NHS
South of England

Report of the NHS Review of commissioning of care and treatment at Winterbourne View

Completed November 2011
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Preface

This report sets out the findings and conclusions of a review which was carried out between July and October 2011 into the commissioning of care and treatment at Winterbourne View by the NHS in England.

I am grateful to the other members of the review panel who gave generously of their time and expertise. I am also grateful to the large number of people who provided detailed information to the panel both in writing and in interviews during the process.

Particular thanks are due to Douglas Blair whose outstanding efforts and dedication have facilitated the efficient running of the process and the production of this report.

I hope that this report will assist in the process of understanding how this group of vulnerable people were let down by the systems and people that were meant to care for them and that it will enable us to ensure that we avoid such failure happening in the future.

Dr Gabriel Scally
Chair of Review Panel
November 2011

NHS South of England

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Section 1

Introduction

This section sets out the context of the review, its terms of reference and membership of the Review Panel.

1. Introduction

1.1 The BBC Panorama programme, broadcast on 31 May 2011, showed images of abuse and ill treatment of residents at Winterbourne View, a private hospital owned by Castlebeck Care (Teesdale) Limited[1]. Winterbourne View was registered with the Care Quality Commission to provide care for up to 24 patients aged 18 years and over with a learning disability.

1.2 The issues of safety of existing residents at the unit were addressed immediately. All residents were subsequently transferred to alternative accommodation and the unit was closed on 22 June 2011. Following the closure of the unit, the organisations involved in the regulation, provision or commissioning of care at Winterbourne View started the process of reviewing the circumstances surrounding the events at Winterbourne View. NHS organisations in England were responsible for the commissioning of care and treatment for the majority of patients at Winterbourne View and, as such, there was a need to review the role that the NHS played in the commissioning of services from Winterbourne View.

1.3 This review was established by the South West Strategic Health Authority on behalf of the NHS in England. It has involved the examination of the commissioning arrangements for all patients placed at Winterbourne View since it opened in December 2006 by the NHS in England. As noted above, this review is one of a number of different reviews being carried out into Winterbourne View.

1.4 This report presents findings from the NHS Review. It is being submitted as part of the NHS contribution to the ongoing Serious Case Review and to the Department of Health to inform its overarching review. This NHS Review is to be published following the completion of the Serious Case Review.

Context

1.5 Winterbourne View was a private hospital owned by Castlebeck. It was based in Hambrook, Bristol and was a purpose-built acute service offering assessment, intervention and support for people with learning disabilities, complex needs and challenging behaviour. It was registered with the Care Quality Commission to provide care for up to 24 patients aged 18 years and over with a learning disability. It was registered for the treatment of patients detained under the Mental Health Act 1983. The hospital opened in December 2006 and closed on 22 June 2011.

1.6 The regular staffing of Winterbourne View consisted of 12 trained nurses and 31 support workers. A further clinical team, including a consultant psychiatrist, provided treatment to the patients. It is reported that the hospital operated as two distinct units referred to as the top and middle floors. The top floor provided assessment and treatment and the middle floor was for patients whose discharge was planned.

[1] In the interests of simplicity, Castlebeck Care (Teesdale) Limited is referred to as 'Castlebeck' in the remainder of this report.

Other Reviews

1.7 In addition to the NHS review, the uncovering of abuse at Winterbourne View has led to the following reviews being carried out:

- Castlebeck commissioned PricewaterhouseCoopers to undertake an independent review of all its provision, and Debra Moore Associates to undertake a clinical review of its services;

- the Care Quality Commission has carried out a review of its internal management systems, a review of the facilities run by Castlebeck across the country and has started visits to all learning disability hospital facilities run by NHS and independent sector providers;

- a Serious Case Review is being carried out under the South Gloucestershire adult safeguarding procedures, which has an independent chair, Margaret Flynn, Chair of the Lancashire Safeguarding Adults Board. This is covering the roles of all the agencies that had contact with Winterbourne View;

- an review is being undertaken by the Department of Health of the roles of the organisations and the lessons to be learned, that will include some independent input from recognised experts (Mark Goldring, Chief Executive of Mencap, Jim Mansell, Emeritus Professor of Learning Disability at the Tizard Centre, University of Kent, and Anne Williams, former National Director for Learning Disabilities at the Department of Health). This review will examine the conclusions reached by the preceding reviews.

1.8 There is also an ongoing police investigation into the abuse at Winterbourne View.

1.9 The Equality and Human Rights Commission has also written to public bodies which commissioned care at Winterbourne View. The Commission has asked a range of questions relating to obligations under equality and human rights legislation and how these were discharged in relation to the placements at Winterbourne View.

NHS Review: Terms of Reference

1.10 The terms of reference for the NHS review were:

To investigate the NHS processes that operated in relation to the role of Primary Care Trusts, and their work with the NHS and other partners, in the organisation of the care of patients treated in Winterbourne View.

This will include the processes used by the NHS to:

i) assess patient need;
ii) determine patient placement;
iii) monitor and review the placement.

Review Panel Membership

1.11 The review was chaired by Dr Gabriel Scally, Director for Public Health, NHS South of England. The other Review Panel members were:

Dr Julie Chalmers	Consultant Psychiatrist (Adults of Working Age), Oxford Health NHS Foundation Trust
Roisin Fallon-Williams	Director of Business Transformation, Coventry and Warwickshire Partnership NHS Trust
Paul Sly	Chief Executive, Dorset, Bournemouth and Poole Primary Care Trust Cluster

Support to the Review Panel

1.12 The Review Panel was supported in its work by a Reference Group of self-advocates, families and carer representatives. The membership of this group is attached as Appendix 1. The Review Panel appreciated the insights and advice provided by the Reference Group.

1.13 The Review Panel was also grateful for the support provided by a small project team at the South West Strategic Health Authority.

Scope of the Review

1.14 The scope of the review was limited to the role of the NHS in the commissioning of care and treatment at Winterbourne View. As such, the processes and actions of the NHS in relation to both the original referral to Winterbourne View and the ongoing monitoring of quality and safety were of interest to the review panel, whether this was carried out by a Primary Care Trust or another organisation.

1.15 The review did not extend to the arrangements put in place by the provider of care, Castlebeck, for the clinical governance and effective management of the unit or extend to the internal processes and actions of local authorities.

1.16 The Review Panel were aware that three patients were placed at Winterbourne View by commissioners in Wales. These placements were therefore outside the scope of this review of the NHS in England. As such, no information was gathered relating to these patients as part of this NHS Review.

1.17 As part of the preparations for the Serious Case Review, a separate examination is taking place of the interaction that local NHS providers of care had with Winterbourne View. This work is being coordinated by NHS South Gloucestershire.

Section 2

Background

This section sets out the background information and knowledge which was used during the review process.

2. Background

2.1 The Review Panel drew on knowledge of the following areas of policy and practice when undertaking the review:

- relevant policy and guidance surrounding learning disability and challenging behaviour;
- the statutory responsibilities of the NHS and local government in this area;
- the role of commissioning in the NHS;
- the Care Programme Approach; and
- mental health legislation.

2.2 The background to these areas of policy and practice is described in more detail in this section of the report.

Relevant Policy

Services for people with learning disabilities and challenging behaviour or mental health needs (the Mansell Report)

2.3 '*Services for people with learning disabilities and challenging behaviour or mental health needs*' was first published in 1993 and revised and updated in October 2007[2]. It was prepared by a project group chaired by Professor Jim Mansell. The report highlighted that, while services for people with learning disabilities were improving in general with the move away from institutionalised care towards community settings, the response to those whose behaviour presented a challenge to services still needed to improve. Local services needed to develop and expand their capacity to understand and respond to challenging behaviour so that they could support good mainstream practice, as well as serve a small number of people with the most challenging needs.

2.4 The report identified the risks of not prioritising services for those with challenging behaviour. These included undermining the overall direction towards care in community settings as there would be an increasing reliance on out of area placements leading to re-institutionalisation and increased risk of abuse.

2.5 The report made a range of recommendations aimed at encouraging Local Authorities to ensure that mainstream learning disability services were able to respond more readily to challenging behaviour. This would prevent situations developing into a crisis and the associated reactive commissioning. The role of the NHS was to support this process of service development.

[2] Services for people with learning disabilities and challenging behaviour or mental health needs, Department of Health, October 2007, Gateway Reference 9019

2.6 The report recommended that health bodies should:

- *'keep contributing the financial resources needed to sustain the transfer of specialist learning disability services to councils;*
- *not undermine the strategy set out in this report by commissioning poor-quality services, especially out of area, themselves;*
- *continue to provide sufficient levels of the professional support required to sustain good practice in community based services;*
- *provide specialist psychiatric assessment and treatment on a short-term basis, but only as part of an integrated pathway of care for the individual that gets them back into the community; and*
- *enable fair access to generic health (including mental health) services for people with learning disabilities whose behaviour presents a challenge to services.'*

Valuing People: A New Strategy for Learning Disability for the 21st Century

2.7 '*Valuing People: A New Strategy for Learning Disability for the 21st Century*' was published as a White Paper by the Government in 2001[3]. The strategy was based on the four key principles of Rights, Independence, Choice and Inclusion and led to the establishment of Learning Disability Partnership Boards, the closure of remaining long stay hospitals and a greater focus on whether more suitable alternatives could, or should, be found for those living in NHS residential campuses.

2.8 Local Authorities are the lead agency for Learning Disability Partnership Boards whose membership includes senior representatives from social services, health bodies, education, housing, community development, leisure, independent providers and the employment services. They are designed to ensure a holistic approach to service planning and provision for individuals.

2.9 The strategy also included a short section on people with learning disabilities who have challenging behaviour:

'Commissioning and providing services for people who present significant challenges was one of the major issues facing learning disability services. The presence of challenging behaviour does not make an individual the responsibility of the NHS, although the NHS is responsible for commissioning and providing appropriate health input including intensive support from health professionals….

…. Learning Disability Partnership Boards should ensure that local services develop the competencies needed to provide treatment and support within the local area. To facilitate this, we have made developing specialist services for people with severe challenging behaviour and/ or autism one of the priorities for the capital element of the Learning Disability Development Fund.'

[3] *Valuing People: a new strategy for learning disability for the 21st century- a White Paper*, HMSO, March 2001

Valuing People Now

2.10 '*Valuing People Now*'[4] was a three year cross-government strategy published in January 2009. This reiterated the strategic direction laid out in Valuing People and delivery plans for 2009-10 and 2010-11 were produced to guide implementation. The delivery plan for 2010-11[5] included the following points in the list of issues which still needed to be addressed at that time:

- *'there continues to be a growing use of private 'Learning Disability' Hospitals;*
- *there remains insufficient focus on personalised local support and service development for people whose behaviour challenges services and gaps in implementing the recommendations of the Mansell 2 report.'*

Guide for commissioners of services for people with learning disabilities who challenge services

2.11 The National Development Team for Inclusion developed the '*Guide for commissioners of services for people with learning disabilities who challenge services*' in 2010[6]. This was intended as practical guidance on how Local Authority and NHS commissioners could implement the expectations set out in the Mansell report. The guidance to commissioners was provided under seven main headings:

- basing all decisions on a clear vision and set of values;
- strong, knowledgeable and empowered leadership;
- strong relationships and a 'no-blame' culture;
- an evidence-based Service Model;
- having skilled providers and support staff;
- evidence based commissioning;
- other commissioning actions, such as flexibility in contracting to enable rapid response to changes in circumstances.

[4] *Valuing People Now: a new three-year strategy for people with learning disabilities*, Department of Health, January 2009, Gateway Reference 10531

[5] *Valuing People Now Delivery Plan 2010-11*, Department of Health, April 2010, Gateway Reference 13960

[6] National Development Team for Inclusion is a not-for-profit organisation. It was funded by the Department of Health to produce this guidance as part of the roll-out of the Mansell Report and the wider Valuing People Now delivery plan.

Transition between different types of services

2.12 The legislation and the respective responsibilities of the NHS, social care and other services are different in child and adult services. *'Transition: moving on well'*, published in 2008[7], sets out good practice for health professionals and their partners in transition planning for young people with complex health needs or disabilities.

Responsibilities of health and local government

2.13 The Secretary of State for Health is required to continue the promotion in England of a comprehensive health service, designed to secure improvement in (a) the physical and mental health of people in England and (b) in the prevention, diagnosis and treatment of illness[8]. The Secretary of State is required to provide services for the 'care of persons suffering from illness and the after-care of persons who have suffered from illness'[9] throughout England, to whatever extent he or she considers necessary to meet all reasonable requirements. This includes accommodation for the purposes of health services. Strategic Health Authorities and Primary Care Trusts, amongst others, carry out this function on behalf of the Secretary of State.

2.14 Each Local Authority is under a duty to assess any person who appears to be in need of community care services[10]. Community care services may include residential accommodation for persons who, by reason of age, illness or disability, are in need of care and attention that is not otherwise available to them[11], as well as domiciliary and community-based services. Following this assessment the Local Authority must then decide whether the person's needs call for the provision of community care services.

2.15 The Local Authority must notify and involve the relevant Primary Care Trust if it becomes clear that the person has health needs, and similarly, the Primary Care Trust should notify and involve the Local Authority if a need for community care services is identified.

Primary Health Need Test

2.16 To assist in deciding what the health service can provide, and to distinguish between those and the services that Local Authorities may provide, the concept of a 'primary health need' has been developed. Where it is assessed that the primary needs of a person are health related, they are eligible for a package of continuing care that is arranged and funded solely by the NHS. Deciding whether this is the case involves looking at the totality of the relevant needs. Eligibility for NHS continuing healthcare places no limits on the setting in which the package of support can be offered or on the type of service delivery.

[7] *Transition: Moving on Well*, Department of Health, March 2008, Gateway Reference 8651
[8] Section 1 of the National Health Service Act 2006
[9] 'Illness' is defined in the National Health Service Act 2006 as including any injury of disability requiring medical or dental treatment or nursing.
[10] Section 47 of the National Health Service and Community Care Act 1990
[11] Section 21 of the National Assistance Act 1948

Assessments

2.17 Establishing that an individual has a primary need for health care requires a clear, reasoned decision, based on evidence of needs from a comprehensive assessment. The individual and, where appropriate, their representative should be enabled to play a central role in the assessment process.

2.18 Local assessment arrangements and processes differ around the country, though a number of models have formed the basis for assessment and care and support planning processes. The Single Assessment Process for older people[12] has been extended in many areas to cover all adults, and the Care Programme Approach[13] is widely used in mental health. Person-centred plans[14] (originally developed for use by people with learning disabilities, but which can be used by anyone) are not assessments; rather they represent an individual's own view of their desired outcomes and support needs and as such can offer key evidence in undertaking an assessment, as can health action plans and health checks[15].

Commissioning in the NHS

2.19 Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. It is the responsibility of the Primary Care Trust to plan strategically, specify outcomes and procure services, and manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS funded healthcare, and for the healthcare part of a joint care package.

2.20 In practice, the funding of care for a person can take many different forms and should be considered on an individual basis. This results in the existence of a range of joint and pooled funding arrangements, all in line with Government policy, such as joint funding, lead commissioner, joint commissioner or pooled resources.

2.21 As with all service contracts, commissioners are responsible for monitoring quality, access and patient experience within the context of provider performance. As part of their joint commissioning responsibility, it is expected that Primary Care Trusts and Local Authorities work in partnership, and share information to enable them to commission the most appropriate packages of care for their populations.

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[12] www.dh.gov.uk/en/SocialCare/Chargingandassessment/SingleAssessmentProcess/index.htm

[13] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

[14] *Valuing People: a new strategy for learning disability for the 21st century- a White Paper*, HMSO, March 2001

[15] Further details may be found in *Health Action Planning and Health Facilitation for people with learning disabilities: good practice guidance*, at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096505

The Care Programme Approach (CPA)

2.22 The Care Programme Approach has been used since the early 1990s to describe the arrangements which support and co-ordinate mental health care for people with severe or complex problems. All individuals placed in Winterbourne View would have met the criteria for the Care Programme Approach.

2.23 Between 1999 and 2008, there were two levels of support and co-ordination. 'Standard Care Programme Approach' described the support for individuals receiving care from one source and who were able to manage their mental health problems and maintain contact with services themselves. 'Enhanced CPA' described the support for individuals with multiple needs and requiring support to maintain contact with services. From October 2008 onwards, the use of the Care Programme Approach as a term has related to the intensive level of support only, as there were concerns that its application in 'standard' situations had led to an overly bureaucratic approach to care planning.

