Internal management review of the regulation of Winterbourne View

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Foreword

People with learning disabilities, challenging behaviour and mental health needs are among the most vulnerable people in our society. When I learned of the abuse of the people at Winterbourne View, I requested a full and in-depth analysis of what had happened within the Care Quality Commission and its predecessor organisations concerning the regulation of Winterbourne View.

It is a matter of public record where we acknowledged that we had the opportunity to respond to the issues of unacceptable behaviours taking place in Winterbourne View raised by the whistleblowing concerns and that we failed to directly respond to the whistleblower.

This review has also highlighted that whilst there was nothing in the pattern of notifiable incidents that would have led us to make different regulatory judgments, it is clear that we and our predecessor organisation, the Healthcare Commission, failed to routinely follow up on the outcomes of safeguarding alerts and incorporate these into the regulatory records.

I particularly wanted this review to be able to look in detail at process and behaviours and to identify what we could have done differently, both as an organisation in our own right, and as part of the wider system, so that we can take action to improve our ways of working.

Where we needed to make immediate changes to our ways of working, these were assessed in CQC through our existing internal governance arrangements and structures and implemented. As a result of the specific issues identified around how we work with whistleblowers, and the lack of appropriate response to the whistleblower in this instance, a review of processes was carried out by our National Customer Services Centre. As a result of this review, a specialist team has been put together to deal solely with whistleblowing allegations. This team has had specialist training, and our compliance inspectors have had additional training on how to work with whistleblowers. Since the publicity around Winterbourne View, we have seen an increase in the number of whistleblowing allegations coming through our National Customer Services Centre, all of which are being followed up by our compliance inspectors as appropriate.

We have strengthened internal governance arrangements and assurance mechanisms around safeguarding alerts and referrals. The CQC Risk and Escalation Committee has a safeguarding development plan that captures changes we need to make to improve our approach and processes as we constantly learn more from the changes we have already made to our regulatory model and from the inspections of the 150 learning disability services across England that we have commenced since the closure of Winterbourne View. I am committed to monitoring the changes we make to ensure they happen and to report regularly on these to the CQC Board in public.

There are of course a number of other internal management reviews being carried out as well as the Serious Case Review, all of which will seek to identify the failings

across the system. This report will be our formal contribution to the Serious Case Review. I want to thank all the staff in CQC and key external stakeholders who were formally interviewed and have provided us with the raw materials we need to make improvements to our management processes and to refine our regulatory model. In particular, I would like to thank Meeta Patel and Molly Corner for their respective administrative and editing functions in helping to put the report together.

The unacceptable events at Winterbourne View have revealed a number of system weaknesses and, from a CQC perspective, process and management failures. The recommendations it proposes identify changes not just to the way we work, but to the ways in which we work with the adult safeguarding teams and boards, commissioners, other regulators the system performance managers and providers of care. I have asked that a detailed action plan be developed in response to these recommendations, and progress against this plan is reported to the Board, who will take a role in ensuring this change happens.

We will play our part and, together, we all have the responsibility to make sure that the care system does all it can to respect the dignity and rights of those who are most vulnerable and in need our protection.

Cynthia Bower

Introduction

1. Winterbourne View was a hospital for the assessment and treatment of people with learning disabilities who had additional complex needs such as mental health problems or conditions such as epilepsy or autistic spectrum disorders. It was run by Castlebeck (Teesdale) Ltd. It closed in June 2011 following a BBC Panorama programme expose about the abuse of patients at the hospital which raised concerns about the failure of the health and social care system to protect some of the most vulnerable individuals in its care.

2. Castlebeck (Teesdale) Ltd was registered with Companies House in 1986. It is a specialist provider of healthcare and support for people with learning disabilities, complex needs and behaviour that challenge services. It also offers specialist support for people with mental health needs; people on the autistic spectrum with and without a learning disability and for people with acquired brain injuries with associated challenging behaviour. The company provides services in locations in the Midlands, North East England and in Scotland. Winterbourne View and Rose Villa were the only two services that the company had in the South West of England

3. A senior member of staff at the hospital raised serious concerns about the care provided at Winterbourne View, initially with the management of the hospital, then with the South Gloucestershire Adult Safeguarding Team and finally with Care Quality Commission. The Care Quality Commission has already acknowledged that we did not respond as effectively as we would have wanted in response to the whistleblowing concerns.

4. In response to the serious issues raised about the care at Winterbourne View, the Care Quality Commission undertook to carry out an internal management review to establish a full and comprehensive picture about the regulation of the hospital from the time of its registration as a provider of services to the time of its closure following the failures of care.

5. We have a duty and responsibility to learn the lessons from the system failure for Winterbourne View so that we make improvements to our regulatory model. But we must also contribute from these lessons learned to improvements in the commissioning, performance management and safeguarding requirements which are delivered by other parts of the health and social care system.

6. The terms of reference for the internal management review (see Appendix 1) set out the scope for the work. Where we have seen the opportunity to make immediate changes to our own internal process, procedures, policies and regulatory framework, we have already done so in the interests of improving monitoring of compliance with essential standards of safety and quality for people who use services.

7. The report is a synthesis of reviewing all the appropriate documentation that the Care Quality Commission holds concerning Winterbourne View, and interviewing all the relevant individuals both in the Care Quality Commission

and externally who, as part of the health and social care system, have had some part to play in the way in which care at Winterbourne View was commissioned, delivered, managed and regulated.

8. It is structured and presented in a chronological fashion. Where there are recommendations linked to the review these are presented at the end of each section. A composite list of the recommendations is shown in Appendix 2.

9. The content and its findings have also been subject to expert challenge by Peter Hay, who is the Strategic Director of Adult and Community Services at Birmingham City Council and current President of the Association of Directors of Adult Social Services, and by Andrew Cozens, Strategic Lead for Adult Social Care and Health at the Local Government Group.

10. This report will be one of several that will be written and published about the events at Winterbourne View and the failures of the system to protect those in its care. It will be submitted to the organisations that are also going to publish reports as our formal position regarding the regulatory processes of Winterbourne View. It will also be our formal contribution to the Serious Case Review being conducted by the South Gloucestershire Safeguarding Adult Board.

11. The recommendations in the report specifically related to the Care Quality Commission will be used as a baseline to measure improvements in our own processes and procedures to improve the regulatory model and outcomes for people who use services. These will be included in the Care Quality Commission business plan and reported on in our corporate performance updates to the Board for 2012/13 as a set of requirements specifically linked to the lessons learned from Winterbourne View failures.

Background

12. Before setting out in detail the chronology of regulatory activity regarding Winterbourne View and the lessons learned it is imperative to lay out the policy context for services commissioned and delivered to those with learning disability, challenging behaviour and mental health needs. This is necessary to better understand the way in which regulation of these services was delivered and more importantly needs to be delivered going forward.

Policy

13. In 1993, the Department of Health published *Services for people with Learning Disabilities and Challenging Behaviour or Mental Health Needs.*[1] This was updated in 2007 by the Department of Health as a revised edition.[2] The reports, authored by Professor Jim Mansell who featured on the Panorama programme, made recommendations to support commissioners in developing local services for people whose behaviour presents a challenge.

14. In 2001, the Department of Health published *Valuing People, a strategy for the development of learning disability services for the 21st Century*.[3] It outlined proposals for changes to the way learning disability services were to be configured, moving away from institutional long-stay hospital and campus style services to services provided in the community closer to people's homes. Where there were particular requirements for hospital services, this would generally be for people with complex needs, such as mental health problems or challenging behaviour, in-patients would be treated in smaller hospitals on a short stay basis. The closure of these institutional style services was initiated in 2002, with a target date of 2004 for these services to be closed.

15. *Valuing People* also made provision for the creation of Learning Disability Partnership Boards, to be implemented from 2004. Their purpose is, amongst other things, "*overseeing the inter-agency planning and commissioning of comprehensive, integrated and inclusive services that provide a genuine choice of service options to people in their local community*".

16. Professor Mansell's second report identified that although good progress had been made on many fronts since the publication of *Valuing People* in 2001, the government strategy for learning disability, challenging behaviour and mental health needs had lagged behind. The report cited that there had been a failure by commissioners to develop the right kind of services and that had led to an increase in the use of expensive placements away from the person's home locality, and where the services were not always of proven quality.

17. He advised that in terms of service models:
"*commissioners should stop using services which are too large to provide individualised support; serve people too far from their homes; and do not provide people with a good quality of life in the home or as part of the community, in favour of developing more individualised, local solutions which provide a good quality of life.*"

1 *Services for people with Learning Disabilities and Challenging Behaviour or Mental Health Needs*, Department of Health, 1993.
2 *Services for people with Learning Disabilities and Challenging Behaviour or Mental Health Needs, Revised edition,* Department of Health, 2007
3 *Valuing People,* Department of Health, March 2001

and that:

"*the appropriate role for psychiatric hospital services for people with learning disabilities lies in short term, highly focused assessment and treatment of mental illness. This implies a small service offering very specifically, closely defined, time limited services*".[4]

Commissioning guidance for learning disability services

18. The Department of Health published a guidance document in October 2007 called *Commissioning Specialist Adult Learning Disability Health Services.*[4] The guidance noted that the commissioning of specialist health services for people with a learning disability is an important function of Primary Care Trusts and one that should be driven by the principles of the Valuing People strategy.

19. The guidance was very explicit:
"*There is growing concern that some areas of the country have found it difficult to develop commissioning strategies for specialist adult learning disability health services that reflect both current policy and best practice. This has led in places to inappropriately funded services, outdated service models, the poor development of a community infrastructure and an over reliance on bed based services including NHS campuses, and distant NHS and independent sector placements*".

