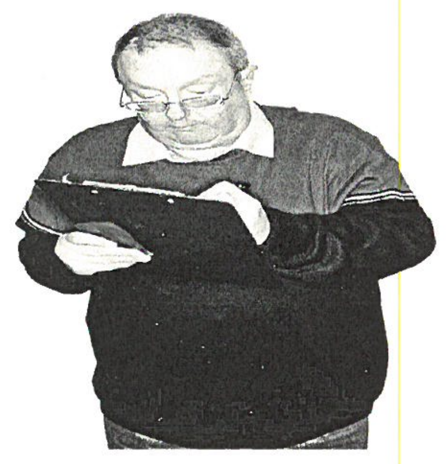
For example:
Some people had poor dental health care.

The Serious Case Review says that for a lot of the time Winterbourne View hospital was open, families were not allowed to visit patients on the ward or in their bedrooms.

This made the abuse of patients even harder to spot.

The patients at Winterbourne View had very little access to advocacy.

Also, patients' complaints were not handled properly.



The abuse of patients at Winterbourne View hospital should have been noticed earlier.

But it was not.

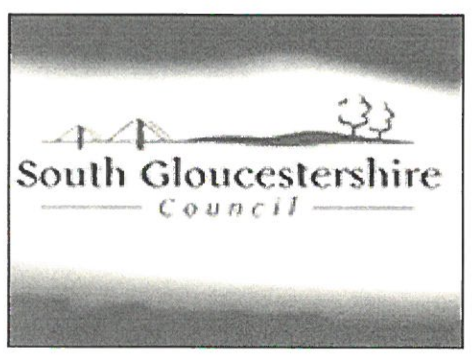
Castlebeck Care Limited

Castlebeck Care Limited had policies and procedures that seemed really good. But the policies and procedure were not put into practice.

For example:

The recruitment of staff did not appear to focus on quality. The job descriptions of staff did not ask for staff to have experience in supporting people with learning disabilities/autism and challenging behaviour.

Evidence also suggests that staff training at Winterbourne View was focused too much on the use of restraint.



The safeguarding authority

South Gloucestershire Council were told about safeguarding issues in Winterbourne View but failed to identify a trend in the number of times they were contacted.

The commissioners

The commissioners are the people who placed people at Winterbourne View.

They paid a lot of money to place people there and should have made sure the hospital provided quality care.

The Care Quality Commission

Before the Panorama programme showed on television, a whistleblower told the Care Quality Commission that he was worried about the way patients at Winterbourne View were being treated.

The Care Quality Commission failed to respond to the concerns raised by the whistleblower.

The Mental Health Act Commission

The Mental Health Act Commission were told about incidents at Winterbourne View and said there was a need to improve but did not follow up to make sure improvements had happened.

The Police

29 incidents were reported to the police. 8 of the reported incidents concerned staff using physical restraint on patients.

The police didn't follow up the incidents because they believed the reasons given by staff at Winterbourne View.

Before the Panorama programme, the police successfully prosecuted one of the members of staff at Winterbourne View.

Part 3: What happened to the people who were at Winterbourne View hospital?

The people who were at Winterbourne View hospital were treated very badly.

The Serious Case Review said that the patients who were at Winterbourne View should get support to deal with the abuse that took place at Winterbourne View hospital.

They said this support should be provided by commissioners.

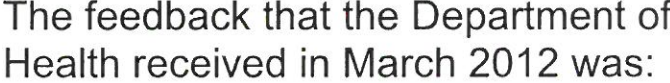
In the Out of Sight report, a report written by Mencap and the Challenging Behaviour Foundation. Simon's mum said that:

- Simon is now living near his family.
- Simon now has his own flat.
- Simon has his own support team.
- Simon is both safe and happy.

The support that Simon is receiving costs less than Winterbourne View hospital.

It is sad that not all the people that were at Winterbourne View have had the same experience as Simon.

The Department of Health asked the NHS South of England to follow up on what happened to the 48 English patients who had been in Winterbourne View. This was done twice.



The feedback that the Department of Health received in March 2012 was:

- 22 patients were in hospital, and 26 were in social care supported places;
- Safeguarding alerts had been raised in relation to 19 of the 48 patients;
- 27 of the 48 patients needed a lot of support to deal with the abuse that took place at Winterbourne View.

2

The feedback that the Department of Health received in September 2012 was:

- 32 people were in social care supported places, while 16 were in hospital.
- But Safeguarding alerts had been raised in relation to 6 people.

The Department of Health will continue to check on the people who were at Winterbourne View to make sure things improve for them.

Part 4: How are people with learning disabilities and autism supported in England?

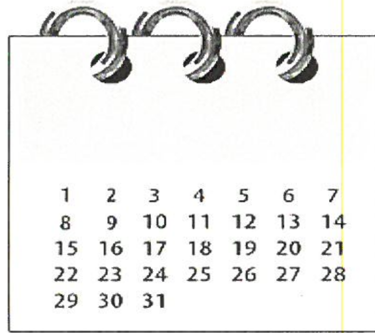
The terrible things that happened at Winterbourne View set off a wider review into how people with challenging behaviour are treated all over England.

By looking at the information from other reports and speaking to families and people with a learning disability and autism, the Department of Health was able to see how people with learning disabilities and autism are supported. We did not like what we found.

We found that:

There are too many people with learning disabilities and autism in hospital, when they should not be.

This is because the right services to support people in the community have not been put in place.



Too many people with learning disabilities and autism are placed in hospital and are staying in hospital far longer than they should.

Hospitals are not homes, so this should not happen.

Too many people with learning disabilities and autism are sent far from their homes and families.

Government guidance says that people should be able to get the support and services they need locally, near to family and friends.

We also found many cases of:

- poor quality care
- Poor care planning around the needs of people.
- Lack of quality activities for people to do in the day
- Too much reliance on the use of restraint by staff

All of these things are wrong. The right services to support people with learning disabilities and autism must be put in place.

Part 5: The Big Goal: What we want to see

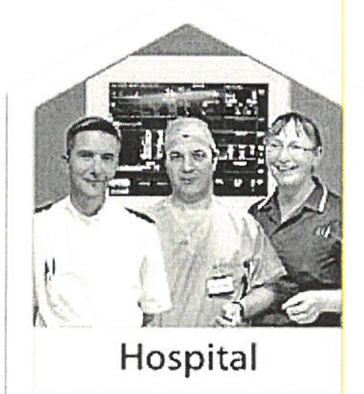
The report sets out the type of care that people with learning disabilities/autism and behaviour that challenges should get.

People should receive local personalised services that meet their needs.

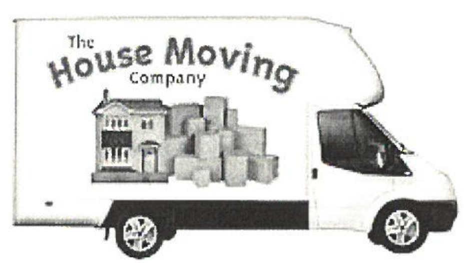
This support should be planned from childhood.

People should be supported in the community, in their home or close to their home and family.

People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service.

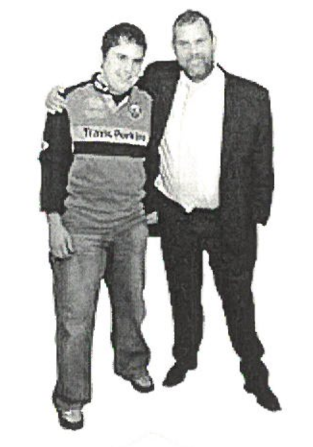


People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible.



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

Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person.



The commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly.

There should be local services that stop people with learning disabilities from having a crisis.

If a crisis does happen then there should be local services to help people deal with the crisis.

Part 6: How will we make change happen?

