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Durham Safeguarding Adults Partnership

Safeguarding Adults Review Whorlton Hall

Commissioned by

Durham Safeguarding Adults Partnership

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1 Introduction

1.1 WHY THIS CASE WAS CHOSEN TO BE REVIEWED

1.1.1 Section 44 of The Care Act 2014 states that a Safeguarding Adults Board (SAB) must arrange for there to be a review (known as a Safeguarding Adults Review – SAR) of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if … (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and … a) the adult is still alive, and (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.1.2 On 22nd May 2019, the British Broadcasting Corporation (BBC) exposed concerns of allegations of physical and psychological abuse of patients residing at Whorlton Hall in a televised programme – Panorama. There was therefore a legal mandate for a SAR on the basis that several adults with care and support needs had experienced alleged[1] serious abuse and there was a reasonable cause for concern about how agencies had worked together to safeguard them.

1.2 CRIMINAL INVESTIGATIONS

1.2.1 Following the Panorama programme criminal investigations have commenced and are continuing with nine suspects charged with criminal offences (ill-treatment or wilful neglect of an Individual by a Care Worker) and awaiting trial at Crown Court. Precautions have therefore been taken to avoid impinging directly upon the criminal prosecution and criminal justice process, by, for example avoiding direct contact with those subject to proceedings or identified as victims or witnesses within those proceedings.

1.3 SUCCINCT SUMMARY OF THE CASE – WHORLTON HALL

1.3.1 Whorlton Hall was an independent hospital registered with the Care Quality Commission (CQC) for two regulated activities: 1). Treatment of disease, disorder or injury; 2). Assessment or medical treatment of persons detained under the Mental Health Act 1983. The CQC inspected this service as a ward for people with learning disabilities and/or autism. Whorlton Hall admitted men and women, with a learning disability and/or who were autistic, who were aged 18 years and over, and who also had additional mental or physical health needs, and/or behaviours that challenged.

1.3.2 The statement of purpose for the hospital stated originally that the hospital could accommodate a maximum of 24 patients which was later reduced to 19. At the time of the Panorama programme there were 13 patients at Whorlton Hall, with two other people having been discharged from the hospital prior to the undercover filming for the Panorama programme. Clinical Commissioning Groups (CCGs) from 10 different areas across the

[1] This phrasing is used because the allegations are denied and a criminal court is seized of determining the facts.

North-East, North-West, the Midlands and Northern Ireland, commissioned these placements. There were no placements commissioned by Durham CCG.

1.3.3 Whorlton Hall was originally operated by Castlebeck Care, but later transferred to The Danshell Group in 2013. Danshell owned and operated Whorlton Hall until August 2018, when all their 25 different facilities (with 288 beds) were acquired by Cygnet Health Care ("Cygnet"), a subsidiary of the United States (US) company Universal Health Services Inc[2]. the latter not having any operational role/responsibility for Cygnet Healthcare. The acquisition of Danshell services by Cygnet occurred on 1st August 2018, and a new senior operational team took over responsibility on 1st January 2019.

1.3.4 An inspection in September 2017 by the Care Quality Commission (CQC) rated the hospital as good (published December 2017). CQC made a responsive focused inspection in early 2018, which was unannounced, following receipt of whistleblowing concerns around staffing, patient safety, culture and incident monitoring. This report was published in May 2018 and did not include a published rating. A further unannounced responsive inspection took place on 12th May 2019, due to concerns raised by the Panorama programme into alleged abuse of patients at this hospital, which looked at all key questions.

1.3.5 All 'placing' CCGs retained responsibility for undertaking their own commissioning quality assurance processes, including commissioner site visits. Statutory safeguarding responsibilities for placed individuals sat with County Durham local authority.

1.3.6 Following the Panorama programme, a criminal investigation was commenced by the police; an executive strategy process to investigate safeguarding concerns was initiated, led by Durham County Council; and an incident coordination group was established, led by NHS England. In addition, Cygnet made several staff suspensions, including interim suspensions of nursing staff. Whorlton Hall was then closed, and all the patients moved to alternative residences by 22nd May 2019.

1.4 METHODOLOGY

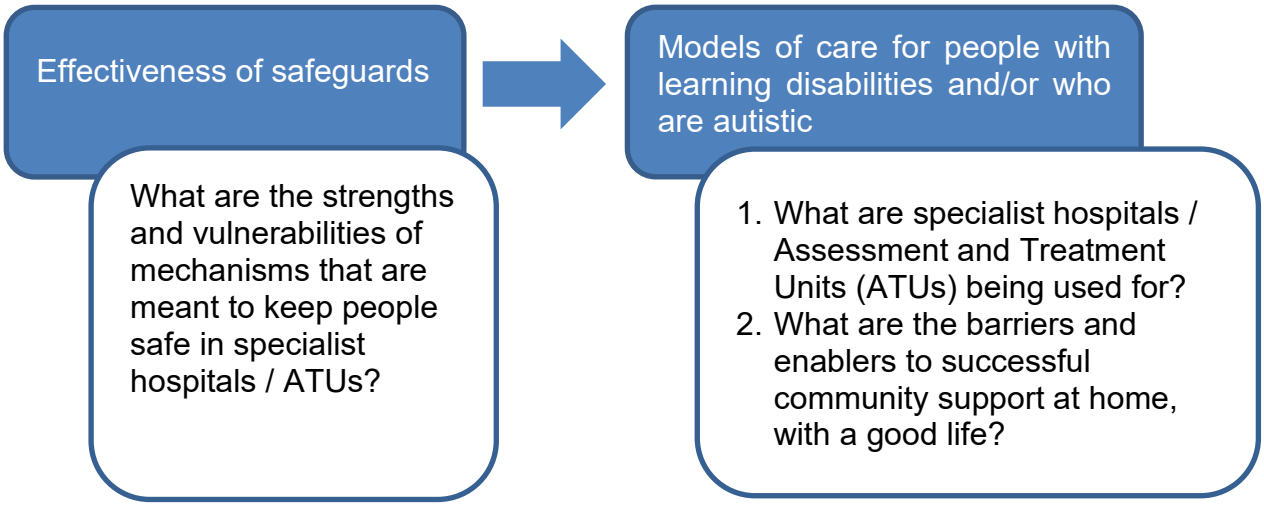
1.4.1 The purpose of a Safeguarding Adult Review is to provide findings of practical value to organisations and professionals for improving the reliability of safeguarding practice within and across agencies (Care Act and Support Statutory Guidance Para 14.178), to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect.

1.4.2 Durham Safeguarding Adults Partnership (DSAP)[3] following commissioning activity decided to use SCIE's tried and tested Learning Together model for reviews to conduct this SAR on Whorlton Hall.[4] Learning Together is a 'systems' model designed to draw out wider learning about what is getting in the way of keeping people safe.[5] (Further details on the methodology are included in Appendix 1).

1.4.3 Improving the safeguarding of people with learning disabilities, and/or who are

[2] [from Glynis Murphy review page 10]
[3] Or 'the partnership'
[4] Fish, Munro & Bairstow 2010 **https://www.scie.org.uk/publications/reports/report19.asp**
[5] **https://www.scie.org.uk/publications/guides/guide24/**

autistic, who are in, or at risk of being admitted to a specialist mental health hospital, needs to address both why people with learning disabilities and/or who are autistic are still being admitted to places such as Whorlton Hall; as well as examining why the mechanisms that should identify concerns about abuse or neglect are not working effectively. Therefore, the Safeguarding Adults Review on Whorlton Hall had a two-part focus:



A systems focused analysis requires engagement with professionals working at both operational and strategic levels within and across involved agencies and professions, as well as with family members to understand current pressures, dilemmas, and constraints. This SAR has collaborated extensively with a local review team of senior leaders as well as being supported by a national expert panel. The CCGs who spot-purchased[6] services from Whorlton Hall also contributed. The exception is Cygnet Health Care who engaged with and contributed to this report but did not share details of their internal investigation in light of ongoing legal processes.

TIME PERIOD

1.4.4 It was originally agreed that the review would focus on the period between 22 May 2018 and 22 May 2019 (airing of the BBC Panorama broadcast). The timeline was later expanded to start in February 2018, with the end-date later in 2019 to encompass additional information which had been shared with the Reviewers.

METHODOLOGICAL LIMITATIONS

1.4.5 The two-part focus detailed above, brought some aspects of practice more into focus in this SAR and excluded others. The working of responsible clinicians (RCs) and the multi-disciplinary team (MDT) for example, has not been analysed to identify wider learning.

1.4.6 There have also been some key gaps in data available to the reviewers. These

[6] Spot-purchasing is the process of buying a particular service for an individual patient as opposed to broader commissioning of services for groups of patients, it can also be described as micro-commissioning

relate to:

- the perspectives of the people who had been living at Whorlton Hall and their families, who are involved in the criminal case
- Internal investigation by the provider Cygnet Health Care in respect of which they assert legal privilege in light of the ongoing legal proceedings as well as analysis of their Due Diligence processes.

1.4.7 At this stage, our engagement with the people who had been living at Whorlton Hall and their families has been very limited due to the on-going criminal process. Some families whose relatives are not involved in the criminal investigation were contacted. The Durham Safeguarding Adults Partnership intend to engage with everyone in a meaningful way once the criminal process concludes.

1.4.8 It is also regrettable that Cygnet Health Care did not inform the lead reviewers or the Durham Safeguarding Adults Partnership that an internal investigation had been undertaken following the Panorama programme, when asked as part of the local Review Team; and only revealed this when confirmation was sought as the SAR was being completed, and then declined to share it on the basis that it is legally privileged. In the context of Whorlton Hall being closed, and the need to craft a proportionate review process, not having access to the findings of Cygnet's internal investigation has meant significant gaps in data. It has restricted the opportunity to draw out wider learning from Cygnet Health Care's internal investigation that is potentially relevant to other providers. It has closed the possibility of situating that data and learning in the wider multi-agency context and potentially identify learning for wider partnerships.

1.4.9 Cygnet Health Care also refused a request for access to information related to their Due Diligence processes at the point they took over Danshell services including Whorlton Hall. Cygnet Health Care explained that the rationale for their action was that due diligence reports related to the acquisition are legally privileged and commercially sensitive and are not part of the regulatory or safeguarding framework. This has further limited the analysis and potential learning we have been able to draw out through this SAR.

1.4.10 The partnership recognises the continuing role of the media to expose alleged abuse and/or neglect in health and care settings. Within the scope of the review, the partnership expressed an interest in exploring the timeliness of alerting statutory safeguarding authorities and whether or not any delay in reporting may have resulted in the adults placed at Whorlton Hall remaining in an allegedly abusive setting for longer than was necessary. However, in the context where the Covid pandemic had created delays to the SAR, the reviewers concentrated their efforts on drawing out learning about barriers to safeguarding mechanisms working effectively and barriers to achieving alternative models of care for people with learning disabilities who may also be autistic. This meant that the timeliness of reporting concerns by the media to relevant authorities was not explored; and this may be an area that investigative journalists wish to consider going forwards.

1.5 STRUCTURE OF THE REPORT

1.5.1 There are two main sections to the report. First, a brief narrative summary is provided of the evaluation of what went well and where there were problems in identifying

and responding to concerns about people's safety in Whorlton Hall. It captures the case findings, detailing where practice was below or above expected standards and, where possible, explaining why.

1.5.2 The second part of the report draws out the wider learning. Systems findings are presented that impacted on the effectiveness of the mechanisms designed to keep people safe. These are issues that impacted on practice in Whorlton Hall and hold true more broadly and continue to impact on other institutions today. Each finding also lays out the evidence identified by the Review Team and national Expert Panel that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in this case

2.1 WIDER CONTEXT

2.1.1 In 2015 a CQC inspection of Whorlton Hall rated it as 'required improvement' but CQC decided at the time not to publish that report. Whorlton Hall was then re-inspected on three occasions (3-4 March, 15 August and 16 November) in 2016, at which point it was deemed 'good' by the CQC. An independent review commissioned by CQC concluded that the decision not to publish the 2015 report was wrong. The author Mr Noble stated: "This was a missed opportunity to record a poorly performing independent mental health institution which CQC as the regulator, with the information available to it, should have identified at that time."[7]

2.1.2 In July 2016, Durham County Council Adult and Health Services (DCCAHS) invoked their organisational safeguarding processes. The advocate in the advocacy service commissioned by Danshell, had raised serious concerns regarding the impact on staffing, safety and practice, of the admission of two new people, with very high support needs. An Executive Strategy meeting was called, CQC were advised and agreed to undertake an inspection. This led to Establishment 'monitoring' meetings taking place approximately monthly led by DCCAHS Practice Improvement Officers and involving thorough discussions with senior hospital staff and review of care files. Concerns continued to be identified by this means through 2016, these included management changes, staffing pressures and gaps in skills and practice of staff. The decision was taken to end the Establishment Strategy procedure in April 2017; however, the monitoring visits continued every three to four months. They were increased to monthly in early 2018 after the identification of further issues related to the use of generic care plans for patients and growing staffing vacancies linked to the admission of new patients with high support needs.

2.2 EVALUATION OF PRACTICE 2018 – 2019

2.2.1 The start of the timeline of this SAR is the response by CQC to whistleblowing allegations in early 2018. There had been whistleblowing reports relating to Whorlton Hall

[7] https://www.cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall

which included for example, one report which made specific reference to a particular cartel of abusive staff and particular management, named the individuals, described them as the 'alpha-group' and reported that they called themselves the 'Cunts Club'.[8] (used pejoratively rather than implying gender). The report stated that there had been previous investigations of similar concerns about these staff and described a culture of bullying and cover-up, and disregard for the people living at Whorlton Hall. Another allegation repeated concerns raised previously about serious issues of understaffing and poor management. Given the known and evident difficulties of understanding what really happens inside a closed institution such as Whorlton Hall, CQC's response was a vital opportunity to make the most of the information provided, and to fully understand any problems that were potentially endangering people living at Whorlton Hall.

2.2.2 CQC's response to the reported whistleblowing concerns rightly reflected the importance of the information shared, and resulted in a responsive, focused inspection in early 2018 which asked whether patients were receiving services that were Safe, Effective, Caring and Well-Led. Following the inspection, Requirement Notices were issued, specifying actions that Danshell must take to address limitations. The issues raised were important and included 24-hour shifts and overtime limits; agency staffing and training; supervision arrangements; and over-use of restraint. What was missing in both the inspection and required actions was a rigorous investigation of the alleged 'alpha group', its members, relationships, and behaviours. Six patients were spoken to as part of the inspection but there were several factors which influenced the effectiveness of this engagement: members of Whorlton Hall staff were present, the patients did not know the inspection staff and no identified communication training or aids where used.[9] A further problem was that CQC had not informed Durham County Council Adult and Health Services (DCCAHS) of the allegations.

2.2.3 A couple of months later in early 2018 further concerns were shared with Durham Constabulary about an alleged assault, of a patient, by a care worker and concerns that it was being covered up. Another person spoke anonymously to a Danshell staff member from a different region, about two Whorlton Hall staff members and their punitive, intimidating treatment of patients, including examples of one 'winding patients up', to be able to restrain them; four patients were named as particular targets of this emotional and physical abuse. It was reported that these concerns had been raised internally previously, but to no effect. All these allegations were passed by Whorlton Hall management to DCCAHS.

2.2.4 This was another opportunity to 'lift the lid' on any problems that were potentially endangering people living in Whorlton Hall. This opportunity was especially prescient because, at the same time, a complaint was made to the CQC that the responses triggered by earlier allegations had been minimal and flawed and had taken the word of the service manager that there was no abuse. The complaint also raised doubts about whether the inspectors had spoken to people outside the 'cartel of abusive staff

[8] See G Murphy (2020) report page 27-28 https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

[9] See G Murphy (2020) report page 50 https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

[…]originally named, or had spoken to the six services users'.[10]

2.2.5 The responses by Durham Constabulary and DCCAHS to these allegations was appropriate in intent, but less than effective in practice. The police investigation into the assault was partial, focusing only on the evidence about the alleged assault and not on the alleged cover-up, and was influenced by limited resourcing and a lack of specialism in conducting investigations in this context. Durham Constabulary concluded they would take no action because the staff members denied the accusations and the CCTV did not provide any corroborating evidence. There was then a misguided decision by DCCAHS to allow Danshell to conduct an internal investigation rather than conducting a 'safeguarding enquiry' under the Care Act 2014 commonly known as a Section 42 (s.42) Enquiry[11], despite there being concerns raised about the way management responded to incidents and allegations, and without due regard to the need to protect the sources of the allegations. **The standard reliance on provider organisations to investigate concerns about the behaviour of individuals involved in toxic, intimidating sub-cultures within health and social care organisations, without quality standards or expertise for this work, is detailed in Finding 1.**

2.2.6 An 'Establishment Safeguarding Referral' was raised by DCCAHS in response to the last whistleblowing allegations, and there was some attempt to coordinate an organisational safeguarding response, through the calling of Establishment Planning Meetings. These meetings were designed to bring together all relevant parties to share information about concerns in the first part of the meeting; following this in the second part of the meeting those concerns were presented to the Danshell managers.

2.2.7 There were various limitations to this process: firstly, individual s.42 enquiries were not conducted on each of the four people who had been identified as being the subject of alleged abuse. This meant that the Establishment Planning Meetings focused predominantly on one instance of alleged assault and ignored the other allegations. Instead, it was decided that Danshell would investigate the other allegations despite concerns having been raised about the way management responded to incidents and allegations. The placing CCGs for each person were informed by email, but without DCCAHS taking a coordinating role. This meant that there was no check to see if any enquiries had been made and no process to collate information leading from the enquiries. This was because DCCAHS had not fully implemented the Care Act and retained a pre-Care Act distinction between Section 42 safeguarding enquiries and 'adult safeguarding' which focused on abuse investigations. This meant they only undertook a small number of focused investigations where they thought abuse had occurred rather than having moved to providing a proportionate, personalised, human rights based safeguarding enquiries in all circumstances. The limitations of these arrangements were highlighted clearly in an independent review commissioned by DCCAHS following the Panorama programme, and recommended that their safeguarding procedures, guidance and training should be updated. Since this time DCCAHS has been working to address the various related issues from this report. The review also reflected a lack of

[10] G Murphy (2020) report page 29 https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

[11] An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

implementation of the Association of Directors for Adult Social Services (ADASS) Out of Area guidance which stipulates the need for the 'host' safeguarding authority to retain a coordinating role.