2.24 The support provided as part of the Care Programme Approach is described in guidance[16] as including:

- *'support from Care Programme Approach care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload);*
- *a comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks;*
- *an assessment of social care needs against Fair Access to Care Services (FACS) eligibility criteria (plus Direct Payments);*
- *comprehensive formal written care plan, including risk and safety/contingency/crisis plan;*
- *on-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly;*
- *at review, consideration of on-going need for Care Programme Approach support;*
- *increased need for advocacy support;*
- *carers identified and informed of rights to own assessment.'*

2.25 This is broadly similar to the expectations set out in the guidance in place before 2008.

[16] Refocusing the Care Programme Approach: Policy and Positive Practice Guidance, Department of Health, 2008, Gateway Reference 9148

Regular review

2.26 There has always been a requirement for regular review within the Care Programme Approach. Before 1999, there was a nationally determined review period of six months. This requirement was removed in 1999 and replaced with a requirement that the date of the next review should be set at each review meeting, and that any member of the care team, service user or carer must be able to ask for a review at any time. The revised guidance published in 2008 referred to 'formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly'. In practice, six-monthly reviews have continued to be considered by many as normal practice.

Role of the care co-ordinator

2.27 The role of care co-ordinator has been the subject of specific guidance[17]. The role should usually be taken by the person who is best placed to oversee care planning and resource allocation. This may be a nurse, social worker or occupational therapist. They should have the authority to co-ordinate the delivery of the care plan and this should be respected by all those involved in delivering it, regardless of agency of origin. The care co-ordinator is responsible for keeping in close contact with the service user, and for advising the other members of the care team of changes in the circumstances of the service user which might require review or modification of the care plan.

Clinical involvement

2.28 Much of the guidance surrounding the Care Programme Approach concerns clinical teams involved directly in the provision of care. There is less clarity about the role of clinicians when patients have been placed outside their home area but clinical teams from their home area retain an ongoing interest. Good practice guidance was produced in 2006[18] which said:

'Links between clinical teams (provider and area of origin)

A crucial issue for service providers will be the link with the team who have had clinical responsibility for the person previously. This is particularly the case if the placement is expected to be relatively short term and it is planned for the person to return. Connections will usually occur through the CPA care coordinator although they should not be the sole contact, especially if the needs of the person are complex. In such cases the area of origin Responsible Medical Officer [now known as Responsible Clinician] needs to be kept engaged...Attendance at reviews is particularly helpful. A key benefit of this will be that both clinical teams ... will be jointly planning care, and the service user, their relatives or friends do not receive mixed messages.'

[17] Effective care co-ordination in mental health services: modernising the care programme approach – a policy booklet, 1999 and Refocusing the Care Programme Approach: Policy and Positive Practice Guidance, Department of Health, 2008, Gateway Reference 9148

[18] 'A Good Practice Guide for Commissioners, CPA Care Coordinators and Independent Sector Providers', Care Services Improvement Partnership, September 2006, Department of Health Gateway Reference 6785.

Mental Health legislation

2.29 The Mental Health Act (1983) as amended covers "the reception, care and treatment of mentally disordered persons, the management of their property and other related matters"[19]. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital and have their disorder assessed or treated in the absence of consent, unofficially known as 'sectioning'.

2.30 There is a range of sections within the Act under which applications for the detention of individuals can be made, but the detained patients at Winterbourne View were detained under one of three categories:

- Section 2: an assessment provision to be used if the full extent of the nature and degree of a patient's condition is unclear for a maximum of 28 days;

- Section 3: a treatment provision to be used when the nature of disorder has been established and treatment is required. It lasts for up to six months, can be renewed for another six months and then can be renewed every 12 months;

- Section 37: a treatment order which provides the criminal justice system with an alternative to a person with mental health problems being punished by imprisonment or otherwise. Section 37 is enacted by a Crown Court or Magistrates' Court on the recommendation of two registered medical practitioners, one of whom must be approved as having special experience in the diagnosis and treatment of mental disorder. A restriction order can be imposed only by a Crown Court under Section 41 and places restrictions alongside a Section 37 treatment order.

2.31 On discharge, a Supervised Community Treatment can be used that allows for a Community Treatment Order (CTO) to be imposed in certain circumstances to allow suitable patients to be safely treated in the community rather than under detention in hospital. It gives the Responsible Clinician the power to recall the patient to hospital for treatment if necessary.

2.32 Relevant professionals determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability. Section 2 and Section 3 orders can be applied following an assessment under the Act by two doctors, one of whom must be approved as having special experience in mental health diagnosis and treatment, and an Approved Mental Health Professional. Section 37 and 41 orders can be applied only by the Courts with clinical advice.

[19] Mental Health Act (1983), Section 1(1)

2.33 Patients who are detained have the right to apply to a First Tier Tribunal (Mental Health) for their discharge. The Tribunal is an independent, judicial body. Most detained patients can also ask the managers of the relevant hospital to discharge them. The Responsible Clinician must also keep the appropriateness of continued compulsory measures under review.

2.34 Under Section 117 of the Mental Health Act, Primary Care Trusts and Local Authorities have a duty to provide after-care services to individuals who have been detained under certain provisions of the Mental Health Act 1983, until such time as they are satisfied that the person is no longer in need of such services.

2.35 The use of the Mental Health Act is reviewed and regulated by the Care Quality Commission through the Mental Health Act Commissioners.

2.36 Learning disabilities and autistic spectrum disorders are forms of mental disorder as defined in the Act. However, someone with a learning disability and no other form of mental disorder may not be detained under Section 3 or made subject to guardianship or supervised community treatment unless their learning disability is accompanied by abnormally aggressive or seriously irresponsible conduct on their part.

Section 3

Methodology of the review

This section sets out how the review was carried out.

3. Methodology of the review

3.1 The NHS Review was established as part of the necessary process of investigation and analysis of the circumstances surrounding the issues identified at Winterbourne View. The review was carried out between July and October 2011. The timescale for the review was set in the knowledge that the outcome would contribute to both the Serious Case Review and the overarching Department of Health review. There were three main stages of the review process:

- **Initial information gathering**. The review collected a standard set of information from all commissioners in England who commissioned care for patients placed at Winterbourne View between 2006 and June 2011. This information covered commissioning responsibilities, the arrangements made for ongoing monitoring of quality and safety and whether any concerns were raised and acted upon;

- **Detailed investigation**. Following analysis of the information received relating to all patients, the Review Panel agreed which commissioners should carry out a further investigation of the circumstances surrounding the commissioning of care at Winterbourne View in line with a common format. These supplemented local investigations already being carried out by Primary Care Trusts;

- **Panel review**. Following the analysis of the detailed investigations, the Review Panel met with a selection of commissioners to explore particular issues, common themes and emerging conclusions in more detail.

3.2 The information submitted by commissioners in the first stage of the review is summarised in Section 4. From the information received, it was clear that, of the 48 patients who had been referred from England, 44 placements had been made by or on behalf of Primary Care Trusts, three placements had been made by a Local Authority social care department and one placement had been made by a Local Authority with responsibility for ongoing monitoring then subsequently transferred to the NHS. Although basic information was provided in relation to these Local Authority placements, the actions and internal processes of Local Authorities were outside the scope of this NHS review.

3.3 The initial set of information was reviewed by the Review Panel in order to identify some early emerging themes and decide upon the areas which would benefit from further investigation. The Review Panel focused in particular on the information provided on the following aspects:

- evidence of clinical responsibility for the referral process;

- the type of pre-referral checks made;

- evidence of involvement of families, carers and advocates in the commissioning process;

- the extent to which the Care Programme Approach had been followed;

- whether concerns had been raised as part of the safeguarding procedures during the time that the patient was placed at Winterbourne View and the outcome of any investigation;

- whether other concerns had been raised during the time of placement by others including the commissioners, families, carers or advocates or other professionals.

3.4 From this review, the Panel agreed that there were 28 patient placements for which further investigation and analysis was required as part of this review. These further investigations provided an opportunity for detailed examination of specific concerns that had been raised, significant events that had occurred during the time of placement and exploration of the general issues surrounding the commissioning process.

3.5 The further investigations were commissioned from Primary Care Trusts on 28 July 2011. Primary Care Trusts were asked to return their reports by 31 August 2011 and make arrangements for appropriate representation to be available if required for follow up discussion with the Review Panel on 9 September 2011. Primary Care Trusts were advised that the panel would want to have at these meetings a mix of senior representation (Chief Executive or Director of Commissioning) and those involved in the commissioning of care itself.

3.6 Following consideration of the investigation reports, the Review Panel agreed that follow up discussions should take place with seven Primary Care Trusts. These discussions offered an opportunity for the Review Panel to explore issues of detail, discuss emerging learning points and provide scrutiny and challenge to the investigations carried out by local commissioners.

3.7 After these discussions had taken place and following further analysis of the investigation reports and supplementary information, the Review Panel discussed and agreed the findings and conclusions of the review which are contained within this report.

Patient confidentiality

3.8 As the review was examining the commissioning process, the Review Panel had no need to see any information that identified individual patients. As such, the Review Panel was not provided with patient names and efforts were made to remove information that might have identified patients from the reports provided by Primary Care Trusts.

3.9 The number of patients referred to Winterbourne View by a single organisation ranged from one to six. Given the small numbers involved, this report does not identify specific organisations when giving examples, so that patients cannot be identified.

Information provided to families, carers and patients

3.10 Arrangements were put in place to ensure that former patients of Winterbourne View and their families or carers knew about the NHS Review and knew how to provide any input they wished to make. The arrangements included:

- some former patients and their families or carers were contacted by the Chair of the Serious Case Review and an interview process set up to gather views as part of this. Where patients and families were interviewed and expressed a wish for their views to be shared with the NHS, this was shared with the Review Panel and the relevant commissioner;

- some former patients and their families and carers were, and are, involved in the ongoing police investigation and detailed communication with them was limited in case it interfered with the ongoing judicial process;

- in all other cases, arrangements were made for local commissioners to make contact with former patients and their families or carers both to provide information about the NHS Review and to ask them to make contact with their local Primary Care Trust if they had any comments or contributions to make.

3.11 Primary Care Trusts were asked to confirm in their investigation reports whether and how patients, families or carers had contributed to the investigative process.

Reference Group

3.12 A Reference Group comprising both representatives of families and carers of those with learning disabilities and self advocates was established to support the work of the review. This ensured that the review was able to address issues surrounding appropriate involvement and engagement that emerged during consideration of the commissioning process and to ensure that the perspectives of self advocates, families and carers was included in the work of the review.

3.13 The membership of the Reference Group is provided at Appendix 1. The group consisted of 16 people with representatives including:

- self advocates and carers from the South West, South Central and West Midlands areas;

- representatives from both the National Forum and South West Regional Forum for self advocates;

- representatives from the Challenging Behaviour Foundation;

- representatives from the Partners in Policy Making Network.

3.14 The discussions of the Reference Group were based on views and experience of members and covered the involvement of patients, advocates and families in following areas:

- involvement in commissioning;
- involvement within Care Programme Approach reviews;
- involvement in checking the quality of a placement;
- use of Care Quality Commission inspection reports;
- reporting of concerns.

3.15 The contributions provided by the Reference Group have assisted the Review Panel in its analysis of the role of commissioners and the involvement of patients, advocates and families. This is reflected in the findings and conclusions of this report.

3.16 In addition to the direct contributions made to the NHS review, the Reference Group has been asked to make further contributions to the wider Department of Health review.

Section 4

Overview of key information

This section includes an overview of key information gathered during the review process.

4. Overview of key information

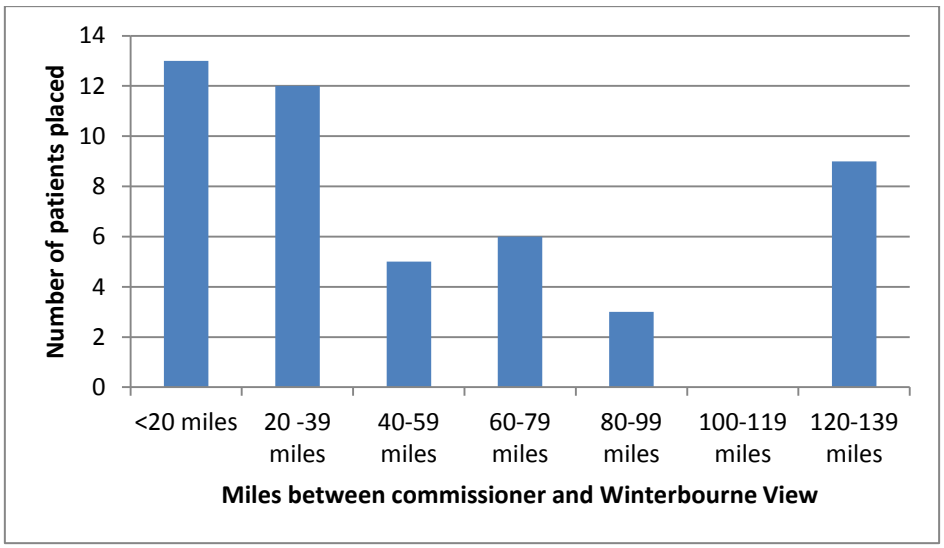
4.1 The initial information provided by all commissioners, including Local Authorities and covering 48 patient placements, enabled the Review Panel to gain an understanding of the patients being placed at Winterbourne View and the type of service being provided there. Analysis of some of the key information is provided in this section. Further analysis is also used as illustration throughout the remainder of this report.

Geographic spread of referrals

4.2 The Review Panel was interested in the geographic spread of referrals. Comparisons were made by calculating the distance from the main offices of the referring Primary Care Trust or Local Authority to Winterbourne View. These can be seen in Figure 1. This demonstrates the distance between those making decisions about referral to Winterbourne View. It does not necessarily represent the distance from either the family home of the patient or where they were living at the time of referral.

4.3 The Review Panel noted that over a quarter of referrals (13 out of 48) came from commissioners located less than 20 miles from Winterbourne View. For these referrers Winterbourne View did not represent a distant out of area placement, rather it was regarded as a specialist unit within the local area. Indeed, further analysis shows that nine of these 13 referrals were from commissioners located less than ten miles away.

Figure 1: Distance between commissioners and Winterbourne View

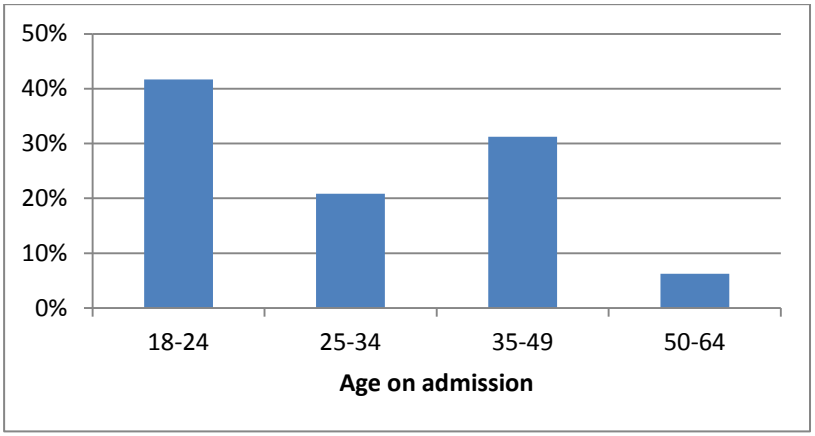


Age and gender

4.4 The age of patients on admission to Winterbourne View (Figure 2) shows that more than 40% of patients were under 25 years old when admitted and 94% of patients were under the age of 50. A recent national census of inpatients in learning disability and mental health services[20] showed that 73% of patients in inpatient learning disability services were under 50 years old at the time of the census (which is not necessarily the same as age on admission). The census showed that the equivalent figure for mental health inpatient services was 54%, with only 7% being between the ages of 18 and 24. Even after accounting for the differences in measurement, it is clear that the age profile of patients within Winterbourne View was notably younger than the inpatient learning disability and mental health populations. It was not possible to assess how Winterbourne View compared with other units specialising in challenging behaviour, as this data was not available.

4.5 The balance of gender in Winterbourne View was more even than in other inpatient populations. The balance of gender when analysing all 48 patient placements from commissioners in England was even, with 50% men and 50% women. The national comparison shows that 70% of patients in inpatient learning disability services were men and 58% of patients in mental health services were men.