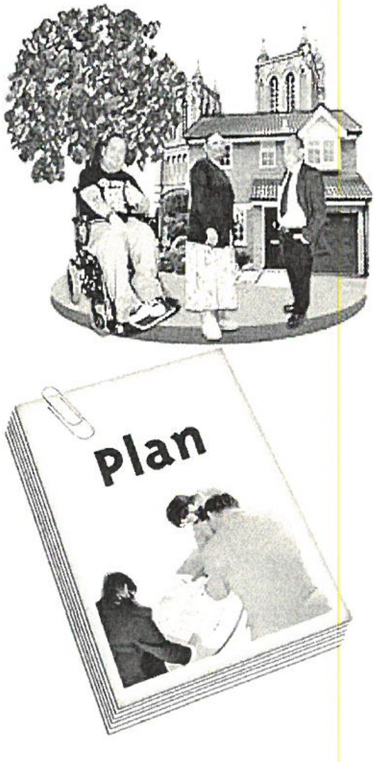
Everyone has a part to play in making things better for people with learning disabilities or autism and behaviours that challenge.

This is why the Department of Health and a number of organisations have come together to make change happen.

This plan will mean better outcomes for all people with learning disabilities or autism and behaviours that challenge.

Everyone who has signed this plan will work together to make change happen by October 2013.

The plan will ensure that:



Health and care commissioners will look at everyone with a learning disability who is in hospital now. If people do not need to be in hospital they will support them to move to community support by 1 June 2014. Before then if possible.

Every area will have a local joint plan for very good care and support services for people of all ages with challenging behaviour.

There will be national leaders to support local change.

The NHS Commissioning Board and the Local Government Association will start a new programme of work called the **development improvement programme.** This will provide national leadership to change services locally.

Planning good care starts with children so that there are good services when people grow into adults.

Making the care people get safer and better.

The Department of Health says it will be law to have Safeguarding Boards for Adults. This is about keeping people safe.

Everybody will make sure that safeguarding boards work to make children, young people and adults safe.

Over the next year everyone who has signed this agreement will help make the skills of the workforce better so that people get better care.

Organisations and their Directors are responsible for care being good and they will be asked to explain and held to account for poor care.

Laws about inspecting services will be stronger.

The Care Quality Commission (CQC) will use the law, or regulations, they already have to make sure service providers are doing the right thing.

CQC will carry on inspecting hospitals and care homes without letting providers know first. People with learning disabilities and family carers will be in the teams who do the inspecting.

We will check to make sure services get better.

The Learning Disability Programme Board, which is chaired by the Minister for Care and Support, will check all the actions in the agreement and report on what is happening.

There are many more actions that different organisations will carry out.

These actions are in a document called the Concordat or Agreement.

Difficult words used:

Assessment and treatment unit	An Assessment and Treatment unit is like a small hospital. Sometimes people go to assessment and treatment units when they are upset or disturbed or when there is a crisis and they are in danger of hurting themselves or other people to help them and find out what treatment they need. People who work there include nurses, doctors, psychologists and therapists.
Association of Directors of Children's Services	The Association of Directors of Children's Services Ltd (ADCS) is the national leadership association in England for statutory directors of children's services and their senior management teams.
Association of Directors of Adult Social Services (ADASS)	This an organisation made up of Directors of Adults Social Services. There is also an organisation for Directors of Children's Services.

British Institute of Learning Disabilities (BILD)	BILD is an organisation that supports people with learning disabilities and provides training, events, meetings, books and magazines for their members to help spread good practice about people with learning disabilities.
CONCORDAT	This is another word for a written agreement that different people agree to.
Children and Young People's Outcomes Framework	The Department of Health wrote this to say what is needed for children and young people to have good health and care.
Clinical Commissioning Groups (CCGs)	A Clinical Commissioning Group (CCG) is the name for the new health commissioning organisation which will replace Primary Care Trusts in April 2013. Commissioning organisations are responsible for planning and buying of healthcare to meet the needs of people.

Care Quality Commission (CQC)	The Care Quality Commission makes sure there are good health services, and good social care for adults in England. They check up on services run by the NHS, local councils, private companies and voluntary organisations.
Education, Health and Care Plans	These are plans which mean there is good planning for children when they grow up and become adults. They cover important areas in one plan.
Forums and voluntary sector organisations	These are organisations like the National Forum for People with Learning Disabilities and the National Valuing Families Forum who speak for people with learning disabilities and the families who care for them.
Healthwatch	Healthwatch England is a national organisation from October 2012. Local Healthwatch will start in April 2013 to give a greater voice to people who live locally about health and social care.

Health and Care Commissioners	These are people whose job it is to purchase health and care services.
Health and Wellbeing Boards	The Health and Social Care Act 2012 set up health and wellbeing boards. They are a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.
Improvement Programme	Local government and the NHS Commissioning Board will work together to lead local change. They will do this through a new development improvement programme which will be set up by end December 2012.
Joint Health and Wellbeing Strategies	Joint Health and Wellbeing Strategies are to do with being healthy and feeling well. They are plans between different groups to make things happen locally.
Learning Disability Professional Senate	The LD Senate has professionals like GPs, Nurses and Psychiatrists who look after people with challenging behaviour.

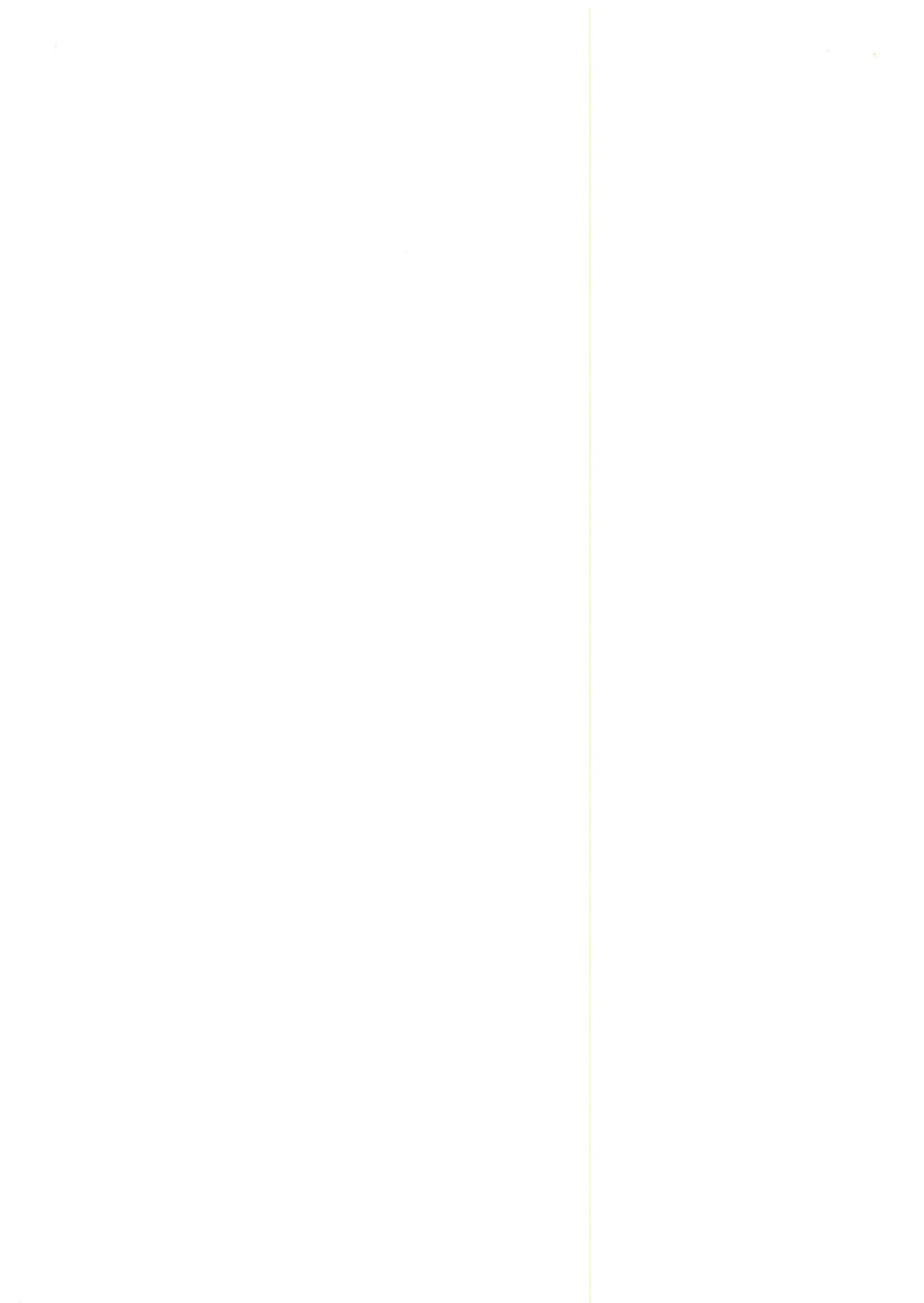
Local Government Association (LGA)	The LGA works on behalf of councils to make sure local government has a strong voice in national government.
Mandate	The Mandate is a formal notice from DH to the NHS Commissioning Board that sets out the objectives for the Board to make care and healthcare better.
NHS Commissioning Board	This started as an independent organisation from 1 October 2012. It helps to set up Clinical Commissioning Groups (CCGs). It is part of the new health system and will take up its new work in full from April 2013.
Health and Social Care Information Centre	This is an NHS organisation that collects facts and figures about health and social care in England.
NHS Serious Untoward Incident Investigations	The NHS in the South of England also carried out a special review of what happened at Winterbourne. They are looking at what happened to patients at Winterbourne View after the hospital closed.

