

28 July 2011

Dear Colleague,

As you are probably aware, the Care Quality Commission has been undertaking a review of all Castlebeck's other locations in England, following the Panorama programme on Winterbourne View.

I am writing to give you advance notice about our key findings, and to let you know that we are publishing all 23 reports at noon today, along with a summary report.

The Care Quality Commission has already notified the Castlebeck Care Group that it has serious concerns about four of the services run by the Group, and that a further seven do not fully comply with essential standards of quality and safety.

Where we have had immediate concerns about people's safety we have taken action. In the four cases where we have serious concerns we are taking enforcement action, but for legal reasons we cannot go into details at this time. We will report fully on these actions later.

The list of services with most serious concerns are:

- Arden Vale (Coventry)
- Rose Villa (Bristol)
- Cedar Vale (Nottingham)
- Croxton Lodge (Melton Mowbray)

### Our review

CQC has reviewed and inspected all the services provided by Castlebeck at its 23 locations in England. The inspections focussed on safeguarding the care and welfare of the people who use the services provided. A 24<sup>th</sup> location, Winterbourne View has already been closed following CQC regulatory action.

Of the 23 Castlebeck services which were reviewed:

- Inspectors found serious concerns at four services; CQC is taking further action
- A further seven services were failing to comply with one or more essential standards: CQC inspectors have told Castlebeck to show how it will make improvements to meet these standards
- 12 services were compliant with the essential standards which were reviewed

A CQC team made unannounced sites visit to all locations. CQC staff were supported by people with specialist expertise where specific issues were identified, for example in relation to the management of medicines and, in the cases of detained patients, Mental Health Act Commissioners.

Examples of the poor practice we have seen include:

- routinely locking bedroom and other doors within the independent hospitals without a clear rationale
- patients staying in rehabilitation services for long periods
- in some services staffing levels dictated the activities that could be offered, so that for some only group activities could take place rather than activities based on an individuals assessed needs.

Where inspectors identified concerns, measures were put in place to address the problems and to ensure the safety of people using services. Where we had any immediate concerns for people's safety we took action to safeguard those people.

As well as finding a range of failings in individual services, CQC has looked across those services to identify company-wide themes. These include:

- Lack of training for staff
- Inadequate staffing levels
- Poor care planning
- Failure to notify relevant authorities of safeguarding incidents
- Failure to involve people in decisions about their own care.

We also set up a national panel to identify any common elements which would require further examination of the provider's overall performance. Issues that emerged included inadequate quality assurance systems and lack of clarity

about how local systems feed into the corporate and governance systems. There was no evidence that any evaluation took place corporately of any changes that had been implemented.

I would like to be clear that we have not found problems on the same scale as were found at Winterbourne View. However – we do have serious concerns at four locations in particular. Our inspections have found a range of problems, many of which are found in a number of different services. This clearly suggests that there are problems that Castlebeck needs to address at a corporate level – the company needs to make root and branch improvements to its processes and services.

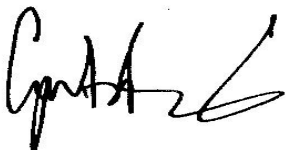
Although our reports set out what Castlebeck and individual services need to do, there is a lesson here for all professionals who have contact with these services and those who commission care from them. Everyone has a clear responsibility to stay alert for the signs of problems; take action if they can, and tell us if they have doubts about the safety and quality of care.

Our review of Castlebeck services represents CQC's first systematic review of services for people with learning disabilities. These services have only been registered with CQC since October 2010; before that time, under previous legislation they may only have been subject to an inspection every five years. Under CQC's latest proposals, every service will be inspected at least once a year. CQC is also following up our inspections of Castlebeck's services with a major review of learning disability services. We will carry out unannounced inspections of 150 of these services. We will keep you updated with our progress on this.

I hope you found this letter helpful. Further information will available later today on our website [www.cqc.org.uk](http://www.cqc.org.uk)

If you any questions or would like any further information please don't hesitate to get in touch with me.

Yours sincerely,



Cynthia Bower

Chief Executive  
Care Quality Commission