    It went on to say:

    "*these and associated problems can mean that:*

    - *people with learning disabilities can get stuck in the NHS system or independent health placements often for many years and many miles from their homes and /or:*
    - *people are often placed in increasingly expensive and inappropriate social care services that are failing to meet their needs;*
    - *people experience serious difficulty getting their health care needs met and are at serious risk of neglect, and at worst, abuse;*
    - *both family carers and paid carers receive inadequate support and training by specialist health care staff, resulting in an increased demand for health interventions at a later date*".

20. It is clear from the Department of Health Guidance on policy and commissioning and the underpinning research that those individuals who have learning disabilities with challenging behaviour and mental health needs and who are placed in institutional care for long periods, sometimes away from

4 *Commissioning Specialist Adult Learning Disability Health Services*, Department of Health, 2007

their home locality, are potentially more at risk of abuse and neglect.[5] This was the case for some of those patients in Winterbourne View.

21. Whilst it is possible that other reviews taking place about the commissioning of services for people at Winterbourne View will come up with their own recommendations, the Care Quality Commission will have to continue to regulate such institutions for as long as they are part of the matrix of care services for people with learning disability, challenging behaviour and mental health problems. We will continue to do this with the safety of patients at the heart of the process.

22. Funding and commissioning of care for people with learning disabilities is split between the Primary Care Trusts (PCTs) and local authorities. PCTs are responsible for commissioning specialist services, with local authorities responsible for the commissioning of social care needs for people with learning disabilities. In 2008, the Department of Health issued guidance[6] on the transfer of funding from PCTs to local authorities, with a consultation launched in 2010 on the permanent transfer of central funding for social care directly to local authorities.

23. In 2009, the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission jointly published a report on Commissioning services and support for people with learning disabilities and complex needs.[7] Key findings of this work included:

- Access to and treatment from mental health services was poor.
- Arrangements to safeguard people needed improvement, especially where people were wholly dependent on health and social care services for their support.
- Joint commissioning arrangements to benefit people with learning disabilities were taking place unevenly and too slowly.
- Many Learning Disability Partnership Boards were not playing the roles expected by Valuing People
- Many staff, in particular non-specialist health service staff, require development to obtain specific skills, knowledge and attitudes to work with people with learning disabilities and complex needs.
- Health and social care organisations should ensure they share information so they can assess how their services and support meet the needs of people with learning disabilities and complex needs
- There were significant numbers of people living outside their home areas, so that they could lose touch with their local communities

5http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_079989.pdf

6 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_087148

7 http://www.cqc.org.uk/_db/_documents/8071-CSCI-LDisability.pdf

Safeguarding adults

24. The Department of Health and the Home Office published *No Secrets,* guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.[8] The document states that it is the responsibility of the local Social Services Authority to coordinate this multi-agency working. It sets out the roles and responsibilities of each of the different agencies involved, and the management arrangements for safeguarding teams.

25. Adult Safeguarding Teams, also known as Vulnerable Adults Teams, are responsible for the day to day management and resolution of safeguarding alerts and cases. Their role involves filtering referrals, sending those which are not deemed to be safeguarding alerts to other bodies for action, and to undertake case management for those referrals which are taken forward through the safeguarding process.

26. Safeguarding Adults Boards are multi-agency Boards which consider the cases and agree a course of action as a result of the investigation of the alert. The membership of the Board varies in response to the nature of the case being investigated, but would generally include commissioners of services, providers, regulators, the police, other local authority departments, as appropriate, carer support groups and user groups and advocacy services.

27. It is likely that Safeguarding Boards will become a statutory function of Local Authorities within the Social Care White Paper, due to be published in 2012. It is expected that there will be a statutory duty for the Care Quality Commission to be involved in Safeguarding Boards, and it is expected that a representative of the Care Quality Commission will attend all relevant Board meetings.

28. Because of the individual nature of safeguarding alerts, and because there is a loose definition of what constitutes a safeguarding alert, there is little analysis across the system to pick up themes or trends coming up from referrals. Information of this type can indicate problems in residential settings, and could be vital in identifying risk of further harm or systemic abuse in a particular setting. Many referrals made to Safeguarding Teams are not deemed by the teams to be safeguarding concerns, and so are not investigated – the detail of the referral is passed to other relevant bodies for information or further action.

29. Councils in England are now required to complete the Abuse of Vulnerable Adults Data (AVA) return on a yearly basis. Data is collated on referrals known to the Adult Safeguarding teams and their subsequent outcomes aggregated at council level. The first collection in 2010 collected data for a six month period September 2010-March 2011 and was conducted on a voluntary basis. Future collections will cover the whole 12 month period. However, the current

8 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

collection of this data cannot be assigned to an individual care setting and so the data is of limited value to CQC for regulatory purposes.

30. It is difficult to identify statistically where there is a high degree of referral relating to poor safeguarding, and where there is under reporting of harm. A high referral rate may indicate an awareness and sensitivity to safeguarding process and procedure, with a tendency to err on the side of caution; in other situations there may be very few incidents which need to be reported. In either extreme, it is difficult on the face of it to use this as an indicator of a problem.

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.

Whistleblowing

31. The Public Interest Disclosure Act 1998 introduced significant statutory protection to employees who disclose information reasonably and responsibly in the public interest.[9] Special provision is made under the Act for disclosure to prescribed bodies, where disclosures will be protected where the whistleblower meets the criteria for internal disclosure and that the whistleblower honestly and reasonably believes that the information and any related allegation are substantially true. Provision is also made for wider disclosures where claims, as well as meeting the criteria for internal disclosure, are additionally not made for personal gain and that they have been raised with the employer (or a prescribed regulator) unless there is reasonable belief of victimisation or cover up and the matter was exceptionally serious.

32. Guidance on whistleblowing has been published by numerous bodies over the years – the Department of Health, the Nursing and Midwifery Council, the British medical Association and others. In response to the BBC Panorama expose on Winterbourne View, the Care Quality Commission updated its own guidance on whistleblowing in July 2011, outlining the roles and responsibilities of employers and employees as well as guidance to its own staff.

9 http://www.legislation.gov.uk/ukpga/1998/23/contents

Roles of the different regulatory bodies involved with Winterbourne View

33. There were three regulatory bodies involved in regulating the services provided at Winterbourne View. These were the Healthcare Commission, the Mental Health Act Commission, and finally the Care Quality Commission. The Care Quality Commission was created by the merger of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection, and came into being as a statutory body on 1 April 2009.

The Healthcare Commission

34. The role of the Healthcare Commission was to assess the performance of NHS organisations and to regulate independent sector health care providers. The first function consisted of an annual assessment of performance (the Annual Health Check) which for PCTs included an assessment of its performance at commissioning as well as provision of services. Its remit in independent healthcare came from the Care Standards Act 2000, modified by the Health and Social Care Act 2003. As a whole, the Healthcare Commission devoted more of its resources to NHS Annual Health Check requirements than private and voluntary health care in most parts of England.

The Mental Health Act Commission

35. The Mental Health Act Commission was created under the Mental Health Act 1983 with the purpose of safeguarding people detained under the Mental Health Act.[10] Its two main functions were the Mental Health Act Commissioner visits, which happened annually, and the Second Opinion Appointed Doctor Service (SOAD), which is intended to ensure that the care and treatment plans for people detained under the Act are appropriate. They were also responsible for producing an annual statement for each location and an annual report on the use of the Act at a national level.

The Care Quality Commission

36. The Care Quality Commission was created on 1 April 2009, in line with the Health and Social Care Act 2008.[11] It took on most of the functions of the predecessor regulators, the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. From 2010, CQC has begun to regulate providers of services under the Health and Social Care Act. All providers of health and adult social care services are required to be registered with the Care Quality Commission to be able to provide services legally.

10 http://www.legislation.gov.uk/ukpga/1983/20/contents
11 http://www.legislation.gov.uk/ukpga/2008/14/contents

Regulation of Winterbourne View

37. This section covers the history of all the regulatory activity that relates to this hospital. In order to understand the issues, system relationships and the ultimate failure to protect the vulnerable patients the analysis is based around two specific time frames.

38. These are regulation of the hospital from December 2006 – March 2009 when the service was regulated by the Healthcare Commission and the Mental Health Act Commission.

39. The second time frame is from April 2009 when the Care Quality Commission took over health and social care regulation, and incorporated the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection.

40. Table 1 provides an overview of the regulatory interaction with Winterbourne View from the time it was first registered in 2006 to its closure in 2011.