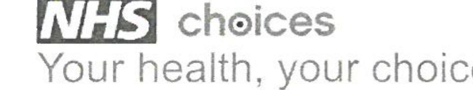
National Institute for Health and Clinical Excellent (NICE)	The National Institute for Health and Clinical Excellence (NICE) helps healthcare professionals and other make sure the care they provide is good quality and is good value for money.
People with challenging behaviour	When we say 'People with challenging behaviour' we mean people with learning disabilities or autism and who have mental health conditions or behaviour that challenges.
Providers	These can be organisations run by the Government, charities or private companies. They provide services for people with learning disabilities.
Personalisation	This means people having choice and control over the health and care they receive so their particular needs are met.
Quality of Health Principles	An organisation called Changing our Lives worked with people with learning disabilities to say how they want to be treated in hospital. The principles will be included in NHS contracts with providers.

Serious Case Review (SCR)	The local authority for Winterbourne View, South Gloucestershire Council, looked at what went wrong. They asked for reports from everyone like the NHS, the Care Quality Commission and Castlebeck Care.
Skills for Care & Skills for Health	These organisations support the people who work in adult social care in England.
South Gloucestershire Council	This is the local council for Winterbourne View.
The National Quality Board	Is made up of stakeholders who make sure there is good quality right across the NHS. The Board is an important part of the work to deliver high quality care for patients.
The Department of Health	This is a Government Department in charge of the policy and law to do with health and social care.

The Department for Eduction	This is a Government Department in charge of policy and law to do with children and education.
The Learning Disability Programme Board	This Board includes people from Government Departments, organisations for people with learning disabilities, like the National Forum for People with Learning Disabilities, the National Valuing Families Forum and Mencap.
The Children and Families Bill	Once it has been agreed in Parliament, this Bill will be a law that brings one way to assess children. This is called a single assessment and covers education, health and social care.
Think Local Act Personal (TLAP)	Think Local, Act Personal is an organisation that works locally on personalisation.
Whistleblowing	Whistleblowing is when a worker reports things they see at work they think are wrong to other organisations who can do something about it. DH has set up a Helpline to make whistleblowing easier.

Winterbourne View	This was a hospital run by a company called Castlebeck Care. The hospital was for people with learning disabilities, people with autism and people who may need support with their behaviour. The hospital is now closed.





Winterbourne View failures lead to care system review

Behind the Headlines

Tuesday December 11 2012

Care facilities for vulnerable people will be reviewed

"Fine and ban care home abuse bosses," the Daily Mirror demands, while the Daily Mail says that "there must be a complete culture change in treatment" for care centres.

Both headlines are in response to a Department of Health report into staff mistreatment and abuse of patients at the private Winterbourne View Hospital. These events first came to light in May 2011.

The 24-bed hospital was registered to provide assessment, treatment and rehabilitation for people with learning disabilities and autism.

Prompted by concerns raised by a former staff member, a journalist working for the BBC managed to get a job working at Winterbourne View. Using a hidden camera, he documented acts of bullying and physical and mental abuse committed by some of the staff of Winterbourne View.

This new report focuses on two main issues:

- Individual failings, that occurred at multiple levels, which resulted in the culture of abuse at Winterbourne View going undetected for so long by the authorities.
- The wider issue of whether the care system, in all parts of the country, is providing effective and appropriate treatment to people with learning disabilities and autism.

In light of the findings of the report, a programme of action has been set out. This addresses the following issues:

- an unacceptably high number of people with learning disabilities and autism are being kept in hospital facilities on a long-term basis – and people who are kept inappropriately in hospital should be transferred to community-based care by June 2014
- the programme of unannounced inspections of facilities needs to be expanded
- better accountability is needed – this may require new laws that make directors of private organisations criminally negligent for serious failures of care that occur under their management

The report says it aims to transform services so that vulnerable people, such as those with learning difficulties, mental health conditions and challenging behaviour, are cared for in line with best practice and that abuse is prevented from happening again.

Why was the report commissioned?

Transforming care: a national response to Winterbourne View Hospital was commissioned by the Department of Health in England.

The report is a response to a BBC Panorama television documentary that aired in May 2011 and raised alarm over the care of patients at a private hospital in Bristol.

The documentary, produced by a journalist working undercover and using hidden camera techniques, showed people with challenging behaviour being bullied and physically and emotionally abused by staff at the Winterbourne View Hospital.

This hospital has now been closed and all 11 staff members who abused patients have been sentenced for criminal acts. Six have been imprisoned.

The Department of Health's report follows an earlier investigation by the Care Quality Commission into its own role in the events leading to the abuse of patients at Winterbourne View.

What evidence did the report consider?

The Department of Health's report drew its conclusions from:

- evidence from the criminal proceedings of the 11 individuals who were sentenced
- a review of all services provided by the organisation Castlebeck Care (which owned Winterbourne View) as well as an additional inspection of 150 learning disability services and homes across England
- a review of serious untoward incident reports from Winterbourne View Hospital
- an independent Serious Case Review produced by the South Gloucestershire Safeguarding Adults Board that was published in August of this year (Serious Case Reviews are inquiries that can be commissioned by a relevant local authority when there are allegations of abuse or neglect affecting the care of vulnerable people or children)
- the experiences and views of different people with learning disabilities, autism, mental health conditions and challenging behaviours, as well as those of families and carers, care staff, commissioners (those who fund services) and care providers (such as nursing staff)

What failings were identified by the report?

The report into the events at Winterbourne View Hospital states that "staff routinely mistreated and abused patients" and that "management allowed a culture of abuse to flourish".

According to the report:

- concerns raised by a whistleblower went unheeded
- patients' reports of abuse were ignored
- warning signs were not picked up by the relevant authorities

Some of the missed warning signs cited by the report included:

- there was a high number of recorded physical interventions (for example, a staff member physically restraining a patient) – one patient was reported as being restrained 45 times in the space of five months
- there was a high rate of admission of patients to Accident & Emergency services, with no follow-up investigations to assess why this was the case
- the Serious Case Review found evidence of a general poor level of healthcare, with many patients being affected by conditions that are often preventable with good quality care, such as constipation and dental problems
- there was evidence suggesting an inappropriate prescribing of anti-psychotic drugs

They say there was also failure to assess the quality of care being delivered for the very high cost of Winterbourne View Hospital (an average cost of £3,500 per week per patient) and other hospitals.

The report also uncovered wider weaknesses in the justice system's ability to hold the bosses of care organisations to account for the safety and quality of their organisations.

Importantly, it also found that many people are in hospital care who don't need to be. Some of the patients at Winterbourne View had been there for a long time, with some there for more than three years.