2.2.8 The second limitation was that these planning meetings were not adequately robust given the nature of criticisms of the service. A range of concerns about the quality of provision, such as staff shortages, lengths of shifts, staff culture, and whether Whorlton Hall recorded all incidents and included sufficient information to assure around restraints, were put to the Danshell managers. They gave assurances and promised action where necessary, but these were not systematically checked for action or improvement. The boundary between quality improvement activity and safeguarding activity was insufficiently clear. This was compounded by the unusual and generous practice maintained by DCCAHS, of having staff in Practice Improvement Officer roles routinely visiting Whorlton Hall as standard, as they would a council commissioned service. In addition, the Establishment Planning Meetings were never formally escalated to Executive Strategy meetings as per local procedure for organisational safeguarding responses. While the process was the same, such an escalation would have better matched the level of concerns. There does not appear to have been adequate clarity about acceptable standards and consequences if they were not achieved; coordination with CQC was poor, with CQC sending apologies for the second, third and fourth meeting. The Establishment Planning Meetings were discontinued by DCCAHS in February 2019 despite many of the issues raised still being of concern, including staffing levels, and extensive use of agency staff. **The lack of clarity about the interface between CQC and host authorities in organisational safeguarding enquiries in specialist hospitals is explored in Finding 4.**

2.2.9 The fact that DCCAHS was not fully implementing the spirit of the Care Act guidance regarding person-centred, outcomes focused safeguarding, or the ADASS out of area guidance to retain a coordinating role, affected the responses to almost all safeguarding alerts raised by Whorlton Hall managers. It meant there were missed opportunities to focus on hearing the voice of people living at Whorlton Hall. It created particular risks for the people identified as making and retracting allegations of abuse. It meant significant levels of trust were placed in Whorlton Hall management to report accurately on events, evidence and judgements. Even in instances where DCCAHS staff logged concerns about how Whorlton Hall management were determining whether an allegation had been 'retracted', these were not followed through with any authority. Therefore, very few safeguarding alerts were ever independently evaluated, and few or no patients were directly engaged or given their statutory right to an advocate in the safeguarding process, and so they were not heard. **The need for individuals with learning disabilities and/or who are autistic to have a long-term, trusted relationship with someone, in order for statutory safeguarding responses to be effective in mental health hospitals and specialist facilities, is explored in Finding 2.**

2.2.10 This was compounded by the failure of both the Independent Advocacy Provider, and the advocacy service commissioned originally by Danshell and later by Cygnet Health Care to deliver a functioning advocacy service. **The inadequacy of current arrangements for the commissioning and oversight of advocacy services with the necessary skill requirements for people with learning disabilities and/or who are autistic and who are in, or at risk of admission to, specialist mental health**

hospitals is discussed in Finding 3.

2.2.11 The absence of the voice of the patients at Whorlton Hall was a feature that was apparent to the Lead Reviewers. Despite the hospital being in many ways a closed service, and therefore a structure that was more vulnerable to developing a toxic culture, there were in fact many people visiting patients at the hospital regularly whilst some patients also attended groups outside the hospital setting. Yet these contacts did not enable patients to report their abuse or convey their lived experience in a meaningful way. Many of the patients had communication difficulties and some had previous experiences of abuse which would have made disclosure more difficult. **The only way in which their voices could truly have been heard would be through the provision of better resourced advocacy services, explored in Finding 3 and more effective safeguarding investigations and responses as detailed in Findings 1 and 2.**

2.2.12 The acquisition of Danshell services by Cygnet Health Care occurred on 1st August 2018 following the expiry of the four-month statutory period in which the Competition and Markets Authority may open a merger assessment under competition law. Only later, from January 2019, did a new senior operational team undertake responsibility for Whorlton Hall, and the other Danshell services. Ahead of both these changes, Due Diligence processes took place. 'Due Diligence' is a process of detailed investigation commonly completed by a business or person, of documents and information provided by the seller to the buyer, prior to signing a contract or starting an ongoing business or employment relationship. Linked to this review, the seller may then make certain assurances (known as 'Warranties') as to the nature of the business being sold and provides details where those Warranties would not be correct. The aim of 'Due Diligence' is to identify any potential problems or unexpected liabilities. The ability to do so depends on both the information and access supplied by the seller to the buyer and the nature of the analysis conducted by the buyer of the information available. 'Due Diligence' processes undertaken by Cygnet Health Care included:

- Commercial
- Quality (A review of serious incidents, complaints and other documents in a 'data room')
- Financial
- Operational (e.g. Site visits)

2.2.13 The SAR reviewers requested Cygnet's analysis of the quality and operational elements to evaluate the extent to which there had been opportunities to identify safeguarding issues at Whorlton Hall by this means. Cygnet Health Care declined to share this information with the SAR. The rationale provided was that transaction due diligence reports related to the acquisition are legally privileged and commercially sensitive and are not part of the regulatory or safeguarding framework. Therefore, it has not been possible for this SAR to evaluate how effective Cygnet Health Care were in identifying risks relevant to safeguarding, or more generally to evaluate the extent to which 'Due Diligence' processes could be effective in identifying organisational safeguarding concerns.

2.2.14 The SAR has not evaluated the individual responses by all agencies after information was received from the BBC detailing the work of the undercover reporter and the evidence of alleged abuse. However, conversations with placing CCGs, raised some

concerns about the impact on patients of such closures even where the closure process was well managed. These conversations identified that hospitals receiving patients from Whorlton Hall were not always briefed adequately and therefore made assumptions about patients' previous experiences that may not have been accurate. **These matters are detailed more fully in Finding 5 which addresses the lack of established mechanisms or processes for the closure of establishments, particularly after an abuse scandal.**

2.2.15 There are two other parts of the safeguarding system that should have been a protective factor for patients at Whorlton Hall who were experiencing abuse. These are the Care and Treatment Review (CTR) meetings and the oversight provided by the commissioning CCGs. This review has not analysed in detail either of these processes. However, the review of CTR documentation and contact with the placing CCGs has provided sufficient information to make the following observations:

2.2.16 The CTR processes were in most cases being followed however, their effectiveness is questionable. There is evidence of delayed discharges; unresolved conflicts regarding funding; and a lack of detailed knowledge by the CTR of investigations of safeguarding concerns listed in DCCAHS records. The CTRs do indicate that many of the delays in discharge were due to insufficient suitable community resources and suggest that placing CCGs were struggling to achieve positive progression out of the hospital setting. The CTR records also show limited input to CTR meetings by advocates and family members. Finally, there was some evidence that there was insufficient continuity of personnel across CTR meetings, leading to drift and delay in achieving positive outcomes for patients at Whorlton Hall.

2.2.17 Input to safeguarding by placing CCGs was variable. Some CCGs provided proactive support to patients while others had a less interventionist approach. It was distressing for some of the CCG staff to realise that, despite significant attempts by them to visit regularly and to enable patients to share any concerns, abuse still occurred. To some extent that reflected the ways in which some of the Whorlton Hall staff, as evidenced in the Panorama documentary, were able to manipulate visitors, but it was also clear however that placing CCGs did not feel they were sufficiently involved in the safeguarding enquiries and there was evidence of confusion about appropriate routes for raising and responding to concerns.

2.2.18 The Lead Reviewer contact with the placing CCGs identified a wide variation in the nature and type of structures in place within the CCGs to commission placements for patients with learning disabilities, and/or who are autistic, and who are in, or at risk of admission to, specialist mental health hospitals. There were very disparate CCG/Local Authority funding arrangements and significant differences in resources and funding for placements. There were also significant differences in the expertise of staff involved in the supervision/monitoring of placements and differing knowledge and oversight by senior managers. These differences suggested that the support provided by placing CCGs to individuals was variable both in terms of safeguarding individual patients, but also with regards to how proactive they were in holding the specialist hospital to account for delivery of assessment and treatment, as well as finding community solutions for individual patients. **The issue of the evidence base for an effective CCG team structure and expertise requirements for commissioning of placements for people**

learning disabilities and/or who are autistic is considered further in finding 7.

2.2.19 Overall, the contact with the placing CCGs combined with the review of patient documents and feedback from some family members gave a picture of a system under significant pressure. Even when the placing CCG provided good individual support for the patient in hospital, and oversight of their care, there were such limited community resources, and such a significant demand, that it was hard for good community services to be made available to patients in a timely manner. The picture provided by commissioners was one of a 'post-code lottery' of service provision that required individual commissioners to work above and beyond to achieve a minimal outcome for the patient. This results in patients being placed for long periods in large hospitals that claim to be specialist, often at a distance from their family, and this provides an opportunity for abuse to occur. **It was apparent to the Lead Reviewers that there is a need for a coordinated national strategy with linked resource to achieve Transforming Care objectives if the necessary improvements in outcomes for patients are to be achieved. This issue is explored further in finding 6.**

3 Systems Findings

3.1 IN WHAT WAYS DOES WHORLTON HALL PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

3.1.1 Cygnet Health Care made the decision to close Whorlton Hall after being informed by the BBC of the evidence of alleged abuse they had captured. However, the analysis of 'what happened and why' in relation to Whorlton Hall allows us to draw out learning about systemic weaknesses impacting on our ability to keep people with learning disabilities and/or who are autistic, who are in, or at risk of being admitted, to equivalent specialist mental health facilities.

3.1.2 Seven systems findings have been prioritised from Whorlton Hall for the DSAP to consider. These are:

	SEVEN SYSTEMS FINDINGS – HEADLINES
1	**LACK OF STANDARDS OR EXPERTISE REQUIREMENTS FOR PROVIDER-LED SAFEGUARDING INVESTIGATIONS OF CULTURES** Currently, concerns about the behaviours of staff allegedly involved in toxic, intimidating sub-cultures within health and social care organisations, are, in the first instance, usually investigated by the provider organisations, at the request of CQC or Local Authorities. They do this without there being any available national standards for such investigations, or guidance on how to meet those standards, or requirements on the providers to demonstrate they have staff with suitable expertise to conduct them. Furthermore, there are few available options for scrutiny and challenge by others, including CQC. This increases the chances of poor-quality investigations of allegations and makes it harder to expose and stop toxic cultures and abuse.

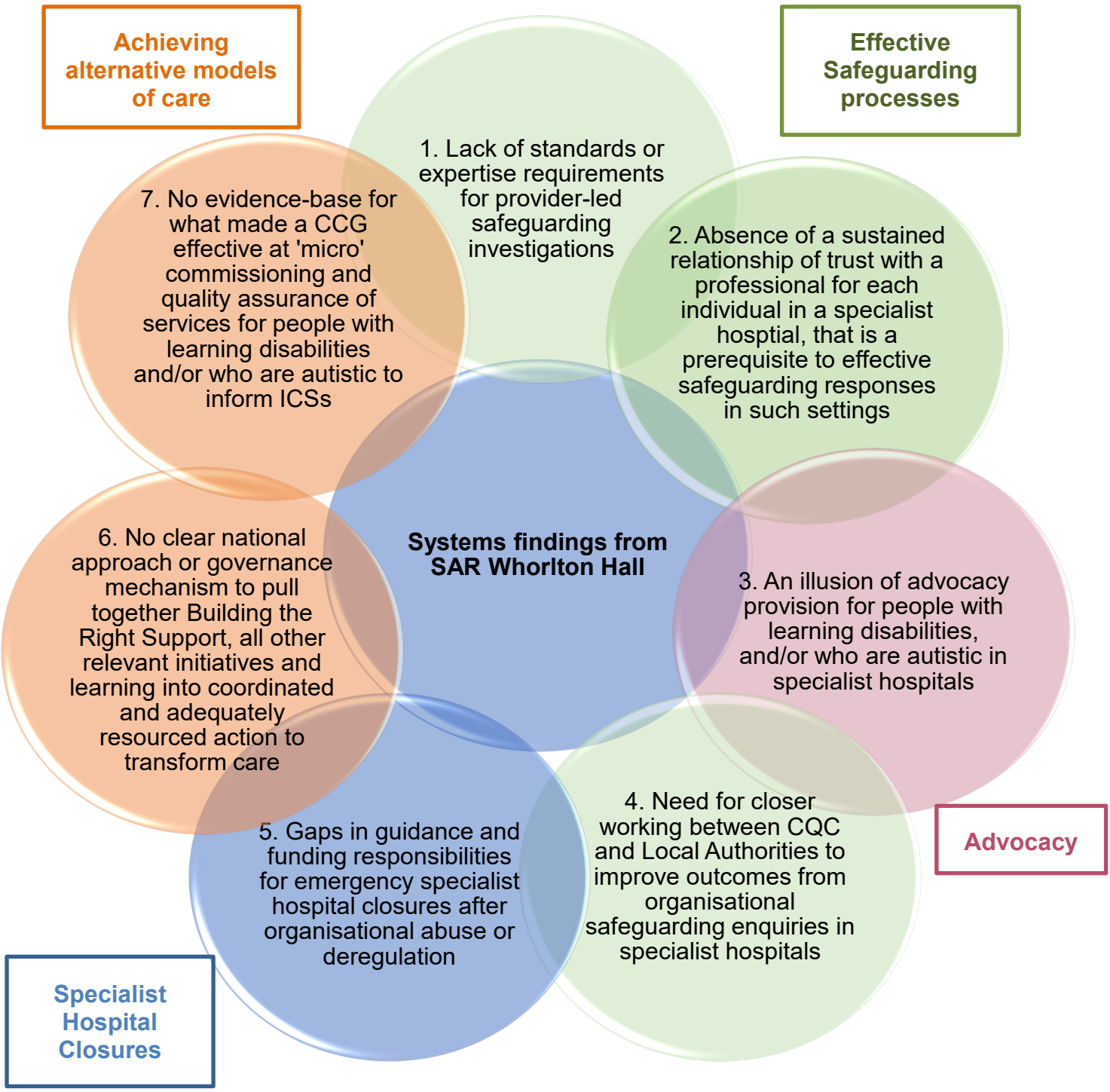
2	**CENTRALITY OF A SUSTAINED RELATIONSHIP OF TRUST WITH A PROFESSIONAL TO ENABLE EFFECTIVE SAFEGUARDING RESPONSES FOR INDIVIDUALS IN SPECIALIST HOSPITAL SETTINGS** For individuals in specialist hospital settings, effective safeguarding responses are dependent on a sustained relationship of trust with a named professional, a social worker or long-term, consistent advocate who knows them well, but this rarely exists. In the absence of a sustained relationship of trust with an independent professional, the host local authority must inevitably rely on the provider as a key source of information about safeguarding concerns that are raised, creating potential conflicts of interest. Current guidance and policy developments do not address this impasse, often leaving people most at risk without independent evaluation of abuse allegations raised.
3	**AN ILLUSION OF ADVOCACY PROVISION FOR PEOPLE WITH LEARNING DISABILITIES, AND/OR WHO ARE AUTISTIC, AND WHO ARE INPATIENTS OR AT RISK OF BEING ADMITTED TO SPECIALIST HOSPITAL** Current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates, are inadequate for people with learning disabilities and/or who are autistic, who are in-patients in specialist mental health hospitals or who are at risk of becoming in-patients. This leaves people in the most high-risk settings, the least well served and creates a false security that advocacy is in place.
4	**NEED FOR CLOSER WORKING BETWEEN CARE QUALITY COMMISSION (CQC) AND LOCAL AUTHORITIES TO IMPROVE OUTCOMES FROM ORGANISATIONAL SAFEGUARDING ENQUIRIES IN SPECIALIST HOSPITALS** Current guidance does not articulate with adequate clarity the necessary collaboration between CQC and host local authorities where there are quality issues that become organisational safeguarding concerns about specialist hospitals. This means that local authorities with a safeguarding role for people living in settings in their area undertake repetitive cycles of organisational safeguarding enquiries which result in them telling providers to do what they should already be doing, and which have little sustained effect on improving the experiences of patients. This risks perverting the purpose of safeguarding and incurs significant cost in terms of resource and time for the host authorities but has little impact on the providers or benefit to the people living in the specialist hospitals.
5	**GAPS IN GUIDANCE AND FUNDING RESPONSIBILITIES FOR EMERGENCY SPECIALIST HOSPITAL CLOSURES AFTER ORGANISATIONAL ABUSE OR DEREGULATION** In circumstances where people must be moved quickly after an organisational abuse scandal and/or cancellation of registration by CQC, current national guidance is not well known and does not adequately address the needs of families, require providers to be accountable financially for additional costs incurred, or include national oversight of such closures. This risks insufficient support and follow-up for individuals and their families, statutory agencies taking total funding responsibility and no national overview of how individuals are impacted by such closures or identification of learning to support on-going improvement.

6	**NO CLEAR NATIONAL APPROACH TO ABSORB LEARNING, COORDINATE AND RESOURCE ACTION TO TRANSFORM CARE** There is currently no clear national approach or governance mechanism that pulls together the national strategy of Building the Right Support[12], with other initiatives, as well as learning from all sources, into coordinated and adequately resourced action. Without such a responsive, whole systems approach, increased ambition and activity, risk not translating into real change and fulfilling lives for people with learning disabilities and/or who are autistic, who are in or at risk of being admitted to specialist hospitals. It risks the promise to 'transform care' continuing to lie beyond reach, at significant cost financially and an incalculable cost to the individuals whose lives are impacted.
7	**NO EVIDENCE-BASE FOR WHAT MADE A CCG EFFECTIVE AT 'MICRO' COMMISSIONING AND QUALITY ASSURANCE OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES AND/OR WHO ARE AUTISTIC, TO INFORM ICSs** Before the establishment of integrated care systems (ICSs), across England there were a wide range of different structures for commissioning, managing and quality assuring individual placements for people with learning disability and/or who are autistic. This resulted in variations in service provision with some CCGs appearing to have more effective systems for commissioning and quality assurance. There did not appear to be any guidance or knowledge base about what made an effective structure, within a CCG, for this work. The establishment of ICSs since 01 July 2022 provides an opportunity to learn about best practice from CCGs and through this enable the future development of improved commissioning and quality assurance in ICS commissioning teams across England.

