

THE PRIME MINISTER

5 August 2011

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Thank you for your letter of 20 June setting out your concerns about the evidence of service failure and abuse of people with learning disabilities shown in the BBC Panorama programme on Winterbourne View hospital, and your suggestions to effect improvements in care and support for people with learning disabilities at a local and national level.

In common with you and your co-signatories, I too was appalled at the horrific catalogue of abuses uncovered at Winterbourne View. I hope that this letter will provide you with the assurance you are seeking that action is underway to ensure that lessons are learned from recent events. I also agree that a joint plan of action is needed both locally and nationally to drive improvements in services and determine how the lessons from Winterbourne View can influence future policy and practice.

The Care Quality Commission (CQC) is committed to taking prompt and timely action where there are signs of poor care. The regulatory framework set up under the Health and Social Care Act 2008 sets out essential safety and quality requirements, with which providers must comply. The CQC's role is to assure compliance with these requirements and take action where it has identified care that is not meeting these requirements. The CQC has indicated that it is looking to increase the frequency with which services are reviewed.

As you will know, Winterbourne View has now been closed permanently. In the light of incidents at Winterbourne View, the CQC launched an immediate review of all services run by Castlebeck Care. Reports setting out the findings from inspections of all 23 locations are now available on the CQC's website at www.cqc.org.uk. Where the CQC has identified concerns, Castlebeck Care is required to make improvements to achieve compliance with the safety and quality requirements.

While half of these services are compliant with safety and quality requirements, the CQC has more serious concerns about four locations and is taking further action in relation to these. Our immediate priority is people's safety and wellbeing.

We have required assurance from the regulator and contacted the local primary care trusts and local authorities to make sure that every necessary step has been taken to ensure the safety and welfare of people using Castlebeck Care services.

The CQC will also undertake a focused inspection programme to review care for people with learning disabilities in independent hospitals. Where inspections identify care and treatment that does not comply with the safety and quality requirements, the CQC has powers to take enforcement action. This includes the power to issue the provider with a warning notice that requires improvement within a specified time, prosecution and the power to cancel a provider's registration, removing its ability to provide regulated activities. The CQC is being advised in this review by a broad-based stakeholder advisory group which, I know, includes some of the signatories to your letter.

Paul Burstow, the Minister for Care Services is overseeing work to ensure that the key lessons from the reviews being undertaken by the CQC, the NHS and safeguarding boards are learnt. A panel of experts including Professor Jim Mansell, Mark Goldring and Anne Williams, who was previously the National Director for Learning Disabilities, will advise the Department. This work will be informed by the views of service users and family carers – not least the National Forum for People with Learning Difficulties and the National Valuing Families Forum. Ministers will then report further to Parliament.

I have forwarded your letter to Bruce Calderwood, the Director for Mental Health and Disability at the Department of Health, who is leading this work. I know he will be keen to talk to representatives from the organisations who signed your letter.

I am grateful to you and the other signatories for taking the time to write to me. The Government is firmly committed to taking all necessary action to minimise the chance of such terrible events recurring.

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Mr Rob Greig CBE