Some patients had been initially 'sectioned' under the terms of the Mental Health Act, and then remained at Winterbourne after this period of being sectioned ended. Others were admitted on an informal basis and then became 'sectioned' after admission.

Being 'sectioned' means that a person is compulsorily detained on a temporary basis as it is thought that their behaviour poses a risk to themselves or others. But being sectioned should only be a temporary step and there should be ongoing reviews of a person's mental state to assess if they can then leave compulsory detention.

In light of these findings, the report says that "people with learning disabilities, autism, mental health conditions or challenging behaviour have a right to be given the support and care they need in the community that is near to family and friends".

Norman Lamb, Minister for Care and Support, said: "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".

On a more positive note, the report does say that some places are getting things right and that examples of good practice at these places have been published and are available on the Department of Health's website to demonstrate what can and should be done in providing the best care for these people.

What recommendations does the report make about care for vulnerable people and people with learning difficulties?

Recommendations and actions outlined in the report are:

- all current facilities will be reviewed by June 1 2013 and all people who are inappropriately in hospital care will move to community-based support as quickly as possible no later than June 1 2014
- that each area will have a locally agreed joint care plan by April 2014 to ensure high quality care for vulnerable people including children and young adults
- the introduction of a new NHS and local government-led joint improvement team to support transformation and monitor and report on progress

- strengthened accountability of boards of directors and managers for the safety and quality of care their organisations provide – with the possibility of new legislation, similar to the current corporate manslaughter law, that means boards of directors and managers have a legal liability for the levels of care their companies provide
- strengthened inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections

The report says that, as a consequence of moving people from in-hospital care to community-based care, there will be a dramatic reduction in hospital placements and closure of large hospitals.

Alongside the report, an agreement is being published that sets out shared commitments and key actions with key organisations.

Analysis by Bazian. Edited by NHS Choices. Follow Behind the Headlines on Twitter.

Analysis by Bazian

Edited by **NHS Choices**

Links to the headlines

"Fine and ban care home abuse bosses": Minister wants action on firms profiting from cruelty. Daily Mirror, December 11 2012

Winterbourne View scandal prompts 'fitness' tests for hospital owners. The Guardian, December 10 2012

Winterbourne abuse scandal: criminal law to hold care home owners to account. The Daily Telegraph, December 10 2012

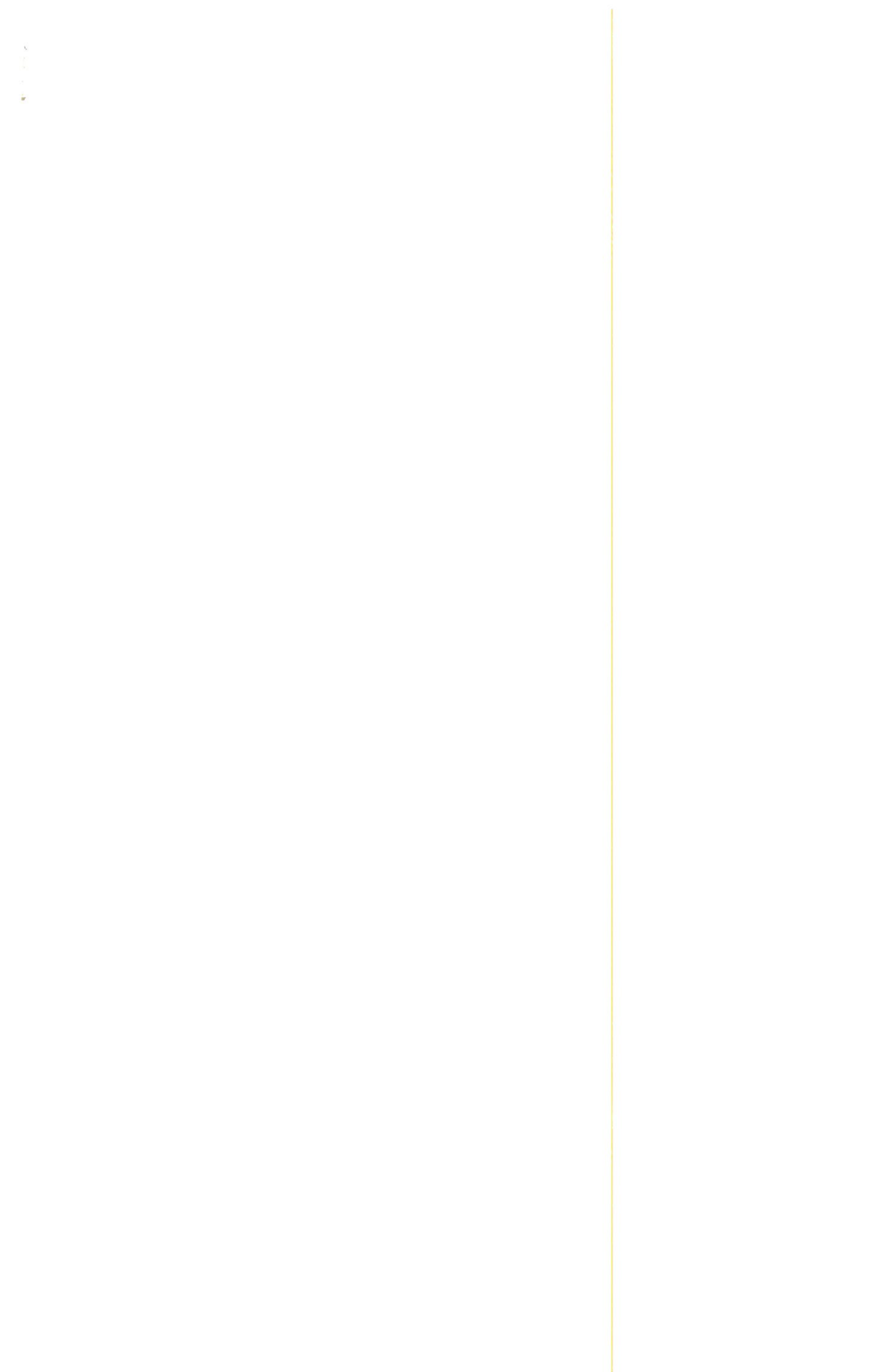
Winterbourne View scandal: Government rethinks use of hospitals. BBC News, December 10 2012

Care home directors and owners to be made criminally liable for abuse. The Independent, December 10 2012

Care centres to be closed after abuse scandal as minister says there must be 'complete culture change' in treatment. Daily Mail, December 11 2012

Further reading

Department of Health. Transforming care: A national response to Winterbourne View Hospital – Department of Health Review: Final Report (PDF 302kb). Published online December 10 2012



CQC publishes critical report of Castlebeck abuse failings

19 July, 2011 **By The Press Association**

There was a "systemic failure to protect people" by the owners of a Bristol hospital at the centre of abuse allegations involving vulnerable adults, care watchdogs have said.

The Care Quality Commission has published its findings following an inspection of services provided at Winterbourne View, owned by Castlebeck Care Ltd, in Bristol.

The report comes after the BBC's Panorama filmed patients being pinned down, slapped, doused in cold water and repeatedly taunted and teased despite warnings by whistleblower Terry Bryan.

Mr Bryan, a senior nurse, had alerted the care home's management and the CQC on several occasions, but his concerns failed to be followed up.

After considering a range of evidence, CQC inspectors found Castlebeck Care had failed to ensure that people living at Winterbourne View were adequately protected from risk, including the risks of unsafe practices by its own staff.

It said: "There was a systemic failure to protect people or to investigate allegations of abuse.

"The provider had failed in its legal duty to notify the Care Quality Commission of serious incidents including injuries to patients or occasions when they had gone missing."

It added that staff did not appear to understand the needs of the people in their care and said "some staff were too ready to use methods of restraint without considering alternatives".

The watchdog said the review began as soon as it found out Panorama had gathered evidence, including secret filming, to show the serious abuse of patients at the centre.

Inspectors said they found people who had no background in care services had been working at the centre, references were not always checked and staff were not trained or supervised properly.