[12] NHS England - National plan – Building the right support

3.1.3 Each finding is presented in turn below, using a common structure. They are presented separately to aid considerations about how best they may be tackled. In reality, of course, they interact and compound each other.

OVERVIEW OF SYSTEMS FINDINGS



3.2 FINDING 1. LACK OF STANDARDS OR EXPERTISE REQUIREMENTS FOR PROVIDER-LED SAFEGUARDING INVESTIGATIONS OF CULTURES

3.2.1 Finding 1 **Headline: Currently, concerns about the behaviours of staff allegedly involved in toxic, intimidating sub-cultures within health and social care organisations, are, in the first instance, usually investigated by the provider organisations, at the request of CQC or Local Authorities. They do this without there being any available national standards for such investigations, or guidance on how to meet those standards, or requirements on the providers to demonstrate they have staff with suitable expertise to conduct them. Furthermore, there are few available options for scrutiny and challenge by others, including CQC. This increases the chances of poor-quality investigations of allegations and makes it harder to expose and stop toxic cultures and abuse.**

3.3 CONTEXT

3.3.1 **Toxic sub-cultures or cliques**. There is currently limited research on toxic cultures or sub-cultures among health and care staff and their impact on people receiving services. There is some research around bullying in the workplace which identifies the impact of such a culture on service delivery however none of this has focused specifically on the effects on closed communities such as care homes or hospitals.

3.3.2 After exposure of the abuses at Whorlton Hall via the Panorama programme, CQC started to focus on the issue of 'closed cultures' within health or care settings. CQC defines a 'closed culture' very broadly as 'a poor culture that can lead to harm, including human rights breaches such as abuse' (CQC 2021). They stress that 'The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones'.(CQC 2019) New guidance *'Identifying and responding to closed cultures: Supporting information for CQC staff'* updated in 2021[13], supports inspection staff in three main tasks:

- Identifying services where there may be a high inherent risk that a closed culture might develop and lead to abuse or breaches of human rights.
- Identifying warning signs that there may be a closed or punitive culture, or risk of such a culture developing.
- How to use existing regulatory policy, methods and processes when there is a high inherent risk and/or warning signs

3.3.3 Feedback or the sharing of concerns about an unhealthy culture within the staff team, is categorised in this guidance as an inherent risk – one that increases the likelihood that a service will develop a closed culture. For example, feedback about bullying, presence of cliques, disrespectful language about people using the service or about colleagues and disrespectful treatment of people using the service indicates a greater risk of the service developing a closed culture.

3.3.4 **Whistleblowers** In services where toxic subcultures or cliques and their abuses

[13] https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures

and breaches of rights are deliberately concealed, there are challenges in identifying them. It often requires a member of staff within the service to 'blow the whistle' for people externally to be alerted. The Public Interest Disclosure Act 1998 legitimised 'whistleblowing' as a way of protecting vulnerable people. Several cases of serious abuse have become known via whistleblowers, including that at Winterbourne View Hospital, near Bristol, and the Long Care Inquiry involving the extensive abuse of adults with learning disabilities in two large care homes in Berkshire. It is noteworthy that in both these case it was the exposure of the abuse by the media that led to change rather than whistleblowing alone.

3.3.5 Within the public sector, whistleblowing has been strongly promoted as a way of making organisations more trustworthy and accountable. It is acknowledged that, particularly when delivering personal care to vulnerable people, there is much that is unseen and that often employees are the only people who can truly report on how services are delivered. Efforts to protect whistleblowers have included the introduction of:

- A statutory 'duty of candour' in 2014, requiring providers to be open and transparent with service users about their care and treatment, including when it goes work.
- The Fit and Proper Person Test which sees individuals in authority in organisations that deliver care to be responsible for the overall quality and safety of that care.
- The Office of the National Guardian and 'Speak Up Guardians' in response to the Francis report in 2015.
- Since April 2015, all health and social care providers have had to comply with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which sets out the requirement for all board level directors to be fit and proper persons.

3.3.6 **Responsibilities in responding to concerns** When investigating safeguarding concerns within a hospital setting there are five main agencies with similar and overlapping responsibilities:

- **The employer/provider** – has a particular responsibility for individual staff members' conduct/performance and for investigations of potential disciplinary issues. They also have a quality assurance and oversight role, linked to their duty to provide safe and effective care more widely and meet regulatory standards. This wider role can involve conducting investigations where concerns are raised.
- **The 'host' Local Authority safeguarding team** – has a particular focus on the adult-patient and they address concerns or allegations that a person with care and support needs has been or may be abused or neglected. They also have responsibilities to investigate organisational abuse where the mistreatment of people is brought about by poor or inadequate care or support that affects the whole facility. In undertaking these responsibilities, they should liaise with the 'placing' CCGs who should know the individuals and can assist with the investigation.
- **The regulator CQC** – Are responsible for the assessing the regulatory standards of the organisation and identifying potential breaches to conditions of registration and/or the fundamental standards as set out in the HSCA Reg Activity Regulations through monitoring, inspecting, and regulating services, as well as taking specific enforcement actions. CQC will undertake responsive inspections to safeguarding concerns raised against their standards.

- **The police** – have responsibilities where criminal offences are suspected. This relates to preserving and gathering evidence against suspected perpetrators as well as having a duty under the Victims Code of Practice 2013 to assess the immediate needs of victims and consider the long- term requirement to enable, for potentially criminal offences, that the person to be appropriately supported through the criminal justice system.[14]
- **Health CCGs commissioning placements –** are responsible for quality assurance of all patients they have placed out of their home area. A key component of quality assurance is effective safeguarding arrangements. The 'Host Commissioner Guidance' produced in 2021 clearly states that '*All health professionals have a duty of care to patients / service users, and should they suspect a safeguarding concern, should raise this via the relevant local authority in line with the Care Act 2014, as well as [with] the host commissioner'* furthermore that '*Host commissioners must ensure they are familiar with local adult safeguarding referral processes, and that there are defined routes for regular liaison with CCG and Local Authority safeguarding leads regarding care provided at the specialist inpatient unit*.'[15]

3.4 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.4.1 There is no doubt that the behaviour exposed through the BBC's undercover filming and aired on the Panorama programme showed that staff concealed information from family and professionals. It was estimated that 37 visits by professionals took place over the nine months to May 2019, including Local Authority representatives and CCGs who had spot-purchased places at Whorlton Hall for their patients. Separately a local GP was seeing patients for routine medical matters, and there were weekly visits by the advocate in the advocacy service commissioned by Danshell, as well. None of these visiting professionals saw abusive behaviour; even though they spoke to the adults living there as patients and had contact with Whorlton Hall staff. The abuse was not visible. The duplicity of the abusive staff toward family members was painfully portrayed in footage showed on the Panorama programme. Professionals employed by the provider (Danshell and later Cygnet Health Care) in regional management roles, who contributed to this SAR, were also horrified when they later realised how 'the wool had been pulled over their eyes' so successfully by people who they trusted.

3.4.2 However, over a year before the Panorama programme, a member of staff at Whorlton Hall had 'blown the whistle' on some of the key individuals involved. Early in 2018 the CQC had received anonymously detailed information that closely resembled what would later be captured on film. So why did this 'gold dust' not work to allow the abuse to be exposed?

3.4.3 A summary of the detail is below, followed by a critique of the methodology used in the provider-led investigation of the allegations about a particular 'clique' of staff and their behaviour patterns, which ultimately concluded that none of the allegations were founded. Some amendments and omissions have been made to the detail provided here to support anonymity.

[14] https://www.skillsforcare.org.uk/Documents/Standards-legislation/Care-Act/Care-Act-changes-to-the-police-role-in-the-safety-and-protection-of-adults.pdf
[15] https://www.england.nhs.uk/wp-content/uploads/2021/01/Host-commissioner-guidance.pdf

THE WHISTLEBLOWING ALLEGATIONS

3.4.4 The information sent to CQC stated that there was a culture of bullying with a clique of management and staff (whose names and job titles were provided) who reportedly considered themselves the 'alpha group' and titled themselves 'the Cunts Club'[16] and have been able to minimise concerns and cover them up. Furthermore, it was shared that this group have previously been investigated. It described that there was little regard for the safety and well-being of staff with favouritism being shown towards staff who were members of this clique. This included staff being given extra time-off and priority when booking leave or shifts to work.

3.4.5 It also described abusive behaviours towards patients including restricting food and drinks and keeping patients restricted to their bedrooms for long periods. There were also examples of abusive language being used to describe patients. The information also reported staff coming into work smelling of alcohol and these staff being inappropriately involved in caring for patients. It was alleged that staff who raised concerns about these matters were penalised and humiliated by involvement management who attempted to 'intimidate, bully and humiliate staff'. It was reported that staff were mocked in front of others or derogatory comments were made.

3.4.6 Understaffing in the unit, overuse of agency staff and the lack of relevant experience of the team was also reported. An increase in incidents of aggressive behaviour and assaults on staff were said to have resulted. It was also reported that there was a lack of adequate PPE of the right sizes provided, after it was made compulsory to wear for bite protection. It described the dismissive and threatening response by particular management when this was raised.

FIRST INTERNAL RESPONSE TO THE ANONYMOUS ALLEGATIONS

3.4.7 The allegations, and further information that the CQC received a few days later, was taken very seriously. The CQC inspector and relationship owner updated the Whorlton Hall Registered Manager and emailed the Danshell Divisional Managing Director for the region with a summary of issues raised, and a request for various information.

3.4.8 Within 24 hours of being alerted to the concerns, Danshell brought a consultant nurse employed by Danshell to work in the West Midlands region, to Whorlton Hall to conduct an unannounced two-day investigation. The need for an internal investigation was not explicitly requested by CQC but was clearly assumed on both sides.

3.4.9 The focus of the Danshell internal investigation and structure of the resulting report is reproduced in Table 1 below and accurately reflects the issues highlighted in the information shared as summarised by CQC below (with minor redactions by the reviewers to support anonymity)

[16] See G Murphy (2020) report page 27-28 https://www.cqc.org.uk/sites/default/files/20020218_glynis-murphy-review.pdf

TABLE 1

Danshell Internal Investigation - Issues reported against

Culture

1. A culture of bullying
2. Disrespectful or derogatory language regarding service users

Staff Safety

3. An increase in aggressive behaviours towards staff
4. Staff encouraged not to contact outside agencies
5. There is not enough protective uniform on site and this has not been responded to by management
6. Senior staff are not responding to attack alarms

Staffing and Patient Safety

7. Senior staff refusing to supply drinks to service user due to him urinating or throwing
8. Staffing numbers are extremely low
9. Agency staff are new, inexperienced and have not received induction or training

Incidents

10. Incidents are allegedly minimised or covered up
11. A member of staff in a non-caring role is said to have been involved in restraining patients

3.4.10 The investigation methodology can be summarised as made up of four aspects: on-site observations, reviewing of data, engagement with patients and their care, and interviews with staff. Further details of each aspect are summaries in the Table 2 below.

TABLE 2

On-site observations	Reviewing data	Engagement with patients and their care	Interviews with selection of staff
• A tour of the service then walking around the service independently • Attending the 'morning flash' meeting	• Reviewing Whorlton Hall data over the past 12 months including incidents of aggression towards staff and staff injuries • Reviewing service statistics about staff supervision,	• Being introduced to service users who were willing • Reviewing care records for four of the nine service users still living at Whorlton Hall	• **Key Management** • Care **Staff member** (with highest number of staff related injuries) • **Support Worker** (recently employed) • **Support worker** • **Nurse** (with

	including for agency staff • Reviewing governance records completed by the senior team		second highest number of staff related injuries) • **Agency Staff member** (employed for a long period) • **Member of staff with non-caring role**

3.4.11 What is striking in this approach, is that while the information shared specifically named members of the toxic clique, the investigation does not appear to have followed up specifically on those named staff, nor to have explored their relationships or alleged favouritism, either with the individuals concerned or with potential witnesses. The allegation of a prior disciplinary processes related to perpetuating this macho, misogynistic toxic clique does not seem to have been checked either. The specificity provided about the toxic clique was therefore lost.

3.4.12 Instead, interviewees were chosen to capture a random cross-section of staff including senior, junior, long standing, new and agency staff and include those related to specific allegations, namely staff employed in non-caring roles; and staff who had the highest rates of staff injury linked to incidents of aggression from patients. The information had included specific people to follow-up in relation to different allegations respectively but these 'leads' do not seem to have been followed.

3.4.13 Looking in more detail at the record of the interviews , contained in the investigation report, it is notable that there does not seem to have been any adaptation of the approach for the possible duplicity of those allegedly involved. By the nature of the allegations, it could be assumed that people might not engage openly and honestly in the investigation. Those implicated might instead lie, deny and cover-up any truth to the allegations but no strategy seems to have been considered to take this into account.

3.4.14 Similarly, the questioning of potential witnesses in this scenario, where they were being asked to corroborate allegations against a long-standing group of permanent staff, whose behaviour it was reported had been condoned by the key management, does not appear to have been given special consideration. More junior staff or those outside the clique might fear the consequences for themselves of speaking out. Or the set-up could have become completely normalised and become simply 'how things work around here' – the very definition of 'culture'.

3.4.15 The interviews appear to consist of a series of simple, closed questions addressing each allegation in turn. In relation to 'culture', for example, all interviewees were asked the following questions:

- Are you aware of any workplace bullying or any emails/actions from senior members of the team that could be perceived as intimidating or inappropriate?
- Do you feel able to raise concerns with management?
- Have you witnessed any 'workplace bullying'?
- Have you ever witnessed or received concerns of service users talked to or

about in a disrespectful manner?

- Have you ever witnessed or received a concern that anybody employed at the service spoke to or about services users in a derogatory way?

3.4.16 The questions invite a simple 'yes' or 'no' answer. They assume a mutual understanding of all the key terms that lie at the heart of the allegations – rather than demonstrating an open curiosity about norms and behaviours, allegiances and dynamics. Most unnervingly, the questions appear to have been the same for potential witnesses as for the alleged perpetrators.

3.4.17 The limitations in the investigative process allowed the investigator to be falsely reassured about the baseline culture, as well as the openness and responsiveness of Whorlton Hall management to concerns. This was compounded by the alleged abusers highlighting to the investigator actions that had been already taken in response to allegations of workplace bullying and/or inappropriate or intimidating behaviour by senior staff. Without any contradictory evidence, the Consultant Nurse internal investigator was understandably, but falsely reassured.

3.4.18 The outcome of the internal investigation was that none of the allegations were substantiated and, indeed, four areas of good practice were identified, with the recommendation they be shared more widely across Danshell provisions. These related to staff supervision; Positive Behaviour Support (PBS) workbooks; agency induction and specification of senior support staff areas of responsibility.

DANSHELL'S SECOND INTERNAL RESPONSE

3.4.19 Danshell regional management had a further opportunity to consider the issues raised when they fortuitously received a copy of the actual concerns sent to CQC. The Regional HR Director took the concerns to cross reference it with the themes shared from the CQC, as the CQC had not originally shared. The Regional HR Director concluded that they were the same themes and therefore it must be the same concerns. At this point, the Regional HR Director did not raise any questions about the appropriateness of the methodology used in internal review. That there were no questions raised about the nature of the investigation suggests that this approach was standard. Instead, the Regional HR Director concluded that, as the issues had now been investigated both by the Danshell Nurse Consultant and by CQC in the responsive inspection, no further investigation was needed.

3.5 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.5.1 Over the last ten years there have been several SARs that have included reference to concerns being raised by whistle-blowers and investigated in an ineffectual way by providers. This includes Winterbourne View Hospital in South Gloucestershire[17] which had a similar four-page email. However, this SAR did not analyse in detail the adequacy of the internal investigation. Recommendations focused instead on whistle-blowers communicating directly with CEOs and Boards, as well as CQC processes for logging and routinely acting on concerns. The SAR on Mendip House[18] likewise

[17] https://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/
[18] https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20180206_Mendip-House_SAR_FOR_PUBLICATION.pdf

highlighted the extent of reliance on internal investigations into poor/abusive conduct of their own staff members by the National Autism Society (NAS) which did not result in effective outcomes. Again, there was not a focus in the SAR about how those investigations were conducted.

3.5.2 As part of this review process, we explored the extent to which such a mismatch between the allegations about a toxic clique and the investigation methodology was standard. This confirmed that this was far from a one-off occurrence. The process used was standard and was neither linked only to the preferences of the particular Consultant Nurse, nor only to norms of Danshell at that time.

3.5.3 The first point relates to the usual practice of relying on providers to conduct internal investigations in the first instance. In response to Whorlton Hall, CQC have worked hard to enable its systems, processes and people to be better equipped to identify 'closed cultures'. However, input from CQC representatives to this SAR indicated that it would still be standard for them to escalate most concerns, including those about toxic culture, to the provider in the first instance, and for the provider to investigate internally. This is especially the case where concerns relate to the conduct of named staff. This may be done in conjunction with other actions such as making a safeguarding alert, informing other regulators, or planned future unannounced inspection activity.

3.5.4 Furthermore, because the provider conducts them as HR investigations, the regulator would not have any grounds to quality assure the process or challenge the outcome. What the CQC can do is check that a provider has appropriate processes in place to respond to concerns and that these are being followed. They can also request further information or carry out inspection activity if they receive investigation reports which do not provide assurance that concerns are being addressed and that good quality or safety care is being provided. But without any standard which sets out how a provider carries out such an internal investigation where this is actioned, in practice feedback suggested this is not experienced as viable or straightforward. Mendip House SAR also highlights this point. At one stage the National Autistic Society were advised by the Local Authority that the outcome of their internal investigation should be reconsidered, and in response they queried whether the Local Authority had the statutory power to require this.

