Written Ministerial Statement

DEPARTMENT OF HEALTH

Events at Winterbourne View Private Hospital

Tuesday 7 June 2011

The Minister of State, Department of Health (Mr Paul Burstow): This Government believes that people with a learning disability have the right to lead their lives free from fear and discrimination, to receive the care and support they need, and to be treated with dignity and respect.

The abuse at Winterbourne View exposed by whistleblower Terry Bryan and documented by the BBC Panorama team, will be a cause of enormous concern not just to the families and patients affected but to all who are concerned about the care and support society provides to vulnerable people. The Department extends its deepest sympathy to those who have suffered abuse and all those who love and support them.

The responsibility for the quality and safety in care crucially depends on:

> providers, who have a duty of care to each individual they are responsible for, ensuring that services meet individual needs and that there are systems and processes in place to ensure there is effective, efficient and high quality care;
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> commissioners (both Primary Care Trusts and Local Authorities), who are responsible for purchasing care which meets people's needs and ensuring that they are clear about the quality and effectiveness of that care; and
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> the regulators (both the quality regulator and the professions' regulators), who are responsible for assuring the quality of care.

Following an approach from Panorama on Friday 13 May, the national and local agencies involved have acted promptly and decisively to resolve the situation. Their first priority was ensuring the safety of patients at Winterbourne View.

A criminal investigation is also underway and the House will understand that I am limited in what I can say about particular events to avoid compromising police activities.

The steps taken since 13 May include:

South Gloucestershire Council called an immediate multi-agency adult safeguarding meeting. This meeting included the local authority, the local NHS and the police, together with the Care Quality Commission (CQC) and Castlebeck Care (who are the providers of services at Winterbourne View) . Immediate action has been taken to assure the safety of current patients, including the suspension of 15 staff and a decision not to accept further patients at Winterbourne View.
NHS commissioners have also put in place independent clinical and managerial supervision, and commissioned independent assessments of all current patients. All people in Winterbourne View now have a personal advocate;

CQC is taking enforcement action;

all admissions to the unit have been suspended; and

CQC is working with others to vacate the unit and appropriately relocate the patients through a systematic search for suitable alternative placements, taking into account the specialist needs of the patients and the wishes of their families.

CQC has acknowledged that there were indications of problems at Winterbourne View which should have led to it acting sooner. CQC has issued an unreserved apology to those it has let down. Jo Williams, Chair of CQC, has also written to the Department expressing her regret for CQC's failure to act in this case. She, and CQC staff are fully committed to learning the lessons from this tragic case and to making sure that when there are signs of poor care, CQC acts quickly to protect vulnerable people. In seeking to strengthen CQC as a quality inspectorate, we will work closely with CQC to ensure it is able to carry out its functions effectively and efficiently.

In the light of incidents at Winterbourne View, CQC has started an immediate responsive review of all services run by Castlebeck Care (a further 22 locations in England). Inspections will be completed within the next 2 to 3 weeks. Reports on these individual services as well as a summary report will then be publicly available on CQC's website.

In addition, CQC will begin a focused inspection programme which will review care provided by hospitals for people with learning disabilities. The three month programme of reviews will involve unannounced inspections at a sample of the 150 hospitals that provide care for people with learning disabilities. 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.

Each patient at Winterbourne View has been regularly reviewed by a multi-disciplinary clinical team on behalf of the primary care trust that commissioned their

care. In many cases, this process has involved conversations with patients and relatives. All patients had been reviewed in the last six months, most in the past three months. Those primary care trusts who commissioned the care for the patients who were resident in Winterbourne View are carrying out an urgent review of the processes used to commission and review patients in privately provided services. The outcome will be fed into the wider multi-agency safeguarding review.

On 1 June 2011 South Gloucestershire Council announced that it will lead an independently-chaired serious case review (involving all agencies) which will look in detail at the specifics of this case and we will consider its findings carefully.

I asked officials on 18 May to undertake an examination of the roles of all of the agencies involved in this case drawing together the key lessons from the reviews being undertaken by the CQC, the NHS and safeguarding boards. The Department will be assisted in that task by Mark Goldring, the Chief Executive of MENCAP, who will not only bring an independent perspective but also a depth and breadth of knowledge of the needs of people with learning disabilities. Ministers will then report further to Parliament.

The planned reforms for health and social care should also increase our ability to drive up standards in services and to deliver joined-up services and optimal care to patients with highly specialised needs. Subject to the NHS listening exercise and the passage of the Health and Social Care Bill, the NHS Commissioning Board will commission specified specialised services, with commissioning consortia responsible for commissioning other complex services. Through consortia, general practitioners and other clinicians will have new opportunities to shape the way that health services are designed and delivered. Taking into account the increasing range of NICE quality standards, consortia will work closely with secondary care and other healthcare and social care professionals, and with community partners.

We will ensure that there is particular emphasis within the 'pathfinder' programme on testing ways of ensuring that consortia quickly develop knowledge and expertise in relation to more complex and specialist services. This will include exploring joint commissioning with local authorities, for instance in relation to care and support for people with long-term mental health conditions, and people with learning disabilities, allowing people to remain in their local communities maintaining their relationships with family and friends.

We will ensure that the NHS Commissioning Board has a particular focus on promoting quality improvement in relation to more complex or specialist services.

We have also announced our intention to make safeguarding adults boards a legal requirement. This will strengthen the local governance and accountability of safeguarding arrangements. It will enable local partners in local authorities, the NHS and the police to work closely with their communities to safeguard vulnerable adults. Safeguarding adults boards currently exist in every local authority but are not mandatory. By legislating we intend them to make them stronger in their efforts to prevent abuse and to respond unequivocally where it does occur.

We will also take steps to support, and respond to, whistleblowers. Our proposals for HealthWatch mean that local HealthWatch organisations could ask CQC to investigate services where they have concerns. In addition, proposals for local HealthWatch to signpost people to information about services and help them if they want to complain about NHS services would provide additional "early warning" of problems with particular services. This could lead to HealthWatch being able to "enter and view" services and make recommendations about improvements.

Every part of the system must be working to drive up standards and take collective responsibility for minimising the chances of this series of events happening again.