They added Castlebeck failed to meet essential standards, required by law, including:

- The managers did not ensure that major incidents were reported to the Care Quality Commission as required;
- Planning and delivery of care did not meet people's individual needs;
- They did not have robust systems to assess and monitor the quality of services;
- They did not identify, and manage, risks relating to the health, welfare and safety of patients;
- They had not responded to or considered complaints and views of people about the service;
- Investigations into the conduct of staff were not robust and had not safeguarded people;
- They did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred;
- They did not respond appropriately to allegations of abuse;
- They did not have arrangements in place to protect the people against unlawful or excessive use of restraint;
- They did not operate effective recruitment procedures or take appropriate steps in relation to persons who were not fit to work in care settings;
- They failed in their responsibilities to provide appropriate training and supervision to staff.

Winterbourne View, which had 24 patients, was closed down last month.

Readers' comments (22)

- munchkin57 19 July, 2011 9:58 am

  After considering a range of evidence, CQC inspectors found Castlebeck Care had failed to ensure that people living at Winterbourne View were adequately protected from risk, including the risks of unsafe practices by its own staff

  Maybe I'm a bit dim but didn't the CQC fail to do that also as they had been alerted to the abuse on at least 2 occasions by ex employees.

- **Anonymous** 19 July, 2011 10:24 am

  "systemic failure to protect people"

  if the CQC did not act on information of abuse, which was reported to them by Mr. Bryan, a senior nurse (although it what rank the complainant held is immaterial, whether patient, visitor, qualified or untrained staff), and it needed a TV report before the so-called 'Care Quality' commission took any action, is this not also a "systemic failure to protect people" on the part of the CQC and its questionable ability to to carry out its functions?

  Doesn't 'Care Quality' also include safety of the individuals being cared for?

  What recommendations and preventative actions are being made for the future so that this or similar cases do not occur? Or is this merely another costly investigation with a report for the archives?!!!!!!!!

- **munchkin57** 19 July, 2011 11:18 am

  and just swept under the carpet without anything being achieved so that it all happens again.

- **Anonymous** 19 July, 2011 11:59 am

  "CQC publishes critical report..."

  no mention of their recommendations or further actions.

  "The watchdog said the review began as soon as it found out Panorama had gathered evidence, including secret filming, to show the serious abuse of patients at the centre."

  why did they wait all this time. after a tv documentary shown to the public they were forced to act and carry out a 'review'!

  why did they not act as soon as the first complaints were made? what is this complacency of this organisation all about?

  why are there no appropriate measures in place to deal with and act on serious complaints?

  "Winterbourne View, which had 24 patients, was closed down last month."

  after the damage was done but if there are no recommendations for action and action actually taken when serious complaints are made what is to stop a similar scenario elsewhere with other vulnerable groups of individuals?

- **munchkin57** 19 July, 2011 12:10 pm

  SOS.............and what's been exposed is probably just the tip of the iceberg. Poor people if action to abuse is so delayed that they have to suffer it day in and day out and no one to effectively go in and help them with a RAPID response. Disgrace and every other adjective that can be used to sum up abuse to the vulnerable. Shame on you CQC.

- **Anonymous** 19 July, 2011 12:28 pm

  CQC report on Winterbourne View confirms its owners failed to protect people from abuse
  18 July 201
  1
  http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=37463&FAArea1=customWidgets.content_view_1&usecache=false

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- **michael stone** 19 July, 2011 1:44 pm

  Anonymous | 19-Jul-2011 11:59 am

  I am pretty sure, I heard (Radio 4)someone from the CQC say that the problems shown by Panorama, were more serious than those Mr Bryan originally raised with the CQC - the comment was along the lines of 'The whistle-blower was as shocked as we were, by the TV programme'.
  This does not excuse the CQC, and other people and bodies, from not acting before Panorama got involved, but perhaps the full nature of the abuse, was not made clear to the CQC until after it had seen the Panorama stuff ?
  This always comes back to the same thing - good staff on the ground behave well, but it is possible to have a group of staff and mamagers who behave very badly, and self regulation within a 'bad group' will fail. And bad managers, allied with bad staff, can effectively intimidate those staff who are good, into keeping quiet (sometimes).
  And it is about 'so what do you plan to change ?'. Saying that people did not follow existing guidelines, tends to prove that something in the existing system needs to be improved - just saying 'everything would be fine, if people followed the guidance' is pathetic, if the evidence is that some people don't follow the existing guidance !

- **michael stone** 19 July, 2011 1:47 pm

  tinkerbell | 19-Jul-2011 12:10 pm

  I fully agree about the 'it is shameful and should not happen' points you make.
  But the staff on the frontline, who see these abuses, should be the 'first resort' for the solutions. It must be made impossible to 'bully' whistleblowers !

- **Anonymous** 19 July, 2011 2:05 pm

  Michael Stone

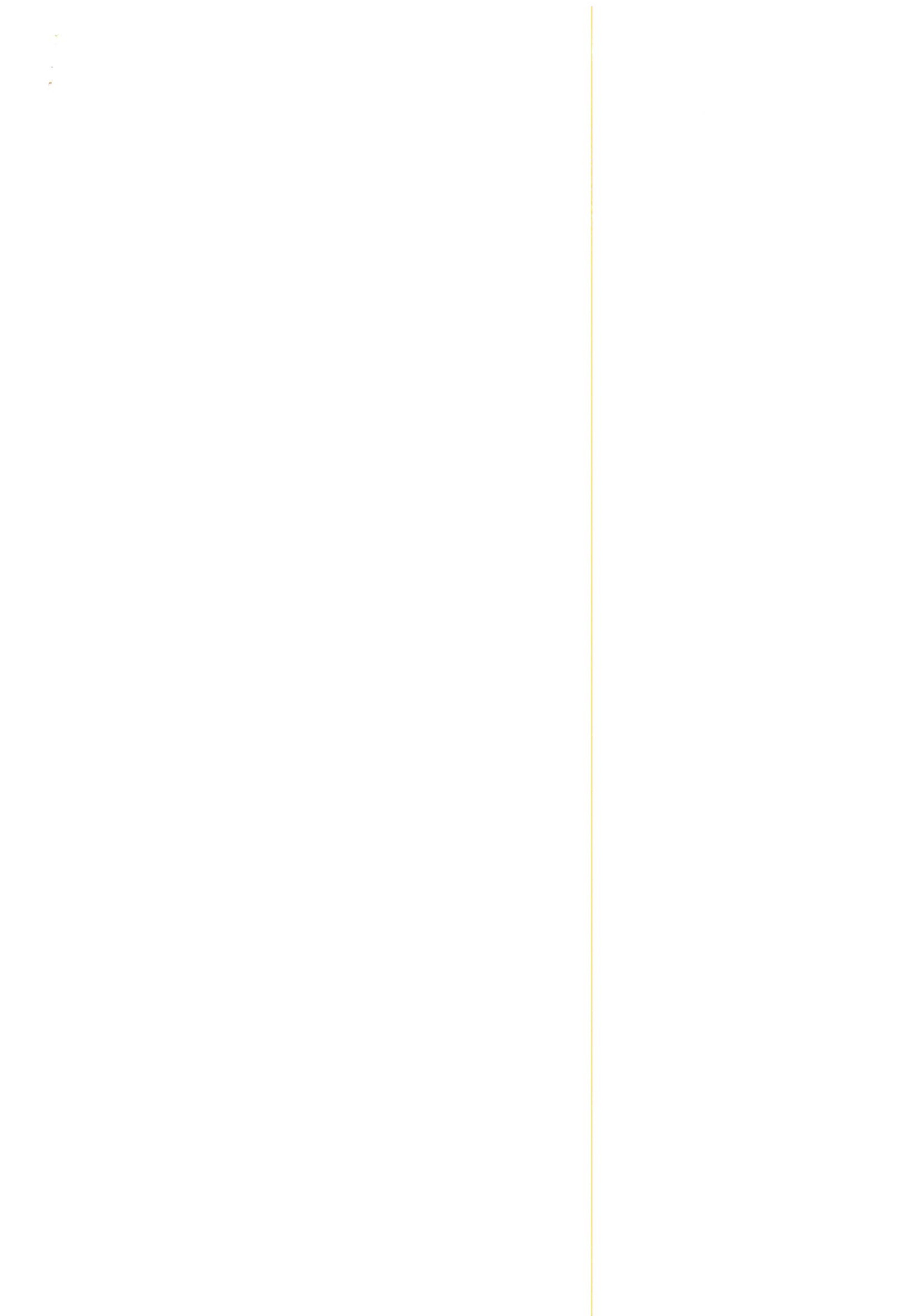
  n answer to another of your ramblings, you seem to be obsessed by 'guidelines' but please note that all qualified nurses have professional autonomy and are capable of, and do work with their knowledge and experience as well as guidelines. we are not robots. guidelines are there for advice on applying 'best practice' to care based on evidence based practice and constructed by a panel of experts which any registered nurse can join if it is in their field but at the end of the day they can be subjective, can get quickly out of date by the time they are published and do not apply to every single situation. Also they are only as good as the panel of people who made them.

