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1st June 2011

Paul Burstow
Department of Health
Minister of State for Care Services
Richmond House,
79 Whitehall,
London SW1A 2NS

Dear Minister

Re: Panorama – Undercover Care: The Abuse Exposed

The BBC programme aired on Tuesday 31 May 2011, Undercover Care: The Abuse Exposed, showed disturbing scenes of people with a learning disability and autism being abused in a secure hospital - Castlebeck's service at Winterbourne View in Bristol. The British Institute of Learning Disabilities is outraged that such abuse can happen again in a care setting in England.

We are particularly concerned as this follows on from the recent investigations into abuse in Sutton and Merton and Cornwall and it reveals a number of common failings in health related provision for people with a learning disability, particularly people whose behaviour is seen to challenge services. These include:

- A failure of Local Authorities, Primary Care Trusts and Strategic Health Authorities to commission and monitor services that are in line with best practice as set out in government policies, e.g. Valuing People Now (2009); Services for people with learning disability and challenging behaviour or mental health needs (2007); Guidance for Restrictive Physical Interventions (2002); Commissioning Specialist Adult Learning Disability Health Services – Good Practice Guidance (2007).

- A lack of effective leadership in organisations that provide health and social care support, as evidenced by workforces that accept poor practices and a lack of supervision, training and development.

- A failure in relation to the policies, procedures, training and record keeping linked to positive behaviour support, risk assessments and the use of physical interventions resulting in the illegal and inappropriate use of restraints.

- A lack of reporting or external monitoring of the use of restraint in terms of incidence or practice.

- A failure of the Care Quality Commission and the other checking and monitoring mechanisms to act on poor practice despite inspection visits. We would expect the regulator to ensure that commissioner led monitoring and review of out of area placements was in place, as well as the provision and promotion of independent advocacy services and an accessible and robust complaints process.

- A lack of a strategic and operational focus on workforce issues including, having sufficient staff with an understanding of good practice around human rights, dignity and respect who receive appropriate training and updates to ensure high quality support.

- A lack of individualised person centred care planning that is acted upon and regularly reviewed and has the full involvement of people with learning disabilities and their family carers.

- A lack of meaningful and purposeful activity and occupation leading to a cycle of boredom, depression and the potential for behaviour that challenges.

- A failure of those commissioning such placements to pro-actively work to return people to their home communities and to develop appropriate local services and support as recommended in the two reports by Professor Jim Mansell.

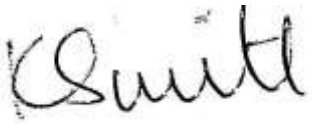
- A failure of record keeping and reporting so that the impact of any therapeutic interventions is lost and what is happening to individuals is kept hidden from families, external professionals and regulators.

There is no reason why people with learning disabilities should continue to be locked away in large hospitals where there is a potential for abuse and institutional care. National policy and research evidence has shown that alternative individualised and person centred approaches provide a better quality of support and a beneficial impact on people's behaviours. The opportunities provided by the personalisation agenda and the use of individual budgets must be pursued as a matter of urgency.

Taken together, these failings must be seen as an integral part of an institutional culture that enables systematic abuse, neglect and a denial of basic human rights. The closure of the long-stay hospitals and the NHS campus provision has been largely in response to an understanding that such institutional care promotes poor practice. However, the lessons that must be learnt from Cornwall, Sutton and Merton and now Winterbourne View is that this model of service provision is totally inappropriate and its monitoring and regulation inadequate.

In the light of this evidence of systemic failures in the provision of support for people with learning disabilities and autism, we ask that you carry out an urgent review of the legislation, statutory and non statutory guidance, inspection and monitoring of provision and then make recommendations to ensure that this is the last time that such abuse occurs.

Yours sincerely,



Keith Smith
Chief Executive

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BILD statement issued 31 May 2011

The BBC Panorama programme broadcast tonight, 'Undercover Care: The Abuse Exposed', shows disturbing scenes of people with learning disabilities and autism being abused in a secure hospital - a place where they should have expected to feel safe. Following on from the comparatively recent investigations into abuse in Sutton and Merton, and Cornwall, where vulnerable people were found to have been abused over a number of years, this is deeply saddening.