Figure 2: Age on admission to Winterbourne View



[20] 'Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales', Care Quality Commission, April 2011

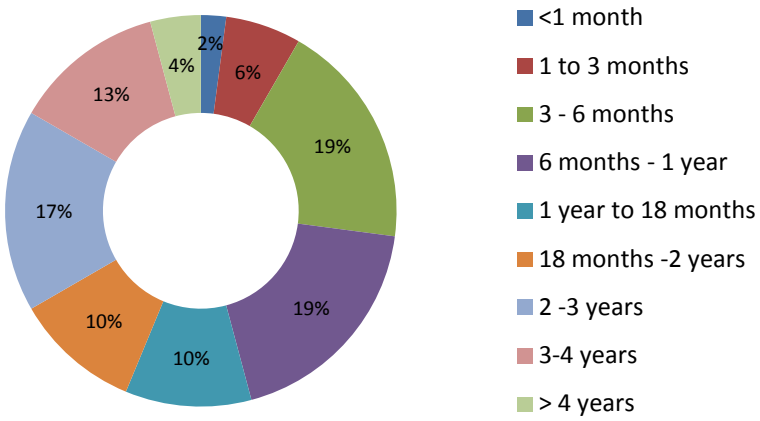
Length of stay

4.6 Figure 3 provides a summary of the lengths of stay of patients at Winterbourne View. This information shows no discernible pattern. The Review Panel noted that just over a quarter of the admissions lasted for under six months and a minority of patients (17%) were in Winterbourne View for over three years. The average length of stay was 573 days (around 19 months).

4.7 It should be noted that the closure of Winterbourne View in June 2011, following the Panorama programme, will have affected this information as the length of stay of some patients was shorter than it would otherwise have been. It is not possible to predict how long patients who were in the unit at the time of closure would have stayed if the unit had not been closed. It should also be noted that, for 42% of patients, the placement at Winterbourne View followed a stay at another specialist hospital, some of which were other Castlebeck facilities. The lengths of stay at Winterbourne View should be viewed in this context.

4.8 There is no directly comparable information from the national census, but it is worthy of note that, at the time of the most recent census (2010), 22% of learning disability patients had been in hospital for between two and five years and 31% had been in hospital for over five years.

Figure 3: Length of stay at Winterbourne View



4.9 Figure 4 provides further analysis of the variation in length of stay in respect of the primary reason for referral to Winterbourne View. This shows that those referred as part of crisis management or for assessment had the shortest average length of stay. Patients who were referred as Winterbourne View represented a move closer to home or a planned step up in care had the longest average length of stay. Figure 5 shows that there was little difference between the average length of stay of patients admitted under the Mental Health Act and those admitted informally.

Figure 4: Comparison of average length of stay by primary reason for admission

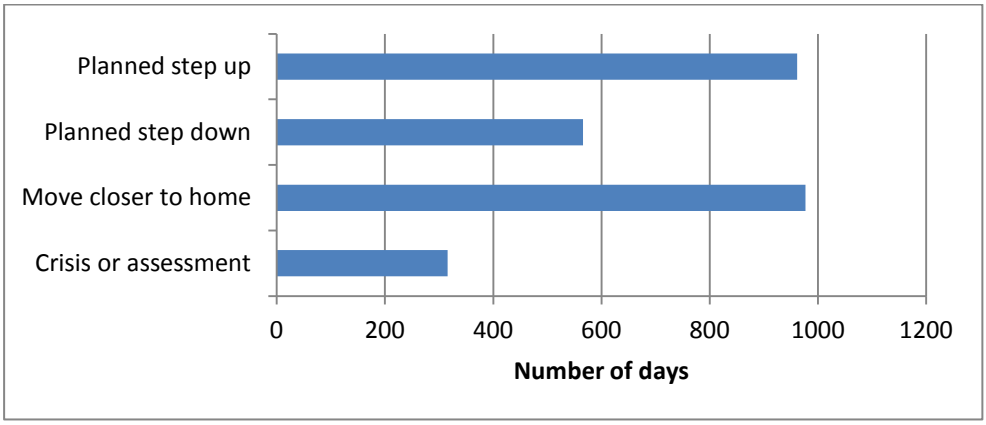
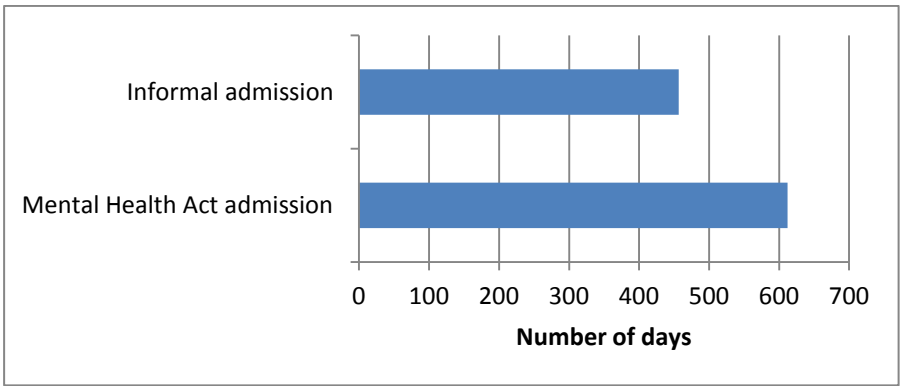
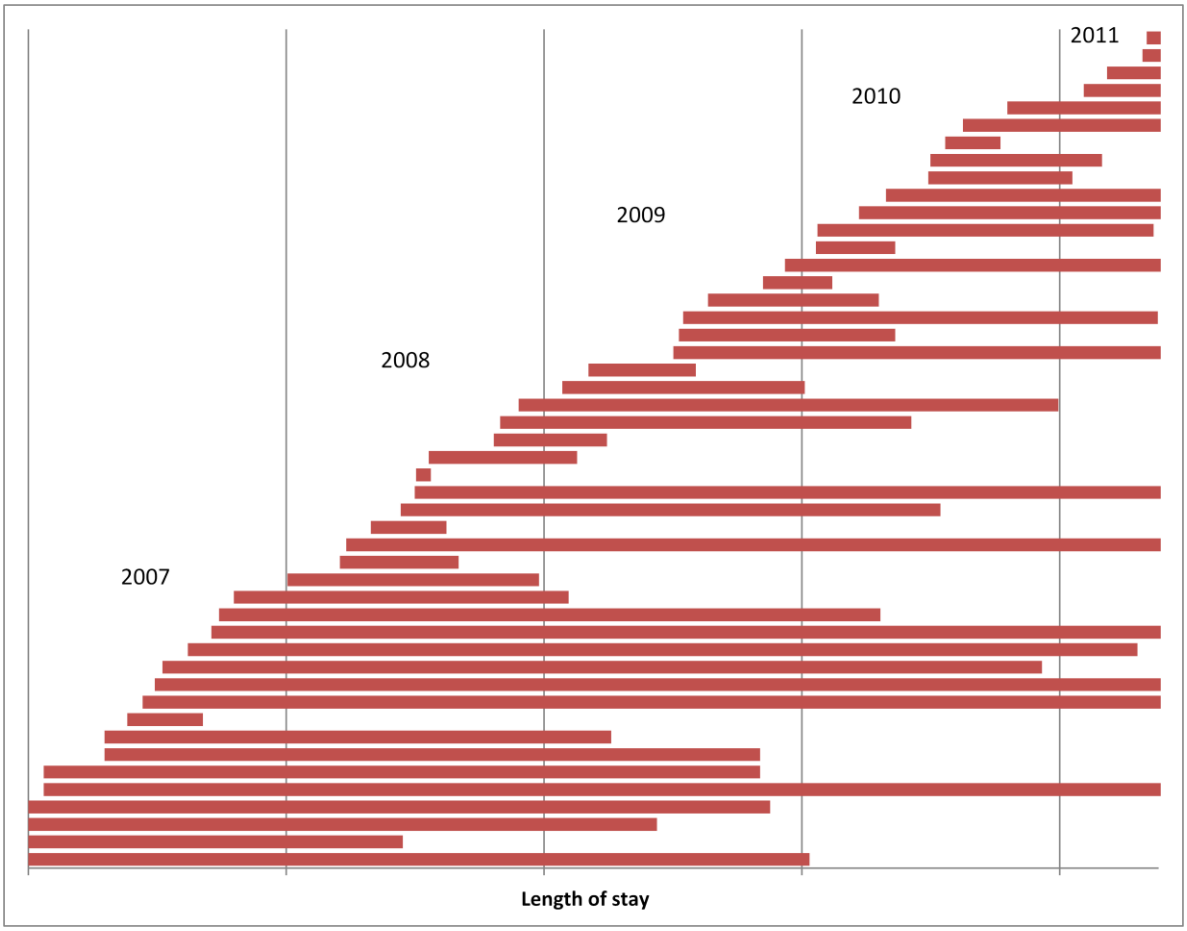


Figure 5: Comparison of average length of stay by status under Mental Health Act on admission



4.10 Figure 6 provides a fuller picture of the pattern of admissions over the years in which Winterbourne View was open and the varying length of stay. Each patient is represented by one bar in the timeline and the length of the bar indicates their length of stay. The timeline shows how the mix of long stay and short stay patients altered from time to time. The proportion of admissions with a shorter length of stay appears to have increased from 2008 onwards.

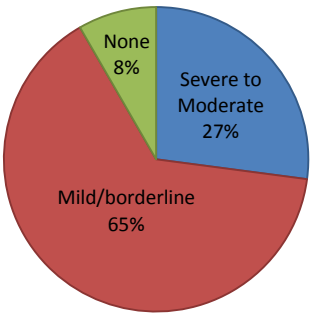
Figure 6: Patients admitted to Winterbourne View by year and length of stay



Learning Disability

4.11 The information provided to the Review Panel showed that the vast majority of patients had a mild or borderline learning disability, with just over one quarter of patients diagnosed with a severe to moderate learning disability. From the information available to the Review Panel, it appeared that a minority of patients had no learning disability. This is summarised in Figure 7.

Figure 7: Proportion of patients with learning disabilities



4.12 The Review Panel also noted that approximately one third of patients at Winterbourne View had been diagnosed with some form of autism and approximately one tenth had been diagnosed with Asperger Syndrome.

Section 5

Findings

This section sets out the findings of the Review Panel.

5. Findings

Commissioning policy and decision making processes

5.1 All Primary Care Trusts conducting full investigations were asked to describe the policies they had in place at the time of referral to Winterbourne View. Although the Review Panel was not conducting a full review of policy, this information provided a broad overview of the position. Overall, the Review Panel found that most commissioners had some policy or procedures in place which sought to limit the number of out of area placements and to repatriate those staying far from home to facilities closer to home.

5.2 For some, this was a general policy around individual patient placements, aimed at limiting these in line with the direction of national policy and because they often represented significant costs. For others, this was a specific policy relating to learning disability services.

5.3 Some commissioners demonstrated that robust decision making procedures were followed before an individual placement outside of locally commissioned services could be made. These were designed to ensure that there was a sufficient challenge to the rationale for placement. Some had out of area panels which met regularly to assess the continued requirement for placement. Others reported that these types of robust processes had been put in place in recent years. All reported that the events at Winterbourne View would lead to further improvements in decision making procedures surrounding individual placements.

5.4 Some commissioners demonstrated evidence of a phased repatriation of patients from out of area placements. It should be noted, however, that in some cases this repatriation was primarily focused on those placed furthest from home and, in this context, Winterbourne View represented the most local suitable service. Some of the placements at Winterbourne View were therefore a direct result of policies in place.

'The placement at Winterbourne View was the closest possible suitable provision for the patient. Close to sister to facilitate regular visit.'

5.5 The Review Panel was provided with information on relevant strategies and policies. Although some were more developed than others, it was not possible for the Panel to assess their effectiveness. The Review Panel did note that it had not seen examples of comprehensive health and social care strategies or commissioning plans designed to prevent placements in community settings breaking down because of inability to cope with increasingly challenging behaviour. Most commissioners reported that there would always be a need to access specialist individual placements in addition to local services:

'It will not always be possible to prevent every inpatient admission, and it will not always be possible to avoid a peak in admissions which necessitates the use of a small number of out of area treatments for a period of time'

'Commissioning of additional inpatient beds locally might have prevented this [the placement], but this would be at great expense if one or more beds were to be kept vacant so as to always be available. There is also a risk that having surplus vacant beds can lead to an increased likelihood of admission in cases where concerted work between community teams and providers might prevent this.'

5.6 The Panel was interested in the details provided of the early development of Winterbourne View within the Bristol and South Gloucestershire areas. It is clear that a gap in services had been identified and that Castlebeck was interested in filling that gap. There were early discussions between Castlebeck and NHS Commissioners about the needs of the population and the need for specialist provision. When Castlebeck established Winterbourne View, it is clear that there were no guarantees or agreements to purchase placements made by the NHS but that the new unit did meet the needs of some commissioners. It provided a local alternative for some Primary Care Trusts which had previously been relying on specialist units located some considerable distance away.

Conclusion

5.7 In relation to commissioning policy and processes, the Review Panel concluded that:

- the commissioning policies that were in place were largely limited to increasing the effectiveness of the way in which the NHS responded to situations where a patient, because of increased needs, could no longer be accommodated within local services;

- the Review Panel saw no examples of fully comprehensive policies and strategic thinking in place within the NHS or across health and social care on how best to respond to increased patient needs and prevent continued escalation;

- most commissioners had identified the general needs of learning disabled people as part of population needs assessments but only a minority appeared to have developed more detailed policy and strategy around challenging behaviour.

Commissioning relationships and responsibilities

5.8 All commissioners were asked to provide details of the organisations responsible for commissioning placements at Winterbourne View. This included details of responsibility for clinical oversight, funding and payment of invoices. Those requested to carry out full investigations were also asked to comment on the state of relationships between organisations and whether it had any impact on the effectiveness of the commissioning process.

5.9 Many commissioners made a distinction between the responsibility for the process of agreeing and funding the placement and the ongoing co-ordination of care. In many cases these were carried out by different parts of the same organisation or by different organisations.

5.10 Three main types of inter-organisational relationships and split of responsibilities in the commissioning of placements at Winterbourne View were identified. Of the 14 NHS commissioners of placements at Winterbourne View:

- eight Primary Care Trusts had sole commissioning responsibility, with the need for ongoing care co-ordination/monitoring fulfilled either by their own clinical staff, the local community health services provider, a joint learning disability team shared with the local authority or by a local specialist mental health provider;

- two Primary Care Trusts had delegated the responsibility for commissioning specialist placements to the local specialist mental health provider as part of contractual arrangements. This provider therefore managed both the commissioning process and ongoing care co-ordination;

- four Primary Care Trusts had formalised joint arrangements with the Local Authority in which funding was provided by the Primary Care Trust to support a joint commissioning team for learning disabilities. This joint team was tasked with making all the necessary arrangements and ensuring appropriate ongoing care co-ordination.

Clarity of relationships and responsibilities

5.11 It appeared to the Review Panel that commissioners had considered that the participation of care co-ordination teams in the Care Programme Approach had represented a system for monitoring the placements. The Review Panel found, however, that the care co-ordination arrangements were often not linked closely to the arrangements for making commissioning decisions. In particular, there was a tendency for there to be a lack of clarity on the respective roles and expectations. This was evident whether the functions were carried out by separate organisations or not. One commissioner remarked:

'Throughout the investigation it was shown that the role of the commissioner and the role of care co-ordinator were unclear. The expectations of both roles were not clearly understood and this [led] to inconsistency in undertaking key tasks. This was particularly the case with the reviewing of placements, quality monitoring and managing safeguarding and other alerts.'

5.12 One of the most obvious effects of this lack of clarity was in respect of the rigour with which information was shared by care co-ordinators with commissioners. There was a general lack of clarity and consistency on thresholds that should trigger the escalation of concerns or quality of care issues. For example, the Review Panel noted many situations in which social workers or nurses within care co-ordination teams held highly relevant information of which the NHS commissioner was unaware.

Health and social care partnerships

5.13 Good relationships between NHS and social care partners at the time of referral to Winterbourne View were seen as important in ensuring a smooth transition when the primary needs of the individual changed from social care to health or vice versa. The majority of commissioners reported that relationships between health and social care were healthy at the time, with some reporting extremely close working relationships. In some areas, it was identified that relationships were not as close but commissioners reported that this had not affected the commissioning process.

