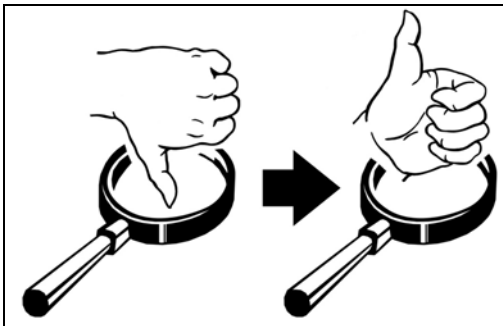
	**An easy to read report looking at how the Care Quality Commission can learn from the way it checked Winterbourne View.**
	The Care Quality Commission checks services meet the government's standards about care for all health and social care services in England.
	**Winterbourne view** was a hospital for people with learning disabilities who also have other care or support needs.

Original Document title:
Internal management review of the regulation of Winterbourne View

	A member of staff at Winterbourne view told the management of the hospital, the South Gloucestershire Adult Safeguarding Team and the Care Quality Commission that they had worries about care in the hospital.
	The Care Quality commission has said it did not respond as well as it would have wanted to these worries.
	The hospital closed in June 2011 after a BBC Panorama programme showed the abuse of patients at the hospital.
	This report looks at the lessons that the Care Quality Commission can learn to make the way it checks services in the future better.



Lesson suggestions

Suggestion 1

The Care Quality Commission should consider that services for people with learning disabilities, challenging behaviours and mental health needs often have a high risk of abuse.

Suggestion 2

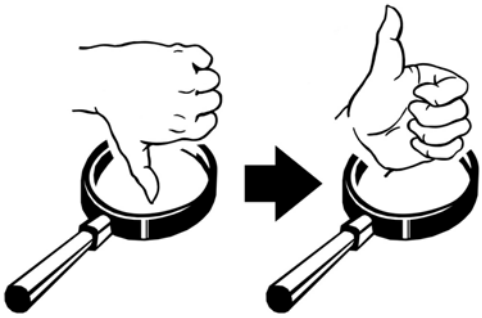
When checking services the Care Quality Commission should think about:

- the different levels of risk at different types of services.
- the different levels of risk for different types of people using those services.

Suggestion 3

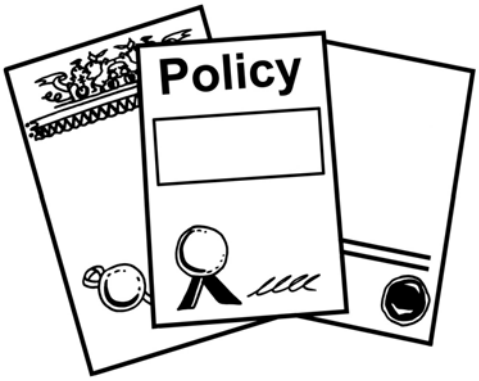
When checking **safeguarding** alerts, inspector should write down what they find.

Safeguarding rules are to protect people from being abused and keep people safe.



Suggestion 4

The Care Quality Commission should follow up the outcomes from safeguarding investigations.

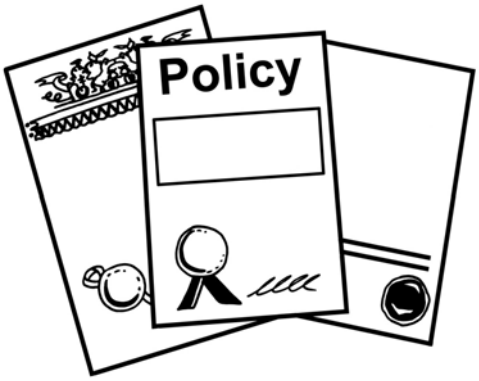


Suggestion 5

The Care Quality Commission should work with local safeguarding adult teams and safeguarding adult boards in investigations.

	**Suggestion 6** The Care Quality Commission should look at the way it handles safeguarding alerts to see if there are any patterns.
	**Suggestion 7** The Care Quality Commission should check how well inspectors and Mental Health Act Commissioners share information.
	**Suggestion 8** Worries that second doctors have for patient safety should be written down and given to the Care Quality Commission.

	**Suggestion 9** An action plan should be written and checked after a Mental Health Act commissioner visits a service and makes any comments or suggestions.
	**Suggestion 10** The Care Quality Commission should look at how it gets information and how it looks at risk.
	**Suggestion 11** The Care Quality Commission's Board should get a report on **whistleblowing** every 6 months. **Whistleblowing** is when people who work (or used to work) at a care service tell us that people are being harmed, or could be.

	**Suggestion 12** The Care Quality Commission should check it is looking at the most worrying services each year.
	**Suggestion 13** The Care Quality Commission should create a set of rules about how it will work with the safeguarding adult board and teams across England.