Table 1

March 2005	Castlebeck apply for registration of Winterbourne View under the Care Standards Act 2000.
June 2006	Statement of Purpose submitted to the Healthcare Commission to support the application for registration.
December 2006	Registration granted for Castlebeck to provide services at Winterbourne View following 2 inspections.
14 December 2006	Winterbourne View admits its first patients.
May 2007	Winterbourne View included in the sample of establishments audited as part of the Healthcare Commission's national audit of in-patient services for people with learning disabilities.
June 2007	First self-assessment submitted as part of the annual review process. Assessed as not needing an inspection under the Care Standards Act for the year 2007/08.
September 2007	Mental Health Act Commissioner visits Winterbourne View and spoke to eight detained patients, the Responsible Medical Officer and other staff at the hospital. Nine recommendations were made as a result of this visit.
September 2008	Healthcare Commission carries out a desk-top review of Winterbourne View. Concerns identified include the lack of a substantive Registered Manager for the hospital. An acting

	manager is in place.
December 2008	Healthcare Commission carries out an unannounced inspection. An Improvement Notice is issued requiring the hospital to take immediate remedial action to address environmental issues identified.
19 January 2009	Detailed action plan submitted to the Healthcare Commission to address issues identified during the course of the inspection in December 2008.
March 2009	Mental Health Act Commissioner visits Winterbourne View.
10 March 2009	Castlebeck carry out a section 26 visit. The report is submitted to the Healthcare Commission on 24 March 2009.
24 March 2009	The Healthcare Commission carried out an unannounced inspection to follow up on action against the Improvement Notice, and other statutory requirements from the previous inspection.
May 2009	Mental Health Act Commission publishes its second annual statement. The statement includes three recommendations, including a repeat recommendation from the previous statement.
June 2009	Mental Health Act Commissioner visits Winterbourne View.
October 2009	Winterbourne View submits annual self-assessment to Care Quality Commission. Care Quality Commission decides to undertake an inspection on the basis of the desk-top analysis.
15 December 2009	Care Quality Commission carries out an announced inspection at Winterbourne View.
January 2010	Winterbourne View submits action plan in response to the inspection.
February 2010	Winterbourne View notifies the Care Quality Commission that the UK Borders Agency had arrested two members of staff.
25 September 2010	Mental Health Act Commissioner visits Winterbourne View. Commissioner identified concerns with the quality of the investigation of an incident and requested additional information to be submitted to the Care Quality Commission.
October 2010	Winterbourne View registered under the Health and Social Care Act 2008 in line with legislative requirements. No conditions were put on the registration.
January 2011	Mental Health Act Annual Statement published – incorporating the visits carried out in 2009 and 2010.

17 & 18 May 2011	Compliance Review carried out at Winterbourne View.
27 May 2011	Notices of Proposal issued to Castlebeck proposing to remove registration from Winterbourne View as a result of the Compliance Review.
22 June 2011	Winterbourne View closes; all Patients moved alternative accommodation.

Regulation of Winterbourne View from December 2006 - March 2009 by the Healthcare Commission

Registration of the service

41. In March 2005, Castlebeck Care (Teesdale) Limited applied to the Healthcare Commission under the Care Standards Act 2000 to register Winterbourne View to provide in-patient services to people with learning disabilities and mental health problems or challenging behaviour.[12] The application to register the hospital was made at the same time as a planning application was made to the local authority with a projected date of completion of the purpose built facility by April 2006.

42. The application made to the Healthcare Commission was to provide a 24-bedded acute hospital unit for people with learning disabilities some of whom were, according to the application, likely to be detained under the Mental Health Act as well as those who would be admitted voluntarily. The location for the hospital was a prime office site in Bristol's northern business district close to other business parks, railway and motorway networks.

43. The statement of purpose (part of the legislative requirements) was submitted in June 2006 by Castlebeck in respect of Winterbourne View. This was comprehensive and set out the objectives, the staffing plans which included qualified nurses, consultant clinical psychologist and a full time Consultant Psychiatrist. The statement made clear the Consultant Psychiatrist and Consultant Psychologist provide on going training, academic sessions and support to the staff team. The statement also made clear and explicit that the role of advocates for the patients was vital and welcomed by Castlebeck and Winterbourne View.

44. It stated clearly that Winterbourne View was committed to helping the patients maintain contact with relatives, friends and representatives and they would be accommodating in their activities and schedules to ensure that this was achieved.

12 http://www.legislation.gov.uk/ukpga/2000/14/contents

45. The Healthcare Commission carried out all the relevant staff checks that were required under the Care Standards Act legislation and undertook two site visits before Winterbourne View was granted registration in December 2006. The hospital opened and started admitting patients on 14 December 2006. One of the conditions of the registration was effectively to split the unit into two 12 bedded facilities with the second floor of the hospital restricted to a maximum of 12 patients at any one time.

Ongoing regulatory assessment of the service from December 2006 - March 2009 by the Healthcare Commission

Period one: 1 April 2000 - 31 March 2008

46. Once the hospital was registered it was required to comply with the on-going regulatory assessment processes delivered by the Healthcare Commission under the Care Standards Act 2000, and the related National Minimum Standards.[13]

47. The Healthcare Commission's model for regulation under this legislation meant 'on-site inspections' were carried out to make assessments of standards only where they did not have sufficient evidence of the required level of performance. If an establishment had never been inspected they could be inspected against all applicable National Minimum Standards as set out in the legislation. In any event the Healthcare Commission was required to inspect establishments only once every five years, and had a policy of inspecting a random selection of establishments in addition to those requiring an inspection, with a total of 10% of inspections in any one year being carried out on this random basis.

48. The Healthcare Commission methodology set out a process for an annual desk top assessment of all independent healthcare establishments and institutions including Winterbourne View. As part of this process, providers were required to carry out and submit a detailed self assessment to demonstrate compliance with the regulations.

49. Winterbourne View having commenced its service delivery in December 2006 submitted its first self assessment to the Healthcare Commission in June 2007. The Healthcare Commission desk top review, which included an analysis of the Winterbourne View self assessment as well as a review of statutory notifications, led to the determination that the hospital had been "assessed as not needing an inspection during the period 1 April 2007 – 31 March 2008".

50. In July 2006 the Healthcare Commission and the Commission for Social Care Inspection published a damning report of learning disability services provided

13 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4078367.pdf

by Cornwall Partnership NHS.[14] In response to this report, the Healthcare Commission committed itself to carrying out a national audit of specialist in-patient services for patients with learning disabilities in England.[15] The audit programme included site visits to a sample of 154 individual services out of a total of 638 in England, and the findings were published in 2007.

51. Having made the judgement that Winterbourne View did not need an inspection as part of monitoring compliance with the Care Standards Act 2000, it was audited by the Healthcare Commission in May 2007 some six months into its service delivery.

52. The service was visited by a Healthcare Commission inspector, a carer of a person with a learning disability, challenging behaviour and mental health needs and an expert in learning disability services, which in the case of Winterbourne View was a nurse.

53. At the time of the audit there were nine patients in the service. The audit team found nothing untoward to report on but they did note that the service was still 'new'. There were several recommendations made as a result of the audit, two of which were: to ensure that all staff working in service user areas should have full training in physical intervention, and that the organisations should also include the whistleblowing and adult protection policies in the staff handbook.

54. No action plan was required after the audit, and there is no evidence to suggest one was submitted to the Healthcare Commission to address the recommendations from the audit.

Ongoing regulatory assessment of the service from December 2006 – March 2009 by the Mental Health Act Commission

Period one: 1 April 2007 -31 March 2008

55. Mental Health Act Commissioners visit all places where patients are detained under the Mental Health Act. Accordingly Mental Health Act Commissioners and where relevant, Second Opinion Appointed Doctors, have visited Winterbourne View from the time of its registration until the closure of the service.

56. The Mental Health Act Commissioner visited Winterbourne View in September 2007. As part of the visit the Commissioner spoke to eight of the eleven detained patients, the Responsible Medical Officer and other staff in the unit.

57. The final statement of the Commissioner made nine recommendations some of which related to process around record keeping relating to detention under the

14 http://www.cqc.org.uk/_db/_documents/cornwall_investigation_report.pdf

15 http://www.cqc.org.uk/_db/_documents/LD_audit_report1.pdf

Mental Health Act, some to the environment, whilst others, notably the following, related to care delivery:

- The unit should consider if the restraint policy should be updated and if an audit of the use and circumstances of restraint are necessary.
- The unit should consider ways by which access to advocacy services could be improved.

58. The Commissioner noted that "the unit's practices fall short of best practice in some respects". However, they were confident that Winterbourne View staff would address the recommendations set out in the action plan and the Mental Health Act Commission would follow up the progress although no target dates were set for the completion of the actions required.

59. There was no mandatory requirement for Winterbourne View to submit an action plan to the Mental Health Act Commission and none was submitted voluntarily.

Data and information sharing between the Healthcare Commission, the Mental Health Act Commission, performance managers, commissioners and the South Gloucestershire Safeguarding Board during period one (April 2007 – March 2008)

60. Both the Healthcare Commission and Mental Health Act Commission had visited Winterbourne View during this period. In the case of the Healthcare Commission the visit was linked to the national audit of services and for the Mental Health Act Commission as part of its statutory remit.

61. The mechanism for data sharing and information exchange between the Healthcare Commission and Mental Health Act Commission was through the 'concordat agreement'. This was an agreement between all relevant regulators and performance managers of the NHS and private and voluntary health care services to share information.

62. There were also local management relationships between the Healthcare Commission and Mental Health Act Commission staff across England and it is the case that any concerns about institutional care for those detained under the Mental Health Act could have been shared outside the concordat agreement and structures.

63. There is no evidence that concerns about Winterbourne View such as they were and as recorded in 2007 – 2008 were the subject of any exchange between the Healthcare Commission and the Mental Health Act commission.

64. There was an on going dialogue between the Healthcare Commission and the South Gloucestershire Safeguarding Adult Team. The Safeguarding Team received its first safeguarding alert during this period and there were meetings which were convened to manage the issues raised. Although the Healthcare

Commission did not attend the safeguarding meetings in this period there was a flow and exchange of information.

65. The Mental Health Act Commissioners were not invited to be core members of the South Gloucestershire Safeguarding Adult Board and that would suggest that the evidence that they held was not formally part of the considerations of the Board. However, the Board did steer Winterbourne View to notify the Mental Health Act Commission in one case when there was a safeguarding incident concerning a patient detained under the Mental Health Act. This suggests that appropriate information was exchanged but not routinely and systematically.

Statutory Notifications to the Healthcare Commission under Regulation 28 of the Care Standards Act during year one (April 2007 – March 2008)

66. There were no statutory notifications made under regulation 28 to the Healthcare Commission in the first year of its operation.

67. In February 2008, Winterbourne View did notify the Mental Health Act Commission on the advice of the Safeguarding Adult team in South Gloucestershire about an incident that was being investigated in relation to a detained patient and the outcome from the investigation.