5.14 The Review Panel did note some examples of considerable delays in respect of patients who were ready for discharge from Winterbourne View into social care settings. This might suggest that good relationships did not always result in effective joint action planning. The Review Panel also noted one placement in which the relationships between different organisations and, in particular, a protracted dispute about which NHS commissioner was responsible for health care did have an effect on the both the commissioning process and the wellbeing of the individual. This suggested that lack of clarity around transition points between child and adult social care, and between social care and the NHS, were risk factors.

5.15 In some areas, learning disability teams shared between NHS and social care not only ran the local learning disability services but also made decisions about individual placements outside of these services. One commissioner identified that the close relationships and joint working arrangements within the learning disability service had been working very well at the time but that a negative aspect had been that this had led to informality in commissioning procedures and a lack of appropriate challenge to commissioning decisions:

'Relationships between commissioners across PCTs and between commissioners and the Learning Disability service were generally very good. There was a commitment to joint working and an intention to work jointly to achieve good outcomes. The consequence of this seems to have been little challenge to the internal (i.e. the shared commissioner and local provider) view over what was required for an individual and how the local service might respond to these needs.'

'Whilst there were processes and policies that described the commissioning of placements these were incomplete and there was an element of informal arrangements about them.'

Provision of primary care services

5.16 As part of the services provided at Winterbourne View, Castlebeck made arrangements with a local GP to provide primary medical services to patients at Winterbourne View. The Review Panel understood that this was normal practice for a type of facility such as Winterbourne View. Although reference was made in the standard Castlebeck contract to ensuring access to GP services, several commissioners identified a lack of clarity about where responsibility lay for the provision of primary medical services to their patients. In particular, they were unclear whether Castlebeck was responsible for ensuring provision through the terms of the contract or whether patients had simply been registered as NHS patients by the local GP, as local residents (albeit temporary residents). This issue is likely to be explored in more detail in the separate review of the provision of services by NHS providers and in the Serious Case Review.

Overlap of roles

5.17 A specific issue of potential conflict of interest was raised as part of the investigative process. This issue related to a consultant psychiatrist who worked part time for Winterbourne View and part time for a NHS community team. The NHS community team was involved in the referral of an individual to Winterbourne View during this time. It was not clear whether this had any detrimental effect on the commissioning process. Indeed, the evidence provided by the commissioner in its investigation report was that, in practice, it was considered at the time to '*offer benefit in terms of continuity of care and good liaison between the placement and the local team*'. It is clear that although the potential conflict of interest was considered within the local NHS team, it was not formally documented or made explicit in respect of decision making.

Role of Strategic Health Authorities

5.18 Primary Care Trusts are accountable to Strategic Health Authorities. As such, Strategic Health Authorities have been engaged in the development of commissioning and also exercise an oversight role in respect of the performance of Primary Care Trusts. As discussed later in this report, information received from Primary Care Trusts did not suggest that any specific information or concerns had been escalated to Strategic Health Authorities about Winterbourne View. The Review Panel wanted to explore this in more detail. The lead managers for learning disability at the three Strategic Health Authorities (South West, West Midlands and South Central) all confirmed that no information relating to Winterbourne View had been received by Strategic Health Authorities before 13 May 2011.

5.19 The Review Panel was interested in the level of awareness about Castlebeck and Winterbourne View within the Strategic Health Authorities before the BBC Panorama programme. Two of the three Strategic Health Authority lead managers said that they had a general awareness of Castlebeck as a provider in the learning disability sector. It was one of a large number of potential providers in the market.

5.20 The lead managers described how the role of Strategic Health Authorities in relation to learning disabilities commissioning combined a strategic overview of learning disability commissioning and services, together with detailed involvement in individual issues when they were raised. All lead managers said that they had no specific knowledge or contact with Winterbourne View as a facility.

5.21 An annual self assessment framework for Primary Care Trusts on learning disabilities has been in place since 2008. It provides a set of 27 areas for a Primary Care Trust to measure performance on four main themes:

- the re-provision of NHS campuses in line with national targets;
- tackling health inequalities faced by people with learning disabilities;
- ensuring that people with learning disabilities who are in services that the NHS commissions or provides are safe;
- progress being made in implementing the service reforms and developments described in 'Valuing People'.

5.22 Strategic Health Authorities have been overseeing the completion of this self assessment and using the results as assurance of the current position of commissioners in relation to learning disability. Particular follow up activity has included:

- encouraging increased registration of those with learning disabilities with General Practitioners and ensuring that they are receiving annual health checks, as part of tackling health inequalities;
- close oversight of the re-provision of NHS campuses where these still existed.

5.23 The lead managers at Strategic Health Authorities also reported more recent activity as part of the Quality, Innovation, Productivity and Prevention agenda aimed at understanding the pattern of use of out of area specialist placements and the resources used as a result. Again, the role of Strategic Health Authorities has been to identify the overall issue and oversee work done by Primary Care Trusts either individually or in partnership.

5.24 The Review Panel considered the role of Strategic Health Authorities in relation to Winterbourne View. It was clear that no information had been provided to Strategic Health Authorities in relation to Winterbourne View. It was also clear that Strategic Health Authorities had no direct relationship or contact with Castlebeck or Winterbourne View, as their lack of commissioning function meant this was unnecessary.

5.25 The role played by Strategic Health Authorities had tended to be focused on the closure of NHS learning disability campuses and steps to reduce health inequalities, in line with Government policy. There did not appear to be any oversight or performance management of the quality of commissioning of individual or specialist placements.

5.26 The Review Panel also observed that, despite commissioning development programmes such as World Class Commissioning, which had been in place during the time under review, there was no evidence that this developmental effort had had any discernible impact on the standard of the commissioning processes used in this area.

Conclusion

5.27 In relation to the responsibilities and relationships, the Review Panel concluded that:

- although there were different models being used to commission and monitor care and treatment, there was no evidence that any of the models offered the best approach. It is not possible to identify any of the models as being more likely, in itself, to have led to more considered commissioning decisions, better process or to have increased the likelihood of issues of concern having been picked up;

- there was an unsatisfactory lack of clarity and consistency about thresholds for communication within the NHS (i.e. between commissioners, care co-ordinators and clinicians making referrals);

- there was an unsatisfactory absence of clarity around respective roles; particularly between commissioners (those who made the decisions) and care co-ordinators (those who monitored ongoing care);

- there was a general lack of structure and process as to how roles would be carried out in practice, even when there were formal agreements in place covering funding and distribution of staff resource;

- there was some suggestion that, in a small minority of cases, strained relationships between organisations had a detrimental impact on the effectiveness of the commissioning process;

- the primary focus of Strategic Health Authorities was on strategic overview and had not encompassed oversight of the quality of commissioning of individual or specialist placements, as this was the responsibility of each Primary Care Trust.

Pre-referral checks and contracting

5.28 All commissioners were asked to confirm what checks were made before referral on the quality of care provided at Winterbourne View. Of the 44 placements made by the NHS in England:

- for 10 placements, commissioners reported that either no checks were made or that there was no evidence in the available files of checks having been made. This does not necessarily mean that no checks at all were made but it does suggest that any checks were informal and not recorded in a systematic way;

- for 25 of the placements, commissioners reported that they had checked that Winterbourne View was registered before making a referral. Some had also read the most recent inspection report from the regulator. It was noted that all such reports had been generally positive. Registration was taken as confirmation that the provider was compliant and would be monitored against essential standards;

- for five placements, commissioners reported that, in addition to basic checks, there had been a personal recommendation from a clinician that Winterbourne View was a suitable placement for the patient;

- in relation to four placements commissioners, care co-ordinators or families visited Winterbourne View before the referral was made. This was obviously possible only where the move was part of a planned pathway. There was no evidence that any of these visits prompted any concerns to be raised. The Review Panel noted that one such visit occurred during the period that undercover filming by the BBC was taking place. There was no evidence that anything untoward was witnessed at that time.

5.29 A common theme emerging from the investigations carried out by commissioners was that checks into the registration of Winterbourne View and the inspections by the regulator had not provided the level of assurance of the quality of care in the facility that had been assumed at the time:

'There was a reliance on the fact that the provider was registered to provide the relevant service by the Care Quality Commission, as the primary regulator of health and social care services, and had received a positive outcome in their most recent inspection'.

'Care Quality Commission registration was in place and the most current report in January 2011 identified no issues and presented a positive picture this was used as the checking process... '

5.30 Following the public exposure of events at Winterbourne View, many commissioners are now putting in place procedures to perform additional checks on facilities before placing any individuals. In some ways, commissioners are therefore acting as 'mini-regulators' before making placements.

5.31 Some commissioners made reference to the positive reputation that both Castlebeck and Winterbourne View had at the time. One commissioner remarked that, until 12 May 2011, it had '*an excellent strategic relationship with Castlebeck as an organisation. They consistently demonstrated innovative and person-centred strategic development plans*'.

5.32 From the information available to the Review Panel, it does appear that Winterbourne View was well regarded both by some clinicians and commissioning managers. Some had seen positive outcomes in relation to previous patients and therefore regarded Winterbourne View as having a good track record. There were at least two examples of commissioners having discussions with Castlebeck as part of longer term plans to move patients closer to home or to consolidate the number of non-local placements into a smaller number of facilities. These discussions were taking place or about to start shortly before the exposure of issues by the BBC. Although this level of confidence now appears misplaced, it was a relevant factor at the time and clearly influenced the level and nature of pre-placement checks.

5.33 The level and rigour of pre-placement quality checks was clearly influenced by the amount of time the commissioning team had before arrangements needed to be made. There were some circumstances in which a local clinical team had identified the need for a placement and had identified Winterbourne View as being suitable. The commissioner was sometimes asked late in the process to agree funding and in these circumstances, the Review Panel formed the view that, beyond basic checks on registration with the regulator, there were few if any checks made.

Contractual Position

5.34 The Review Panel asked all commissioners carrying out a full investigation to identify the contractual basis on which the placement was made. This revealed that, of the 28 placements:

- 15 were covered by a signed contract provided by Castlebeck;
- six were covered by a local authority standard contract, as part of formal pooled arrangements for commissioning;
- five placements (all arranged by the same commissioner) were covered by the standard Castlebeck contract and a supplementary agreement based on the standard NHS contract;
- for two placements, the commissioner could not find evidence of any contract having been signed.

5.35 The Review Panel was told that the use of a contract set by the provider of care for the 'spot purchase' of individual placements was not unusual. Although standard NHS contracts have been developed for agreements between commissioners and NHS providers, the Review Panel understands that it was uncommon for these to extend to agreements relating to individual patients, rather than an agreement covering a large number of patients.

5.36 The standard Castlebeck contract set the following expectations about the nature of the service to be provided for patients:

2.6 The Placement shall commence from when the Patient commences their stay at the Registered Premises. From the commencement of the Placement, the Company will provide what it considers to be an appropriate multi-disciplinary care and treatment regime comprising (but not necessarily limited to):

2.6.1 24 hour nursing care (oversight within our Registered Establishments) by [RNLD/RNMH/RMN trained] nurses supported by a team of care staff;

2.6.2 Psychiatric clinical care by the Company's in-house team comprising (as reasonably required) consultant psychiatrists and specialists, consultant psychologists and behavioural therapists;

2.6.3 Neurophysiological assessment provided on a sessional basis, if deemed necessary by the Company's medical staff;

2.6.4 Positive programming comprising education by systematic instruction as needed in socialisation, occupation, diversion, rehabilitative therapy and training of daily living or other specific skills;

2.6.5 Access, where appropriate, to community services at a level consistent with the Patient's clinical condition and level of functioning;

2.6.6 Access to general practitioner and other generic services available under the NHS as required by the Patient;

2.6.7 Provision of full weekly board at the Company's Registered Premises deemed by the Company as providing an appropriate environment for the Patient; and

2.6.8 Recreational community outings and, where appropriate, a holiday (up to 7 days) within the UK both under the supervision of appropriately trained employees of the Company.

5.37 The contract also provided details of the steps the company would take to ensure appropriate and adequately trained staff and other safety measures as shown in the following excerpts:

The Company:

3.1.1 will ensure that all its Registered premises are run in accordance with the requirements of the Care Standards Act and meet all appropriate standards in respect of fire regulations and health and safety

3.1.2 will allow access at all reasonable times and on reasonable notice by a nominated and appropriate representative of the Referrer to the Patient at the Registered Premises where the Patient has been placed...

...3.2.1 will take appropriate steps to seek to ensure the honesty, integrity and reliability of all staff engaged by the Company. These steps will include the requirement to provide two satisfactory impartial, and where possible, written references and obtaining a satisfactory disclosure record from the Criminal Records Bureau for all staff...

...3.2.5 Will provide suitable and appropriate initial and refresher training to all its employees working in its Registered Premises; and

3.2.6 Will ensure that relevant employees will be fully trained to carry out, in appropriate circumstances, dignified restraint of residents in accordance with the guidelines and codes of practice issued by the relevant statutory bodies...

...3.5.2 The Company will endeavour at all times to provide a safe environment for the Patient and employees of the Company. In the event of a significant assault on a Patient or employee, they each have the right to involve the police.

5.38 The Review Panel was struck by the fact that the sections of the contract reproduced above were the only ones that referred in any way, no matter how indirectly, to the quality of the service to be provided. In comparison with contracts put in place elsewhere by the NHS, there was a poverty of quality measures or outcomes. For example, there was no explicit contractual requirement for Castlebeck to report any serious incidents to commissioners nor any provision for reporting on general indicators of quality or clinical outcomes.

5.39 Some commissioners used Local Authority contracts as the placement was arranged as part of formal pooled commissioning arrangements. There was no evidence that these contained any more content on the quality of service and clinical outcomes. Indeed, one commissioner identified a learning point about ensuring that the standard contract being used by the pooled commissioning unit reflected the need to included specific material about hospital quality and clinical outcomes when required.

5.40 The Review Panel received evidence from a commissioner which supplemented the Castlebeck contract with a contract of their own based on a standard NHS contract. It told the Review Panel that, although efforts had been made to put all individual placements on to a NHS contract, there had been no resource available for establishing a more robust monitoring of these contracts. As a result, the use of an NHS contract had made little practical difference although it did have a subtle effect on the commissioner/provider relationship. The commissioner told the panel that Castlebeck had been reticent about signing the NHS contract but did so after the commissioner insisted that it was essential. This was seen to have strengthened the position of the commissioner although, as explained above, there appeared to have been no tangible benefits.

5.41 As a result of interviewing a number of the commissioners, the Review Panel concluded that there had been no systematic monitoring of the terms of the contract, nor of whether the expected level of service was being delivered. The engagement that took place following admission was carried out as part of the Care Programme Approach and dealt with the circumstances of the individual patient. This meant that opportunities to monitor the effectiveness of Castlebeck as a company and Winterbourne View as a hospital were not taken.

'The initial placement and subsequent monitoring and review of learning disabled patients was weighted towards patient level oversight (albeit effective) rather than provider level monitoring led by the commissioning team.'

'Commissioners need to ensure that there is a direct relationship with providers, framed by an effective, regularly monitored contract with agreed realistic outcomes'

5.42 It was also evident that the nature of the individual spot contracts with a private sector provider provided no collective overview of the quality of the whole service or outcomes being achieved for groups of patients. There is no established process to share collective intelligence gained by commissioners.

Conclusion

5.43 In relation to pre-referral checking of quality and the arrangements made for contracting, the Review Panel concluded that:

- many commissioners placed reliance on the registration of the provider and the regulator's inspection. The events at Winterbourne View have raised real questions as to the extent to which a commissioner can rely on the regulation regime when seeking to assure themselves of the quality and safety of a provider;

- the apparent lack of **any** pre-referral quality checks in the case of some commissioners was unacceptable;

- the poverty of quality measures in contracts was very surprising and highly regrettable, as it might have offered an opportunity to identify some issues of concern. At the very least, the inclusion of a requirement to report serious incidents directly to the commissioner might have avoided some of the difficulties discussed later in this report;

- this review has highlighted the problems associated with 'spot purchased' individual placements being governed only by contracts drawn up almost completely by the service provider;

- the lack of any effective contract monitoring by commissioners meant that, whatever type of contract was in place, they were not used as an effective commissioning tool.

Appropriateness of care

Source of Referral

5.44 All commissioners (including Local Authorities) for the 48 patients from England were asked to provide information about the reason for the referral to Winterbourne View and the status of each referral under the Mental Health Act.