3.5.5 Secondly, further consideration as part of this SAR revealed that the process used in the internal investigation in this case, is a standard HR-driven one, which it is likely all providers would use. Standard protocols and guidance for HR investigations describe the goal as determining the validity of a complaint, through talking to the accused and to witnesses, asking questions and seeking other information to confirm or refute the allegations, while maintaining both impartiality and confidentiality of all involved. They are therefore not effective tools for unpicking behavioural norms and attitudes particularly where the individuals concerned are deliberately concealing their views and behaviour. This means that different methods of investigation are needed to unpick toxic cultures and at present there is little support or guidance available for providers unlike that which is now available to CQC staff.

3.5.6 Lastly, discussions with the Review Team and National Panel supporting this SAR, suggested that despite the common reliance by CQC and local authorities on providers to conduct internal investigations of safeguarding concerns and potential disciplinary matters related to staff conduct, there are currently no set expectations about how to fulfil this function, even for large specialist providers. There is not, for example,

the requirement to have staff with dedicated roles or any specification of the expertise required. Therefore, it is common, as in this case, for clinical staff who are independent of the service under review, to be brought in to conduct such investigations despite not having any specific expertise in investigative work.

3.6 HOW WIDESPREAD IS THIS SYSTEM'S FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

3.6.1 This finding is likely to affect all provider-led investigations of concerns about the staff team culture in health and care service settings. There does not appear to be any reason why this finding would have geographical limits. It is therefore likely to be a national issue, impacting on the quality of provider-led investigations of concerns about toxic subcultures in health and care services, across all regions. It may disproportionately affect regions that have more specialist residential facilities and more people placed from out-of-area.

3.6.2 In 2018/19 CQC received 8,906 (an increase of 9% compared to 2017/18) whistleblowing enquiries across all types of service. By the end of October 2019, they received 6,188 whistleblowing enquiries again across all types of service. The volume of enquiries received in the first two quarters of 2019/20 increased by 14.5%. In the first quarter figures remained stable but quarter two saw an increase to an average of over 900 per month (October 2020 continued this trend with over 1,000 received) in comparison to an average of 742 per month in 2018/19.

Whistleblowing and other information of concern received by CQC

	2018/2019				2019/20		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Whistleblowing Enquiries	2,189 *(15%)*	2,294 *(15%)*	2,042 *(14%)*	2,381 *(15%)*	2,326 *(15%)*	2,807 *(16%)*	1,055 *(17%)*
Other Information of Concern	12,129	13,105	12,933	14,013	13,588	14,897	5,140

3.6.3 CQC Board reports do not detail the type of concerns/allegations raised, or the percentage of instances when they asked the provider to conduct an internal investigation.[19]

3.6.4 Media reports highlight that during the Covid-19 Pandemic, CQC data showed whistleblowing in care settings had increased by more than 50 per cent to 6,972 in the year up to September 2020. The explanation provided was that the CQC had changed the way it operated, with routine inspections stopped, and the focus shifting to supportive conversations with care providers and managers. This inspection vacuum led to more people coming forward with their concerns:

> *"With CQC site visits reserved for services which are considered to present a significant risk to service users - more risk-based inspections*

[19] https://www.cqc.org.uk/sites/default/files/CM111905_Item5_performancereport_annexeb.pdf

are being triggered as a result of information of concern. Of the 888 inspections up to September, 53 per cent were triggered by whistle-blowers…"[20].

3.6.5 Information provided by Chris Hatton to the 'Joint Parliamentary Committee on Human Rights: Inquiry into the detention of children and young people with learning disabilities and/or autism' analysed data from 12 independent sector inpatient services and 8 NHS inpatient services and showed that in all cases there was evidence of either or both safeguarding concerns and whistle-blowing reports[21]. It is probable that this research is reflective of the overall picture.

3.6.6 In terms of numbers of people potentially affected by the finding, we can look to data available on people with learning disabilities and/or autistic people living in specialist residential settings. The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings.

3.6.7 The finding could also potentially impact on a much wider number individuals in a range of other residential settings where people may not be able to raise or explain their concerns or are not free to leave.

3.7 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.7.1 The difficulty of identifying secretive, toxic cliques within residential health and care settings is well-established. There has been significant focus on encouraging and protecting whistle-blowers. However, there has been little focus, to-date, on how best to investigate the information that whistle-blowers have provided, particularly as it relates to toxic cliques and their closeted, abusive behaviours. This means even opportunities created by whistle-blowers are not routinely maximised and people in high-risk settings could be left longer without help in the hands of abusive staff.

[20] **https://www.thecarehomeenvironment.com/story/35070/cqc-whistleblowing-up-more-than-half-in-care-settings**

[21] **https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/Hatton-analysis-inpatient-units.pdf**

FINDING 1. LACK OF STANDARDS OR EXPERTISE REQUIREMENTS FOR PROVIDER-LED SAFEGUARDING INVESTIGATIONS OF CULTURES

Currently, concerns about the behaviours of staff allegedly involved in toxic, intimidating sub-cultures within health and social care organisations, are, in the first instance, usually investigated by the provider organisations, at the request of CQC or Local Authorities. They do this without there being any available national standards for such investigations, or guidance on how to meet those standards, or requirements on the providers to demonstrate they have staff with suitable expertise to conduct them. Furthermore, there are few available options for scrutiny and challenge by others, including CQC. This increases the chances of poor-quality investigations of allegations and makes it harder to expose and stop toxic cultures and abuse.

SUMMARY OF SYSTEMIC RISKS:

Detecting the abusive practices of toxic cliques of staff that can exist in pockets of a health and care service, when they are concealing their behaviour, is not straightforward. Information from staff who 'blow the whistle' externally, often provides the first realisation that there is something to investigate. There are roles and responsibilities for all partners including the CQC, Local Authority, Health commissioners and providers in seeking to expose the emboldened, potentially abusive inner circles exercising or threatening control of other staff as well as service user/residents, in order to reveal an accurate picture of the way people are being treated. But to-date there has not been equal focus on all these different players in terms of how they progress their respective investigations about these kinds of concerns to increase the chances of success.

3.7.2 In response to the concerns highlighted by the Panorama investigation at Whorlton Hall, CQC have updated the knowledge base, revised guidance, and refined the tools they use, to better equip their inspectors to investigate 'closed cultures'. However, there has been no equivalent focus on internal investigations by provider organisations, despite these happening more regularly. There are several questions that remain unanswered about such investigations:

- What are the most effective approaches to investigations in these circumstances when deception and/or coercion of witnesses and bystanders may be a factor?
- What expertise is required to lead such an investigation well?
- Is a specialist role/department/function needed within providers of a certain size?
- Who quality assures the process and outcomes?
- Where does scrutiny occur?

3.7.3 This creates a significant systemic weakness. It makes it likely that the task will be undertaken by qualified health professionals who are ill-equipped to conduct difficult investigations. It increases the chances that even in the situations where a whistle-blower has flagged the existence of a toxic clique of abusive staff, their abusive patterns will not be sufficiently substantiated to enable action.

Questions for the DSAP and partners to consider:

- Given this finding what is the role of the Durham Safeguarding Adults Partnership (DSAP) in opening discussions with large hospital and specialist providers locally about their responsibilities to be adequately equipped to conduct internal provider investigations of alleged toxic cliques of staff?
- Is there an evidence gap here in terms of what good practice looks like and how it differs from more standard HR approaches to investigation? Are there other sectors that could be drawn on? Who is working in this area? Can guidance be created?
- Should organisations of a certain size be required to have a specialist role for internal investigations, in order to meet agreed quality standards? How would this idea best be stress tested and/or progressed?
- Should there be a stronger scrutiny role for the Local Authority and/or CQC regarding internal provider investigations? Similarly, should they be aware of complaints from relatives/residents and/or trusted representatives and when/if there is involvement of the Local Government and Social Care Ombudsmen Service (LGSCO)? How would this work in practice?
- What are the forums/opportunities that DSAP can use to raise these issues at a national level?

3.8 FINDING 2. CENTRALITY OF A SUSTAINED RELATIONSHIP OF TRUST WITH A PROFESSIONAL TO ENABLE EFFECTIVE SAFEGUARDING RESPONSES FOR INDIVIDUALS IN SPECIALIST HOSPITAL SETTINGS

3.8.1 Finding 2 **Headline: For individuals in specialist hospital settings, effective safeguarding responses are dependent on a sustained relationship of trust with a named professional, a social worker or long-term, consistent advocate who knows them well, but this rarely exists. In the absence of a sustained relationship of trust with an independent professional, the host local authority must inevitably rely on the provider as a key source of information about safeguarding concerns that are raised, creating potential conflicts of interest. Current guidance and policy developments do not address this impasse, often leaving people most at risk without independent evaluation of abuse allegations raised.**

3.9 CONTEXT

3.9.1 Finding 1 focused explicitly on safeguarding investigations of alleged toxic cultures and behaviours of staff in specialist facilities for people with learning disabilities and/or who are autistic. Here, in Finding 2, our focus is wider, on the conduct of any allegation or disclosure of abuse or neglect of a patient in such settings.

THE AIMS AND MEANS OF ADULT SAFEGUARDING

3.9.2 Making Safeguarding Personal has long been a key agenda of the Department of Health and Social Care (DHSC) in relation to Adult Safeguarding responses. The Care and Support Statutory Guidance emphasises the importance of a person-centred approach, adopting the principle of 'no decision about me without me'. Personalised care and support is for everyone, but some people will need more support than others to make choices and manage risks. A person led approach is supported by personalised information and advice and, where needed, access to advocacy support.[22] It is also reflected in the statutory duty for the local authority to arrange for an independent advocate to support and represent an adult who is the subject of a safeguarding enquiry where the person would otherwise have substantial difficulty being fully involved in the process, and there is no appropriate other person to support and represent them.

3.9.3 The aims of safeguarding, as set out in The Care Act 2014 and then replicated in local SAB policy and procedures, include stopping abuse or neglect wherever possible, and preventing harm and reducing the risk of abuse. Local Authority-led safeguarding systems tend to be designed around a staged process, to support the Local Authority to discharge their legal obligation to cause or make a safeguarding enquiry under section 42 (Care Act 2014), to protect individuals who have care and support needs, who are at risk of abuse or neglect, and who are unable to protect themselves from harm. The specific stages include making initial inquiries regarding a safeguarding concern or alert, s.42 enquiry planning, enquiry outcome, and safeguarding review. There is an expectation that the Local Authority will receive safeguarding "concerns" or 'alerts' from

[22] https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf

others, applying the statutory criteria for enquiry under section 42 (Care Act 2014), conduct initial inquiries and decide on the level of risk, before determining whether the concern should be treated as a safeguarding referral and the enquiry planning stage begin.

3.9.4 The initial communication of and response to a safeguarding concern or alert is therefore crucial to the success of the rest of the safeguarding process and wider risk management planning – evaluating risk, agreeing an approach, cross-agency risk plan with roles, timescales, and review. The response to the concern or alert stage includes a judgement about levels and immediacy of risk. It requires clear, accurate communication of relevant information, and also the ability to check out the facts and urgency of the situation have been communicated and understood.

3.9.5 A failure at the concern stage to adequately assess the risk of harm to adults at risk can potentially introduce bias into the remainder of the safeguarding process and response. An error of judgement not to proceed with a Section 42 safeguarding enquiry may leave a person being abused and closes the door on a person's right to an independent advocate to support and represent an adult who is the subject of a safeguarding enquiry, where that person would otherwise have substantial difficulty being fully involved in the process, and there is no appropriate other person to support and represent them.

SAFEGUARDING IN SPECIALIST HOSPITALS

3.9.6 Correctly identifying safeguarding concerns and abuse of people with learning disabilities and/or autistic people in inpatient mental health hospitals or specialist facilities is often not straightforward. Factors include:

- The kinds of restraints and involuntary treatments entailed, may *all* be experienced by the patient as frightening and forms of violence, even when they are lawful and part of the providers duty of care.
- Abuse can take the guise of 'lawful' violence, i.e. restraint and the over-giving or withholding of medication prescribed to be taken 'as needed' (PRN treatment).
- People have often been placed there at times of crisis, or a succession of crises, and present distressed behaviours that can be a risk to themselves or others. These behaviours that challenge may also be that person's only way to communicate an unmet need (e.g. pain, sensory overload), or abuse, but can be used to justify restrictive practices such as restraint, seclusion and inappropriate use of medication.
- Some people will have compound trauma, whether from previous abuse, or because they are neuro diverse and/or have experiences of inpatient settings and unsuitable care and/or abuse. Some people will have been removed from their home environment (often at short notice), their usual routines and activities and from people they know and who know them well
- Placements are not generally commissioned by local 'host' authorities, and often they are not commissioned by local CCGs, who therefore do not know the people there, or have access to their case files.
- Some people may be non-verbal or have significant communication challenges; some will have learning disabilities that are significant.

SAFEGUARDING RESPONSIBILITIES IN OUT OF AREA ARRANGEMENTS

3.9.7 The multiple and overlapping roles in relation to safeguarding have been detailed in Finding 1.

NAMED SOCIAL WORKER PILOTS

3.9.8 Between 2016 and 2018 the DHSC has supported the Named Social Worker (NSW) programme, which was led by Innovation Unit and SCIE, and involved nine local authorities from across England over its two phases.[23] Through this initiative, people with learning disabilities, mental health conditions and who were autistic were assigned a 'named' social worker – a social worker who could build a trusting relationship with them, advocate on their behalf and coordinate their care and support in a more holistic and person-centred way. The two main groups of people who were the so-called 'transforming care cohort' were people with learning disabilities and/or who were autistic who displayed behaviour that challenges (including behaviour that is attributable to a mental health condition), who are currently living or at risk of being admitted to hospital settings, as well as people in transitions i.e. young people with learning disabilities, mental health conditions and who were autistic who were preparing for adulthood. None of the patients at Whorlton Hall received support as part of this initiative.

3.9.9 The evaluation evidence suggested that the Named Social Worker pilots had impact across three levels. The first two are relevant to this finding and summarised below:

3.9.10 Impact on the individuals and the people around them

- trusted relationships with people supported by services and those around them
- increased and meaningful opportunities for people to shape their plans that respond to individual communication needs and preferences
- new packages of support that better meet their strengths, aspirations and needs and those of the people around them
- high levels of satisfaction reported including that people felt that the named social worker listened to them and acted on their behalf
- evidence that people have been better able to live the lives they want including faster and smoother discharges, restrictive decisions overturned and greater stability of placements.

3.9.11 Impact on the named social workers:

- increased levels of skills, knowledge and confidence to do good social work e.g. the NSW survey found that confidence to meaningfully engage the person they are working with and those round them to deliver a person-centred plan increased from 47% to 94%

[23] https://www.scie.org.uk/social-work/named-social-worker https://www.innovationunit.org/projects/named-social-worker/

- confidence to advocate for the people they work with and bring their voices to the fore e.g. the NSW survey found that confidence to constructively challenge other professionals/ services increased from 43% to 88%
- higher levels of satisfaction with quality of work.

3.9.12 Learning from the Named Social Worker pilots has been taken forward in the British Association of Social Workers (BASW) Homes Not Hospitals campaign and resources[24]. The description outlining the role of the named social worker has been reviewed and refreshed by the Homes not Hospitals roundtable group to strengthen and reflect the context within which social work is taking place. NICE Quality Standard QS101 'Learning disability: behaviour that challenges statement 4' is about people with a learning disability and behaviour that challenges having a named lead practitioner. BASW is advocating for the role of the named social worker to be implemented across the country but this has not yet happened. Data does not appear to be available to confirm how many of the more than 2000 people in the 'Transforming Care cohort' have already had or continue to have a named social worker before or since the Named SW pilots.

3.10 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.10.1 During the time period of this SAR (between February 2018 and May 2019) there were 60[25] safeguarding alerts from Whorlton Hall to DCCAHS. However only seven were progressed to a safeguarding enquiry. An over-reliance on the provider to carry out initial inquiries and share accurately key information in order to determine whether to initiate a s.42 safeguarding enquiry had become the norm. The reliance on investigations, information and judgments from the Whorlton Hall management appeared to make sense at the time because the majority of alerts came from Whorlton Hall management and staff who therefore appeared to be being fully open and transparent. There was also evidence (over a longer timespan) of the provider having reported action to dismiss or discipline staff, where they had found evidence of wrongdoing and suspending staff whilst investigations were made and/or removing staff temporarily from duty with a patient. As a result, the significant levels of trust placed in Whorlton Hall management to report accurately on events, evidence and judgements was rarely tested – some of which the undercover reporting later proved misplaced. It meant that very few safeguarding alerts were ever independently evaluated and opportunities to identify and stop abuse were missed.

3.10.2 In relation to these safeguarding alerts, information was also passed to placing authorities, who would have had access to more personalised information to support initial investigations, but this made no material difference. The independent internal review commissioned by DCCAHS, clarified that while information was passed to the relevant placing CCGs, it was routinely sent after the decision not to progress a s.42 enquiry had been made and so was for information only rather than with the intention of gathering more information. Discussion with the CCG would have allowed for the gathering of more

[24] https://www.basw.co.uk/homes-not-hospitals

[25] The independent review commissioned by DCCAHS covered a longer time frame so we have attempted to capture figures as accurate for the window of this SAR but without accessing all the source data. We believe the numbers are adequately accurate for the purposes of this finding.