- **Anonymous** 19 July, 2011 2:10 pm

  Anonymous | 19-Jul-2011 2:05 pm

  Michael Stone

  further to your comment above, I posted the reference to the report from the CQC site above yours.



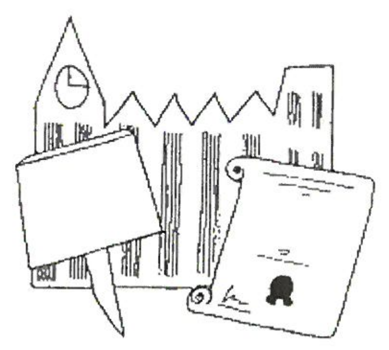
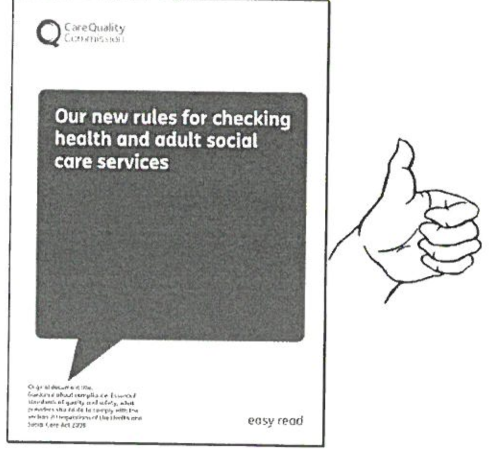
What we think about Castlebeck Care (Teesdale) Ltd

Easy read report

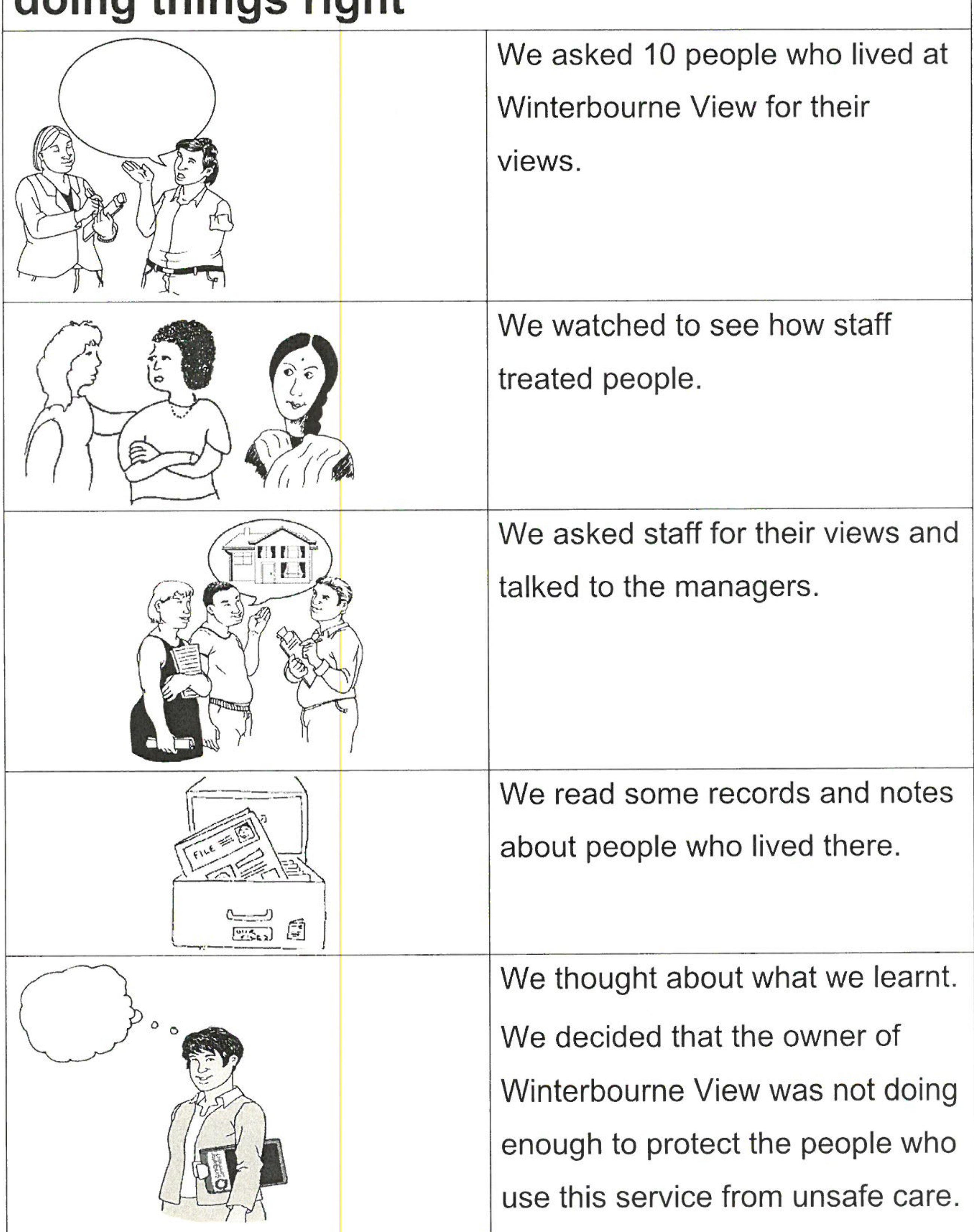
Castlebeck Care (Teesdale) Ltd Winterbourne View	
Region:	South West
Location address:	Winterbourne View Vantage Park Old Gloucester Road Bristol BS16 1RS
Type of service:	Independent healthcare provider
Date the review was completed:	2 June 2011
Overview of the service:	Winterbourne View was an independent provider of health care and support for adults who have learning disabilities and other needs. They may also have been kept in care by a law called the Mental Health Act.

If you would like this report in another format or language or you want a copy of the full report please contact us.
Telephone: **03000 61 61 61** or Email: **enquiries@cqc.org.uk**

Introduction

	The law says that health and social care services must meet essential standards. This is so that people know what to expect from health and social care services.
 	We, the Care Quality Commission, have made rules about what people can expect when services are meeting the essential standards.
 	We register services that meet the standards. We check services keep doing things right so people feel safe.

How we checked if Winterbourne View was doing things right



We asked 10 people who lived at Winterbourne View for their views.

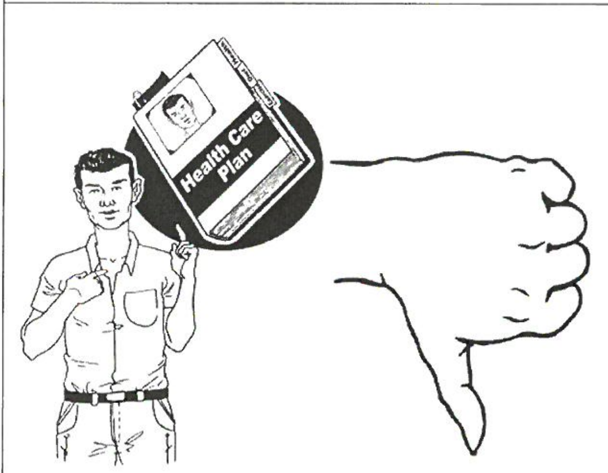
We watched to see how staff treated people.