Period two: 1 April 2008 -31 March 2009

Healthcare Commission regulatory activity

68. During the first year of its operation the Winterbourne View facility was not operating at full capacity and there was confidence that the issues raised about service delivery by the Healthcare Commission and the Mental Health Act Commission and the planned responses would be delivered by management and staff of Winterbourne View.

69. The Healthcare Commission received the second annual self assessment from Winterbourne View and commenced their desk top assessment in September 2008. Analysis of the self assessment clearly showed that there were now concerns about Winterbourne View of a different magnitude. The following gaps in assurance were highlighted through the Healthcare Commission analysis:

- There was still no Registered Manager although an application had been received by the Healthcare Commission.
- Safeguarding concerns had been shared with the Healthcare Commission by the South Gloucestershire Adult Safeguarding team but not by Winterbourne View.

- Winterbourne View were unable to give comprehensive details and records about serious untoward incidents (SUIs) for the period of the annual assessment.
- Winterbourne View had declared that they were fully compliant for all mental health standards but could not have been as they had no Registered Manager in post.
- There were protection of vulnerable adults (POVA) concerns noted in the Healthcare Commission analysis. There had been meetings between Cornwall PCT and the South Gloucestershire Safeguarding Board with concerns expressed about the treatment programme for a patient being funded by the Cornwall PCT.

70. As a consequence of this analysis the Healthcare Commission determined that it needed to carry out an unannounced inspection of the Winterbourne View. The proposed date was set for the 1 December 2008.

71. The unannounced inspection focussed on those national minimum standards that the self assessment had indicated were the most relevant. These were around staff training and development, record keeping and information for patients. The assessment found that Winterbourne View was not meeting most of the standards for which they were inspected.

72. The inspection team also observed significant damage to the fabric of parts of the building such as exposed electrical wires, damaged light sockets and damaged power sockets. They also noted that some walls needed replastering because they had been damaged. The Healthcare Commission issued a statutory notice under regulation 51 of the Private and Voluntary Healthcare Regulations 2001. This required Winterbourne View to take immediate remedial action to manage the environmental dangers.

73. The report did not make any link between the damage to the fabric of the building and causality. It is a matter of speculation that it must have been related to the challenging behaviours of the patients, and how effectively and safely these were managed, and satisfactorily resolved.

74. The report rightly recognised that there were issues that Winterbourne View needed to address urgently and set out very specific timescales for all the actions to be delivered. This also meant that the Healthcare Commission would need to follow up with a further inspection to assess the progress against the regulatory actions it had specified in the report.

75. The manager of Winterbourne View also submitted a detailed action plan to the Healthcare Commission on 19 January 2009 setting out actions taken against the statutory requirements identified in the unannounced inspection in December 2008.

76. The submission of an action plan by the provider was a voluntary requirement under the Care Standards Act. The Healthcare Commission could not demand a plan of action.

77. Another unannounced inspection took place on 24 March 2009, some three months after the first inspection and two months after the action plan had been received. These were also the last days of the Healthcare Commission's existence, prior to the establishment of the Care Quality Commission the following month.

78. The report of the follow up inspection in March 2009 noted that the required actions as set out under regulation 51 and specified in the inspection report from the December visit had been met.

79. However, the assessor noted that Winterbourne View was again failing to comply with the regulations in a number of other areas and they were concerned with the lack of progress to address actions other than for the regulation 51 requirements since the December inspection. There were a further set of required actions with specific timescales for their delivery.

80. Winterbourne View failed to submit a further action plan setting out how they were going to address the actions cited in the report following the unannounced inspection in March 2009, although this was not a requirement. This was only picked up in the subsequent annual self assessment which Winterbourne View submitted in September 2009.

On going regulatory assessment of the service from 1 April 2008 – 31 March 2009 by the Mental Health Act Commission

81. The second Mental Health Act Commissioner's annual statement on Winterbourne View was published in May 2009 following the Commissioner's visit in the March 2009.

82. The assessment and subsequent statement made reference to the progress Winterbourne View had made against some but not all of the recommendations since the first visit by the Mental Health Act Commissioner.

83. As a consequence of this assessment there were three recommendations noted in the statement, one of which related to the need for managers in Winterbourne View to audit the restraint of patients detained in the unit. The previous Annual Statement noted this as a recommendation and the Commissioner noted that this had not been undertaken.

84. The action plan agreed with Winterbourne View had no target dates for completion of the actions required. Winterbourne View again did not submit an action plan setting out how it would deal with the requirements set out in the Mental Health Act Annual Statement, because it was not required to.

85. Again there is no evidence to suggest that the Mental Health Act Commission annual statement was seen by the South Gloucestershire Safeguarding Adults Board and the content discussed because the Mental Health Act Commissioners were not members of the Safeguarding Board.

Statutory notifications under regulation 28 to the Healthcare Commission during year two (1 April 2008 – 31 March 2009)

86. The Healthcare Commission received one statutory notification in this period. It was dated the 17 March 2009 and concerned allegations made by one of the patients to their advocate against the staff. Winterbourne View also notified the South Gloucestershire Safeguarding Adult team who advised that a strategy meeting could be arranged if required. Winterbourne View was committed to investigating the allegations.

Statutory notifications under regulation 30 to the Healthcare Commission during year two (1 April 2008 – 31 March 2009)

87. The Care Quality Commission was notified of a change to the responsible individual for Winterbourne View.

Regulation 26[16] report to the Healthcare Commission during year two (1 April 2008 – 31 March 2009)

88. The operational manager for Castlebeck (Teesdale) Limited submitted a section 26 report on 24 March 2009. It was based on a six monthly unannounced visit which was carried out on 10 March 2009.

89. The operational manager had a conversation with a number of staff from the unit. Staff raised their concerns about their vulnerability to allegations and investigations by the police and safeguarding agencies.

90. The operational manager gave patients the opportunity to meet and talk individually. Few accepted the offer but of those who did none raised any complaints on the day. It was noted that there were no patient representatives available to talk to on the day, and that no patients were offered advocacy support. The limitations of the report because of limited input from external sources were not identified as a cause for concern by the Healthcare Commission.

Regulation of Winterbourne View from April 2009 – July 2011 by the Care Quality Commission

91. The Care Quality Commission came into existence on 1 April 2009. The assimilation of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection did not lead to immediate

[16] http://www.legislation.gov.uk/uksi/2001/3965/regulation/26/made

changes in the way that the Care Quality Commission regulated Private and Voluntary Health Care providers.

92. There were legislative transitional arrangements in place which meant that institutions like Winterbourne View were still regulated under the Care Standards Act in April 2009. The transitional regulations required providers who were regulated under the Care Standards Act to re register under the Health and Social Care Act by October 2010.

93. This meant that for the first eighteen months of its operation the Care Quality Commission had to regulate existing providers including Winterbourne View against the National Minimum Standards of the Care Standards Act as had been the case since it was first registered in December 2006. It also had to continue to utilise the existing Healthcare Commission methodology for assessing these providers.

94. In this section of the review, the regulation of Winterbourne View is set out in time frames covering the period of transition from regulation under the Care Standards Act, April 2009 – October 2010 and then covering the period from October 2010 until July 2011 when the institution was regulated under the Health and Social Care Act.

95. It also covers the increasing integration of regulatory activity, process and function between our staff who have duties under the Mental Health legislation and under the Health and Social Care Act.

Period 3: 1 April 2009 – 31 March 2010

96. Having come into existence on the 1 April 2009, the Care Quality Commission was required by government to undertake a substantial programme of registration of regulated providers. The NHS were to be registered for the first time in their history by April 2010, the providers of adult social care and independent health care were to be re-registered by October 2010, dental practices by April 2011 and primary medical services by April 2012.

97. The Care Quality Commission whilst undertaking this significant transformational reform continued to regulate providers like Winterbourne View throughout the change process and did not lose sight of the concerns about the quality and safety of care during this transition.

98. The Care Quality Commission Mental Health Act Commissioner visited Winterbourne View in June 2009 as part of our statutory obligation to visit those patients who were detained under the Mental Health Act. During the visit the Care Quality Commission Mental Health Act Commissioner met with and spoke to patients detained under the Mental Health Act. The patients were complimentary about the medical and nursing care they received.

99. There was acknowledgement that where issues had been raised in previous visits about process and procedure regarding the Mental Health Act and Code of Practice requirements that the Winterbourne View management and staff accepted what was needed and then set about delivering the improvements.

100. Regulation of Winterbourne View during this period was still undertaken against the Care Standards Act using the methodology from the Healthcare Commission.

101. Accordingly, Winterbourne View submitted their annual self assessment to the Care Quality Commission in October 2009. The failure of Winterbourne View Hospital to submit their action plan voluntarily following the second unannounced inspection in March 2009 was immediately picked up through that process. The analysis of the self assessment also took account of the statement made by the Care Quality Commission Mental Health Act Commissioner who visited Winterbourne View in the June 2009.

102. Although that annual statement about the service was favourable the desk top analysis of the self assessment revealed a number of concerns including:

- Reports of serious injuries to patients through regulation 28 notifications;
- No reports of any regulation 26 visits carried out in the previous 12 months. This is where the service is visited by a responsible individual or director or manager of the provider service not directly concerned with the day to day running of the service;
- Increase in safeguarding alerts reported to South Gloucestershire Adult Safeguarding Team by the transfer management team from Cornwall PCT;

103. It was clear to the staff in the Care Quality Commission through the analysis of the self assessment that there were concerns about quality and safety, and that pointed to the need for another inspection of the Winterbourne View.