5.45 The following three patterns of referral to Winterbourne View were identified:

- the patient had an acute mental health need (and in particular needed to be detained under the Mental Health Act) but this could not be met within local NHS mental health inpatient services as the patient was assessed as too vulnerable, challenging or otherwise unsuitable either at the point that an admission was being considered or following an initial admission to a local NHS inpatient unit;

- the patient had a learning disability but their mental health needs and/or challenging behaviour meant that they could no longer remain within their existing social care service;

- the patient was already placed in a specialist hospital and a move to Winterbourne View represented one or more of the following:

    * a move closer to home;

    * a planned step down in care;

    * a court requirement;

    * a step up in care, because Winterbourne View was perceived to specialise in treating patients with challenging behaviour.

5.46 The following comments from commissioners illustrate this:

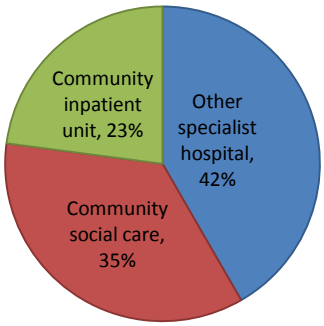
'[the patient] would have been extremely vulnerable if placed on a generic psychiatric ward, which would have been the only service available to accommodate her locally, given her Mental Health Act status'

'The status of the patient under the Mental Health Act and Ministry of Justice influenced the nature of the placement and the limited availability locally to provide a placement for this patient.'

'Immediately prior to this client's admission to WBV they had exhausted all local NHS specialist provision for people with LD and challenging behaviour. They had spent a significant amount of time at ... a LD inpatient unit...They were then transferred to [a NHS Assessment and Treatment Unit]...This client's behaviour escalated ... and he was detained under Section 3 of the Mental Health Act. It was established that [the NHS Assessment and Treatment Unit] was not an appropriate placement as the coming and going of other patients and the nature of others' mental state were all having a significant impact on the client, and alternatives were explored. Although this client's parents expressed very strong wishes for him to return to the residential care home he had left prior to moving to [LD patient unit], it was deemed to be inappropriate on the grounds of his clinical needs and the nature and persistency of his complicated behaviours.'

5.47 The largest group of placements to Winterbourne View were part of a transfer between specialist hospitals (Figure 8). Approximately one third of these transfers were from other facilities operated by Castlebeck.

Figure 8: Previous settings before referral to Winterbourne View



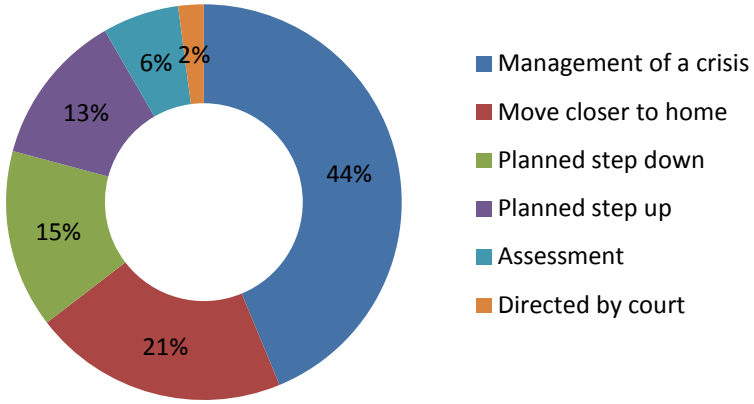
5.48 Evidence provided to the Review Panel indicated that patients referred from a community inpatient facility had been under the care of a local consultant psychiatrist or a local multidisciplinary clinical team, and that patients transferred from another specialist hospital had been under the care of the consultant who was the Responsible Clinician at the referring hospital. Where individuals were referred to Winterbourne View by clinicians from specialist hospitals that were far away from the home of the patient, the clinical leadership lay with the referring clinician and the level of clinical involvement from the 'home team' tended to be minimal.

5.49 For individuals referred to Winterbourne View following a breakdown in a community social care placement there was evidence of local clinical opinion being sought but not always direct involvement in decision-making.

Reason for Referral

5.50 All commissioners were asked to identify the primary reason for the placement at Winterbourne View. These are illustrated in Figure 9 below.

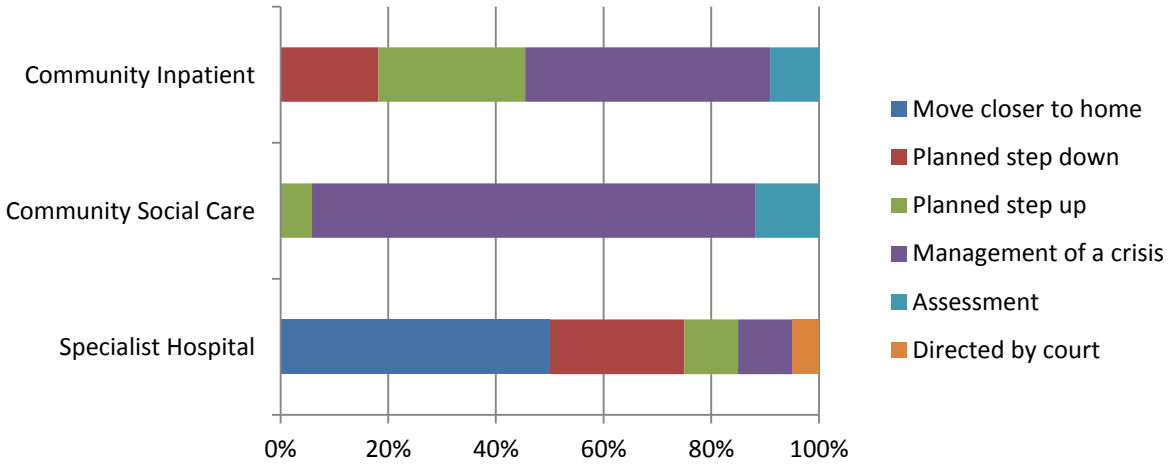
Figure 9: Primary reason for placement at Winterbourne View



5.51 The evidence provided to the panel identified 'management of a crisis' as the most common reason for referral to Winterbourne View (Figure 9). The second most common reason for referral was that Winterbourne View represented a move closer to the patient's home.

5.52 When the Review Panel analysed the reasons for referral alongside the setting from which the patient was referred, clear patterns emerged (Figure 10). Over 90% of referrals of individuals from community social care settings were due to a crisis. The reasons for referral from community inpatient facilities were relatively evenly balanced. The main reason that individuals were referred from other specialist hospitals was that it constituted a move closer to home.

Figure 10: Comparison of primary reason for referral by previous setting

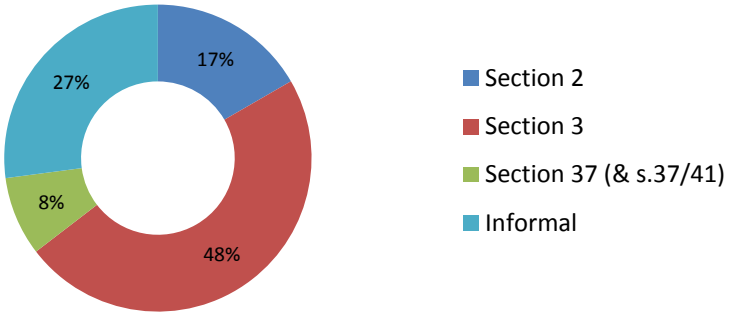


5.53 The Review Panel was interested in the length of time those admitted as part of a crisis situation or for assessment stayed in Winterbourne View. The Review Panel found that there were 24 patients who were admitted for these reasons. The length of time these patients stayed in Winterbourne View ranged from 21 to 1,245 days. Their average length of stay was 316 days. The median length of stay (the mid-point of all lengths of stay) was 226 days. The Review Panel was concerned that this appeared to be a disproportionate length of time for crisis management and/or assessment.

Use of the Mental Health Act

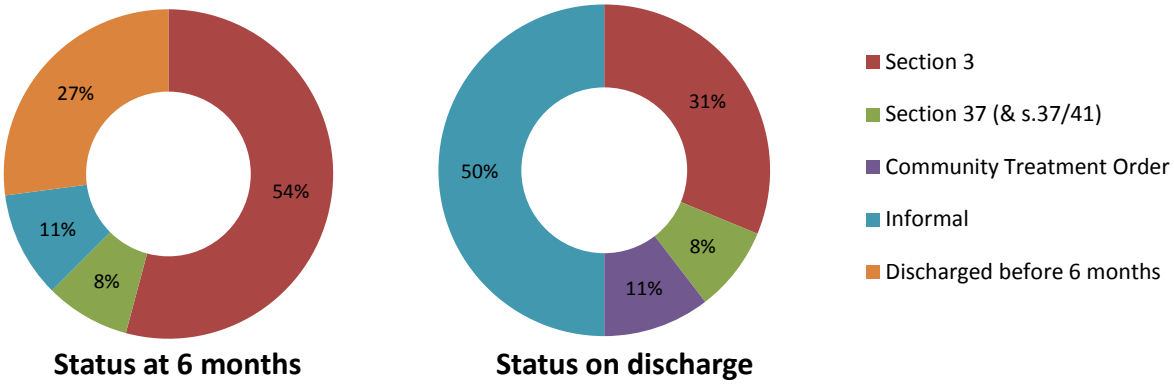
5.54 A high proportion (over 73%) of all admissions to Winterbourne View were made under a section of the Mental Health Act (Figure 11). This is an indicator of the level of need of the individuals being placed at Winterbourne View. It also explains why many commissioners said that there had been limited options when trying to find a suitable placement as, if the clinical opinion was that an individual required detention under the terms of the Mental Health Act, this required a registered hospital setting able to detain patients under the Act.

Figure 11: Mental Health Act status on admission to Winterbourne View



5.55 The Review Panel was interested in how, if at all, the mental health status of patients altered while at Winterbourne View. Based on the information provided, the mental health status of all patients at six months following admission and at discharge was analysed further. The results are illustrated in Figure 12.

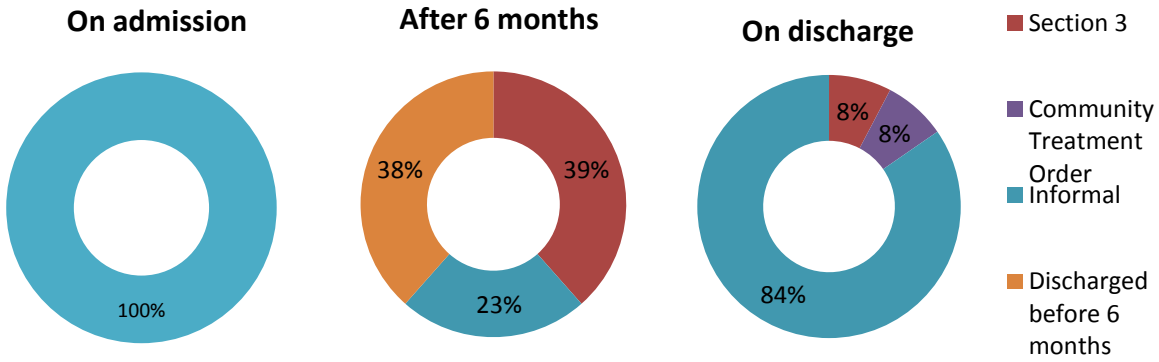
Figure 12: Change of mental health status during admission



5.56 These data show that a larger proportion of patients were covered by Section 3 at six months. This increase is due to a proportion of the patients who were admitted either under Section 2 or informally, subsequently being detained under Section 3. The position on discharge shows that half of all patients were discharged from the unit as informal patients.

5.57 Figure 13 illustrates the changing status of patients under the Mental Health Act for those patients who were admitted informally. A total of 13 patients were admitted informally. Of these patients, seven remained informal patients throughout their stay. The remaining six patients were detained following admission, one of whom was discharged before six months.

Figure 13: Changing Mental Health Act status for patients admitted on an informal basis



5.58 Since April 2009, there has been a requirement for patients to be considered under the Deprivation of Liberty Safeguards if it is thought that they are being deprived of their liberty and thus having their human rights affected[21]. The Deprivation of Liberty Safeguards provide legal protection for those people who do not fall within the scope of the Mental Health Act. In this context, this would be patients with a learning disability who did not exhibit abnormally aggressive or seriously irresponsible conduct but who were deprived of their liberty in order to receive treatment.

5.59 The Review Panel saw evidence of Deprivation of Liberty Safeguards being considered formally in references made to review meetings and First Tier Tribunals (Mental Health). There was also further evidence of informal awareness and discussion about the status of certain patients in relation to the safeguards.

5.60 The Review Panel did not see enough evidence to suggest that the legal status of informal patients was being reviewed in a systematic manner. Given what has become known about the care regime at Winterbourne View, the Review Panel has concerns that these patients may have potentially been deprived of their liberty. This should be considered further in the Serious Case Review.

[21] Article 5 (Right to Liberty and Security of Person), Human Rights Act 2005

5.61 The Review Panel reviewed the summary information available from commissioners in order to see whether there was any discernable pattern in the way in which the provisions of the Mental Health Act had been applied. No discernible pattern was found. The Review Panel noted that, on the limited evidence available, it appeared that no decision to detain an individual had been overturned or challenged by a First Tier Tribunal (Mental Health). The Review Panel was cognisant of the fact that the application, governance, monitoring and review of the use of the Mental Health Act at Winterbourne View was the responsibility of the Mental Health Act managers and the Responsible Clinicians employed by Castlebeck.

5.62 There were some wider policy issues raised about the application of the Mental Health Act in these type of independent sector settings, which are discussed in more detail later in this report.

Conclusions

5.63 In relation to the appropriateness of the original referral and ongoing care, the Review Panel concluded that:

- there was a high proportion of patients coming from other specialist hospitals, and for whom the move represented a potential improvement in care (due to it being closer to home or part of a step down plan);

- the proportion of patients admitted under a Section of the Mental Health Act 1983 was high. This was an indication of both the level of need and the fact that patients were either being transferred from other hospitals (in which they were also detained under the terms of the Act) or were being referred because a crisis situation had escalated to a serious level;

- there were many examples provided of local services and clinicians declining to accommodate a patient as the patient was deemed unsuitable for the local service or the local service was deemed unsuitable for them. In many cases, this reduced the range of options available to commissioners. In some cases local services had been tried in the past and the placement had broken down;

- the lack of available local services might suggest that, on the one hand, commissioners were faced with local services with specific admission criteria and, on the other, Winterbourne View with broad acceptance criteria. Alternatively, admission might have been operationally difficult for local services as they did not have the specialist skills, experience or resource, but straightforward for a privately run hospital filling a specialist gap in the market by accepting those for whom many other services were unsuitable. The Review Panel observed elements of both scenarios;

- there were clear examples of short term decision making, albeit made with few or no alternative options and a pressing need to act, which did not meet the long term needs of the individual.

Co-ordination and monitoring of care

5.64 One of the main issues identified by the Review Panel following analysis of the information gathered during the first phase of the review was the need for further exploration of the arrangements which had been in place for ongoing monitoring of care and treatment. The Panel was particularly interested in the extent to which the Care Programme Approach had been followed, the level of clinical involvement in ongoing monitoring and the overall effectiveness of the monitoring processes. These were all issues that were included in the brief for the 28 further investigations carried out.

5.65 All patients were covered by the guidance on the Care Programme Approach. In the absence of any contractual or other monitoring of the service as a whole, the monitoring of individual care plans under the Care Programme Approach was the only possible way in which some aspects of the quality and effectiveness of the service being provided might be monitored.

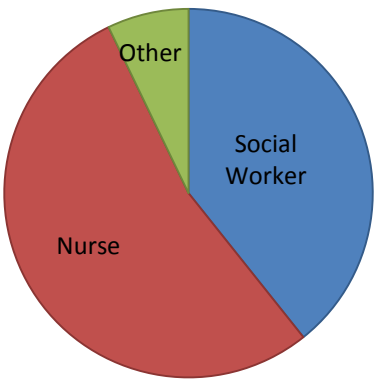
Allocation of care co-ordination responsibilities

5.66 The Review Panel found variation in the way in which the commissioner of care was represented within the Care Programme Approach process. This was related to where care co-ordination responsibilities sat within the organisational split of responsibilities discussed earlier in this report.