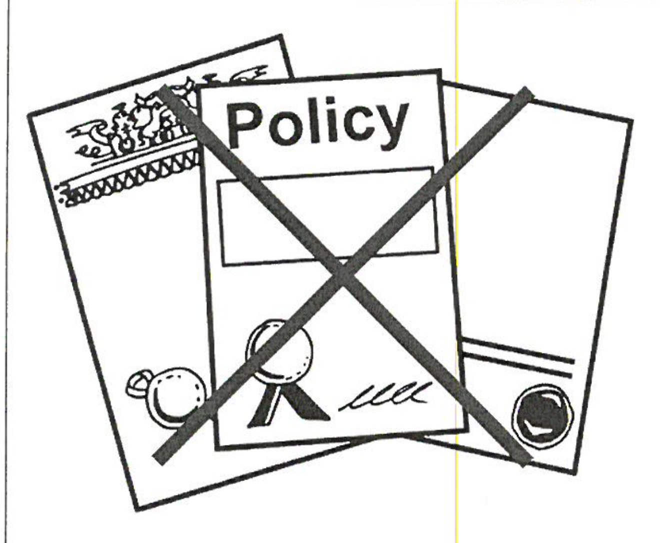
We asked staff for their views and talked to the managers.

We read some records and notes about people who lived there.

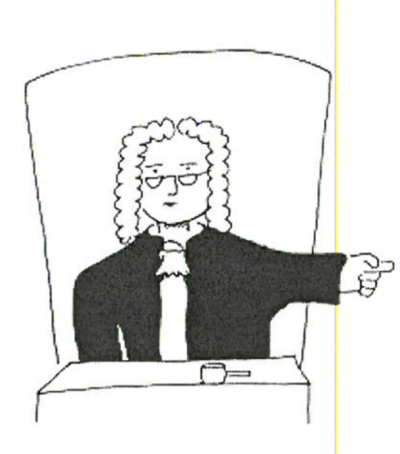
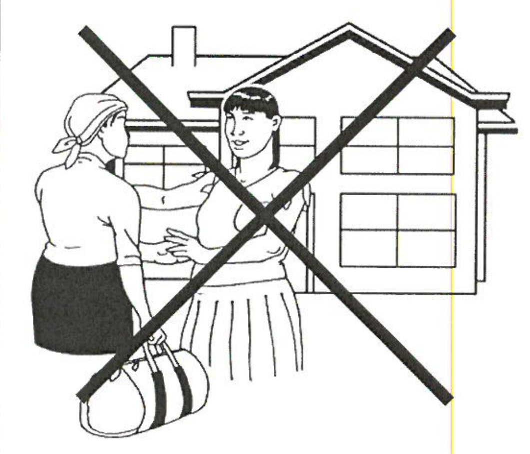
We thought about what we learnt.

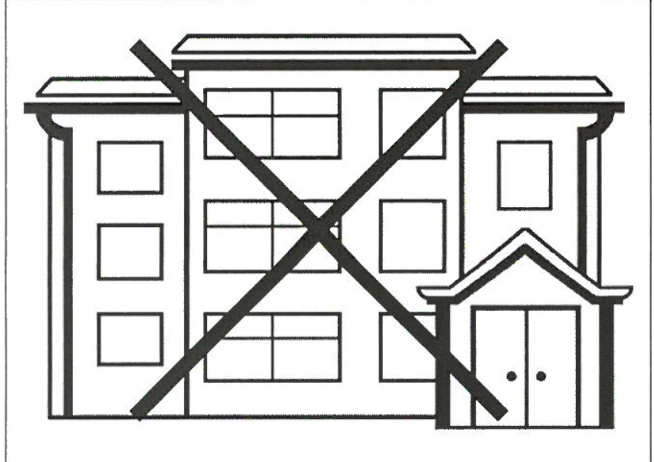
We decided that the owner of Winterbourne View was not doing enough to protect the people who use this service from unsafe care.

What we found out about Winterbourne View	
	What Winterbourne View was not doing well
	The managers did not tell us about important things that happened at the service, like people getting injured. They did not tell us when some people left the house without permission.
	The ways that the service planned and delivered care did not meet the needs of people who used the service.

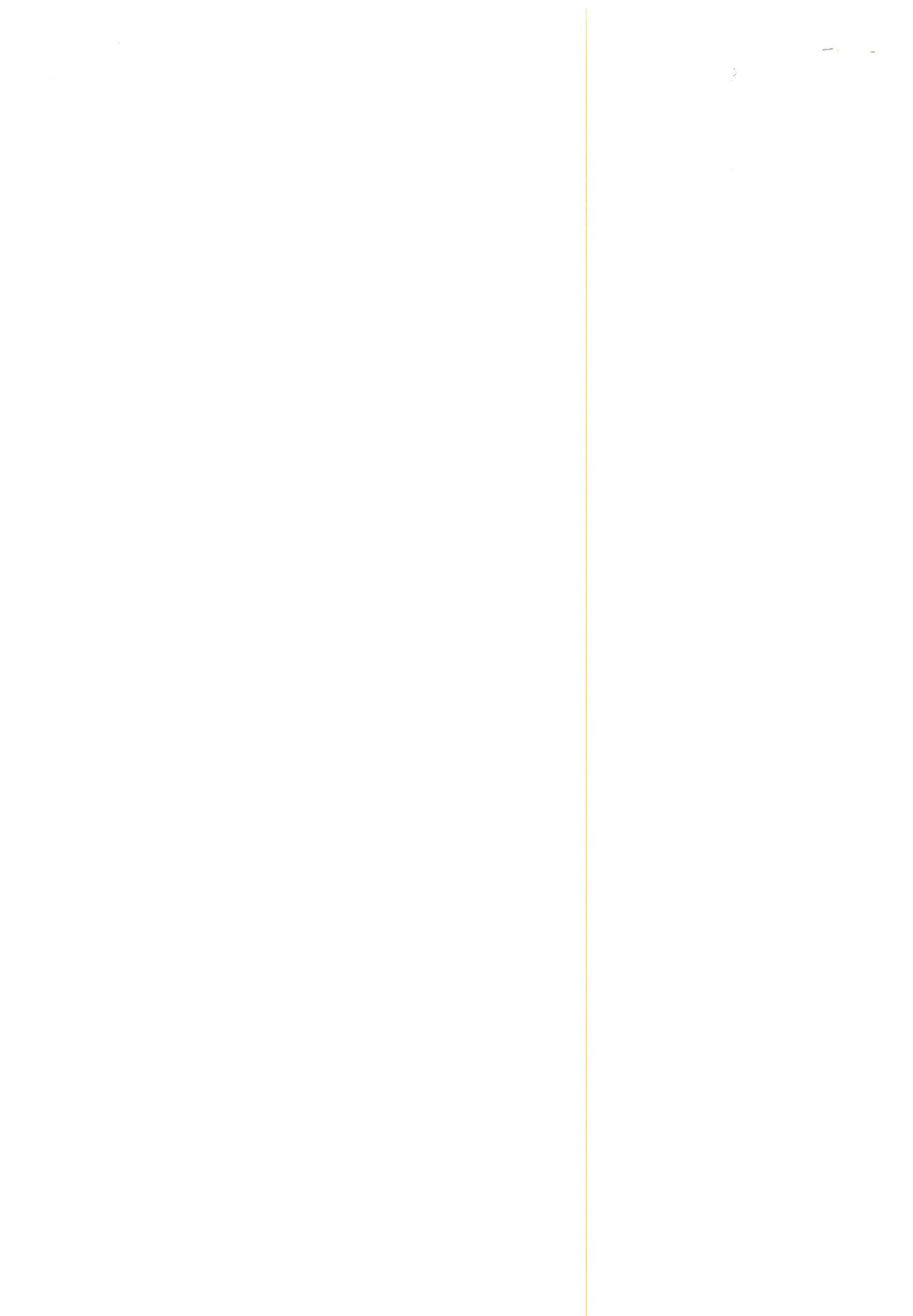
	The systems that the service used to check the quality of care were not good enough.
	The managers were not able to deal with any problems that could affect the health and safety of people who used the service. This included people being abused.
	They did not reply to some of the complaints made by people who used the service. This included complaints about abuse.