104. The inspection was carried out on 15 December 2009 and on this occasion it was an announced visit. Inspections were generally unannounced unless there was a particular reason for it to be announced. An example would be to ensure a particular member of staff, such as the Registered Manager, is present at the time of the inspection. The other legacy methodology from the Healthcare Commission was to make an announced inspection if there were regulatory concerns that needed follow up. However, it is not recorded why this inspection was announced, what the rationale was and how the decision was made about announced versus unannounced.

105. The assessments and requirements from that visit were set out in the report and again, there were clearly specified timescales for the actions that needed to be taken by the staff and management of Winterbourne View.

106. Winterbourne View did submit an action plan in January 2010 in response to the requirements set out following the inspection. They gave specific dates for the actions to be achieved and what was to be done.

107. Winterbourne View did notify the Care Quality Commission that in February 2010, three months after the inspection, two members of staff had been arrested by the United Kingdom Borders Agency having allegedly used false documentation to gain employment.

108. The statutory notifications made under regulation 28 in this period are shown in Table 2 and it is notable that the number of statutory notifications in the period after the inspection between January and March was the largest number made in any one period although no particular inferences can be drawn from this.

Table 2

Date	Notifiable event	Additional Information	Outcome
20 April 2009	A patient with epilepsy suffered a seizure, fell to the floor and sustained a fracture to the wrist.	The patient was taken to hospital and admitted the following day for an operation.	No investigation was undertaken by the provider as the incident was considered to be due to the due to the unstable nature of the patient's epilepsy.
7 October 2009	A patient was being restrained with approved physical intervention techniques to prevent them throwing a chair at staff. In a struggle the patient was alleged to have bitten the staff member. In the attempt to remove their hand from the mouth of the patient the patient's tooth came out. The staff member also had broken skin injury.	The patient had no history of biting and the staff member had no disciplinary record of being involved in similar incidents. It was not clear if the staff member had a disciplinary record for other incidents. The police were informed and attended the hospital statements gathered and incidents forms completed. The South Gloucestershire Adult Safeguarding Team was also notified.	The provider failed to notify the Care Quality Commission about the outcomes of the investigation.
10 January 2010	A female patient alleged that she had been sexually assaulted by a male patient.	The staff at Winterbourne View had immediately notified the South Gloucestershire Adult Safeguarding	There was a thorough investigation. It found that there was "little evidence to indicate whether an assault had

		Team and the Police Service. They also pointed out that the Care Quality Commission notifications form had no relevant category box which covered this type of allegation but they listed under the section on alleged misconduct resulting in actual or potential harm to a patient.	taken place". One of the patients was moved to the step down facility for their own safety and staff were reminded of the need for constant vigilance of those in their care.
8 February 2010	A patient disclosed on 7 February that on 2 February they had been pushed and struck on the back by a staff member because the patient did not want to have dinner with others in the dining room.	The matter was referred to the South Gloucestershire Adult Safeguarding Team and the Police Service. The member of staff had been suspended pending the outcome of the investigation.	There was no further evidence submitted to the Care Quality Commission by the provider indicating what outcomes had been reached regarding this incident.
22 February 2010	A consultant psychiatrist and a manager observed a member of staff "yank a patient forcefully, forcefully push the patient and then shout at them".	The staff member was immediately suspended and the South Gloucestershire Adult Safeguarding Team notified.	There was no further evidence submitted to the Care Quality Commission by the provider indicating what outcomes had been reached regarding this incident.
24 February 2010	A patient disclosed to a consultant psychiatrist that they had self harmed by inserting the refill part of a biro into the abdominal wall some days before the disclosure.	The patient was admitted to hospital and investigations confirmed the claims and an operation was carried out.	No investigation was carried out by the provider into this incident.
24 March 2010	Patient revealed to their advocate that they had been unable to swallow	The provider gave no other information.	The provider failed to notify the Care Quality Commission about the outcomes of any

	whilst being restrained by a support worker.		investigation.

109. The completion of the announced inspection in December 2009, the voluntary submission of the resultant action plan by Winterbourne View, and the annual statement from the Mental Health Act Commission closed out the period of regulation in period three between 1 April 2009 and March 2010.

110. The notable shortcomings on the part of the CQC was a failure to follow up and ascertain what the outcomes were from the alerts made to the Adult Safeguarding Team or in response to the regulation 28 notifications. It is a vital component of the regulatory management of safeguarding concerns that CQC follows up and records the outcomes linked to the alerts.

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.

Period 4: 1 April 2010 – 31 October 2010

111. The Care Quality Commission's model of regulation under the Health and Social Care Act 2008 no longer required providers to submit an annual self-assessment. There would be no further desk top analysis of the service based on this annual submission from the provider. The planned methodological approach to be delivered by the Care Quality Commission for all regulated providers under the new legislation was widely consulted on and agreed following that process[17].

112. The period from April 2010 leading up to the re-registration of Winterbourne View in October 2010 was critical in terms of the overlap from one methodological and systems approach to another. Whilst the Care Quality Commission had not lost sight of concerns about the hospital, the issues that were now being raised tested the Care Quality Commission systems during this significant transitional period.

113. The next visit to the Winterbourne View was made on 25 September 2010 by the Care Quality Commission Mental Health Act Commissioner, just prior to the completion of their registration under the new Health and Social Care Act.

[17] http://www.cqc.org.uk/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_0.pdf

114. On that visit the Commissioner noted that one of the patients interviewed had their left arm in plaster. The patient said that during a restraint procedure on 23 July 2010, they suffered a fracture to their left wrist. Whilst all appropriate action was taken as evidenced in the patient's notes to deal with the immediate incident, it was noted that the patient was not offered an opportunity to seek independent legal or advocacy advice from the resulting injury.

115. Documents, including a "mini root cause analysis" of the incident carried out by the Unit Manager and Deputy, were made available to the Commissioner at their request, and these, in the view of the Commissioner, demonstrated a poor quality of the review and lessons to be learnt recommendations after the incident.

116. The Commissioner also made clear that Winterbourne View managers were required to advise the Care Quality Commission of the policies and procedures in place regarding the reporting and investigation of serious untoward incidents, the policy and training for staff in restraint procedures and the hospital's safeguarding policy and procedure.

117. They were also to provide evidence of how they ensured independent external reviews (external to the unit) are carried out when serious untoward incidents occur, as in this case which resulted in serious injury to a patient from a restraint procedure as described in above. No clear dates were set for the actions listed above.

118. There is no evidence in the Care Quality Commission records that the Mental Health Act Commissioner reported this observation back to the Compliance Inspector. The need for integrated communication across the functions of the Care Quality Commission is addressed as a recommendation in this report.

119. There is no evidence in the Care Quality Commission records that Winterbourne View staff submitted the details as specified by the Mental Health Act Commissioner. This was not followed up internally between the Mental Health Act Commissioner and the Compliance Inspector.

120. The only two statutory notifications made to the Care Quality Commission under regulation 28 in the period from 1 April 2010 to 31 October 2010 when Winterbourne View would be reregistered are shown in Table 3. As with the previous notifications we failed to follow up on the outcomes and so formally sign off any further agreed actions. See recommendation above 3 for future management and handling of safeguarding alerts.

Table 3

Date	Notifiable event	Additional Information	Outcome
19 July 2010	One support worker made allegations against another support worker whilst they were delivering personal care. The allegation was made that the care worker slapped the patient on two occasions on the arm and shoulder in the shower and in the patient's bedroom.	The incident was reported to the South Gloucestershire Adult Safeguarding Team and the Police Service.	The provider failed to notify the Care Quality Commission about the outcomes of any investigation.
29 July 2010	A patient, whilst being restrained on the floor, was allegedly still struggling and making attempts to attack the staff. Whilst struggling, the patient twisted and fractured their wrist.	Patient was taken to the A&E department to seek emergency treatment. The Care Quality Commission Mental Health Act Commissioner noted concerns about process for external review of this type of notifiable incident.	The provider failed to notify the Care Quality Commission about the outcomes of any investigation.

121. The visits by the Care Quality Commission Mental Health Act Commissioner in June 2009 and September 2010 formed the basis of the Care Quality Commission Mental Health Act Annual Statement which was published in January 2011.

122. Whilst the statement highlighted deficits in regard to the processes of those detained under the Mental Health Act legislation, it made no reference to the issues about safety and vulnerability of patients and the actions that the Mental Health Act Commissioner identified were needed as part of the visit in September 2010. There was no explicit reference to the issues and concerns about Winterbourne View approach to reviewing and learning from restraint incidents.

Regulation of Winterbourne View under the Health and Social Care Act 2008 from October 2010 until its closure in July 2011

123. In line with the legislative requirements placed on the Care Quality Commission, Winterbourne View was re-registered at the end of October 2010 and would, from that point forward, be regulated under the Health and Social Care Act. It was re-registered without any compliance conditions.

124. During this period, there were 13 statutory notifications made to the Care Quality Commission relating to alleged abuse or neglect. The majority of these were relating to altercations between patients at the hospital; none of the notifications involved members of staff in any reports of alleged abuse.

125. A notification was received from the Managing Director of Castlebeck (Teesdale) Ltd on 12 May 2011, enclosing a letter from the BBC outlining instances of abuse their reporter had witnessed whilst working undercover at the hospital, together with the action being taken at the hospital to address this.

126. On 13 May 2011, the local safeguarding team held a strategy meeting, the outcome of which was that the Care Quality Commission would carry out a responsive compliance review at the hospital. This included a two-day site visit which happened on 17 and 18 May 2011. This review found that Winterbourne View was non-compliant in 10 of the 16 outcome areas. As a result, Castlebeck agreed that there would be no further admissions to the hospital.

127. After this review, a Notice of Proposal was issued to Castlebeck, effectively cancelling the registration for Winterbourne View. Winterbourne View finally closed on 22 June 2011 after all of the patients had been found alternative accommodation.