As a result, BILD is calling for an urgent government review of the legislation and inspection process as it is clear from the recurring serious incidents of abuse that neither are able to protect some people with learning disabilities and autism.

We are also calling for a thorough police inquiry into the actions of the individuals and the organisation involved.

We know that viewers will be shocked that abuse of this type goes on in the UK today. It is important to recognise that it's not like this everywhere, as there are many organisations which deliver good quality care and outcomes with compassion and respect. But, as was made clear tonight, it can happen.

Abuse in such environments is a systemic issue. Where abusive working cultures are allowed to develop, the abuse of people's human rights will inevitably occur. As a society, we must all take responsibility when the human rights of the people who should be protected are so shockingly violated.

Change needs to happen.

1. All support for people with learning disabilities and their family carers should ensure that they can exercise their human rights and be valued members of their community

   This means that all those involved in the support of people with learning disabilities and their family carers must understand that people should be treated as individuals with fairness, respect, equality, dignity and autonomy.

2. All individuals should be supported to develop choice and decision making skills and have access to independent advocacy.

   This means that their support must be person centred and purposeful and they are able to speak up and be heard. People's individual communication needs should be recognized and properly supported, and they should have access to an accessible comment and complaints policy, and the support to use it. When they use it they should then be taken seriously and their issues addressed. Independent advocacy will ensure that people are heard and kept safe.

3. Organisations that provide health and social care support need effective leadership, at all levels.

   This means that senior managers need to understand good practice and how to implement it. Leaders need to recognise when problems have become endemic and to take appropriate action to make change happen. Good leadership in relation to positive behaviour support would include:

   - Vision and drive to deliver excellence with a refusal to accept poor standards
   - Developing and implementing a framework of good practice guidance that focuses on positive behaviour support and person-centred approaches.
   - Identifying, disseminating and promoting good practice in reducing the use of restrictive practices and the implementation of positive behaviour support.
   - Educating all staff that the use of restrictive practices is potentially dangerous and eliminating the use of unnecessary restrictive and aversive practice.
   - Ensuring that appropriate training and learning opportunities are available for all staff and supporters.

4. Those supporting people with a learning disability, need to be able to access ongoing learning and development opportunities so that they can confidently provide high quality person centred support.

   This means that all training and development is underpinned by a human rights based approach and is focussed on the needs and aspirations of the people being supported. An integral part of the training should be led and provided by people with learning disabilities and family carers. Workers need support to implement good practice in their workplace with respect and dignity and feel confident in implementing policies and procedures on positive behaviour support, safeguarding and protection, and whistle blowing.

5. We believe the best support for people is person centred and developed around the individual.

We need to focus on early intervention, in supporting people in their local communities and supporting the personal development of the individual. Commissioners and providers should give priority to improving the capacity of local services to understand and respond to the needs of all people with a learning disability and avoiding increasing the burden on family carers.

6. Those who regulate, commission and monitor services have a responsibility to focus on promoting people's rights and keeping people safe. They have a duty to act swiftly in cases of bad practice.

   This means inspectors, commissioners and those with strategic responsibility should have a thorough understanding of good practice and the range of possible community based service models. If people have to be placed away from home the emphasis should be placed on an ongoing care plan and review that aims to return the person to their own community as soon as is possible.

BILD will contribute to making change happen and we will continue to work with others to promote the human rights of people with learning disabilities. However, the government needs to act swiftly to review the current legislation and regulatory framework so that they provide the protection that people with learning disabilities rightly deserve.

It is extremely saddening that, yet again, it has taken the media to highlight a problem many work so hard to prevent. We sincerely hope that the people affected by this terrible case are now safe and are being helped by people who will work to help them survive the trauma they have experienced. It will be important that their families are also given support.

Keith Smith
BILD Chief Executive

31 May 2011