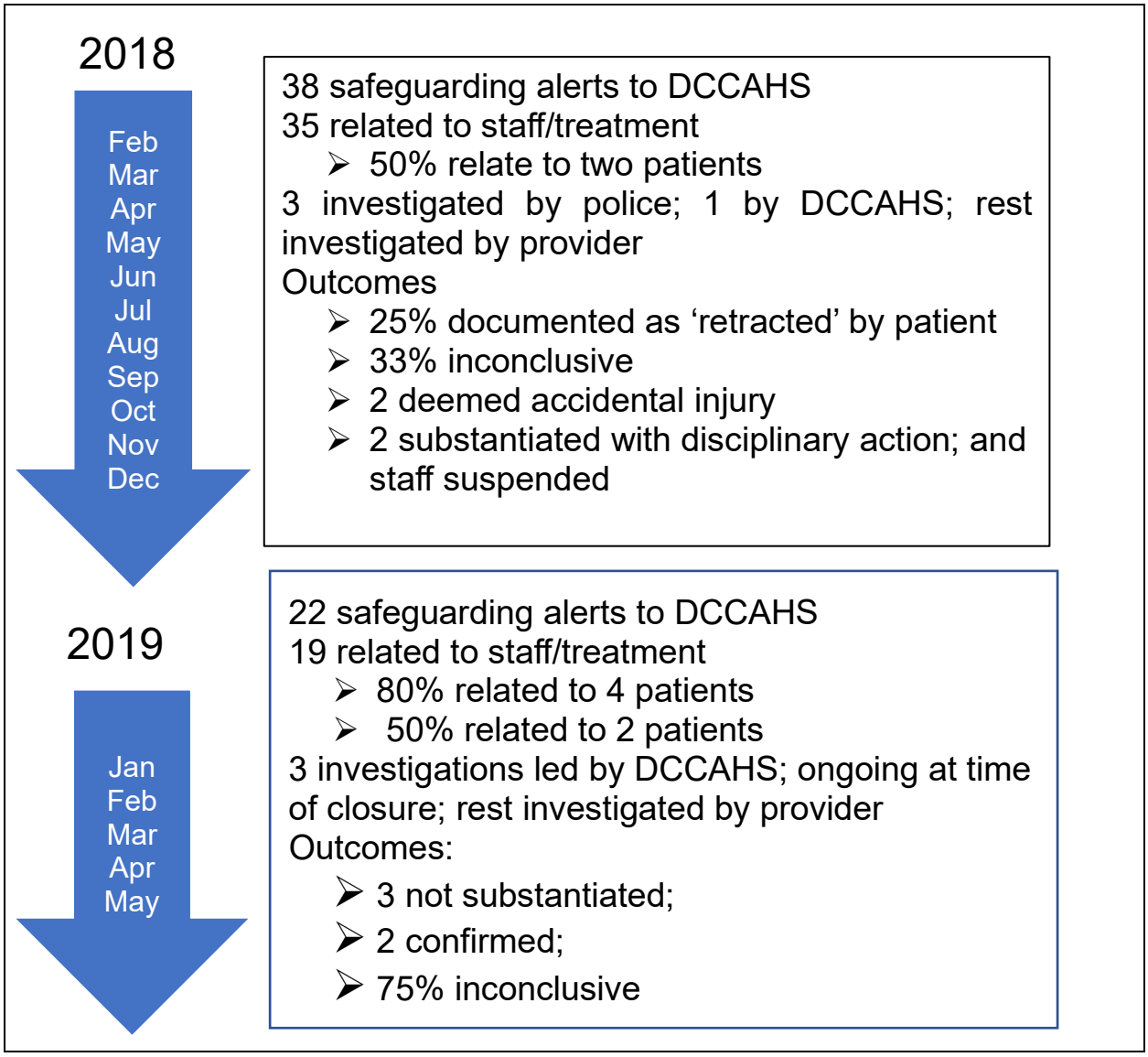
personalised information to which the placing CCGs would have had access, to inform decision making and initial judgements about risk. The letters sent 'frequently refer to the placing agency following up through care co-ordination, care management or their Care Act responsibilities and state that Durham County Council had decided there was no basis for multi-agency safeguarding or Adult Protection'. DCCAHS retention of a pre-Care Act distinction between 'Adult Protection' and lower levels of risk referred to as 's.42s' mean the nature of the request would have been unclear. In addition, DCCAHS were not fully implementing the ADASS out of area guidance to retain a coordinating role, so there was no routine follow-up on activities or outcomes. We have not analysed the placing CCG's responses to these requests in detail; we speak to the effectiveness of placing CCGs roles micro-commissioning roles in Finding 7.

3.10.3 DCCAHS's heavy reliance on the provider also appeared to make sense at the time because a significant portion of the alerts related to just a small number of people who were known to often make allegations of abuse against staff, many of which were then reported to be untrue, often these patients would also retract the allegations. In 2018, of the 38 alerts, half related to two patients. A quarter were logged as retracted by the patient and a third deemed inconclusive, which was taken to remove the need for any further enquiries. In 2019, of the 22 alerts, four-fifths related to four patients and half related to two patients. Three quarters were deemed inconclusive, which was interpreted as removing the need for any further enquiries. The fact that some patients made many complaints and regularly made allegations was probably a factor that resulted in some allegations being inadequately investigated.

3.10.4 In relation to these individuals, Whorlton Hall had 'allegation management plans' in place but the independent internal review of DCCAHS, states that DCCAHS had seemingly little specific clarity about how these were to be managed, including what counted as a retraction, who and how one would be determined. This has serious implications for carrying out the statutory safeguarding function of the host authority. Further, even in instances where DCCAHS staff logged concerns about how the management at Whorlton Hall were determining whether an allegation had been 'retracted', these were not followed through with any authority. This left the individuals, possibly at highest risk of abuse, least protected by statutory safeguarding functions, and without the independent, third-party critical review of the evidence and evaluation that should occur.

3.10.5 Another consequence of not progressing most safeguarding alerts received to s.42 enquiries, was that there were missed opportunities to focus on hearing the voices of people living at Whorlton Hall and understanding what they were communicating when alerts were raised. In a s.42 enquiry, individuals would have had a statutory right to an advocate, to enable their contribution to the safeguarding enquiry. Yet it is also doubtful that this would have resulted in any meaningful communication or advocacy. As we evidence in Finding 3, the advocate would have been engaged on an issue specific basis, without any on-going professional relationship with the person; it would not have been someone who knew them well or was skilled in communicating with them or reading their behaviour for signs of change or distress. Similarly, such professionals were not standardly available from the placing CCG or, where relevant, the linked local authority despite it being a statutory requirement to provide advocacy to people in relation to safeguarding enquiries.

TABLE 3. SUMMARY OF SAFEGUARDING ALERTS IN TIME PERIOD OF REVIEW



3.10.6 Where safeguarding enquiries were initiated, these deficits were, unfortunately, rarely rectified as there was insufficient multi-agency working. When they were initiated, they tended to be investigated by the police on a single-agency basis. When the police decided no further action was needed, based on insufficient evidence to substantiate, or pursue prosecutions, this was wrongly taken by DCCAHS as evidence that there were no safeguarding concerns or need for protection. Again, in these cases, opportunities to try to hear the voices of the individuals, and appreciate their day-to-day experiences were missed. As stated above, however, even if DCCAHS had been fully implementing the spirit of the Care Act guidance regarding person-centred, outcomes focused safeguarding in relation to Whorlton Hall, the lack of a named social worker or long-term advocate for the individual, who really knew and cared for them, means it seems highly likely they would again have ended up reliant on the provider for information and interpretation, and ultimately a judgement about whether the person had suffered harm or needed protective action.

3.11 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.11.1 Input from the Expert Panel supporting this SAR suggested that the experiences of families of people with learning disabilities and/or autistic people in specialist and hospital settings resonate with this finding. A common pattern reportedly experienced by families is that they raise concerns with the local authority about abuse, who ask the provider to investigate, which invariably finds the concerns are not substantiated. It appears a common family view therefore that their reports of abuse are never accepted as true. This was true of physical injury, derogatory language and also of the use of restrictive practices or segregation. There was a strong view across participants of the need for people contributing to responses to safeguarding alerts/concerns to understand good practice as regards distressed behaviours, sensory needs, restraint, segregation and strength-based, positive behavioural approaches such as was integral to the named social worker pilots. Without ready access to someone in this role, who knows the person well, and understands good practice, the host authority is not in a position to provide authoritative challenge to provider views. They can be too easily 'fobbed off' for example, allowing concerns or allegations from certain people to be disregarded as 'serial complainers'. Input also highlighted the difficulties of escalation in these circumstances.

3.11.2 At the time of writing this report there was press coverage of care home staff jailed for degrading acts to vulnerable man. The lawyer representing the man stated that before the criminal charges were brought, one of the convicted carers had been cleared of any wrongdoing by an earlier internal investigation at the care home. [26]

3.11.3 Members of the Expert Panel also highlighted problems (separate from Whorlton Hall) that providers and/or the regulator had in trying to encourage host authorities to be more responsive regarding safeguarding concerns, both in relation to particular individuals and/or establishments as a whole.

3.11.4 Interim findings of the DHSC managed programme of independently chaired case reviews (IC(E)TRs) for people with a learning disability and autistic people detained in long-term segregation (LTS), chaired by Baroness Sheila Hollins, also highlighted the lack of a robust process for safeguarding in such settings or escalation – see Table 4 below.

3.11.5 We were interested to see whether current policy developments and available guidance address this impasse faced by host local authorities, who are responsible for conducting safeguarding enquiries in these contexts, without access to the kinds of resources that would allow a person-centred, outcomes focused process, rather than routinely relying on the provider as the source of information and judgement about safeguarding concerns raised. The ADASS guidance on inter-authority safeguarding adults enquiry and protection arrangements, updated in 2016, is clear that over-all responsibility for coordinating the enquiry remains with the host authority, and will coordinate the enquiry in line with Making Safeguarding Personal principles.[27] However, it also states that the host authority may discuss the concern with the provider and confirms that the statutory guidance is clear that the provider should look into the concerns unless there is a compelling reason why it is inappropriate or unsafe to do this.

[26] https://www.bbc.co.uk/news/uk-england-gloucestershire-60069876
[27] https://www.adass.org.uk/media/5414/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf

These reasons may include:

- Serious conflict of interest on the part of the employer, for example a family-run business where institutional abuse is alleged, or where the manager or owner of the service is implicated.
- Concerns having been raised about non-effective past enquiries or serious, multiple concerns
- A matter that requires investigation by the police.

3.11.6 The guidance does not speak to the innate conflict of interest in specialist hospitals that we have raised in this finding, whereby there is a de facto reliance on the provider for information and judgment about the validity of safeguarding alerts raised.

3.11.7 As regards the role of placing CCGs, the ADASS guidance states that the host authority is expected to liaise with placing authorities, who should provide all relevant information and it may be necessary to assign the placing authority tasks. The guidance states that it is expected that the placing authority/CCG has an established relationship with the adult at risk. They may therefore be the most appropriate organisation to ascertain the person's views and wishes and to undertake initial enquiries with them. If a mental capacity assessment and/or an independent advocate are needed as part of the safeguarding enquiry, the placing authority should confirm with the host authority how this will be provided or commissioned, as part of the planning discussions. However, it does not raise any of the challenges that we have identified in this finding in terms of the lack of sustained- relationship with a professional or limitations of one-off, issue-based advocacy for people with learning disabilities and/or autistic people detained in specialist facilities or mental health hospitals.

3.11.8 The 'Learning disability and autism - Framework for commissioner oversight visits to inpatients'.[28] sets out core requirement for placing CCGs in these contexts, where they are responsible for commissioning and overseeing the individual's placement and pathway of care back into the community, and for undertaking regular commissioning reviews of the individual patient – including new commissioning oversight visits. Regarding safeguarding, the guidance states:

> *'All health professionals have a duty of care to individuals/service users, and should they suspect a safeguarding concern, they should raise this via the relevant local authority in line with the Care Act 2014, as well as the host commissioner.'*

3.11.9 It does not however detail any specific issues to consider in support of any subsequent early investigations or statutory enquiry. The Named Social Worker has the potential to be one that fundamentally strengthens safeguarding for this group of people at such high risk of abuse in specialist hospital settings. However, in neither the original pilots nor the resources developed by BASW Homes not Hospitals campaign is there any detailed reference to safeguarding enquiries.

[28] **https://www.england.nhs.uk/publication/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/**

TABLE 4. IMPROVEMENT AREA: TO COMMISSION SKILLED, SAFE, KIND AND APPROPRIATE PERSON-CENTRED SUPPORT[29]

What we found (through ICETRs)	What we want to see	Immediate actions	Proposals to be developed for inclusion in a final report	DHSC's response
There was a lack of understanding / attention to the legal responsibilities of the differing agencies involved, including safeguarding	Where there are concerns about a person's safety and wellbeing (as perceived by any party) while they are in LTS, a robust escalation process that is transparent and generates clear action and recommendations must take place to ensure that a person's safety is immediately protected.	DHSC's Chief Social worker is examining the safeguarding concerns that were raised as part of the IC(E)TR process. The findings will feed into work to improve the Safeguarding Code of Practice and provide clarity on current safeguarding processes for people in LTS and strengthen the mechanisms for intervention as part of this. The Children's Chief Social Worker at DfE should be engaged in this process. (DHSC, DfE).	There must be a robust process of safeguarding (for children and adults) including a strengthened Code of Practice and escalation process, that is transparent and generates clear action to ensure that a person's safety is immediately protected.	DHSC's Chief Social Worker is developing a practice guide for adult safeguarding teams, which will ensure statutory responses are informed by a consistent and person-centred approach. As part of this, consideration will be given to improving understanding of the safeguarding process and supporting good quality adult safeguarding. DHSC's Chief Social Worker will be engaging with a wide range of sector partners, including the DfE's Chief Social Worker for Children and Families, throughout this process.

[29] https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/the-oversight-panels-interim-conclusions-and-recommendations

3.12 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

3.12.1 The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings. All these people would be potentially affected by this finding about the inadequacy of safeguarding investigations.

3.12.2 The safeguarding adult collection held by NHS Digital only distinguishes safeguarding concerns from s.42 enquiries at a global level, and not differentiated by location or source of risk.[30]

3.12.3 The finding will also affect a wider group of people with learning disabilities and/or who are autistic, who may not currently be in an inpatient setting, but may have had and/or may be at risk of a hospital admission. It may also affect safeguarding responses to people without learning disabilities and/or autistic people who are detained under the Mental Health Act.

3.12.4 There does not appear to be any reason why this finding would have geographical limits. It is therefore likely to be a national issue.

3.13 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.13.1 Effective safeguarding of vulnerable adults is fundamental to the function of the DSAP and its partners. Effective protection of individuals is always reliant on enabling victims of abuse to be able to tell professionals when they are experiencing abuse. This group is the most vulnerable and currently the systems in place do not enable them to be kept safe. For the DSAP to be successful at a basic level, therefore, it is essential that guidance and policy is developed to enable all staff to work effectively with people with learning disabilities and/or are autistic whether they are in a specialist hospital or living in the community.

[30] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2020-21

FINDING 2. CENTRALITY OF A SUSTAINED RELATIONSHIP OF TRUST WITH A PROFESSIONAL TO ENABLE EFFECTIVE SAFEGUARDING RESPONSES FOR INDIVIDUALS IN SPECIALIST HOSPITAL SETTINGS

For individuals in specialist hospital settings, effective safeguarding responses are dependent on a sustained relationship of trust with a named professional, a social worker or long-term, consistent advocate who knows them well, but this rarely exists. In the absence of a sustained relationship of trust with an independent professional, the host local authority must inevitably rely on the provider as a key source of information about safeguarding concerns that are raised, creating potential conflicts of interest. Current guidance and policy developments do not address this impasse, often leaving people most at risk without independent evaluation of abuse allegations raised.

SUMMARY OF SYSTEMIC RISKS

3.13.2 Statutory safeguarding responses are designed to be a key safeguard for adults who are unable to protect themselves against abuse or neglect as a result of their needs for care and support (Care Act 2014 section 42). They place a lead coordinating role on local authorities in the place the abuse, or risk of it, is happening, and a duty to cooperate on other key partner agencies. Given the Winterbourne View SCR recommended that specialist hospitals for people with learning disabilities and/or who are autistic should be considered high risk services, where patients are at risk of receiving abusive and restrictive practices, one can argue that all safeguarding alerts or concerns coming from such an institution should be automatically triaged[31] as high risk. Finding 2 has highlighted a pattern of the opposite occurring.

3.13.3 Many safeguarding concerns raised do not trigger a statutory s.42 safeguarding enquiry and are instead closed down after an initial investigation phase.[32] Key here is a lack of ongoing professional relationship for individuals, with somebody who knows them well, cares about them, is skilled in communicating with them (and reading their behaviour for signs of distress), who can advocate for them, and provide the host local authority with useful information at the early triaging stage. This leads to there being a de facto reliance on the specialist hospitals' staff/management as the source of key information about patients when responding to safeguarding concerns. This is accentuated by the 'holistic' package of care and support that tends to be provided in an independent specialist hospital which means that psychiatric and psychological opinions also all originate from a single provider, and even advocates are often funded by the provider too. Together this provides the opportunity for a "perfect storm", whereby the adults most at risk of abuse, and of not being heard if they do try to tell someone, are most reliant on their provider to ensure their safety with limited independent scrutiny.

3.13.4 There are two potential professionals who could fill this relationship of trust (although having both would be ideal) but neither are currently resourced to do so:

[31] Initial assessment to determine the levels of risk

[32] A Section 42 enquiry must take place if there is reason to believe that abuse or neglect is taking place or is at risk of taking place, and the local authority believes that an enquiry is needed to help it to decide what action to take to support and protect the person in question.

named social workers as piloted, or long-term advocates of the kind statutory advocacy currently does not cater for (see Finding 3). This creates innate and significant challenges in conducting effective safeguarding responses. Yet there does not seem to be any recognition of this fact in available guidance either in the Association of Directors of Adult Social Services (ADASS) guidance (2016), on out of area safeguarding arrangements, or in NHS England and NHS Improvement's (NHSE/I's) more recent host commissioner and placing commissioner guidance, or support and guidance in how best to work together in such circumstances. At worst, this leaves a safeguarding system reliant on CCTV as the only source of evidence that routinely triggers a response. This may reduce the false-positive responses, but will leave many false-negatives, even where the person, their family members or staff are shouting loudly for help.

