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

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

Date: 21 September 2011

**Gateway Reference number: 16651**

Dear colleague

**DH REVIEW - WINTERBOURNE VIEW:**
**UPDATE ON CQC LEARNING DISABILITY REVIEW**

This letter is to update you on the Department of Health review following the events at Winterbourne View Hospital; to alert you to the forthcoming inspection by the Care Quality Commission (CQC) of 150 services that provide care for people with learning disabilities; and to set out the action needed by NHS bodies and local authorities.

## Background

As you will be aware, on Tuesday 31 May 2011, BBC Panorama broadcast a programme uncovering details of systematic abuse of patients by staff in Winterbourne View, a 24-bedded independent hospital run by Castlebeck Care (Teesdale) Ltd specialising in assessment and treatment for people with learning disabilities and challenging behaviour. The Care Quality Commission undertook a responsive review of Winterbourne View in June 2011. This found serious concerns about the safety and quality of the service. The CQC took enforcement action and the hospital has now closed.

The CQC inspected another 23 Castlebeck Care services in England and reported on 28 July (reports are on the CQC website at www.cqc.org.uk). While half of these services were found to be compliant with safety and quality requirements, the CQC had serious concerns about four locations and has taken further action. Two of those services, Rose Villa and Arden Vale, were closed in August.

Departmental officials will undertake a review of the roles of all the agencies involved in this case drawing together the key lessons for policy and practice from the reviews and investigations being undertaken by CQC, the NHS and safeguarding boards. The terms of reference (published on 21 June) cover the implications of Winterbourne View for the policy and practice of providers, commissioners, regulators and the Government[1]. The Written Ministerial Statement published on 8 July provides further details on the different elements of the review.[2]

**CQC wider learning disability review**

The CQC is carrying out a focused inspection programme that will review care provided by hospitals for people with learning disabilities. The review will be in two phases:

- **phase one** - will consist of the inspection of around150 services that provide health care for people with learning disabilities. CQC have trained the teams for the first phase of inspections and are undertaking pilots. The roll-out will start in early October and is planned to complete in February. Where CQC identifies care that is not meeting requirements, it will be able to use its full range of enforcement powers to take immediate action to require hospitals to make necessary improvements.
- **phase two** will use the learning from phase one to look at a sample of other registered services covering alternative models of provision for people with learning disabilities. As it is using the learning from phase one the detail of this has not yet been developed but CQC expect this to be completed in March 2012.

<u>Action needed</u>

These CQC inspections will be unannounced. However, on the day of the inspection, CQC will alert the learning disability lead at the relevant Strategic Health Authority and the DH Deputy Regional Directors Social Care and Partnerships who will in turn alert the PCT cluster, PCT and local authority involved.

Where the CQC advise that regulatory action may be taken against a facility, we are asking agencies to appoint a lead commissioner to coordinate the work of all commissioners of patients/residents for that facility to ensure the welfare of the individual residents.

Where lead commissioning arrangements are not already in place and the facility is a health care organisation we would expect the host PCT to take this lead commissioner role. Where the facility is a residential care home we would expect the host local authority to take this lead commissioner role.

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[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127739

[2] http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110718/wmstext/110718m0001.htm#1107182000010

I appreciate that some host organisations may not have commissioned services from the facility on their patch but feel that they are best placed to provide local co-ordination with CQC on the inspection and subsequent report as well as any improvement plan to ensure compliance. I asked the relevant PCTs and local authorities to take a similar approach in working with the CQC when their reports on Castlebeck Care services were published in July.

The key priority is to ensure the safety and well being of the people involved. This will include identifying what additional supervision and support is needed to assure that the quality of services are sufficient for the individuals concerned. Where there are safeguarding concerns, the Local Safeguarding of Adults Boards need to be closely involved.

Yours sincerely

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Director, Mental Health and Disability

Lyn Simpson
Director of NHS Operations