	When managers looked into the poor behaviour of staff, they did not do this carefully enough to keep people safe.
	Staff sometimes held people down in a way that is not legal.
	The service did not make sure that it only gave jobs to people with the right skills. It did not manage staff properly, and it did not give them the right sort of training.

	**Action we have taken against the service at Winterbourne View to make things better for people**
	We stopped any more people coming to stay at the service.
	We worked with the council and the NHS to make sure that people were kept safe until they went to live in a new place.

	Because we were still so concerned about what we found, we stopped the owner from running any more services at Winterbourne View.

What some words and pictures mean	
Owner	The person or organisation that owns the service.
Staff	People who work at the service and help people who use it.
Essential standards	The most important rules about how a service should keep people safe and meet their needs.
	People should have a written plan about how they will stay healthy.



While none of us would have wished for the events at Winterbourne View to have happened, if nothing else they provided the impetus for the government and organisations that have responsibility for standards and quality in care provision to reform and change the sector and its practices.

Even if this is a case of locking the stable door after the horse has bolted, all of us must now face up to the challenge to, as Norman Lamb said in his statement, "act decisively and end the scandal of poor care".

Many of the recommendations in the Department of Health's report on Winterbourne View have already been met by the new board at Castlebeck; we have acted decisively in making changes and believe our experience can provide lessons for others in the sector.

Central to these changes has been active engagement with our stakeholders, including service users, their families and our staff, to find out what they expect from us, what they are happy with and - most importantly - what they think needs changing. We are now using tools to help us to establish a baseline and measure organisational progress.

This work has culminated in the publication of a new quality strategy - a blueprint for our organisation with a primary goal of doing our best for every individual in our care and to do that in a way that is safe (person-centred and rights-based), sound (high quality and appreciative) and supportive (empowering and transforming).

The document sets out the practical steps for services to achieve seven real strategic aims.

These include to work in partnership with the people who use our services and their families, increasing choice and creating opportunity for their voices and feedback to be heard and acted on at all levels of the organisation.

We also want to ensure we always respect the individuality of our service users and uphold their right to a safe, respectful and dignified experience.

We will encourage the people who use our services to be part of their local communities and to provide opportunities for them to participate in activities that promote their independence.

Maximising health and wellbeing and agreeing clear outcomes for those we serve and demonstrating good value for money are key elements of our quality strategy.

This is underpinned by actions to strengthen the skills and competency of our workforce, including a restating of our values; and finally, we have improved our systems of compliance and audit and want to ensure we embed quality and governance in all we do.

Even before the Department of Health's report, we had a strong commitment to working closely with commissioners, people who use our services and their families to create care pathways that enable people to return to their communities as soon as possible. This now reflects government policy as recently restated by Norman Lamb.

But the Department of Health's plans go beyond the type and quality of care provided, including holding boards, directors and senior managers accountable for the safety and quality of care that their organisations provide. One implication of this is that the sector needs to reflect on how information about patient experience and outcomes is gathered, made available and discussed at each level of the organisation and importantly, at executive board level.

At Castlebeck, we now ensure that matters relating to the safety of service users, their experience and the quality of care are prioritised at board meetings, individual service review meetings and in corporate communications.

While there is always more to do, in the relatively short time I have been at Castlebeck I have seen real and positive change. Key to this has been an unwavering organisational commitment to the delivery of services that are safe, sound and supportive and a zero tolerance approach to poor practice.

There is now purposeful leadership at all levels that is committed to putting the aims of our quality strategy into operation, and making real the aspirations contained within it. All this bodes well for the future.

Let us hope that Winterbourne View may indeed be a watershed moment that results in positive changes in the sector that garners our energies and talents and reminds us that the stakes are truly unbearable if we fail. As a family carer of someone who is supported in one of our services responded simply and succinctly: "It is all built on trust, so I trust you to look after my son." I don't think I have ever heard a more powerful call to action.

Debra Moore is the Castlebeck's group director of nursing and patient safety

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Winterbourne View nurses jailed as allegations of abuse spread

By Sally Gillen

The RCN has welcomed the jailing of two learning disability nurses for neglect at Winterbourne View, ahead of a documentary that suggests mistreatment of patients is more widespread.

Kelvin Fore and Sookalingum Aboo were jailed for six months last week after admitting wilfully neglecting people with learning disabilities at the residential hospital in Bristol.

Their neglect was exposed by BBC Panorama documentary makers in 2011, who were due to broadcast a follow-up investigation on the treatment of learning disability patients as Nursing Standard went to press.

The pair, who entered guilty pleas, have been placed on interim suspension orders by the Nursing and Midwifery Council. They were sentenced alongside four care workers.

This week's Panorama was due to reveal that 19 of the 48 former Winterbourne residents have been involved in incidents of concern since being moved to other institutions. The documentary claims families were alerted to safeguarding issues, but it is not clear how many of the alerts related to abuse. One former resident, Simone, was moved to Postern House, run by Ridgeway Partnership NHS trust. Her notes reveal she was restrained a dozen times in three hours.

Whistleblower

A trust spokesperson said: 'We do not believe that anything that happened at any Ridgeway site is comparable to the cases at Winterbourne View.'

An RCN spokesperson said: 'The college condemns abuse of vulnerable people in any form. We welcome the fact that the original abuse has now led to custodial sentences for several of the perpetrators.'

Nurse Terry Bryan, whose concerns led to the original documentary, welcomed the sentences, saying they send the right message about turning a blind eye to abuse.

Winterbourne View was closed by its owners Castlebeck in 2011.

Castlebeck claims extensive changes have been made across its 12 hospitals since the abuse was exposed. It is working through a 51-point change programme, and has already implemented 46. In October 2011, learning disability nurse Debra Moore was appointed to develop professional leadership within its nursing workforce.

Castlebeck will no longer be a sponsor of RCN Publishing's 2013 learning disability nursing award. A company spokesperson said: 'The decision to accept sponsorship from Castlebeck was taken last month based on the substantial developments within the company since the first Panorama programme was shown.

'However, the very strong reaction from many learning disability nurses across the country has led to RCN Publishing withdrawing from the sponsorship arrangement.

'As a prime opportunity to promote excellence in learning disability nursing throughout the UK, it is important that the award continues to have the support of the profession.'

'We don't use end of life pathway to clean NHS of the old and infirm'

Palliative care nurses have reacted furiously to criticism that some patients are 'shunted' on to an end of life care pathway because they are a burden to the NHS.

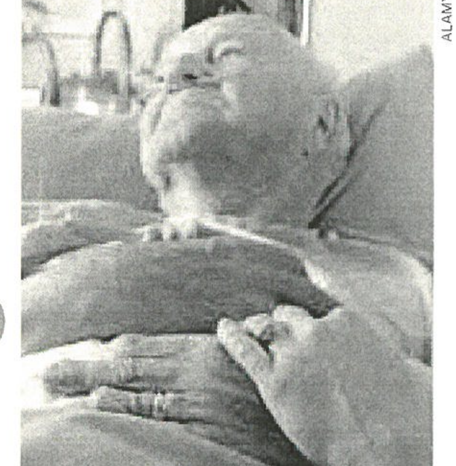
The National Nurse Consultant Group (Palliative Care) said it deplores such charges against the use of the Liverpool Care Pathway.

Speaking for the group, Margaret Kendall, a nurse consultant in palliative care in Lancashire, said: 'The pathway was not introduced to "clean the NHS of the old and the infirm" as has been cruelly suggested in some press reports. It is a specific document developed to guide the assessment, delivery and evaluation of care during the last days of life.'

The Association for Palliative Medicine began a review of the pathway's processes last week. Some families say their relatives were put on the pathway prematurely and without consultation with loved ones.

Join the debate online

Do you support the Liverpool Care Pathway? Share your views on the issue by voting at www.nursing-standard.co.uk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