Questions for the DSAP and partners to consider:

- What are the forums/opportunities that DSAP can use to raise the centrality to effective safeguarding specifically, of a long-term relationship of trust with a professional who knows the person well, at a national level?
- Has DHSC responded to the British Association of Social Workers (BASW) calls for the named social worker pilot to be rolled out nationally for people with learning disabilities and/or autistic people who are in, or at risk of admission to specialist facilities?
- How might the named social worker role be better integrated into statutory safeguarding processes and the key relevance of the role to effective safeguarding be better highlighted in Job Descriptions and other linked resources?
- Is there a need locally, regionally, or nationally for specific procedures or guidance regarding how to respond to safeguarding concerns raised about/from specialist facilities and specialist hospitals for people with learning disabilities and/or autistic people, given this finding?
- Do ADASS have plans to update the 2016 out of area guidance in light of the Host Commissioner Guidance, creating the possibility to speak to this finding?
- Do validated risk assessment tools exist anywhere that are explicitly designed to address safeguarding concerns in establishments such as secure hospitals?

3.14 FINDING 3. AN ILLUSION OF ADVOCACY PROVISION FOR PEOPLE WITH LEARNING DISABILITIES, AND/OR WHO ARE AUTISTIC, AND WHO ARE INPATIENTS OR AT RISK OF BEING ADMITTED TO SPECIALIST HOSPITAL

3.14.1 Finding 3 **Headline: Current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates, are inadequate for people with learning disabilities and/or who are autistic, who are in-patients in specialist mental health hospitals or who are at risk of becoming in-patients. This leaves people in the most high-risk settings, the least well served and creates a false security that advocacy is in place.**

3.15 CONTEXT

3.15.1 **Definition** Advocacy can be defined as:

> *'Advocacy is taking action to help people say what they want, secure their rights, represent their interests, and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.'* [33]

3.15.2 **Statutory vs. non-statutory advocacy** There are different types of advocacy. 'Statutory advocacy' is advocacy that must always be provided by law to people who meet the eligibility criteria. In contrast, extra advocacy is available which is sometimes called, 'generic' or 'general advocacy' or non-statutory advocacy and varies between areas.

3.15.3 Statutory Advocacy includes advocacy for:

- for anyone making a complaint about an NHS service (NHS complaints advocacy)
- for (almost) anyone detained under the Mental Health Act to get help understanding their rights and issues related to their mental health and treatment. (Independent Mental Health Advocacy IMHA)
- for decisions about care or support when it is difficult for the person to be involved, and friends and family aren't there to help (Care Act advocacy)
- for decisions related to safeguarding when it is difficult for the person to be involved in a Safeguarding Enquiry (s.42) under the Care Act
- to contribute to a Safeguarding Adult Review where it would be difficult for the person and/or their family to contribute otherwise
- for accommodation and treatment decisions, if you do not have decision-making capacity or friends or family (Independent Mental Capacity Advocacy IMCA)
- for people who are deprived of their liberty in a community or domestic setting (Rule 1.2 representative) Rule 1.2 representatives are not necessarily advocates. They could well be the person's friends and family. People who are subject to a Deprivation of Liberty Safeguards Authorisation are also entitled to an IMCA, unless they have a paid Relevant Person's Representative (RPR).

[33] The Advocacy Code of Practice, https://www.blackbeltadvocacy.com/what-is-advocacy

- when people are deprived of their liberty in a care home or hospital, under the Mental Capacity Act 2005 deprivation of liberty safeguards, an RPR must be appointed. This role was originally envisioned as being undertaken by family and often it is. However, sometimes family are unable to take on this role or they are considered inappropriate, and an advocate might perform this role as a 'paid RPR'. RPRs must maintain contact with the person and support and represent them throughout the duration of any deprivation of liberty authorisation.

3.15.4 Advocates providing statutory advocacy have clearly defined roles and functions. They support specific people in pre-defined circumstances with particular decisions or activities. Advocacy therefore tends to be episodic and focused on specific issues.

3.15.5 **Instructed vs. non-instructed advocacy**. Instructed advocacy means the person is able to state their wishes as well as the actions they would like the advocate to take, for example write a letter on their behalf, represent them in meetings or contact professionals in their lives. Non-instructed advocacy takes place when a person is unable to instruct an advocate due to communication issues, comprehension, or ability, this might be because they have dementia, a learning difficulty, be acutely unwell (mentally or physically) or have a brain injury. The non-instructed advocate seeks to ensure the persons wishes, views and beliefs are still represented and ensures their rights are secured.

3.15.6 **Who commissions and funds advocacy**. The local authority in which the service is located has a duty to commission and fund IMHA, IMCA and Care Act advocacy, including safeguarding. However, NHS and private hospital providers also commission and fund advocacy provision. This usually excludes advocacy required by law. The result is that people often must relate to more than one advocate, and it is not unusual for there to be several advocacy providers in a single hospital or hospital ward, with different remits

3.15.7 **Provider commissioned advocacy**. Hospital providers are more likely to commission advocacy because of detail contained in NHS standard specifications for low and medium secure services, as well as high secure services. These indicate that the provider is responsible for the provision of independent advocacy. Because local authority provisions are often not adequately resourced to achieve this, the providers instead commission it themselves rather than be penalised for gaps that are not within their control. However, this contradicts the emphasis on independence as a principle of good practice in advocacy provision – as embedded in the national Advocacy Quality Performance Mark (QPM) benchmarking scheme, its QPM standards and the advocacy charter.[34]

3.15.8 **Quality standards.** The provision of independent advocacy, in all its forms is based on a set of underpinning principles and values. These are set out in The Advocacy Charter which Action for Advocacy developed and published in July 2002. Since then NDTi has updated it in 2014 and again in 2018.

3.15.9 **Mental Health Act revisions to IMHA provisions.** The Government white

[34] https://qualityadvocacy.org.uk/home/introducing-the-advocacy-quality-performance-mark/

paper 'Reforming the Mental Health Act' published in August 2021[35] makes recommendations to strengthen the role of Independent Mental Health Advocates stating that all inpatients would be entitled to advocacy without having to ask, and that this would help people to be involved in their care and to exercise their rights. The White Paper does not recommend a right to advocacy before detention, on the grounds that it might be impracticable, but does recommend piloting this approach. The white paper also recommends improving the quality of advocacy through improved training, regulation, and better commissioning. There is little discussion about the resourcing of advocacy in the white paper. Whilst these potential improvements for advocacy for mentally ill people are to be welcomed, it is noteworthy that there is the possibility that people with learning disability and/or who are autistic will be removed from the remit of the Mental Health Act meaning that they would not benefit from these improvements. Currently the Government has not yet decided what action to take.

3.15.10 **Advocacy and safeguarding in 'closed' provider environments.** The ADASS guidance, 'Strengthening the role of advocacy in Making Safeguarding Personal' highlights the role advocates play in strengthening safeguarding arrangements particularly in closed settings such as hospitals.

> *'Advocates have a regular presence in closed provider environments such as care homes, hospitals, mental health wards and treatment and assessment units. They provide additional safeguards in the prevention and identification of abuse and/or neglect. The potential contribution of advocacy to safeguarding in these environments can be further supported and enabled, including through commissioning of advocacy that has a focus on and supports this important aspect of the role.' And furthermore, 'Through their role in care provider services, advocacy providers can identify patterns and themes of safeguarding issues and concerns. There needs to be robust practice as well as systems in place across agencies to make sure these are raised appropriately with health and social care teams, commissioners, contract managers*'.[36]

3.16 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.16.1 There were two sources of advocacy for people living at Whorlton Hall. County Durham local authority had, since 2009, commissioned the independent national advocacy provider that we will call **External Advocacy Provider** to provide statutory advocacy across County Durham, including to Whorlton Hall. Patients at Whorlton Hall could directly refer themselves to the External Advocacy Provider, or the Whorlton Hall staff, who should have had an awareness of the criteria for advocacy could refer patients. The External Advocacy Provider reinforced knowledge of the service by promotion and training. In addition, Danshell commissioned a service that Cygnet later continued, of 'internal' independent advocacy provision from a different independent national advocacy

[35] https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act

[36] https://www.local.gov.uk/publications/strengthening-role-advocacy-making-safeguarding-personal

provider that we will call **Internal Advocacy Provider**. They provided generic or non-statutory advocacy services to people living at Whorlton Hall from 2011. Services provided by the two agencies were not as effective in supporting people as might have appeared or been expected.

3.16.2 At the External Advocacy Provider, work was allocated on a geographical basis, with one advocate assuming responsibility for an area including County Durham. This meant that there was only one advocate covering each establishment, including Whorlton Hall but there was no system for deputising or providing contingency cover when needed. From September 2018, the advocate was unavailable for a prolonged period, which meant that there was at this time no statutory advocacy provision for people living in Whorlton Hall. The independent internal review commissioned by External Advocacy Provider after Panorama noted that during 2019, only two visits were made to the hospital. Some patients had not yet engaged with the Advocate despite being referred over 12 months earlier.

3.16.3 The independent internal review of the External Advocacy Provider also identified significant problems in the type and quality of provision. This included:

- **Poor standards of competence and professionalism**
    - No clear knowledge of the Good Practice Manual or familiarity with the Advocacy Quality Performance Mark (QPM) standards (despite the organisation only recently having been awarded the QPM).
    - No contact with clients' families to get information about people's preferences, communication styles and presentation of client in different moods. This is flagged in the QPM standards for people who are non-verbal or have significant communication challenges.
    - No proficiency with communication aids such as cards, Makaton, visual boards to enable communication with clients.
    - Limited knowledge of what good care provision should look like, and therefore no recognition of oppressive behaviour or noncompliance with care plans as a concern
    - Limited safeguarding awareness, lacking awareness of negative behaviours or markers for institutional abuse
    - Uncritical acceptance of Whorlton Hall staffs' risk assessment about access to individuals; justifications for restraint.
- **Lack of supervision or oversight**
    - Challenges with staffing at management level over the last 12-18 months, had seen supervision reduce and the quality of supervision decline, with staff feeling that the team self-manage.
- **Gaps in basic processes**:
    - No template for notes made by advocates clarifying what is expected
    - No timescales for when handwritten notes are entered into the case management system
    - No guidance for escalating and managing situations when they were not able to see a client
    - Lack of process for handover of a client if they move, or effort to allow the advocate to move with the person to sustain relationships and trust

3.16.4 The internal advocacy provision commissioned by Danshell and later Cygnet Health Care, was also sparse. The internal investigation conducted by the Internal Advocacy Provider described that their service delivered approximately the equivalent of one day per week of advocacy, which included time spent with and on behalf of people who were resident at Whorlton Hall. One advocate undertook most of the work. A second advocate and a Managing Advocate also delivered some advocacy there, when the regular advocate was unavailable for a prolonged period. This Managing Advocate provided the line management for most of the time. The Service Manager, who was employed on a part time basis working exclusively on this contract provided oversight, and at times direct line management.

3.16.5 The internal review of the internal advocacy provision was highly critical, including:

- **Poor standards of competence and professionalism**
    - Very poor-quality record keeping
    - Not seeing individual clients privately on a consistent basis; with, for some patients, advocates prioritising attending MDT meetings over individual meetings with clients.
    - Not complying with the Advocacy Provider's safeguarding policy. Rather than personally verifying with the local authority when the advocate had already been told safeguarding alerts had been provided to the local authority, the advocate usually relied on assurances from managers at Whorlton Hall and on inspecting the hospital's records
    - From 2017, no evidence that advocates challenged statutory authorities about the action which they were taking on safeguarding concerns, as required by the advocacy provider's policy and little indication of expectations on the part of advocates that safeguarding alerts sent to local authorities would lead to inquiries or investigations.
    - No clear evidence of advocates checking on the existence or contents of 'allegations management plans' or 'allegations care plans', nor checking if the local authority agreed with them or challenges to the wisdom of them.
    - Little focused questioning by advocates on the use of restraint.
- **Lack of effective supervision or oversight**
    - The service was insufficiently integrated into the Internal Advocacy Provider's usual operations with dedicated part-time service manager and insufficient senior management over-sight to prevent a shift in norms and standards.

3.17 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.17.1 When these issues were discussed as part of this SAR both the External Advocacy Provider and the Internal Advocacy Provider highlighted resource shortfalls as, in part, providing explanatory context for the limited provision of advocacy to people living at Whorlton Hall. The External Advocacy Provider highlighted the wider context in which the organisation's advocacy services were delivered including their remit and relationship with other commissioned advocacy services and each establishment where people

eligible for statutory advocacy resided. For example, there were 164 nursing, residential homes, hospitals, or units across County Durham where potential users of advocacy resided so it was always a challenge to ensure they had a presence in each site.

3.17.2 The Internal Advocacy Provider clarified, in their internal report, that they had sought to negotiate an increase in funding to pay for their service over a protracted period, as they were concerned that the funding level was insufficient to provide the service required by people who were in-patients at Whorlton Hall, including recognising the risks which they faced. These negotiations led to notice being served upon them in February 2019. Input from Cygnet Health Care for this SAR, stated that they increased the advocacy service provision at Whorlton Hall, but with an alternative provider. At the request of Cygnet Health Care, the Internal Advocacy Provider agreed two separate extensions to their contract to cover the service until the new provider was ready to take the service on. Their contract ended on 31st May 2019.

3.17.3 The Internal Advocacy Provider stressed that the resource shortfall and consequent limited time available might have exacerbated some of the existing issues, but these were not merely ones of resource level but also linked to the contractual arrangements. They state, 'It is possible that the funding of the service by the service provider negatively impacted the delivery arrangements and psychological independence of [our] staff and managers'. While it could not be categorically proved, they noted that: 'it may be speculated that it is non-coincidental that a highly critical attitude to the advocacy service on the part of the provider (then Danshell) appears to have been adopted shortly after major concerns being expressed by [the Internal Advocacy provider] to their senior management about their service provision."

3.17.4 As well as a resource shortfall, the compromise of independence created by the contractual arrangements, one final factor, indicates that the limitations in Whorlton Hall were not a one-off. Prior to the alleged abuse at Whorlton Hall becoming known, the Internal Advocacy Provider had already instigated a change programme, including:

- The implementation of service standards
- Ensuring absolute clarity of roles and responsibilities of operational managers and practitioners
- A review of end-to-end processes and systems for safeguarding, including recording, reporting, follow through, supervision management and monitoring
- The development of new training and professional development programme, to include the 'hard' and 'soft' skills required of advocates working in in patient mental health environments with people with learning disabilities and autistic people
- Strengthening the approach to quality assurance

3.17.5 The issues raised in provision at Whorlton Hall were not therefore a one-off to either advocacy provider. Evidence also exists to show that the limitations to the extent and quality of advocacy provision for this cohort of people extends to other advocacy providers. For example, CQC's 'Out of sight – who cares report'(CQC 2020) brought into focus the significant limitations to the provision of advocacy more broadly for people with learning disabilities and/or who are autistic, or at risk of being admitted to specialist mental health hospitals. Their report, requested by the Secretary of State for Health and Social Care, presented analysis of a review specifically focused on autistic people, and people with a learning disability and/or mental health condition who may be subject to restrictive

practices because of ongoing concerns in this area. Regarding advocacy, the review found:

> *It can be extremely difficult for people and their families to influence changes to care so that they have their human rights upheld. People having access to independent advocacy is crucially important, but the availability and quality of advocacy was very variable (2020: page).*

3.17.6 Specifically, the CQC review found:

- Access to high-quality advocacy varied across the hospitals we visited, and that the role of an advocate was not consistent.
- There was some confusion between the provider and commissioner about who the advocate was, or which organisation provided the services. This led to people being denied access to the service. In some cases, there was no evidence that advocacy had been offered to people. Even where people were allocated an advocate, they were not always engaged in decisions about the person's care.
- There were examples of where the advocate was not informed of certain people on the ward.
- When people did have access to advocates, there were examples where advocacy was of a poor quality, where advocates were not upholding people's rights.
- Advocates were also under pressure themselves and felt they did not have enough time to support everyone that they were responsible for.
- One reviewer noted: "IMHAs [Independent Mental Health Advocates] feel they are not able to have enough time to advocate fully for people at [hospital]. They have been asked to increase their input by the [clinical commissioning group] but there is no additional funding available."

3.17.7 The pilot Enhanced Health and Welfare Checks conducted after the closure of Whorlton Hall also found that advocacy provision was problematic:[37]

- Quality of advocacy across the services visited, both in terms of access and quality was very variable:
- Majority of services were provided by Statutory services (IMHAS and IMCAS)
- In most cases Advocacy was commissioned by the provider services
- In some services Advocates worked on behalf of several patients on the ward which raised issues around objectivity and effectiveness
- Overall, the advocacy provided was not considered independent or effective, and highlighted:
- Issues around visibility, availability, and inconsistency of advocacy
- Families were not at the forefront of their relative's care and support, e.g. reports of families feeling ignored and isolated
- Lack of data and reporting on advocacy within services
- Lack of training and support for families to act as advocates.[38]

[37] Kitching, Margaret; From a Powerpoint Shared with lead reviewers as part of the SAR.
[38] Kitching, Margaret;. 2021. "Family Advocacy Introductions. Shared with lead reviewers as part of the SAR.

3.17.8 In response to CQC's 'Out of sight – who cares report' two prominent independent advocacy providers produced a briefing paper setting out the key issues and suggestions of how to address the problems. This was part of an effort to get the advocacy community to come together to have an honest discussion and to a) get specificity on what these issues are b) create a plan to fix and address these problems. Again, this demonstrates that the inadequacy of advocacy provision is a systemic issue.

3.17.9 Key issues raised in the briefing paper reflected many of the issues seen in Whorlton Hall, further indicating that these are underlying issues and not ones restricted to that particular time, or to providers and commissioners involved in Whorlton Hall.