5.67 For some, the care co-ordination responsibilities were shared by a multi-disciplinary team even if one individual was identified as the care co-ordinator. For others, it appeared that the care co-ordination arrangements did not extend beyond the individual identified as the care coordinator. This does not appear to meet the requirements of the guidance surrounding care co-ordination described earlier in this report.

5.68 All patients appear to have had a named individual from their 'home' area co-ordinating their care. Figure 14 summarises to whom the care co-ordinator role was assigned to for the 28 patient placements subject to further investigation.

Figure 14: Assignment of care co-ordinator role



5.69 Where care co-ordination was carried out by a joint health and social care learning disability team led by the local authority, the responsibility for care co-ordination often remained with the social worker who had the long term relationship with the patient. Some commissioners described the benefits of this in terms of continuity of contact with the patient, families and carers and long term planning, however there were occasions in which the Review Panel was unclear how additional input from local clinicians had been achieved within these arrangements.

5.70 There were, however, also examples in which the move from social care to health and the associated shift of responsibility for care co-ordination to health-only teams was seen as detrimental:

'Once continuing healthcare funding had been secured, [the] social work team withdrew active engagement in care management as the NHS was the lead commissioner. With hindsight it would be helpful for social care to remain involved in care management where the placement is for assessment and or treatment and there is an expectation of transfer to a step down placement and care being provided more locally in the future.'

The Care Programme Approach process

5.71 All but one commissioner reported that the Care Programme Approach process was run by Winterbourne View. Meetings were set on a fixed timescale, generally every six months, were held at Winterbourne View with Castlebeck staff producing the minutes. They were attended by, at least, a representative of the commissioning organisation and, in some cases, by family members.

5.72 The one exception to this involved a Primary Care Trust which reported that:

'the meetings were not obviously held under the auspices of the Care Programme Approach process...we as the commissioning authority produced the minutes from the three reviews.

5.73 Although the process was run by Winterbourne View, it would have been possible for commissioners or care co-ordinators to influence it:

'There was a timetable set for CPA at point of admission by Castlebeck...but at any time could be altered or brought forward by care co-ordinators or commissioners'.

5.74 There were no examples of Care Programme Approach meetings being called at the request of the commissioner or care co-ordination team. The nature of the timetable also meant that the review meetings did not appear to be planned around important events, such as Mental Health Act decision making, Tribunals or appeals. Similarly, Care Programme Approach meetings were not arranged in response to incidents or concerns.

5.75 The Review Panel also found that there did not appear to have been a consistent process of raising recent safeguarding alerts or other concerns at the Care Programme Approach meetings themselves. For example:

'Despite the regular and detailed review of care no issues of concern were identified in relation to the individual's care or Winterbourne View'.

5.76 Some investigations carried out by commissioners found examples of poor record keeping, relating in particular to notes and minutes from Care Programme Approach meetings. It was unclear whether this pointed to a lack of rigour in the process for circulating notes of review meetings by Winterbourne View, or simply poor record keeping by care co-ordination teams.

Representation of commissioners

5.77 The Care Programme Approach meetings were often attended by the local care co-ordinator. In many cases they were the sole representative of the commissioner. There were very limited examples of senior commissioning participation from the local commissioning team at the review meetings.

5.78 The involvement of senior clinicians from the 'home' area was also very limited. Of the 28 investigations, the Review Panel saw evidence of a significant level of involvement of consultant clinicians in five cases and some involvement in six cases. There was no evidence of any discernible senior clinical involvement or challenge in the ongoing monitoring and discharge planning in the remaining 17 cases.

5.79 The effective exercise of care co-ordination responsibilities, and in particular the level of clinical involvement, seemed in some cases to be affected by the extent to which the team had a clear 'line of sight'. For example, where patients had been placed in services a long way away from the local area for some time, they were less likely to be known to local clinical teams and therefore attracted less clinical involvement in their case.

'Whilst it was clear that the Learning Disability Partnership had the long term responsibility for this patient, her placement outside of [her home area] for a very long time has created a distance from the clinical team and a lack of detail in the planning for her return. All planning for her return was limited by a lack of daily involvement and regular contact.'

5.80 The Review Panel noted and agreed with the following conclusions drawn by commissioners when considering how the Care Programme Approach could have been used more effectively:

'there was insufficient clinical challenge to the provider/Responsible Clinician view at Care Programme Approach reviews'.

'reliance was placed on the very detailed assessment information presented by the provider and not enough on robust presentation of information held by the placing authority'.

'The process of relying on Care Programme Approach for monitoring of a placement by the care co-ordinator on behalf of the commissioner allowed the provider, i.e. Castlebeck, to define progress, delivery of outcomes, the timescale for discharge and the need for extra support. This passive acceptance of control by a provider rather than by the commissioner leaves both commissioner and care co-ordinator without the opportunity to challenge treatment and support plans.'

'Although it was correct to use Winterbourne View (Castlebeck) systems to deliver Care Programme Approach whilst [the patient] was an in-patient it is arguable that there could have been a more proactive approach from the LDT[22]/Commissioners. The Care Programme Approach co-ordinator, care manager and commissioner could have requested planning meetings to formalise and underline the move towards discharge rather than wait for Winterbourne View to organise'.

Clarity of roles

5.81 Some commissioners reported either confusion or a lack of clarity about how the guidance on the Care Programme Approach[23] should have been applied. This lack of clarity was particularly evident in relation to commissioner expectations of the person holding the role of the care co-ordinator, and the extent of local clinical involvement in the process:

'The responsibilities of care co-ordinators were not fully spelled out which [led] to uncertainty in what was required of them and an inconsistency of approach. Care co-ordinators were unclear over the quality monitoring expectations that were inherent in the role and certainly felt that they did not have the skills or the tools to deliver this role effectively.'

'Care co-ordinators seemed to have significant expectations placed upon them without clear guidance on how to deliver these roles.'

'Guidance around Care Programme Approach co-ordination when a person is admitted to hospital does not appear to have been followed. There appears to have been some confusion around the role of the Care Programme Approach Care Co-ordinator when someone is admitted to hospital which has been exacerbated when the placement is an OAT [Out of Area Treatment]. There was an assumption that his role automatically fell to the receiving in-patient service. There also appears to have been some confusion whether when someone moves to an in-patient service between continuation of a clinical role (e.g. the service has x professional and I am from the same profession therefore I am not needed) and the care coordinator role.'

5.82 The Review Panel also noted several references to the Responsible Clinician at Winterbourne View being the care co-ordinator, which it took as further evidence as confusion of roles.

[22] 'LDT' stands for Learning Disability Team
[23] *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*, Department of Health, 2008

5.83 The Review Panel found that this lack of clarity contributed in particular to the lack of challenge, clinical or otherwise, within the Care Programme Approach reviews. In many cases, it appeared that care co-ordinators were fulfilling their role of keeping in touch with the patient, focusing on the individual care plan and attending the review meetings but there was less clarity about what their role was in relation to overall monitoring of quality, challenging issues as they arose or escalating concerns within the NHS.

5.84 The Review Panel considered that the point raised about the skill set and relatively junior status of care co-ordinators was also relevant. The skills required to challenge effectively and hold people to account, especially as one participant in a large meeting, are not necessarily the same skills as those required to build a long-term relationship with a vulnerable person and their families. Care coordinators were being expected to fulfil both roles. The Review Panel felt that, in many cases, this contributed to the lack of robust challenge.

Discharge planning

5.85 The Review Panel noted a pattern of some patients staying in Winterbourne View for long periods of time after they were no longer detained under the Mental Health Act. The Review Panel identified 10 patients whose detention under the Mental Health Act ended during their stay at Winterbourne View rather than at the point of discharge.

5.86 The Review Panel recognised that the removal of the need to detain was not, in itself, an indicator that the patient was ready for discharge from the unit. It can be taken, however, as an indication that the needs of the patient had reduced and that, at the very least, consideration should have been given to whether the setting remained appropriate. The length of time between ending of detention and discharge for these 10 patients ranged from six weeks to 18 months, with the average length of time approximately eight months. This tended to suggest to the Review Panel that there was a general lack of urgency in finding suitable alternative care options and planning discharge, although it is difficult to reach a definitive view on this point as other factors such as the complexity of finding suitable alternative accommodation were also present.

5.87 A lack of focus on discharge planning for all patients was highlighted by commissioners in their investigation reports:

'Records of Care Programme Approach meetings consistently show that reviews of the case start with a decision to maintain the detention and does not list any actions that are about are about planning for discharge. That does not mean it wasn't happening but the Care Programme Approach process seems not to have prioritised discharge.'

'In essence the key outcome was preparation for discharge from hospital and developing independent living solutions but this was never achieved. Whilst it was referred to consistently in documentation no deliverable plan was ever made and implemented.'

5.88 Some commissioners suggested that they had found it difficult to achieve a focus on discharge planning in their discussions with staff at Winterbourne View:

'[social worker] wrote in case profile notes that [Learning Disability Nurse] and herself had found communication with Winterbourne View very difficult and was concerned that there might be a delay in discharge'

5.89 The fact that the consultant psychiatrist at Winterbourne View was the Responsible Clinician under the terms of the Mental Health Act was also raised as a factor in the arrangements for discharge:

'Requirement of Castlebeck Responsible Clinician agreement to discharge plans led to a delay in care pathway'

'The authority to change the treatment plan for [the patient] therefore remained with the Responsible Clinician at Winterbourne. It was the view of the Responsible Clinician which therefore determined whether discharge would be planned for and it appears that this was the key factor in the duration of a placement.'

In a letter from Castlebeck: [The Responsible Clinician] states that further work for at least another 6 months is required at Winterbourne View to include specific anxiety management interventions and further fine tuning of medication. Team at Winterbourne View do not believe that supported living is appropriate in the near future; however the Castlebeck step down facility being opened in Bristol in the near future may be appropriate'.

5.90 The Review Panel felt that this raised a broader policy question about the level of independence of Responsible Clinicians employed within a private hospital and their ability to practise without any potential conflict of interest. The Review Panel noted that the Mental Health (Conflict of Interest) Regulations 2008 and the Mental Health Act Code of Practice[24] both focus on the potential conflicts of interest which might arise on the point of admission. The situation relating to renewal of detention under Section 20 of the Mental Health Act 2003 is less clear.

5.91 In order to renew detention, the Responsible Clinician must consult with one or more persons from a professional background different to his/her own who have been professionally concerned with the medical treatment of the patient. The relevant guidance [25] suggests that this should be interpreted as someone directly involved in the provision of care. The consultee must state in writing that he/she agrees that the conditions for further detention are met before the Responsible Clinician can provide a report to the hospital managers. In a situation such as Winterbourne View, where both professionals involved in the medical care might be employees, the potential for a conflict of interest arises.

[24] The Code of Practice states at 7.4 "Where the patient is to be admitted to an independent hospital and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital. That it, there will be a potential conflict if both doctors giving recommendations are on the staff of the independent hospital."

[25] Mental Health Act Manual 12th edition, Richard Jones

5.92 Although the potential for conflicts of interest existed, the Review Panel noted that there were no patients who had their detention renewed for whom the decision was overturned by a First Tier Tribunal (Mental Health).

Monitoring of the environment

5.93 Given that Care Programme Approach review meetings were held at Winterbourne View, it could be assumed that this would have provided opportunities for care co-ordinators and others to become familiar with the hospital and, therefore, increase opportunities to identify any issues of concern. It became clear to the Review Panel during this review that this was seldom possible at Winterbourne View.

5.94 There was a consistent pattern of Care Programme Approach meetings and other review meetings being held in a room beside the reception area and not involving visits to clinical areas. The Review Panel heard reports that participants, even when they specifically requested it, were denied access to the ward areas of the hospital. Although there were a small number of exceptions, the vast majority of reports supported the same pattern of events:

'Individual rooms were not visited. [The patient's] advocates contrived to 'accidentally' reach the first floor but was quickly escorted back down to the ground floor. The Advocate saw [the patient] with head bowed and carers/nurses talking over her.'

'The LD team's awareness of activities and occupation of patients at Winterbourne was limited as the environment was highly controlled'

'Arrangements were in place for an advocate to visit, who reports that she always interviewed [the patient] in a downstairs office and had no access to the actual ward environment'

5.95 The reported reason given for the lack of access was that it would be disruptive to other patients and invade their privacy. Although many commissioners have reported, with the benefit of hindsight, that the lack of access was of concern, the Review Panel did not see any evidence to suggest that the policy, or the reasons given to explain it, had been challenged at the time.

5.96 The Review Panel wanted to find out if this was common practice in this type of facility. The Reference Group, involving self-advocates, families and carers, was asked for its view. Its collective view was that this type of policy was not one they recognised. One parent whose son had spent time in similar hospital environments over a number of years confirmed that they had never been denied access to their room. This issue also highlighted the need for clarity about what commissioners and care co-ordinators should be trying to observe when they meet patients in a hospital environment:

'Clarity is required regarding the requirement for additional observational aspects of a review e.g. the environment, posters, other resident's behaviour'

Conclusions

5.97 In relation to co-ordination of care and ongoing monitoring, the Review Panel concluded:

- given the lack of robust contract monitoring, the Care Programme Approach process formed the major element of monitoring systems used by the NHS to monitor ongoing care;

- Care Programme Approach reviews took place and were attended by representatives of the local team or commissioners. However, the role of local representatives attending the reviews was inconsistent and unclear;

- the Care Programme Approach process focused on the care planning for the individual patient and did not include wider quality and performance monitoring of the service or any wider perspective of the welfare or needs of the patient;

- reviews were co-ordinated, chaired and led by Winterbourne View staff and the content of the reviews was based on information provided by the Responsible Clinician and Winterbourne View team. Local representatives often lacked the seniority or clinical expertise to scrutinise or challenge the information or plans provided;

- there was a general lack of focus on planning for discharge in the process and this contributed to the long term nature of placements;

- the nature of the decision making powers under the Mental Health Act alters the balance of power between commissioner and provider towards the provider and this could potentially distort decision making in some instances;

- commissioning teams, on the whole, delegated the care co-ordination to other teams or other organisations. They expected to be informed of any significant developments or concerns, including safeguarding alerts or Serious Untoward Incidents, but did not appear to have clarified the threshold beyond which an issue should have been escalated or shared for information;

- the closed and controlled environment at Winterbourne View inhibited monitoring of the culture, atmosphere and functioning of Winterbourne View. It is unclear whether this was a deliberate attempt by Winterbourne View to restrict the number of external 'eyes and ears' monitoring patient care but it did have that effect. This should have raised some concerns at the time. The fact that the policy of not permitting access to patient areas was not contested robustly at the time is a further indication of lack of appropriate challenge in the system.

Involvement of families and advocates

5.98 All commissioners were asked to provide details of the extent of involvement of families, carer or advocates in both the initial commissioning process and the ongoing monitoring of care and treatment at Winterbourne View.

Involvement in commissioning decisions

5.99 Of the 44 patients placed by NHS Commissioners, it was reported that in 30 cases families, carers or advocates were involved in some way in the commissioning decisions leading up to the placement. Of the 14 patient placements for which there was no involvement in the commissioning process, the Review Panel noted that all but one was an admission under the provisions of the Mental Health Act. The Panel recognised that, in some cases, the fact that a patient was being detained under the Mental Health Act and therefore both they and their families were not deciding on whether treatment was appropriate, might, but not necessarily, have limited the extent to which families, carers and advocates could be involved in the initial decision making.

Involvement in ongoing monitoring

5.100 There was greater involvement in ongoing monitoring, with commissioners reporting that in all but one case there was some involvement of families, carers or advocates in ongoing monitoring. The level of involvement in monitoring varied according to proximity, personal preference and family history. Some families were content to have relatively minimal involvement with the monitoring of care:

'family involved in ongoing care but tended to allow professionals to manage the case...They registered no complaint about their involvement and seemed to be satisfied with the situation.'

5.101 The Review Panel saw evidence of many families being actively involved in ongoing monitoring and attending the Care Programme Approach review meetings. There were, however, no obvious examples of situations in which families had been able to influence the process by having an opportunity to contribute to the review reports provided by Winterbourne View in advance of the meetings or to the running and content of the meetings. The Review Panel identified that this was consistent with the minimal influence that commissioners and care co-ordinators had on the process, described earlier within this report.

View of families, carers and advocates

5.102 There was evidence that at times some families were enthusiastic about Winterbourne View as they felt that their relative was progressing well. Some provided positive feedback to Primary Care Trusts along these lines:

'[The commissioning manager] had contact with several families and service users who were placed with Castlebeck, and had received positive feedback about the services.'