128. A decision was then taken to undertake a compliance review of services at all 19 locations registered by Castlebeck (Teesdale) Ltd in England. Serious concerns about the quality of care were identified at a further three locations, which led to the closure of those locations as well.

129. We now know that, in spite of the commitments from Winterbourne View's management and staff that they were responding to the issues raised by the Care Quality Commission's previous inspections including the Mental Health Act Commissioner visits, there were in fact on-going failures by management and staff to protect those in their care.

130. However, the Care Quality Commission and Healthcare Commission staff who crossed the threshold of Winterbourne View at no time witnessed behaviours that were subsequently identified and reported on by the BBC Panorama expose of abuse, broadcast in May 2011. The whistleblower, whilst cataloguing a number of serious issues, did not witness the abuse that was captured by the undercover filming.

131. The failure by the staff and management to protect those in their care from abuse at Winterbourne View was identified by a member of staff at the hospital, Mr A, when he reported his concerns in a systematic way to those who needed to know and act on the information.

132. This part of the report considers the way in which the concerns raised by Mr A were managed across the health and social care system and in particular how the Care Quality Commission responded to the concerns. The sequencing of

events, actions and reactions has been a vital component of how the Care Quality Commission has learned lessons and made changes to the way we deliver our regulatory responsibilities.

Key issues from period one (April 2007 – March 2008)

133. Winterbourne View was a newly commissioned service and had not yet reached its full operating capacity of 24 patients. After the service had submitted its self assessment to the Healthcare Commission the decision was taken that it did not warrant an inspection. However, the Healthcare Commission as part of the national audit of learning disability services did include the service in the review of services in England. The issues identified through the audit were such that they were considered to be not immediately serious or severe.

134. The Mental Health Act Commissioners visit in September 2007 and subsequent annual report in October 2007 did highlight that there were concerns that some practices fell short of best practice but that staff at Winterbourne View accepted in full the findings and were intending to respond accordingly. There was no evidence that the Mental Health Act Commission required an action plan or that one was submitted voluntarily by Winterbourne View management.

135. Overall in the first year of its existence there were no significant concerns by the Healthcare Commission, the Mental Health Act Commission or the South Gloucestershire Safeguarding Adult Board about the care for those patients who were being treated in Winterbourne View. Where issues had been formally raised there was confidence that the Winterbourne View management and staff would respond appropriately to deal with the identified improvements. This confidence in the provider to manage and deal with the issues was based on their willingness to engage with the regulators and the South Gloucestershire Adult Safeguarding Team and respond to rather than challenge the findings about their service delivery.

136. There are no obvious indications in any documentation about the extent to which the Healthcare Commission and the Mental Health Act Commission were routinely providing information about the Winterbourne View to commissioners of the service and the system performance managers.

137. Similarly there is no evidence that the commissioners or system performance managers routinely or systematically sought information about Winterbourne View from either the Mental Health Act Commission or the Healthcare Commission.

138. The links, relationships and roles and responsibilities between the commissioners, the system performance managers, adult safeguarding teams and safeguarding boards, and the regulator going forward is addressed under recommendation 4.

Key issues from period two (1 April 2008 – 31 March 2009)

139. It is clear from the review of the documentation that both the Healthcare Commission and the Mental Health Act Commission had concerns about the quality and safety of care at Winterbourne View during the second year of its operation.

140. The basis for the concern about care was prompted by the self assessment submitted by Winterbourne View, the exchange of information flows between the Healthcare Commission and South Gloucestershire Adult Safeguarding Team regarding safeguarding concerns, and the proposed changes to the Registered Manager and that the role was unfilled for some time.

141. The concerns resulted in two unannounced inspections by the Healthcare Commission with clearly articulated improvement requirements.

142. What is not clear is how the requirements placed on the provider by the Healthcare Commission were systematically and routinely shared with the South Gloucestershire Adult Safeguarding Team, the commissioners or the system performance managers. It is not clear how the staff supervisory arrangements in the Healthcare Commission would have monitored the ways in which a watching brief was maintained in response to Winterbourne View.

143. There was no legislative power to require Winterbourne View to submit an action plan either to the Healthcare Commission or to the Mental Health Act Commission. Winterbourne View management did not voluntarily submit an action plan to the Healthcare Commission following the unannounced inspection in March 2009. They had done so after the unannounced inspection in December 2008.

144. There is no evidence that the Mental Health Act Commission Annual Statement and the findings and recommendations from this were systematically shared with the South Gloucestershire Adult Safeguarding Team.

145. Again the issues about routine information exchanges, roles and responsibilities between the commissioners, system performance managers, the adult safeguarding teams, the Safeguarding Boards and the regulator and recommendations for this going forward are set out in recommendation 13.

Key issues from period three (1 April 2009 – 31 March 2010)

146. The service at Winterbourne View had been inspected during this period against the Care Standards Act National Minimum Standards. As with the two previous inspections the basis for the inspection was prompted about concerns about the safety and quality of care which were determined by the evidence that was available from Winterbourne View statutory notifications and safeguarding alerts.

147. As with all previous inspections and the one audit carried in the early operational stages of Winterbourne View, there was no obvious and overt evidence of any kind of systematic abuse being meted out to the patients.

148. The inspection did reveal that there was no clear record of staff training and that staff did not receive annual update training in physical intervention techniques.

149. A set of requirements with clear timescales was set out in the report and Winterbourne View staff did voluntarily submit their action plan to deal with the matters raised following the inspection. However, there was no apparent follow-up of action plans by the Care Quality Commission.

150. Although there were a large number of notifications indicating there may be particular issues at the hospital, there was no follow-up on these notifications to ensure they had all been investigated effectively, and that the outcomes of those investigations had been shared with the Care Quality Commission.

151. Equally, there was no follow-up by either the Inspector or the manager with the South Gloucestershire Adult Safeguarding Team to ensure that cases of particular concern were investigated in a timely way. No further action was taken in these cases until strategy meetings were held meaning individuals remained at risk of harm. In the case of Winterbourne View, it took several months to arrange meetings.

152. There were exchanges of and a flow of information between the Care Quality Commission and the South Gloucestershire Safeguarding Adult Team during this period. There was nothing in that analysis of the information between the members of the Team that suggested that there was on-going systematic abuse of the patients in Winterbourne View.

153. The Care Quality Commission was now engaged in the detailed preparatory stages of planning for the re-registration of all regulated services such as Winterbourne View from the Care Standards Act to the new requirements of the Health and Social Care Act 2008. This had to be completed by October 2010.

154. It has been a matter for the public record that the re-registration of regulated service providers during this period required a significant effort on the part of the operational staff in the Care Quality Commission and that this had an impact on the number of inspections undertaken during this time.

155. The action plan submitted by Winterbourne View in January 2010 was not monitored going forward and any progress or otherwise not shared with the South Gloucestershire Safeguarding Adult Team.

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.

Key issues from period 4 (1 April 2010 – 31 October 2010)

156. The number of statutory notifications made under regulation 28 during this period was two and the Care Quality Commission was satisfied that the proposed actions being taken by the management and staff at Winterbourne View were adequate.

157. The incident where a patient had a fractured their left wrist linked to a restraint incident was identified by the Care Quality Commission Mental Health Act Commissioner as part of a statutory routine visit to Winterbourne View. The incident had been reported to the Care Quality Commission as a statutory notification, however, information about Winterbourne View had not been shared with the Commissioner in advance of their visit.

158. The routine and systematic exchange of information and data as part of an integrated approach across compliance and the Mental Health Act functions in the Care Quality Commission was not evident in the period between April and October 2010.

159. There is no evidence to suggest that had the exchange of information been more integrated during this period that the problems of abuse would have been prevented. We now know that the abuse problems were endemic and out of view of the regulator.

160. The concerns about the welfare and safety of the patients that were picked up by the Care Quality Commission Mental Health Act Commissioner were not subsequently reported on in the annual statement. In the future the Care Quality Commission must ensure that concerns of this nature are always reported in the public domain.

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.

Whistleblowing concerns about the abuse of patients at Winterbourne View from October 2010 onwards and the system response

161. It has been critical for the Care Quality Commission to analyse the sequencing, timing and actions taken to the reporting of abuse of patients at Winterbourne View. Our ability to make improvements to the regulatory model and to improve joint working with the commissioners, performance managers and Adult Safeguarding Teams and Boards is reliant on our understanding where

the processes fell short.

162. Mr A first wrote to his manager at Winterbourne View on 11 October 2010 raising significant concerns about the aggressive and confrontational nature of some staff in their interactions with patients. Writing to his manager in October was not the first time that Mr A had raised concerns. He makes clear in his written message to the manager of Winterbourne View in his correspondence of 11 October 2010 that he had verbally highlighted concerns in September 2010 about the way that certain staff inappropriately interacted with the patients.

163. The 11 October communication to the manager of Winterbourne View went on to detail specific inappropriate behaviours by some staff on specific dates. This level and precision of detail and the fact that they could be dated indicates the seriousness of the concerns and should have been a sufficient alert for the system as a whole to potentially act more quickly.

164. The communication makes clear to the manager of Winterbourne View that the issues have been raised as a 'whistleblowing concern'. If Castlebeck Care (Teesdale) Limited had a whistleblowing policy in place at the time then there is no reference made to this policy and what specific and dedicated actions the organisation was taking to deal with the serious concerns raised by a qualified member of their staff team when the information was forwarded to the South Gloucestershire Safeguarding Adult Team.

165. The manager of Winterbourne View having been the recipient of an 'official whistleblowing' report by a member of their nursing staff, Mr A, only then forwarded the original email setting out all the concerns with dates to the Manager of the South Gloucestershire Safeguarding Adult Team on the 28 October 2010. There were 14 working days that elapsed between the initial whistleblowing concern raised with the manager at Winterbourne View in writing and notification of the issues being raised with the South Gloucestershire Safeguarding Adult Team.