3.17.10 The briefing sets out a coherent picture of how advocacy provision needs to be enhanced for all for all people with learning disabilities and/or who are autistic, who are in-patients and recommend: Key points are summarised below. Advocacy must be:

- Accessible
- Highly competent. Advocates must be:
    - be skilled to communicate effectively with people with autism and learning disabilities
    - understand trauma
    - understand the potential of quality community-based provision
    - be able to challenge decisions in clinical and specialist setting
    - be skilled in identifying, raising and escalating safeguarding issues
    - understand the use and misuse of segregation and restraint
    - work across legislation and advocacy roles (Mental Health Act, Mental Capacity Act, Deprivations of Liberty, and Care Act)
    - be skilled in using non-instructed advocacy.
- Holistic: people should only need to form a working relationship with a single advocate, who works across different statutory duties, and focuses on all areas of a person's life.
- Urgent and persistent: Support must be available at such intensity and duration as required to enable the person to move on from their current situation.
- Independent and perceived to be so: It should not be funded by the service provider. Any conflicts of interest need to be transparent and managed.
- Connecting and navigating: Advocates must work effectively and supportively in tandem with families, and support the person to access expert and legal advice, and to navigate complex multi-agency professional and funding systems
- Well supported and managed roles: Advocates need appropriate supervision, training and in-depth learning and development to enable them to be confident, skilled, robust in their work, knowledgeable and resilient
- Preventative and on-going advocacy: access to advocacy should be available to help maintain community-based support and prevent admission.

3.17.11 The recommendations are copied in full below

Recommendations

1. Advocacy for people in long term segregation must be provided on an opt-out basis

Opt-out is essential to make sure that more people in long term segregation receive the timely advocacy support and representation they need for their voice to be heard and their rights upheld. Opt-out only strengthens people's rights. A person can still make a free choice to not have the support of an advocate but opt-out dismantles barriers that stop many people getting needed support. Opt-out is recommended by the Mental Health Act review and is already in place under the Mental Health Measure in Wales.

2. The provision of advocacy must be on a continuous, frequent, and regular basis until the person is settled in appropriate community-based provision

This contrasts with much existing provision which is episodic and focused on specific issues. The fact that a person is in long-term segregation is self-evidently an issue which requires attention until it is resolved. The advocate must be able to work flexibly with the person and not be restricted by the types of issues they can support with.

3. Service specifications for advocacy provision must incorporate the capabilities and approaches noted above: accessible, highly competent, independent, holistic, connecting, supported, and joined up.

4. Enhanced access to advocacy of the nature outlined in this paper ought to be provided to people with learning disabilities, autism, or both

• who are in-patients – not solely those in long-term segregation

• who are at risk of becoming in-patients, in order to help pre-empt and prevent admission and the use of long-term segregation

5. Resources need to be identified and allocated. Advocacy of this nature, intensity and duration is necessarily more costly to provide than other types of advocacy. The current nature of contracting makes it very difficult to ensure the level of service required because it is based on working with someone for few hours.

6. There should be national agreement on the most appropriate form of commissioning of advocacy for people with learning disabilities, autism or both who are in long term segregation, and for the wider population of people who are in-patients.

7. Additional support for families must be made available. The advocacy service must work closely and effectively with family members, other than in the rare event that the person does not wish this to happen. Additionally, support should be made available specifically to family members, based on what families want and need. This may include advocacy provision specifically for relatives.

8. Monitoring the provision of advocacy should be reviewed and improved. There is no nationally available reliable data on the uptake of advocacy. This must be addressed. Clear data is vital to assessing the extent to which this essential safeguard to people's human rights is in place across the country and to inform action.

3.17.12 A number of agencies responding to the white paper 'Reforming the Mental Health Act' addressed concerns about the resourcing and effectiveness of current and proposed advocacy services. Whilst broadly most agencies welcomed the strengthening of the role of the IMHA there was skepticism about whether the resources were available to provide the enhanced service.

3.17.13 NHSE/I has also been running a project to carry out a review of advocacy for children, young people, adults with a learning disability and autistic people in inpatient settings and parent carers. The review has been split into four parts:

- Advocacy as a whole and commissioning

- Adult inpatients and self-advocacy
- Young people and families who advocate
- Families advocating for adults

3.17.14 The project has included practical pilot projects to improve the range and quality of advocacy available, that can be evaluated to see what difference they made. Priorities are people in long-term segregation and people in hospital for 5 years or more (2 years for children and young people). There are

- Projects that will benefit other patients and families who advocate as well e.g.
- Projects to increase existing advocacy
- Projects to increase self and peer advocacy
- Projects to support families who advocate for family members

3.17.15 Budget was allocated from Spending Review monies, to be carried out by end of March 2022. Overall project managed by the Improving Quality team, in the national Learning Disability and Autism programme.[39]

3.18 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

3.18.1 The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings. All these people would be potentially affected by this finding about the inadequacy of advocacy provision.

3.18.2 The finding will also affect a wider group of people with learning disability and/or who are autistic, who may not currently be in an inpatient setting, but may have had and/or may be at risk of a hospital admission.

3.18.3 There does not appear to be any reason this finding would have geographical limits. It is therefore likely to be a national issue.

3.19 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.19.1 Since the abuse at Winterbourne View Hospital was exposed over ten years ago, it is accepted that hospitals for people with learning disabilities and/or who are autistic are high-risk services i.e., 'places were patients are at high risk of receiving abusive and restrictive practices within indefinite time frames' (Margaret Flynn 2012) In precisely these settings, independent advocacy is needed most. It should make a significant difference: "Advocates… Be the thorn in the side, the critic, the reminder, the complaint and the appeal. You are the safeguard, and you are vital' (Rob Mitchell Tweet 22 December 2021). However, this finding highlights that to date no action has been taken to provide what is needed to deliver consistent and effective advocacy to people in these settings and circumstances. As a result, even where advocacy services exist, they are an illusion of what is needed.

[39] https://www.ndti.org.uk/news/a-review-of-inpatient-advocacy

FINDING 3 AN ILLUSION OF ADVOCACY PROVISION FOR PEOPLE WITH LEARNING DISABILITIES, AND/OR WHO ARE AUTISTIC, AND WHO ARE INPATIENTS OR AT RISK OF BEING ADMITTED TO SPECIALIST HOSPITAL

Current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates, are inadequate for people with learning disabilities and/or who are autistic, who are in-patients in specialist mental health hospitals or who are at risk of becoming in-patients. This leaves people in the most high-risk settings, the least well served and creates a false security that advocacy is in place.

SUMMARY OF SYSTEMIC RISKS:

The concept of 'requisite variety' highlights that a system must have available a variety of responses that is as great as the variety of circumstances it confronts.[40]

This finding highlights a notable gap between the provision of advocacy services and the needs of the Transforming Care 'cohort' of people with a learning disability and/or who are autistic in specialist mental health facilities or at risk of admission. This is perhaps not surprising given that the commissioning and oversight of advocacy does not reflect a differentiation of levels of seriousness of a person's circumstances, or extent of their communication difficulties. This means that the time, skills of and support to individual advocates are often not adequate to the task. It increases the chances that only an illusion of advocacy provision can be provided for people in the highest risk institutions and circumstances, without anyone noticing until after an incident of abuse triggers a review.

Questions for the DSAP and partners to consider:

- Is there agreement among DSAP members in principle of the need for enhanced advocacy provision for people with learning disabilities, and/or who are autistic who are inpatients, at risk of being admitted to a specialist mental health facility, that is:
  - a continuous, frequent, and regular basic provision (rather than it being episodic, and in response only to particular issues)?
  - delivered by highly competent professionals who specialise in working with people in these exact circumstances, and covering all statutory provisions in the single relationship
- How can an enhanced advocacy offer be secured locally in County Durham for people with learning disabilities, who are autistic or both, who are inpatients, or at risk of being admitted to a specialist residential facility?
- What are the opportunities and avenues for the DSAP to raise this finding at a national level and to lobby for the need for agreement on a commissioning and funding solution?
- How can there be improvements in data collection locally about the uptake of advocacy?
- How will the DSAP know if the availability, quality and effectiveness of statutory advocacy provision for this group of people has improved in the Durham area?
- What are the opportunities to feed this finding into NHSE/I's project on advocacy?

[40] Munro, E (2011). The Munro Review of Child Protection: Final Report. A child-centred system. London; DfE https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf .

3.20 FINDING 4. NEED FOR CLOSER WORKING BETWEEN CARE QUALITY COMMISSION AND LOCAL AUTHORITIES TO IMPROVE OUTCOMES FROM ORGANISATIONAL SAFEGUARDING ENQUIRIES IN SPECIALIST HOSPITALS

3.20.1 Finding 4 **Headline: Current guidance does not articulate with adequate clarity the necessary collaboration between CQC and host local authorities where there are quality issues that become organisational safeguarding concerns about specialist hospitals. This means that local authorities with a safeguarding role for people living in settings in their area undertake repetitive cycles of organisational safeguarding enquiries which result in them telling providers to do what they should already be doing, and which have little sustained effect on improving the experiences of patients. This risks perverting the purpose of safeguarding and incurs significant cost in terms of resource and time for the host authorities but has little impact on the providers or benefit to the people living in the specialist hospitals.**

3.21 CONTEXT

MANAGING ALLEGATIONS OF ORGANISATIONAL ABUSE

3.21.1 Organisational abuse is an umbrella term, defined as occurring:

> *when the routines, systems and regimes of an organisation result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk' (SCIE 2010).*

3.21.2 The definition indicates the interface and interdependence between the quality of care in health and social care settings and organisational safeguarding concerns.

3.21.3 The Care and Support Statutory Guidance outlines that safeguarding enquiries are not a substitute for:

- Providers' responsibilities to provide safe and high-quality care and support.
- Commissioners regularly assuring themselves of the safety and effectiveness of commissioned services.
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action.

3.21.4 The aim of every commissioner and service provider should be the delivery of effective, high-quality care and support for every individual. If the quality of a service falls short, adults may be put at risk of abuse or neglect.

3.21.5 Effective partnerships between safeguarding and commissioning functions including quality assurance and contract monitoring, together with an understanding of their interdependent roles and responsibilities, are therefore essential to support a positive culture of cooperation and information sharing. Working in partnership, can assist with early identification when health and social care providers are at risk of not meeting required standards that might lead to wider concerns and the need for organisational safeguarding interventions.

3.21.6 The circumstances in which an enquiry into organisational abuse may be

required can include, but are not limited to:

- Criminal offences specific to adult safeguarding, for example physical or sexual assault or rape, psychological abuse or hate crime, wilful neglect, unlawful imprisonment, theft and fraud and certain forms of discrimination.
- Where it is suspected that several adults have been abused by the same person, or group of people in the same setting.
- Where there are indicators from safeguarding activities relating to an individual adult that other adults are at risk of significant harm.
- Where patterns or trends are emerging which suggests serious concerns about poor quality of care from a provider.
- Where a provider has failed to engage with other safeguarding activities resulting in continued harm or continued risk of harm to one or more adults.
- Where there is evidence that despite contract monitoring, quality improvement and/or provider action following CQC regulatory action there remains insufficient improvements within the service, resulting in continued harm or continued risk of harm to one or more adults.

3.21.7 Two challenges emerge. Firstly, in the context of mental health hospitals and specialist residential facilities until recently there was no single commissioner of services (the effect of this is discussed further in finding 7). Instead, a variety of CCGs and/or local authorities, dispersed geographically, would spot-purchase services from the hospital. While the quality and contract monitoring of the spot-purchased provision continued to be required, there was no mechanism through which to gain an overview of quality of the provider.

3.21.8 Secondly, organisational safeguarding enquiries usually result in action plans and monitoring about the basics of good practice to achieve required standards. However, the host local authority has no enforcement power in relation to a specialist hospital whose services they do not commission. This can lead to intermittent cycles of safeguarding activity and limited improvements with only deaths or a high-profile exposure bringing about more substantive changes.

HOST-COMMISSIONER GUIDANCE

3.21.9 In this context, in January 2021 the Government published two sets of guidance aimed at strengthening the oversight and monitoring of the quality of care in learning disability units entitled 'Learning Disability and Autism – Host Commissioner Guidance' and 'Learning disability and autism - Framework for commissioner oversight visits to inpatients'.[41] This guidance for CCGs was intended to strengthen the oversight and monitoring of the quality of care in learning disability units to ensure people were not '*out of sight and out of mind'.* [42] and to strengthen the ability to have an overview of a single provider. The two guidance documents set out core requirement for CCGs.

3.21.10 The 'Host Commissioner Guidance' provides new responsibilities for CCGs to

[41] https://www.england.nhs.uk/publication/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/

[42] https://healthcareleadernews.com/news/ccgs-given-march-deadline-to-implement-host-commissioner-role-for-learning-disability-units/

act as 'Host commissioners' which requires that they develop systems to maintain effective quality surveillance of all independent hospitals within their geographical boundaries. Host commissioners must:

- Maintain quality surveillance of Independent Hospitals in their geographic area.
- Be the point of contact for all placing CCGs in relation to quality assurance queries.
- Collate intelligence and triangulate information to address any quality or safety issues.
- Share and request intelligence across commissioners placing people in the area.

3.21.11 Alongside this the 'Framework for commissioner oversight visits to inpatients' strengthens the responsibilities of CCGs who are placing commissioners and who are therefore responsible for commissioning and overseeing the individual's placement and pathway of care back into the community, and for undertaking regular commissioning reviews of the individual patient – including new commissioning oversight visits. Placing commissioners must:

- Talk to the Host CCG prior to admitting a person.
- Retain oversight for the clinical care of people placed.
- Report any quality or governance concerns to the Host CCG.
- Collaborate with the Host CCG when they set up collaborative assurance meetings to share intelligence.

3.21.12 A key component of quality assurance is effective safeguarding arrangements. The 'Host Commissioner Guidance' guidance clearly states that '*All health professionals have a duty of care to patients / service users, and should they suspect a safeguarding concern, should raise this via the relevant local authority in line with the Care Act 2014, as well as [with] the host commissioner'* furthermore that '*Host commissioners must ensure they are familiar with local adult safeguarding referral processes, and that there are defined routes for regular liaison with CCG and Local Authority safeguarding leads regarding care provided at the specialist inpatient unit*.'[43]

3.21.13 The 'Framework for commissioner oversight visits to inpatients' also states, '*All health professionals have a duty of care to individuals/service users, and should they suspect a safeguarding concern, they should raise this via the relevant local authority in line with the Care Act 2014, as well as the host commissioner.*' It continues '*The chair of the local safeguarding adult board should include the host commissioner as a partner when investigating any concerns that have been raised.'* [44]

3.21.14 Both sets of guidance are clear about the duty to raise safeguarding concerns with the host local authority, neither provides any more specifics in terms of how to achieve an effective safeguarding enquiry in these contexts. The guidance is clear about the importance of oversight visits but does not follow this up by clearly enunciating the

[43] https://www.england.nhs.uk/wp-content/uploads/2021/01/Host-commissioner-guidance.pdf
[44] https://www.england.nhs.uk/publication/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/

importance of the personal knowledge and relationship for effective safeguarding.

3.21.15 There is also no information in the guidance about responsibilities for service providers. There is in the commissioner 'Host Commissioner Guidance' a requirement that they '*Ensure there is an interface with the relevant local authority adult social care safeguarding service and also with the Local Safeguarding Adult Board and with local partners so that any identified actual or potential safeguarding concerns are raised with the host local authority and dealt with as appropriate'*. There is not however a similar reference in the 'Framework for commissioner oversight visits to inpatients' which only references the involvement of the local DSAP despite the responsibility for undertaking safeguarding enquiries clearly lying with the Local Authority and the DSAP input being quality assurance.

3.22 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.22.1 In the appraisal synopsis as well as giving an indication as to the limitations of responses to safeguarding concerns about individuals, we also summarised limitations to the response to organisational safeguarding concerns. For the purposes of illustrating this finding, it is important to highlight that these planning meetings were not adequately robust given the nature of criticisms of the service. A range of concerns about the quality of provision, such as staff shortages, lengths of shifts, staff culture and whether Whorlton Hall recorded all incidents and included sufficient information to assure around restraints were put to the Danshell managers. They gave assurances and promised action where necessary, but these were not systematically checked for action or improvement.

3.22.2 There does not appear to have been adequate clarity about acceptable standards and consequences if they were not achieved. Therefore, the boundary between quality improvement activity and safeguarding activity was insufficiently clear. Coordination between DCCAHS and the CQC, which should have helped, was poor. And the Establishment Planning Meetings were discontinued by DCCAHS in February 2019 despite many of the issues raised still being of concern, including staffing levels, and extensive use of agency staff. For the purposes of this finding, what is most important is that the DCCAHS had very limited options in responding to organisational safeguarding issues in such settings, beyond encouraging providers to create and implement action plans. It seems likely therefore, that but for the Panorama programme, DCCAHS would have continued in repetitive stop-start cycles of organisational safeguarding responses, that had been occurring since at least 2016. [45]

[45] We have not looked back at the wider history of organisational safeguarding responses as part of this SAR.

3.23 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.23.1 A recent Safeguarding Adults Review conducted by Margaret Flynn, for Norfolk Safeguarding Adult Board, on the deaths of three people in Jeesal Cawston Park, highlighted the ineffectiveness of safeguarding activity. It stated:

> *The purpose of safeguarding has been subverted to setting out (a) what it is that providers, service commissioners, contract monitors and inspectors should be doing anyway, and (b) reminding these organisations of their remit, powers and enforcement resources.*
>
> *Despite action-planning and promises arising from adult safeguarding activity – of which there is a great deal - it appears that what is achieved is soon eroded. Overall, Norfolk ASSD notes "There is ongoing S.42 enquiry for the [Hospital] chaired by…Director of Social Work. [In spite of] serious concerns regarding this provider [Norfolk ASSD] cannot take any enforcement action – this is the role of the CQC…a repeated pattern of limited improvement followed by a decline in standards which has led to difficulty in identifying the point when more robust action should be taken."*[46]

3.23.2 The number of inpatient services for people with learning disabilities and/or autistic people that have been rated 'inadequate' has more than tripled over the last year – from 4% to 13%.2[47] We do not know how many of those have had repetitive cycles of organisational safeguarding activity of the kind described in Jeesal Cawston Park, or whether the inadequate ratings were closely informed by safeguarding activity.