'the family reported on a number of occasions how they had observed improvements in behaviour since their son was admitted to Winterbourne View.'

5.103 For some families, the move to Winterbourne View had seemed to meet the needs of their relative and was judged a positive development, particularly where their relative had previously been receiving treatment further away from home or had had a succession of different placements over a short space of time:

'parents were very pleased with [the patient]'s progress whilst in Winterbourne View and the stability that this provided and they were not keen to consider an alternative step down placement.'

5.104 The Review Panel noted that some families were regular visitors to Winterbourne View, in some cases over many years, and had not witnessed anything which had caused them concern, although they had also been subject to the policy of restricted access to patient bedrooms and treatment areas.

5.105 The Review Panel was also made aware of examples of families raising concerns about the treatment of their relative. Of the 28 patient placements subject to further investigation, there were 10 examples of families, carers or advocates raising some type of concern.

5.106 The routes for families to raise issues of significant concern were not clear. Of the 10 examples of concerns being raised, three were raised directly with the commissioner, five were raised with the care co-ordinator and two were raised with either the police or Winterbourne View directly. The Review Panel was told of a situation in which a parent had raised concerns directly with the police and therefore reasonably expected that there was no need to also raise the issue with the NHS Commissioner or local Council. As a result, the care co-ordinator and commissioner were completely unaware of the alleged incident until it came to light following the broadcast of the BBC Panorama programme.

5.107 Another example was given of parents of a patient being contacted by Winterbourne View about a serious incident of harm, receiving an apology and financial compensation. In this case, the NHS was not informed through formal channels. In its investigation, the Primary Care Trust identified that a better and more structured flow of information with relatives might have helped to close the information gap:

'Although [the patient]'s parents were actively involved in her care reviews and her placement at WV, in retrospect it would have been helpful for the [Primary Care Trust] Care Manager to have made contact with the family prior to care review meetings, to ask for an update from them of their view of [the patient]'s progress for both positive feedback and also any concerns. This might have resulted in the family sharing information about the safeguarding incident.'

Views of the Reference Group

5.108 The Review Panel asked the Reference Group of self advocates, families and carers to concentrate in particular on the issues raised by the events at Winterbourne View in relation to the involvement of families, carers and advocates. The views expressed by the Reference Group included;

- families and people with a learning disability should be involved in selecting a service. Where this happens, it may be common to visit the service before a placement, visit their relative during the placement or to attend a review. These contacts however provide limited opportunities to have a wider view of the quality of the service or to meet other relatives or family members to share experiences;

- families and people with a learning disability rely on the same information published about a service by the Care Quality Commission as the commissioners and care co-ordinators do.

5.109 On the involvement of family carers and self advocates the Reference Group said:

'Family carers, self and peer advocates should be at the 'heart of everything ….involved in the whole commissioning cycle.'

'Families should be able to talk to and see staff and their relative without having to make an appointment.'

'People should see all areas of a place – if it's not safe for relatives to go into those parts of a building then it can't be safe for their relatives who are living there.'

'There should be appropriate support, advice and help from a peer advocate (other carer or self advocate) to people and families.'

'Self advocacy groups should be going into services to check them.'

'There are lots of types of advocacy, there needs to be a national benchmark and consistency around good practice. We need to ensure the quality of advocacy and that it is independently funded.'

'People with learning disabilities should be involved where decisions are made – not down the line.'

5.110 On involvement in Care Programme Approach reviews, the Reference Group said:

'When you go to a review you need information in advance.'

'Families need knowledge before reviews of what's happening e.g treatments, incidents and everything that's happening with their relative.'

'Families could be chairing review meetings where they want to.'

‘The balance of power is wrong, the professionals have too much power and control – it needs to be about partnership - relatives, self advocates and professionals working together.’

‘Family members need information to know how to question Doctors. You have got to have the knowledge to question professionals.’

‘You can only check on quality if you know what quality looks like.’

‘People need to know how to make complaints, including people who don’t use words.’

‘There is a need for bench marking. We need to know what good looks like. What I would have accepted 20 years ago about the care of my son I would not accept now.’

Conclusions

5.111 In relation to the involvement of families, carers and advocates, the Review Panel concluded that:

- while recognising the constraints on choice involved when patients are detained under the provisions of the Mental Health Act, there could and should have been more involvement in the original commissioning decisions;

- the fact that some families, carers and advocates had been regular visitors to Winterbourne View suggests that, if poor standards of care at Winterbourne View had been practised for some time, it had not been obvious, for whatever reason, from the perspective of a family member, carer or advocate;

- more structured communication, particularly around Care Programme Approach review meetings, would have increased the opportunities for identifying underlying concerns and the influence of families, carers and advocates on the Care Programme Approach process itself;

- communication about how to raise concerns and the fact that the commissioner of care and treatment needed to know of any concerns was not clear enough in many cases;

- there is a manifest case for relatives and advocates to have access to areas where patients are cared for.

Responding to concerns and issues

5.112 It is not unusual for issues to arise or incidents to take place during the course of assessment and treatment of patients whose behaviour challenges services. Reporting of serious untoward incidents and of safeguarding alerts is encouraged to ensure that vulnerable adults are protected. Safeguarding alerts can cover a wide range of issues or varying levels of concern including incidents that have occurred in the facility, disagreements or violence between patients or issues relating to the patient themselves. If no safeguarding alerts were raised in relation to a service of this type, this might suggest that issues were not being reported properly.

5.113 The arrangements for safeguarding adults include the Local Authority for the area in which a unit is located acting as lead safeguarding authority. South Gloucestershire Council was the lead safeguarding authority for patients at Winterbourne View. A Safeguarding Adults Board, which includes representatives of all agencies, including the local Primary Care Trust, met quarterly to ensure that the safeguarding process was working effectively and produced an overview report on an annual basis.

5.114 In respect of patients at Winterbourne View, South Gloucestershire Council identified in August 2011 that there had been a total of 32 safeguarding alerts relating to patients at Winterbourne View. During the NHS Review, commissioners were asked to confirm the safeguarding alerts for which information had been received at the time. After reconciling the two sources of information, a further six safeguarding alerts were added to the agreed total. The revised total of 38 safeguarding alerts related to 20 different patients. Alerts were raised by Winterbourne View, NHS staff, other health professionals, a family member and the police.

Notification of issues of concern

5.115 In the course of this review the Review Panel found that, when safeguarding alerts were made, there was inconsistent communication between the lead Local Authority and the NHS. Given the variation found in transmission and receipt of information, it appears that there was not a standard method being used for the communication of such information.

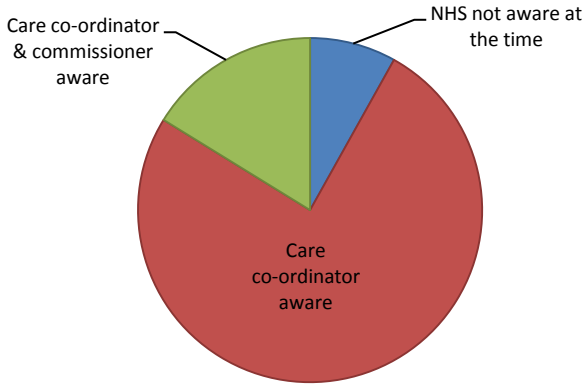
5.116 The Panel analysed how information was provided to the NHS in more detail. The results of this analysis are shown in Figure 15. In the majority of cases, the care co-ordinator for the patient was informed of the safeguarding alert. Commissioning managers were only made aware (either by a care co-ordinator or directly) of approximately one fifth of the alerts.

5.117 There were three alerts about which the NHS does not appear to have been notified in any way. These include:

- one allegation made about abuse by staff;
- concerns raised about the attitude of some staff;
- a serious allegation of assault by a member of staff, about which a police investigation was carried out and compensation paid to family members by Castlebeck.

5.118 There was no evidence that any NHS commissioner or care co-ordination team received information from 'whistleblower' staff employed by Castlebeck.

Figure 15: Awareness of safeguarding alerts



5.119 The Review Panel concluded from this information that there had been no formal process for commissioners in Primary Care Trusts to be informed directly of any safeguarding alerts. In respect of these important matters reliance seems to have been placed on good informal communication existing within the NHS or between the NHS and teams shared with Local Authorities:

'The alert system across county borders did not work effectively. No information provided by host authority to lead commissioner.'

'issues such as safeguarding being dealt with entirely within the integrated learning disability service rather than routinely shared with commissioners and being used as part of the overarching contract management process'.

5.120 As discussed earlier in this report, the Review Panel found that this communication had been generally poor and had lacked clarity on thresholds for information sharing and escalation. As a result, those ultimately responsible for the commissioning and funding of the care package were not informed routinely of safeguarding alerts or other concerns. In some cases, commissioning managers became aware of serious historic alerts only during this review process.

5.121 One of the common themes emerging from the investigations carried out by commissioners is the feeling that more would have been done if safeguarding alerts had been more widely shared at the time:

'There are instances in which commissioners would have acted differently if the information had been made available'

5.122 This judgement is obviously being made with the benefit of hindsight although, on balance, the Review Panel believes that, if a more robust system of communication both within and outside the NHS had been in place, the chances of abuse being uncovered sooner would have been increased significantly.

5.123 While it was difficult to get a complete picture from the information available to the Review Panel, it was clear that there was variability in relation to whether the commissioner was represented at safeguarding meetings. There were examples of active representation. There was also more than one example of late notification of meetings (one example involved notification the day before) making attendance impossible. Regardless of whether or not there was a representative of the commissioner attending, no examples were highlighted of the NHS taking a different view or challenging the multi-agency consensus at the time, or indeed afterwards.

Follow up and escalation of concerns

5.124 The Review Panel found no evidence that the information received by care co-ordinators or commissioners was treated in a systematic manner. This appeared to be true irrespective of the gravity of the issue, whether the concern might apply to others or whether the response to it had been deemed adequate. A common theme was the absence of formal policies regarding the approach to be used in judgements made by professionals about when to escalate concerns arising from the day-to-day information received as part of the care co-ordination procedures.

5.125 The Review Panel found evidence that there was a failure on the part of commissioners to follow up important issues. Some commissioners admitted that there had been an over reliance on the fact that the concerns were being examined by the safeguarding process even when the concerns clearly merited some further additional consideration or escalation by the NHS itself. The Review Panel also noted that all agencies participating in the multi-agency safeguarding procedures tended to rely on internal investigation by Winterbourne View to resolve issues. The Review Panel agrees with the observations made by one commissioner:

'There was an over–reliance by [the care co-ordination team] on both the Safeguarding Adults lead local authority to follow up on outcomes, particularly where there was an expectation that Winterbourne View would follow up through their internal investigation process.

There was an over reliance on and/or too much trust placed on Winterbourne View to follow up internal investigations and report back to the placing authority and the Safeguarding Adults lead investigating authority re outcomes/actions taken.

There also appears to be no reference to the involvement and/or consideration given to the involvement of CQC.'

5.126 The Review Panel noted some examples of concerns being followed up directly with the management at Winterbourne View. There appears to be a common theme of reassurance and plausible explanation being provided by Winterbourne View in these circumstances, and commissioners or care coordinators being reassured as a result. There was one example in which a consultant psychiatrist and care co-ordinator had discussed a serious safeguarding alert with the manager at Winterbourne View:

'Prior to the review meeting held in October 2009 at Winterbourne View there was an extensive conversation that took place between..(Manager at Winterbourne View), [consultant psychiatrist from 'home' area] & [care co-ordinator] ...where a very clear and plausible explanation was given to how he [Winterbourne View manager] had carried out a thorough investigation and how they (Winterbourne View) had a very good relationship with [the] local Safeguarding team.

At the time due to the explanation given by [Winterbourne View manager] and the notes from South Gloucestershire Safeguarding team the commissioner was assured that the alert had been concluded appropriately and there were no further actions to be taken.'

5.127 In some cases, there was no obvious reason why information of serious concern was not followed up appropriately and robustly. This pattern of failure calls into question whether individual members of staff had carried out their responsibilities in line with their professional duties. Individual commissioners are examining these issues in more detail as appropriate.

5.128 The NHS has well developed systems for raising concerns about patient safety and quality of care. Issues of concern are raised as Serious Untoward Incidents, which then require further consideration and investigation. While the process of reporting within the NHS serious incident system has been developing over time, the relevant guidance has been clear that serious incidents, including abuse or potential abuse, should be reported by providers or commissioners (using the NHS system and processes), whether the provider of care is an NHS or independent sector provider. The guidance surrounding abuse of vulnerable people has been particularly clear since March 2010[26].

5.129 Unlike NHS providers, independent sector providers do not have access to the electronic reporting system used for this purpose. This places the responsibility for reporting on to the commissioner of care and heightens the importance of clear contractual requirements surrounding communication of serious incidents.

[26] "Allegations of abuse" is one of the definitions of a serious incident requiring investigation set out ini the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, National Patient Safety Agency, March 2010, Department of Health Gateway Reference 13733

5.130 No concerns, issues or alerts arising from Winterbourne View prompted NHS organisations to raise Serious Untoward Incidents within the NHS. If Serious Untoward Incident reports had been raised this would have escalated the issues within Primary Care Trusts and to Strategic Health Authorities, thereby increasing the opportunities for others to identify links and patterns. While it is unlikely that individual alerts on their own would have flagged up concerns, multiple alerts from a wide range of commissioners might have allowed Strategic Health Authorities in particular to identify wider concerns.

Identifying patterns and trends

5.131 The way in which services at Winterbourne View were commissioned as individual placements 'spot purchased' by individual commissioners operating in isolation meant that majority of NHS commissioners or care coordinators had either limited or no opportunities to make the necessary links between any issues and identify patterns in care. Furthermore, there was no systematic sharing of information between NHS or Local Authority commissioners about the experience of placing patients in Winterbourne View. Indeed, as each individual placement was commissioned in isolation, commissioners were generally unaware of who the other commissioners were:

'There is no structured opportunity for commissioner to share information about risks and issues relating to independent hospital services they may be utilising as out of area placements;

'Commissioners within one PCT or LA are not made aware of adult protection issues in every instance that involve patients from another PCT or LA placed in a common out of areas service'

'[Local] Authorities hosting nationally or regionally-used services such as independent hospitals are not able to share information about [safeguarding] issues beyond those directly concerning the patients of the placing PCT or Local Authority. This means that there is no opportunity to consider aggregated risk for out of area services.'

5.132 In relation to identifying areas of concern, most NHS Commissioners were therefore holding some pieces of the jigsaw but were not in a position to complete the picture. The Review Panel observed that the safeguarding process was the obvious process in which the broader context could have been identified.

5.133 As a result, the Panel has serious concerns about the effectiveness of the safeguarding system in this case and the apparent failure to link episodes of failure of care in order to identify wider concerns. This issue did not fall within the remit of the NHS Review but will be a focus of the Serious Case Review.

5.134 A small number of commissioners or care co-ordinators did have the opportunity to make some links and to identify a pattern that should have caused real concern. This opportunity arose either because of the nature of the issues raised, because there were multiple alerts in relation to one individual, or because there were alerts in relation to a number of patients whose care was commissioned by the same organisation. These opportunities to link concerns were generally missed.

5.135 The Review Panel became aware from the reports provided by commissioners of one example in which links had been made between separate concerns and issues raised within the NHS as a result. The Review Panel therefore examined the sequence of events in more detail.

5.136 During the latter half of 2008, safeguarding alerts and concerns were being expressed in relation to a patient at Winterbourne View. In November 2008, when consideration was being given to the referral of another patient to Winterbourne View, links were made to the issues surrounding the experiences of the first patient. Within the health community, significant concerns were expressed about whether these issues represented systemic abuse and doubt was cast on the suitability of Winterbourne View in relation to the referral of the second patient. The commissioning managers within the Primary Care Trust were made aware of these views at this point by care co-ordinators.

5.137 The involvement of the commissioning managers at the Primary Care Trust can be summarised as consisting of:

- seeking further explanation and clarification of exactly what was being claimed or suggested by the care co-ordination team;

- setting up a face-to-face meeting to seeking explanation and reassurance from Winterbourne View and the lead safeguarding authority on the gravity of the issues being considered and the implications for future referrals.

5.138 The evidence supplied to the Review Panel suggests that the outcome of this process can be summarised as the lead commissioner in the Primary Care Trust having concluded that:

- there had been a breakdown in the relationship between Winterbourne View and the care co-ordination team;

- the safeguarding alerts were being handled appropriately and assurance had been given that they did not represent serious systemic issues;

- the referral of the second patient could go ahead.

