Transforming care:

A national response to Winterbourne View Hospital

Department of Health Review: Final Report

Easy Read version

What will you read about?

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

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.

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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?

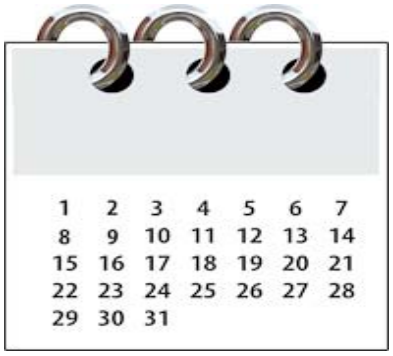
The terrible things that happened at Winterbourne View set off a wider review into how people with challenging behaviour are treated all over England.

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.

Safeguarding

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.