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Winterbourne View

Summary of the Government Response

What happened at Winterbourne View?

On 31 May 2011, an undercover investigation by the BBC's Panorama programme revealed criminal abuse by staff of patients at Winterbourne View Hospital near Bristol. After its broadcast:

- Winterbourne View closed, with the remaining residents placed in other settings;
- South Gloucestershire Safeguarding Adults Board began a Serious Case Review;
- the police launched their own investigations, with 11 criminal convictions; and
- The Care Quality Commission (CQC) inspected all hospitals and homes operated by Winterbourne View's owners (Castlebeck Care) and conducted a wider "health check", inspecting 150 learning disability services across England.

In addition, the Government set up its own Review, led by the Department of Health (DH) to:

- investigate the failings surrounding Winterbourne View;
- understand what lessons we should be learning to prevent similar abuse; and
- explore and recommend wider action to improve quality of care for vulnerable groups.

An interim report was published in June 2012, followed by the full Government response to Winterbourne View in December 2012.

About Winterbourne View Hospital

Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients in two separate wards, and was registered as a hospital providing assessment, treatment and rehabilitation for people with learning disabilities. It closed in June 2011 after the Panorama investigation.

What did the Government Review find?

Drawing on the Serious Case Review, as well as reports from the police, the CQC and the local NHS, the Review drew the following conclusions:

- **Patients stayed at Winterbourne View for too long and were too far from home** – the average length of stay was 19 months. Almost half of patients were more than 40 miles away from where their family or primary carers lived.
- **There was an extremely high rate of ‘physical intervention’** – well over 500 reported cases of restraint in a fifteen month period.
- **Multiple agencies failed to pick up on key warning signs** – nearly 150 separate incidents – including A&E visits by patients, police attendance at the hospital, and safeguarding concerns reported to the local council – which could and should have raised the alarm.
- **There was clear management failure at the hospital** – with no Registered Manager in place, substandard recruitment processes and limited staff training.
- **A ‘closed and punitive’ culture had developed** – families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.

The Review also exposed wider concerns about how people with learning disabilities or autism and with a mental health condition or challenging behaviours were being treated in England:

- **Inappropriate placements** – too many people are being placed inappropriately in hospitals for assessment and treatment, and staying there for long periods.
- **Inappropriate care models** – too few people are experiencing personalised care that allows them to be in easy reach of their families, or their local services.
- **Poor care standards** – there are too many examples of poor quality care, and too much reliance on physical restraint.

“We should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment.” –

Transforming Care: a National Response to Winterbourne View Hospital

What actions did the Government Review propose?

The Government has proposed a series of measures to improve care for people with challenging behaviour in a new **Programme of Action**. These include:

An end to all inappropriate placements by 2014 – so that every person with challenging behaviour gets the right care in the right place:

- any adult who is in a specialist autism or learning disability hospital setting will have their care reviewed by 1 June 2013; and
- if they would be better off supported in the community then they should be moved out of hospital as quickly as possible, and no later than 1 June 2014.

Stronger accountability and corporate responsibility for owners and directors of private hospitals and care homes:

- The Department of Health will examine how organisations and their Boards of Directors can be held to account for the provision of poor care or harm, and set out proposals in the Spring to strengthen the system where there are gaps.

Tighter regulation and inspection of providers

- the CQC will tighten inspection and regulation of hospitals and care homes for vulnerable groups, with more unannounced inspection and greater involvement of service users and their families; and
- the CQC will hold organisations to account more vigorously for any failures to provide good quality care in line with the legal requirements.

Improving quality and safety standards, including more staff training and better leadership in care settings:

- new guidance will be published on training standards, codes of conduct, better commissioning practices and a code of ethics by various national bodies in 2013;

- stronger rules on social services departments' responsibilities for safeguarding issues are included in the draft Care and Support Bill; and
- the Department of Health will work with professionals, providers, people who use services and families to develop and publish by end 2013 guidance on best practice so that physical restraint is only used as a last resort where someone's safety is at risk and never to punish or humiliate.

Better local planning and national support:

- the NHS and councils are expected to work more closely on joint plans in future, with pooled budgets to ensure adults with challenging behaviour get the support they need; and
- a new NHS and local government-led joint improvement team, funded by the DH, will help guide local teams, supported by a Concordat pledging commitment from over 50 national partners to raise standards.

Greater transparency and strong monitoring of progress:

- The DH will develop a range of measures and key performance indicators to help local councils assess the standard of care in their area; and
- The Learning Disability Programme Board, chaired by the Minister for Care and Support, will monitor progress and publish milestones.

What happens next?

The Review makes it clear that the Government expects urgent progress to be made on improving standards. In your area you can expect that:

- NHS and social care commissioners will review all current hospital placements by June 2013;
- NHS and social care commissioners will support everyone inappropriately placed in hospital to move to community based support as quickly as possible and no later than 1 June 2014; and
- 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 which accords with the model of care by April 2014.