5.139 This is set out in the text of an email written by a commissioning manager provided to the Review Panel:

'It was agreed between commissioner, local clinicians and Castlebeck yesterday that an admission to Winterbourne View for a 12 week assessment was the most appropriate option....In the meantime I have concluded following discussion with the Healthcare Commission, the South Gloucestershire [safeguarding team], Castlebeck that no issue outstanding is sufficient to warrant either [second patient] being admitted [sic] or [first patient] being removed.

Should any individual have any evidence or reason, other than those already discussed before, at and or after yesterday's meeting that further compromises the appropriateness of this placement, then please feel free to contact me on [phone number] as a matter of urgency to discuss.'

5.140 The Review Panel noted that, in this example, links had been made between individual issues and a potentially worrying pattern of events identified. On this occasion, communication between the care co-ordination team and the commissioning team had ensured that these concerns had been escalated. These concerns were taken seriously and the lead commissioner was personally involved in further investigation. The Review Panel felt that this represented the closest the NHS had come to identifying the wider concerns about Winterbourne View.

5.141 The Review Panel, however, considers it very unfortunate that – having come close to identifying widespread issues – the NHS team accepted the assurances provided from the provider and other agencies and did not probe even further. In particular, the 'closure' of issues under the safeguarding process was taken as meaning that there was no underlying issue to be revisited or raised again.

5.142 The Review Panel saw evidence related to this sequence of events from another commissioner. This was based on personal recollection rather than documentary evidence and suggested that at the time of the events described above the concerns were shared with a commissioning manager at a neighbouring Primary Care Trust. The recipient of this information, the lead commissioner at the neighbouring Primary Care Trust, did not share these concerns, so the opportunity to link more widely was missed.

5.143 In addition to missed opportunities to link individual issues of concern, there were a few key safeguarding alerts that, even when considered in isolation, could have indicated broader areas of concern. While the majority of safeguarding alerts concerned individual incidents and events, or individual allegations being made, there were alerts or issues raised which were more systemic in nature:

- three separate alerts were raised by staff working for an independent care agency that was providing in-reach support to one individual at Winterbourne View. They raised concerns about the poor standard of care they witnessed there. The fact that these concerns were raised by externally employed health professionals working in the unit at the time should have flagged up wider issues;

- an issue was raised which included concerns of a Continuing Healthcare Assessor nurse about lack of care planning and deprivation of liberty issues. This was reported to the lead safeguarding authority but was not logged as a safeguarding alert, although the information was circulated more widely. Again, the fact that this was raised by a health professional employed by the NHS should have prompted wider questions to be asked;

- a patient raised concerns about the way in which other patients were being treated. The fact that this alert was not related to an individual incident and suggested the mistreatment of more than one patient should have indicated broader issues of concern.

5.144 Unfortunately, from the information provided by NHS commissioners, the Review Panel saw no evidence that the NHS or the other agencies involved in these safeguarding meetings considered the broader nature of these issues and the more obvious signs of possible institutional problems that they signalled.

Other issues of concern

5.145 The Review Panel was made aware of the following incidents or concerns which should have been raised as safeguarding alerts and were not:

- one patient suffered a dislocation of the knee during restraint. This was reported to the care co-ordinator. The investigation carried out by the commissioner as part of this NHS review of Winterbourne View identified that this should have been raised as a safeguarding alert at the time;

- the parents of a patient reported to a care co-ordinator that they had heard mistreatment of their child at the end of a telephone call. There is evidence that the care co-ordinator tried to make contact with the lead Local Authority to report this incident as further evidence before a pre-planned safeguarding meeting, but no evidence that this information was in fact provided. The Review Panel did not see any evidence that this was subsequently raised as a separate safeguarding alert.

5.146 The Review Panel found that these were incidents for which safeguarding alerts should have been made and the failure to do so demonstrated both lack of rigour in the processes in place and failure of judgement by NHS staff.

5.147 The Review Panel was also made aware of one example in which information provided by the NHS to the lead safeguarding authority did not result in a formal safeguarding alert being recorded, and another in which a safeguarding alert was raised but does not appear to have been investigated fully at the time.

5.148 The Review Panel also saw some evidence of information which might have raised concerns being considered as part of the medical condition of the patient rather than as an indication of wider concerns about treatment. For example:

'Call from [Winterbourne View Responsible Clinician] to discuss discharge plan, as he does not feel [the patient] is ready to leave Winterbourne View. He reported that [the patient] needs to complete treatment around concept of death and overdoses. He continues to make accusations against staff, and telephoning police and ambulances.'

Conclusion

5.149 When considering how the NHS responded to issues and concerns, the Review Panel concluded that:

- the communication of concerns and alerts was not robust or consistent;
- this failure was apparent in respect of both internal and external communication by those working for NHS organisations;
- there was a serious lack of internal escalation by care co-ordinators and commissioners in respect of information regarding serious incidents;
- there were some situations relating to the lack of follow up or escalation of information which called into question whether individuals had fulfilled their professional duties adequately;
- the NHS had limited opportunities to make wider links and identify a wider pattern;
- when the limited opportunities did occur, the wider patterns were generally missed;
- the NHS came close to identifying wider concerns, but was too reliant on assurances provided by the provider and other agencies;
- there was over reliance on the local investigation process and consideration of the multi-agency view within the safeguarding process;
- commissioners, or NHS providers undertaking the care co-ordination function, failed to report what were clearly Serious Untoward Incidents through the established NHS process;
- the weaknesses of monitoring systems in place were compounded by the lack of clearly communicated information or alerts.

Section 6

Conclusions and Recommendations

This section sets out the overall conclusions drawn by the Review Panel and recommendations for the future.

6. Conclusions and Recommendations

6.1 This report sets out the findings of the Review Panel which emerged following the review of information, investigation by commissioners and further discussion and deliberation by the Panel. The Review Panel is mindful that it examined one part of the picture relating to the events at Winterbourne View and that the review was based on the information available to the NHS. It was, however, able to draw some overall conclusions about the role of the NHS as a commissioner of care and treatment. From these, recommendations have been formulated for the NHS and some issues identified for further consideration by the Serious Case Review and Department of Health Review.

6.2 When reaching some overall conclusions, the Review Panel considered the context within which the NHS was carrying out its commissioning responsibilities and identified the following features:

- a provider with a good reputation providing a high cost specialist service which appeared to be successful at maintaining reassuring and professional relationships between managers and commissioners;
- a hospital increasingly run as a controlled environment, with some aspects deliberately closed to most external scrutiny;
- the possibility that some incidents were concealed from scrutiny by dishonest staff;
- the provider had dominance in the balance of power with commissioners given the contractual arrangements, the Mental Health Act legal requirements and the way in which the Care Programme Approach process was operated;
- inconsistent and unreliable communication of safeguarding alerts;
- a multi-agency safeguarding process which appeared to place reliance on internal investigation by the provider to resolve concerns;
- poor communication between different teams and lack of clarity of roles within the NHS;
- the complexity of finding alternative accommodation contributed to a reluctance to disturb existing arrangements with Winterbourne View if not absolutely necessary.

6.3 The Review Panel also notes that the level of need of most of the patients has not been fully acknowledged thus far, in particular, the fact that the majority of patients were admitted under a section of the Mental Health Act and therefore required detention within a hospital setting.

6.4 The Review Panel considers that, to a large extent, commissioners were attempting to do a difficult job in a complex context. In many ways, contextual factors constrained the ability of commissioners to be fully aware of the situation within Winterbourne View. The review has highlighted, however, that the NHS as a commissioner could, and should, have done more, including:

- agreeing a contract for the placement which both met the needs of the patient, and the needs of the commissioner for ongoing monitoring;
- prioritising monitoring of the provisions of the contract rather than relying solely on the Care Programme Approach as the only monitoring tool;
- ensuring that communication within and between NHS organisations and between the NHS and local authority teams was functioning well and was adequate to fulfil ongoing monitoring responsibilities;
- providing more challenge within the Care Programme Approach. This includes ensuring that those being asked to represent the commissioner as care co-ordinator had the right mix of skills and, if not, were adequately supported. It also means ensuring that there is clinical involvement and challenge built in to the system;
- being more structured in communication with families, carers and advocates, in particular with those actively involved in Care Programme Approach review meetings;
- not taking explanations and reassurances at face value, or taking the fact that an issue had been dealt with through the safeguarding process put in place by the lead Local Authority as an indication that no further consideration or action was required on the part of the commissioner;
- following up information of concern far more robustly.

Follow up action suggested by commissioners

6.5 All commissioners carrying out detailed investigations were asked to identify follow up actions which would be pursued locally. This has ensured that those commissioners have identified lessons to be learnt and have implemented changes as the NHS Review has progressed. The next stage is to bring these lessons to the attention of the NHS as a whole. Some of the actions identified by commissioners have the potential to be applied more widely and are therefore discussed in more detail below.

Additional quality checking

6.6 As described in Section 5, the majority of commissioners who had placed patients at Winterbourne View said that they were now performing additional checks on providers as a result. This involves a significant level of duplication among commissioners. The Review Panel understands why commissioners feel the need to do this. However, this is not a sustainable situation over the long term. The current arrangements for Primary Care Trusts do not easily support this type of work and it is doubtful whether Clinical Commissioning Groups will be in a position to perform this role in the future.

6.7 There is therefore a need for greater clarity on whether the engagement of regulators can be taken as adequate assurance of quality or, if not, for what areas of care quality it is necessary for commissioners to make their own separate arrangements.

Lead commissioner arrangements

6.8 The fact that the NHS had limited opportunities to aggregate information and was often working at arms length in relation to Winterbourne View leads some to suggest that there should be a 'lead' commissioner identified for each independent provider receiving referrals from a number of different commissioners. This would mirror arrangements already made within the NHS, where one commissioner leads on the contracting and oversight of NHS providers. The current level of activity that some Primary Care Trusts are undertaking in relation to regulation type checks has added weight to this suggestion.

6.9 This would involve asking the Primary Care Trust in the area in which a facility is located to perform checks and be the local 'eyes and ears' for the NHS whether or not they themselves are commissioning services from the facility. The Review Panel feels that this would certainly reduce the duplication of additional checks being performed by commissioners. The Panel is more cautious, however, about the suggestion that a lead NHS commissioner would also improve the intelligence available to the NHS and be motivated and empowered to act effectively in relation to issues of care quality in an institution with which they did not necessarily have a significant commissioning relationship.

6.10 The Review Panel was cautious about suggesting the setting up of a system that might become over-reliant on the processes and judgement of one organisation. The Panel notes that the safeguarding process uses a lead organisation model and, as discussed earlier in this report, does not appear to have identified patterns and trends in relation to Winterbourne View. A further potential risk is that a lead commissioner model would lead to individual commissioners disengaging from the monitoring of the patient placement. This would be a backwards step.

6.11 This proposal for a lead commissioner system should be considered further in the Department of Health Review, particularly alongside consideration of the balance of roles between the regulator and commissioner. The NHS Review Panel would, however, urge caution in relation to implementing what might be seen as a 'quick fix' but might have unintended negative consequences.

Increasing clinical involvement in care co-ordination functions

6.12 The Review Panel identified a lack of robust clinical challenge and involvement in the care co-ordination function. One commissioner told the Review Panel that it was in the process of increasing the availability of consultant psychiatrists specifically for this purpose as part of its action plan. The Review Panel thought that, in general, a clearer expectation that local clinicians were expected to be actively involved in review meetings and other care co-ordination functions would be beneficial.

Recommendations

6.13 The Review Panel identified the following follow up action for NHS commissioners who commissioned placements at Winterbourne View:

6.13.1 Continue to ensure that patients who were at Winterbourne View are supported over the long term to ensure that the effect of any abuse received or witnessed while at Winterbourne View is minimised as far as possible;

6.13.2 Carefully review the actions of staff involved in the commissioning and care co-ordination process in order to identify if any of the failures to act that have emerged warrant disciplinary action or referral to professional regulatory bodies.

6.14 The Review Panel identified the following actions which should be taken by the NHS as a whole as part of its learning from the events at Winterbourne View. The NHS should:

6.14.1 Insist on the use of a standard NHS contract for all 'spot purchased' patient placements which includes prominently both quality and safety measures, and in particular a requirement for the commissioner to be informed directly of any untoward incident;

6.14.2 Assess the performance of the provider against the contract on a regular basis;

6.14.3 Clarify the relationships and respective roles of organisations in relation to the commissioning and care co-ordination arrangements in place for learning disability and mental health specialist placements. In particular, ensure that there is a formal schedule setting out the arrangements and consistent thresholds for communication between care co-ordination teams and the commissioner;

6.14.4 Specify the expectations placed on care co-ordination teams and commissioners with regard to their input to the Care Programme Approach process and ongoing communication with families, carers and advocates;

6.14.5 Ensure that there is clinical expertise available to care co-ordination teams and that this is being deployed as necessary in order to provide appropriate clinical input to decision making;

6.14.6 Clarify the routes available for families, carers and advocates to make known any concerns about care being provided directly to the commissioner of care;

6.14.7 Together with social care partners, review policy and strategies surrounding those whose behaviour challenges services, and in particular ensuring that there is a clear focus on preventing escalation within community settings and develop criteria for situations in which specialist placements outside of mainstream services are required;

6.14.8 Monitor the length of stay in assessment and treatment units and ensure a clear focus on discharge planning is part of the Care Programme Approach;

6.14.9 Ensure that the Deprivation of Liberty of Safeguards are being applied systematically in relation to all relevant patients.

6.15 The Review Panel identified the following issues which were outside the scope of the NHS Review and would benefit from further consideration as part of the Serious Case Review:

- the experience of Local Authorities as commissioners of care at Winterbourne View;
- the effectiveness of communication within the safeguarding system;
- the extent to which the system of regulation might have provided unmerited assurance to commissioners of care and treatment about the standards at Winterbourne View;
- whether issues were considered and resolved appropriately within the safeguarding process;
- the extent to which patterns and trends in incidents of concern could have been identified more clearly within the safeguarding process;
- the adequacy of the systems of clinical governance and the quality of clinical care provided by Castlebeck at Winterbourne View, including the discharge of professional responsibilities by those employed by Castlebeck.

6.16 The Review Panel identified the following policy issues which should be considered further as part of the Department of Health review:

- the extent to which lead safeguarding authorities are able to share information with other commissioners;
- whether lead commissioning arrangements would be beneficial;
- whether the guidance surrounding the Mental Health Act contains adequate safeguards against conflicts of interest arising;
- whether the guidance surrounding the Care Programme Approach could be clearer about the particular role of the commissioner and the retention of responsibility for clinical oversight in situations in which the patient has been placed outside of local services;
- whether existing standards and expectations of independent skilled advocacy support advice are sufficient;
- whether there are adequate checks and balances available in relation to situations in which patients are transferred between two facilities operated by the same provider organisation;
- how to achieve clarity on the appropriate balance between checks and assurance carried out by the regulator, the necessary additional checks and assurance that should be pursued by commissioners before making any referral;
- what additional contribution families, self and peer advocates can make to monitoring and reporting on experiences of quality.

Conclusion

6.17 The Review Panel is grateful to the commissioners which provided information and carried out further investigation over a short space of time in order to contribute to this review process. The Panel hopes that, as one of several reviews, this review of the NHS role as commissioner of care and treatment at Winterbourne View will contribute to a better understanding of how we can prevent such appalling acts of abuse ever happening again.

Appendix 1

Membership of the Reference Group

This appendix sets out the membership of the Reference Group which supported the work of the NHS Review Panel.

Appendix 1

Membership of the Reference Group

A Reference Group comprising representatives of families and carers of those with learning disabilities and self advocates was established to support the work of the review. The Group consisted of 16 people with representatives including:

- self advocates and carers from the South West, South Central and West Midlands areas;
- representatives from both the National Forum and South West Regional Forum for self advocates;
- representatives from the Challenging Behaviour Foundation;
- representatives from the Partners in Policy Making Network.

The members were:

- John Attrill
- Richard Bow
- Julia Erskine
- Karen Flood
- Dot Goldsworthy
- Philippa Hamilton
- Jo Hogg
- David Jack
- Jill Jack
- Tom Kane
- Si Langridge
- Rachel Mason
- Philip Pearce
- Mark Savage
- Chris Shumacher
- Margaret Upham