166. The Safeguarding Team forwarded details of the whistleblowing allegations to the Care Quality Commission on 29 November 2010. This included the initial email from Mr A to his manager at Winterbourne View dated 11 October 2010. This was now some thirty five days after the initial whistleblowing communication was made, and the first time the regulator became aware of the issues identified in the email. At no point had the manager of Winterbourne View contacted CQC to share this information.

167. Once the Care Quality Commission became aware of the seriousness of the issues being raised in the whistleblowing communication, there was an ongoing dialogue with the South Gloucestershire Safeguarding Adult Team about the next steps. It was clear and unequivocal that the matter was being handled by the manager of Winterbourne View and the South Gloucestershire Safeguarding Adult Team. Between them they had determined the clarifications that they were seeking from Mr A could not be resolved until 20 December 2010.

168. As a consequence of the lack of action, Mr A then wrote to the Care Quality Commission on 6 December 2010 making clear that he wanted to make a "serious complaint" about Winterbourne View. He appended the original email which he sent to his manager in the 11 October 2010 communication.

169. The communication was received in the National Customer Services Centre and was assigned to the Compliance Inspector for Winterbourne View on 8 December 2010. The initial processing took two days, longer than is normally managed for a whistleblowing incident because the initial communication was not immediately identified as a whistleblowing incidence.

170. The email from Mr A into the Care Quality Commission did specifically and reasonably request that "someone get back to me as a matter of some urgency please". During this period, neither the Care Quality Commission, his employers, nor the South Gloucestershire Safeguarding Adult Team contacted him about his concerns. Each assumed the other was doing so.

171. Having made the initial whistleblowing concerns to his employer on 11 October 2010, some nine weeks had passed and no action had been taken in response to the issues initially raised.

172. At this point there were now ongoing discussions between the Care Quality Commission and the South Gloucestershire Safeguarding Adult Team about the issues that had been raised. It was the intention of the South Gloucestershire Safeguarding Adult Team to convene a meeting to discuss the whistleblowing concerns. This meeting was arranged by South Gloucestershire Safeguarding Adult Team for 1 February 2011.

173. Mr A, in the meantime, contacted the Care Quality Commission again on 31 December 2010 this time by calling the National Customer Services Centre. He wanted to know if we had received his initial complaint on 6 December 2010. It was confirmed that we had received the complaint and that it had been passed to the Compliance Inspector in the region. This further contact by Mr A was not highlighted to the region and so no further information was passed on to the Compliance Inspector.

174. There was one further telephone call made to the Care Quality Commission National Customer Services Centre regarding the Winterbourne View. This call was made on 11 February 2011 from a relative of a staff member who worked at Winterbourne View. The caller asked about the staffing levels and the

restraint procedures being used at the hospital. The contact centre passed the details of the callers query that day to the Compliance Inspector for Winterbourne View.

Key issues about the response to the whistleblowing concerns

175. The detailed whistleblowing concerns made by Mr A in October 2010 with specific dates and staff involved warranted an immediate response of all the relevant agencies including the NHS commissioners and performance managers, the police service and the Care Quality Commission.

176. The initial contact from Mr A to the Care Quality Commission was not identified as whistleblowing in the National Customer Service Centre. This resulted in a delay of two working days before the information was passed to the Compliance Inspector.

177. There was an assumption between all three parties – the Care Quality Commission, the South Gloucestershire Safeguarding Adults Team and the manager at Winterbourne View – that the others were in contact with Mr A about his concerns, when in fact none of the bodies involved had contacted Mr A.

178. The Care Quality Commission has already noted that there are significant personal and professional challenges that whistleblowing raises for staff in the health and social care system. The system needs to respond quickly, appropriately and always with the interests of the patients and people using the services in mind.

179. The Care Quality Commission carried out an internal disciplinary procedure against the Compliance Inspector in light of the issues that were raised about how the whistleblowing concerns were managed. There are distinctive issues that this whistleblowing incident and the disciplinary process has raised for the Care Quality Commission. These are:

- How staff in our National Customer Services Centre respond to concerns raised with us by whistleblowers;
- How we manage the concern once it is known by the Compliance Inspector;
- How we improve the supervisory arrangements between the Compliance Inspector and the Compliance Manager, and the Compliance Manager and the Regional Director, that addresses the management of services where risks to quality and safety have been identified.

180. As a result of this review and a further review in the National Customer Services Centre, the Care Quality Commission has already made changes to management of whistleblowing concerns raised through the National Customer Services Centre. We have set out clearly the definitions of what whistleblowing means so there is little room for ambiguity.

181. A whistleblowing team has been created within the National Customer Services Centre. The whistleblowing team logs the calls, emails and correspondence coming into CQC and track and traces all whistleblowing information until an outcome has been reached.

182. The whistleblowing team is responsible for tracking and chasing all whistleblowing reports to their respective regions and follow each of these up to ensure they are being progressed to an end resolution. The whistleblowing team will keep chasing the region until there is a final outcome, taking into account that these reports may result in enforcement action against the provider.

183. Compliance Inspectors have portfolios of between 40-55 providers that they are regulating. The scope and scale of the regulatory work can be complex and challenging. The Care Quality Commission has embarked on a 'portfolio management' training programme for Compliance Managers and Compliance Inspectors that will cover how to weight complexity in the portfolio and how to allocate resources flexibly. Priority is always given to those services where there is clear evidence that quality and safety of care of patients and people in the services is being compromised.

184. The regular 1:1 supervision sessions between Inspectors and Managers and Mangers and Regional Directors will always have a case management component that considers the services and activity where there are most concerns about quality and safety, and will always include responses we are making where whistleblowing concerns have been made.

RECOMMENDATION 11
The Care Quality Commission's Board should receive a report on the whistleblowing 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.

The role, function and responsibilities of the commissioners, the performance managers, the South Gloucestershire Safeguarding Adult Board and the Care Quality Commission in responding to the safeguarding issues at Winterbourne View

185. The role of the system players in responding to the safeguarding concerns about Winterbourne View were not clear and explicit from the time it was first registered in 2006.

186. The commissioners and performance managers were not routinely sighted on the regulatory concerns or the follow-up actions that were needed following inspections by the Healthcare Commission, the Care Quality Commission or publication of the Mental Health Act Commission annual statements.

187. It was notable that the local PCT, South Gloucestershire, commissioned only one place at the hospital. All other patients were placed by other PCTs, with patients coming from as far as Cornwall, Wiltshire and Worcestershire. This meant there was no clear overview among commissioners of what was happening at the hospital. There appears to have been very little sharing of information between the different commissioners, and between the commissioners, the Safeguarding Adults Team and the regulator.

188. There is no documentary evidence that commissioners and their performance managers were in regular contact either with the Healthcare Commission, the Care Quality Commission or the Mental Health Act Commission about the quality and safety of care at Winterbourne View as part of their statutory functions.

189. The Care Quality Commission Annual Performance Assessment for South Gloucestershire Council for 2009/10 included an assessment of the adult safeguarding function. The report concluded that the council was performing well on safeguarding adults, and in particular was found to be taking prompt action to help minimise risks and keep vulnerable people safe, and worked well with poor performing providers to drive up the quality of local services.

190. Recommendations included:

- Ensuring safeguarding thresholds were robustly applied and all appropriate cases reliably followed the safeguarding process;
- That case recording was strengthened to profile managers' involvement in safeguarding cases;
- To establish reliable mechanisms for feeding back the outcome of the safeguarding referrals to the people who raised the initial concerns, and
- To build upon the existing case audit process to bring greater challenge and increase the learning from the findings of the audits.

191. This was the last Annual Performance Assessment carried out at the council as the Care Quality Commission no longer has the remit to inspect local authority social services departments.

192. The South Gloucestershire Safeguarding Adult Board is the forum to bring together all the relevant multi agency partnerships to promote the safeguarding of adults. Like all Safeguarding Adult Boards in England it has no statutory basis.

193. The relationship between the Healthcare Commission, subsequently the Care Quality Commission, and the South Gloucestershire Safeguarding Adult Manager did exchange information regarding Winterbourne View. However, the Mental Health Act Commission annual statements and requirements linked to those annual statements were not routinely shared.

194. The South Gloucestershire Safeguarding Adult Team convened to meet on 1 February 2011 to discuss the whistleblowing concerns that had been raised by Mr A in October 2010. Present at that meeting were the manager of Winterbourne View, the operations manager of Castlebeck (Teesdale) Limited, the Care Quality Commission and South Gloucestershire Council. There were no police service representatives, commissioners, performance managers or people representing patients such as advocacy services representatives or their families, and so any concerns they may have had about Winterbourne View were not shared at this strategy meeting.

195. As a result of this meeting, Winterbourne View management were given a series of actions including an internal review of the specific concerns made by Mr A and then decide whether any further action was needed. At the end of this meeting there was no further date set for a follow-up meeting and no dates were set for the actions to be completed.

196. The South Gloucestershire Safeguarding Adult Team did not convene again between the meeting on 1 February 2011 and the BBC letter, which was sent to Castlebeck (Teesdale) Limited on 12 May 2011 setting out in detail the key concerns that they had about patients based on the Panorama programme undercover filming during February and March 2011 .

Key issues about roles, responsibilities and functions between the Care Quality Commission and the South Gloucestershire Adult Safeguarding Team

197. There were clearly timely information flows and exchanges about Winterbourne View between the Care Quality Commission and the South Gloucestershire Adult Safeguarding Team concerning notifiable incidents. The one notable exception to this was the delay in informing the Care Quality Commission of the whistleblowing issues that were raised by Winterbourne View with them in October 2010.

198. CQC failed to follow up on the outcomes from the safeguarding alerts, record these and have them formally signed off by Managers.

199. The assessment and reporting activity of the Mental Health Act Commissioners was not routinely and systematically part of the data and information flows, either between the bodies, or subsequently internally within the Care Quality Commission.

200. Collectively, there was detailed information among the other multi agency partners of the South Gloucestershire Adult Safeguarding Board about the Winterbourne View care delivery and a view that the managers and staff of Winterbourne View not only accepted the issues that were raised concerning safeguarding but that they would action the changes needed.

201. At no time in the history of the regulation of the Winterbourne View did any of the multi agency members ever request or suggest that either the Healthcare Commission or the Care Quality Commission carry out an inspection in response to deep concerns about safety of care.

202. None of the multi agency members of the South Gloucestershire Safeguarding Adults Board proposed that all the information in the system was reviewed in the context of the serious issues raised by the whistleblowing concerns of Mr A.

203. Adult safeguarding boards have no statutory remit in England. One of the recommendations from the Law Commission's review into adult social care proposes that Safeguarding Adults Boards are made mandatory.[18] The Coalition Government has already said that it accepts this recommendation and will seek to pass the necessary legislation.

204. In light of the proposed mandatory nature for Safeguarding Adult Boards in England and on the basis of the lessons learned about Winterbourne View, the Care Quality Commission will review the way in which data and information of notifiable incidents is now shared with and acted on by multi agency partners on Safeguarding Adult Boards, commissioners and system performance managers.

205. The Care Quality Commission will also ensure that information held by us regarding those who are detained under the Mental Health Act is utilised internally to inform the QRP, as well as sharing it with other bodies when appropriate to do so as part of the Safeguarding system.

18 http://www.justice.gov.uk/lawcommission/areas/adult-social-care.htm

RECOMMENDATION 12
The Care Quality Commission should immediately audit the interaction that it has with Safeguarding Adult Teams and Boards across England. The audit should focus on which staff normally represent the Care Quality Commission at meetings, the circumstances which trigger our attendance at a meeting and how we sign off the actions agreed at a multi agency safeguarding meeting.

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.

Care Quality Commission regulatory action following the BBC Panorama letter

206. A multi agency safeguarding meeting was convened on 13 May 2011 following the BBC Panorama letter sent on 12 May 2011.

207. The Care Quality Commission met Castlebeck (Teesdale) Limited on the same day and they provided us with assurances that there would be no new admissions to the hospital until all investigations were completed.

208. The Care Quality Commission carried out a responsive review to follow up on the specific information provided by the BBC Panorama reporter and from Mr A. The BBC Panorama programme provided clear evidence of abuse that was not available from any other sources.

209. Site visits were carried out on 17, 18 and 24 May 2011 and on 2 June 2011. Our review of the compliance inspection was published in June 2011.
210. Due to the major concerns identified from the review, the Care Quality Commission took enforcement action to remove the Winterbourne View location from the provider's registration. Castlebeck (Teesdale) Limited did not lodge an appeal and the service was closed when all the patients had been safely relocated.

Conclusions

211. The Care Quality Commission wants to learn lessons from the unforgivable abuse of the patients at the Winterbourne View.

212. This management review has identified failings in the way in which the information from the whistleblower was handled, and in the way in which the whistleblower was involved in the process.

213. The Care Quality Commission has yet to ensure that information from its different functions is shared across the organisation. This sharing of information between Compliance staff, Mental Health Act Commissioners and SOADs will ensure that the full range of information is taken into account when assessing the degree of risk to quality and safety at individual locations.

214. There is a lack of clarity in the safeguarding system about roles and responsibilities. Assumptions that other bodies were in contact with the whistleblower meant that, in fact, none of the bodies involved picked up directly the concerns that were raised. To address this, protocols on interaction with other bodies need to be developed to ensure CQC staff are aware of their responsibilities. Guidance and training should be further developed

215. In October 2010, when Castlebeck (Teesdale) Ltd applied for registration for Winterbourne View under the Health and Social Care Act 2008, Castlebeck declared full compliance with the regulations which led to the registration of Winterbourne View without conditions, despite there being a history of notifications of alleged abuse and other concerns about the hospital. At this stage, Castlebeck declared full compliance for all of its locations except one. All were registered without conditions, although subsequently several of their facilities were closed because of concerns about the quality of care and the safety of the patients being treated there.

Actions the Care Quality Commission has taken

216. The end-to-end review of the service, from the time it was first registered and regulated by the Healthcare Commission through to the closure of the service following the BBC Panorama expose, was significant in helping us make improvements to our management practices and regulatory model:

- The way in which we now weight and track the concerns of whistleblowers has been improved.

- We are sharpening up the supervisory arrangements between Compliance Inspectors and Compliance Managers and Compliance Managers and Regional Directors, so that there is always a focus and tracking on services where safeguarding concerns have been highlighted through any relevant data and information sources including from whistleblowers.

- Inspectors and mangers must sign off the outcomes arising from any actions taken in response to safeguarding alerts.

- The evidence from the Mental Health Act Commissioners and the Second Opinion Appointed Doctors is increasingly an integral component of our regulatory evidence set.

- We are actively engaged in the way in which we liaise and work with Adult Safeguarding Teams and Boards across England, including developing protocols and agreements covering information sharing, attendance and sign off of multi agency action plans.

217. Since the abuse at Winterbourne View was exposed, the Care Quality Commission has begun a programme of unannounced inspections of all those services that are delivering care to those with learning disabilities, challenging behaviour and mental health needs.

218. The work is being supported by an advisory group who have helped to shape the methodology and also provide access to experts by experience and professionals who will be part of the inspection teams.

219. This programme of inspection will be completed by January 2012 and inspection reports published soon after.

220. This approach to inspecting services will not be a one-off activity. The Care Quality Commission is proposing to carry out unannounced annualised inspection of, all independent hospitals and adult social care providers from April 2012. We are currently consulting on changes to the judgement framework and our enforcement policy[19] and subject to an endorsement for those changes we will deliver a simplified inspection process.

221. Whilst the Care Quality Commission can never ensure that abuse does not take place in the myriad of regulated care settings, we are committed to making sure that our management processes and the delivery of our regulatory activity play their part in the overall system attempts to protect those who are most vulnerable.

19 http://www.cqc.org.uk/yourviews/consultations/keyguidancechanges.cfm

Appendix 1: Terms of reference

Internal management review: Winterbourne View Hospital

Terms of reference

CQC has committed to complete an internal review to identify recommendations for improvement to regulatory systems and practice to minimise the risk of recurrence of the same or similar instance. The CQC internal review will fulfil the purpose of the individual management review which will be required as part of the serious case review, which has been initiated by South Gloucestershire Safeguarding Adults Board.

The review will include:

- Chronology of events from December 2006 (date of registration) to May 2011.
- A review and recommendations relating to sharing of information between external partners and stakeholders, including South Gloucestershire DASS and safeguarding lead, commissioners and other relevant statutory and non-statutory bodies.
- A review and recommendations relating to actions taken at key points of regulatory activity, including inspection reports, Mental Health Act Commissioner visits, SOAD visits, transitional registration of Winterbourne View Hospital from Care Standards Act to Health and Social Care Act 2008 and action taken following the information provided by BBC Panorama.
- A review and recommendations relating to how CQC collected and collated information about Winterbourne View Hospital during that period, how it was acted upon or not. This will include information collected via notifications, inspections etc.
- Recommendations relating to how CQC ensures that safeguarding alerts and whistleblowing information are handled and responded to effectively.
- Reviewing the roles, responsibilities and limitations of regulating high-risk service providers, including resource constraints and public expectations.

Timeline

The work will commence in the week beginning 21 June 2011 and a draft report will be available for CQC consideration in mid July with the final report being made available in Mid August.

Appendix 2: Recommendations

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 whistleblowing 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.

Appendix 3: Glossary

Quality and Risk Profile (QRP)	An internal tool used by the Care Quality Commission to collate all data and information known about a care provider. The information is tagged against outcome areas, highlighting where there is a particular risk of non-compliance with essential standards of quality and safety.
Regulation 26 reports	Under Regulation 26 of the Care Standards Act 2000, all registered providers were mandated to carry out an inspection of their services on an annual basis. The report of this inspection was required to be shared with the Healthcare Commission, and later the Care Quality Commission. This report was used as part of the desk-top analysis of data and information to determine whether a particular establishment would receive an inspection. There is no similar requirement under the Health and Social Care Act 2008.
Regulation 28 reports	Regulation 28 of the Care Standards Act listed a set of events which, if they occurred, should be notified to the Healthcare Commission, later the Care Quality Commission. There is still a requirement under regulations under the Health and Social Care Act 2008 to report notifiable events to the Care Quality Commission.
Mental Health Act Commissioners	Mental Health Act Commissioners are responsible for carrying out visits to locations where people are detained under the Mental Health Act 1983. They come from a variety of backgrounds; many of them are former users of mental health services and all have an interest in mental health services.
Second Opinion Appointed Doctors	Second Opinion Appointed Doctors (SOADs) have a distinct role in relation to reviewing the appropriateness of clinical plans for people detained under the Mental Health Act.
Assessment and Treatment Centre	Assessment and Treatment Centres are hospitals where people generally stay for a short period of time to be assessed and diagnosed for disease or disorder, and for treatment related to the diagnosis. In these terms, the length of stay should generally be relatively short, and at a maximum months, unless there is really challenging behaviour which needs to be managed. Often, however, people stay longer in these settings than is intended and there is a risk that they become ‘covert’ campus accommodation.