3.23.3 Input from the Expert Panel suggested that collaboration between CQC's adult social care directorate and local authority safeguarding teams is more routine and embedded. Communication between CQC's hospitals directorate which oversee specialist facilities and mental health hospitals for people with learning disabilities and/or autistic people is less established.

3.24 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

3.24.1 How many local authorities would this impact on? There are 152 local authorities in England[48] with responsibility for investigating safeguarding concerns. As of April 2022, there will be 42 Integrated Care Systems[49] who will be picking up the responsibilities from CCGs for patients placed in specialist hospitals or settings. Whilst there may be differences in how services are delivered across England the basic structures operate under the same guidance so it is probable that the issues raised in this review will apply to all local authorities and ICS.

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[46] https://www.norfolksafeguardingadultsboard.info/assets/SARs/SAR-Joanna-Jon-and-Ben/SAR-Rpt-Joanna-JonBen_FINAL-PUBLICATION02-June2021.pdf

[47] www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf

[48] https://lgiu.org/local-government-facts-and-figures-england/

[49] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/integrated-care-systems-icss

3.25 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.25.1 The most vulnerable people are placed in specialist hospitals, and they are totally dependent on the care they are given there. It is well known that investigating abusive practices in such establishments is notoriously difficult and requires dedicated and skilled interventions. For these to be successful there needs to be close collaborative working between all professionals involved and in particular between CQC and relevant local authorities. This is therefore a priority for all SABs and in particular the DSAP.

FINDING 4. NEED FOR CLOSER WORKING BETWEEN CARE QUALITY COMMISSION AND LOCAL AUTHORITIES TO IMPROVE OUTCOMES FROM ORGANISATIONAL SAFEGUARDING ENQUIRIES IN SPECIALIST HOSPITALS

Current guidance does not articulate with adequate clarity the necessary collaboration between CQC and host local authorities where there are quality issues that become organisational safeguarding concerns about specialist hospitals. This means that local authorities with a safeguarding role for people living in settings in their area undertake repetitive cycles of organisational safeguarding enquiries which result in them telling providers to do what they should already be doing, and which have little sustained effect on improving the experiences of patients. This risks perverting the purpose of safeguarding and incurs significant cost in terms of resource and time for the host authorities but has little impact on the providers or benefit to the people living in the specialist hospitals.

SUMMARY OF SYSTEMIC RISKS:

3.25.2 Specialist Hospitals present additional and significant challenges for effective safeguarding of vulnerable adults. Local authorities in which these services are based bear the responsibility for ensuring patients within them are safeguarded. Yet there is often not adequate clarity about acceptable standards and consequences if they were not achieved and sustained. Close coordination between host local authorities and the CQC would be needed for any definitive action, but this is not currently well embedded. This means it is not unusual for host local authorities remaining stuck in repeated cycles of organisational safeguarding processes, with limited improvements followed by a decline in standards. Without better clarity about the nature of collaboration, there is an increased chance that much safeguarding activity occurs, at significant cost in resources to host local authorities, but with little meaningful improvement for individuals being harmed and/or having their human rights abused and having minimal impact on providers in terms of finance or reputation.

Questions for the DSAP and partners to consider:

- Is there agreement that the purpose of safeguarding has been, or risks being, subverted, in specialist mental health settings when it ends up duplicating quality assurance and regulatory functions in organisational safeguarding concerns?
- Who can DSAP most usefully bring together to address this finding?
- What are the forums/opportunities that DSAP can use to raise these issues at a national level?

3.26 FINDING 5. GAPS IN GUIDANCE AND FUNDING RESPONSIBILITIES FOR EMERGENCY SPECIALIST HOSPITAL CLOSURES AFTER ORGANISATIONAL ABUSE OR DEREGULATION

3.26.1 Finding 5 **Headline:** In circumstances where people must be moved quickly after an organisational abuse scandal and/or cancellation of registration by CQC, current national guidance is not well known and does not adequately address the needs of families, require providers to be accountable financially for additional costs incurred, or include national oversight of such closures. This risks insufficient support and follow-up for individuals and their families, statutory agencies taking total funding responsibility and no national overview of how individuals are impacted by such closures or identification of learning to support on-going improvement.

3.27 CONTEXT

3.27.1 In the Serious Case Review of Winterbourne View hospital abuse, the author stated that hospitals for adults with learning disabilities and autism should not exist but while they do, they should be regarded as high-risk services i.e., places where patients are at high risk of receiving abusive and restrictive practices within indefinite time frames'.[50]

3.27.2 There are several different mechanisms that have been introduced specifically with the aim of minimising these risks and making sure that people with a learning disability and/or people who are autistic are safe and are getting high quality inpatient care. These include CTR/CETRs; Oversight visits; Host-Commissioner roles; and a new national review to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting.

3.27.3 When there are serious quality and/or safeguarding concerns raised about a mental health hospital or Assessment and Treatment Unit (ATU), the regulator (usually CQC) has a responsibility to visit and review the services provided. If the CQC inspection finds major issues of concern they can cancel the registration of the service forcing an emergency closure or impose restrictions or requirements on how the service should be run. In these circumstances the provider can also decide to close the service. In either scenario the closure is usually abrupt, with little notice given, and Local Authorities and NHS England must find alternative placements for patients and resident within very short timescales. Current guidance for agency response to an urgent hospital closure is the 'Joint Working Protocol: When a hospital, services or facility closes at short notice' [51] which was issued in February 2018. This document briefly outlines the responsibilities of the key agencies: health commissioners, local authorities, providers, CQC, NHSE and NHS Improvement. The main focus of the document is the practical arrangements for the identification of alternative placements and the movement of patients. It outlines roles and responsibilities for the key agencies: health commissioners, local authorities, providers, CQC and NHS England.

[50] https://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/
[51] https://www.england.nhs.uk/publication/joint-working-protocol-when-a-hospital-services-or-facility-closes-at-short-notice /

3.28 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.28.1 Cygnet Health Care, Durham Safeguarding Adults Partnership and DHSC and Care Quality Commission received letters on 03 May 2019 from the BBC's Panorama producers informing them of the undercover filming that had taken place at Whorlton Hall, the alleged abuses recorded and requesting interviews. The Panorama programme was scheduled to broadcast on 22 May.

3.28.2 A System Incident Co-ordination Group was rapidly established. This was initiated because there was not just a single CCG involved. It was the mechanism through which the '*Joint Working Protocol: When a hospital, services or facility closes at short notice*' was operationalized. Fortuitously, the Regional Chief Nurse for the North East and Yorkshire (NEY), NHS England, had initiated the development of this guidance, after being involved in the closure of NHS Mental Health Hospital Bootham Park hospital in Leeds, 2016. This had raised the issue of needing to mirror guidance for emergency care home closures, for the closure of mental health and specialist hospitals. The guidance had then been jointly produced with the then CQC Chief Inspector for Adult Social Care and published by NHSE/I. So, fortuitously, the Regional Chief Nurse (NHSE NEY) had a deep familiarity with the guidance.

3.28.3 Immediate action was taken to assure the safety of patients. All the staff named in the letter were suspended. All new admissions were suspended. Staff from other areas were brought in to run the service. Cygnet contacted all the families and placing CCG commissioners by telephone and subsequently with a letter. Unfortunately, the reviewers were not given access to the minutes of these meetings due to a lack of clarity about whose authorization would be needed. We were told that, in-line with the guidance, significant effort was made to work together to prevent the closure of the service. However, it became apparent to all involved, quite quickly, that closure was necessary due to concerns about their ability to protect patients, and staff, from the media interest once the Panorama programme was broadcast, and the impact of staff suspensions on staffing levels. There was a linked concern that the programme broadcast increased the risk that staff would not come to work, creating additional challenges to the provision of care and support for the patients. The reviewers were also told that the decision had anyway been made by Cygnet Health care to close the hospital, so it is unclear whether local agencies would have any authority to keep the hospital open, if they had disagreed with Cygnet's proposed timescales. By 7 May 2019 some of the 13 patients had transferred to other facilities. By the 16 May seven people had moved, and six remained. The remaining six had left the hospital by the 20 May.

3.28.4 As part of the SAR, Reviewers spoke to representatives of the placing CCGs and discussed with them the processes associated with the patients move from Whorlton Hall and where the individuals from Whorlton Hall were now living. The CCGs described the closure as being very difficult placing significant pressure on them to find emergency placements. This meant that in many instances patients had to move to interim placements while more permanent arrangements could be commissioned. The reviewers were told about one person (Patient H), who was transferred from Whorlton Hall to another specialist autism hospital but within three weeks that hospital was deregistered by CQC. As well as the instability and disruption caused by needing to find a new placement for a second time in such a short period, the logistics of this second closure were particularly high risk for the patient. All patients had to leave the hospital within a 24-hour period and those without alternative placements were to be taken, by the new

provider, to the Accident and Emergency unit in a local hospital which would have been catastrophic for Patient H, because people in uniforms was an established trigger to cause distress. As a result, this patient lived in 4 placements within one year but is now settled in purpose-built accommodation in the community. Of the 15 patients at Whorlton Hall in Spring 2019, 5 moved to permanent homes (4 of which were underway prior to the closure) but 10 moved to interim placements. In 2021 8 of those 10 still did not have permanent accommodation albeit that 1 person was moving soon, and commissioning was underway for 2 others.

3.28.5 Moving from Whorlton Hall was stressful and difficult for many of the patients. Reviewers were told by the CCG representatives that on occasion inappropriate and abusive techniques were used to facilitate the move. One person (Patient B) was persuaded into the transport from Whorlton Hall by being told that he was going to stay with one of his family members, which would have been a dream come true for him. This lie impacted negatively on his trust of the professionals into whose care he was delivered, who were unaware of the deceit. The attitude of the staff who escorted Patient B (above) to the new hospital was described as extremely negative, his behaviour was simply seen as a problem. Reviewers were also told that some patients experienced significant deterioration after the move. Another patient (Patient M), whose medication had reduced significantly with improvement in levels of distress while at Whorlton Hall, was described as having deteriorated massively after moving back to a local ATU.

3.28.6 The examples above are not intended to be comprehensive. They were not lines of enquiry the SAR reviewers pursued systematically. Nonetheless they illustrate why assurance as to the safety and well-being of all those who were moved out of Whorlton Hall was called for and why there is a need for clear guidance around how such closures are undertaken which should include the nature of support provided after the move.

3.28.7 This need was identified at the time. After Whorlton Hall had closed and all those who had been living there had moved, NHS County Durham CCG and the Regional Chief Nurse (NEY, NHS England) identified a need to check-up on the patients who had moved. 'Were they settled and were they being looked after well? Had there been any further disclosures of abuse?' No established mechanism or approach existed, so the Regional Chief Nurse for NEY suggested Enhanced Health and Well-being checks should be completed and a project group was set up to progress this.

3.28.8 Separately, families involved in advocacy for people with learning disabilities and/or who are autistic, were also concerned. They considered that the available mechanisms of CTRs, and commissioner review meetings had not previously worked for the patients in Whorlton Hall, which meant that something else was needed, particularly given the increased risk of further abuse. The CEO of the Challenging Behaviour Foundation therefore contacted the Regional Chief Nurse (NEY NHSE) asking who was checking up on these people. The two voices of concern were brought together, with CBF CEO being asked to Chair an "advisory group" for the project.

3.28.9 A pilot of a new way of supporting patients, who had moved to new placements in an emergency following organisational abuse, was commenced. At the time of writing, no learning has been shared formally about the pilot process. Informal feedback from the Expert Panel confirmed concerns about placements being steppingstones and an on-going challenge to find community placements. It also confirmed a diversity of approaches to responding to the legacy of trauma for patients. So, for some patients, clinicians suggested that Whorlton Hall should not be mentioned because it was too upsetting. It

wasn't evident that there was any therapeutic input specifically to address this, and certainly no services were consistently offered or provided to all patients.

3.28.10 A third limitation was identified through the closure process that was reported to reviewers which was the absence of guidance about the support that should be provided to families of patients involved in the hospital closures. Discussion with some of the family members indicated that the closure was a very challenging experience particularly since the Panorama programme highlighted in detail the abuse their relatives had experienced. The nature of the immediate closure meant that family members were doubly anxious both about the possible abuse their relative had experienced and about where they were going to be living in the future. The reviewers were very aware that, whilst being a disparate group, family members had a shared experience and could have provided each other mutual support if there had been a process that enabled them to be in contact with each other.

3.29 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.29.1 During the review the Lead reviewers asked the CQC about what guidance was available to professionals involved in the closure of hospitals and were told that currently there was no specific published guidance on closing a hospital although the CQC would consider the good practice from other closure guidance. Such guidance is available for the closure of residential care homes and schools[52]. The reason given for this was that a "hospital" can be one building with 6 people in it providing a specific service or a huge site providing a range of different services with hundreds of people using that service. Some people may be detained under the MHA, some people may have Ministry of Justice restrictions and others may require a secure provision. Commissioners may be NHSEI, provider collaboratives, ICS's / CCG's or from outside England. This means very specific approaches need to be taken to respond to the risks identified in each scenario.

3.29.2 Reviewers were also told by advocacy representatives that when hospitals are closed because of CQC action it is common for families to feel that there is a lack of transparency with them and that there is little good communication about what is happening. Input from the Expert Panel also suggested that consistency of support afterwards for families is variable and that therapeutic input for families to recognise trauma is rare.

3.29.3 When the review was almost completed representatives from NHS England provided the 'Joint Working Protocol: When a hospital, services or facility closes at short notice' and confirmed that the Whorlton Hall closure was managed in accordance with it. It was clear to the reviewers that agencies were generally unaware of the protocol, and this was probably because emergency hospital closures are considered to be very unusual. The protocol is brief and focuses mainly on the tasks of identifying alternative placements and moving patients to them. The detail regarding input for families is limited to informing them of what is happening to patients with little consideration of their needs for support. There is no suggestion that there could be gain in enabling families to support each other or thought about family members' therapeutic needs. The role for providers is

[52] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/1577_QuickGuide-CareHomes_9.pdf

limited to ensuring there are interim measures in place to enable the immediate safety of patients and assisting with the process of communicating with and assessing patients to facilitate their move to alternative placements. There is no consideration in the protocol of how the decision to close the hospital should be made, whether alternatives to closure should be considered, or whether any ongoing financial contributions should be made by the providers whose role otherwise ceases at the point of closure. This means that if there are difficulties it becomes in the provider's interest to push for a rapid closure even if this may not be in the best interests of patients.

3.29.4 It is understood that NHS England consider that the current protocol requires updating and the experience of this review would support that stance. A particular weakness of the current arrangements is the absence of any national oversight of closures despite them becoming a more common event. This means that there is little evidence of what has worked well and what could be improved, with limited information about or oversight of the impact on patients affected by closures. Some people may have already experienced moves because of closures. This was the experience of several patients at Whorlton Hall and input from the Expert Panel suggested this was not an unusual experience. However, there is no national picture of this currently, nor of how people have been further disadvantages as a result.

3.29.5 Recent evidence from the CQC Restraint, segregation, and seclusion review: Progress report (December 2021) underlines the importance of such an overview. It highlights that they '…have found that there is currently a problem in the system. We have seen people being moved from hospitals that have closed due to concerns about the care to other hospitals or community services that are unsuitable to meet their needs. Commissioners must make sure that they find the right home and train the right staff to meet each person's needs, rather than locating any available bed.'[53] How widespread is this system finding and how many people are actually or potentially affected?

3.29.6 The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings. All these people would be potentially affected by the lack of an established mechanisms for closure of hospitals if they were victims of organisational abuse and/or required to move at short-notice due to such or to deregistration of mental health hospital or other specialist unit where they are staying. As far as the reviewers understand, there is no way of knowing how many people have been affected by organisational abuse and/or related rapid inpatient unit closures.

3.29.7 At the time of this review a national Safeguarding Adults Review library does not exist to enable the ready collation of SARs linked to organisational abuse of people with learning disabilities and/or who are autistic, in specialist mental health inpatient settings. There is work underway and the national network of chairs has begun to collect recent SAR reports. Reviews published recently include:

- Jeesal Cawston Park, Norfolk[54]

[53] **https://www.cqc.org.uk/publications/themes-care/restraint-segregation-seclusion-review-progress-report-december-2021**

[54] **https://www.norfolksafeguardingadultsboard.info/publications-info-resources/safeguarding-adults-reviews/joanna-jon-and-ben-published-september-2021/**

- Long Leys Court private hospital/ATU, Lincolnshire[55]
- Muckamore Abbey hospital, Belfast, Northern Ireland[56]

3.29.8 There is a longer list of specialist inpatient facilities for people with learning disabilities and/or who are autistic, with inadequate CQC ratings and exposures of abuse which have not had accompanying SARs. A report published by CQC in October 2019 warned that the quality of care provided by mental health and learning disability services had deteriorated in the past year and said that fourteen independent mental health hospitals had been placed into special measures since October 2018, and three were closed permanently.[57] Since then, the following have closed after abuse scandals

- Yew Trees hospital in Essex, a 10-bed hospital for women with learning disabilities and mental health needs, part of Cygnet Health Care, was closed in September 2020, after Cygnet notified the CQC that residents had suffered abuse. [58]
- St John's House in Suffolk, a 49-bed independent hospital for patients with a learning disability and associated mental health problems, part of the Priory Group, was closed in September 2021,[59] after it had previously been rated inadequate and placed in special measures. A further inspection in July 2021 found it had not sufficiently improved and admissions should remain restricted. The Priory Group, which runs the hospital, said closing it was "the most appropriate course of action".
- Eldertree Lodge in Staffordshire, an independent specialist hospital for over 40 patients, closed in June 2021, after The Care Quality Commission published a report saying it had uncovered abusive behaviour by staff - including multiple incidents caught on CCTV. [60]

3.29.9 Inadequate CQC ratings were also given to the following private hospitals providing for people with learning disabilities and/or who are autistic. It is not known at time of writing whether these providers will decide to close the service, rather than implement an improvement plan.:

- St Erme Campus, in Cornwall, A care home for autistic adults was placed in special measures because of a shortage of staff, poor leadership and a staff member describing it as "filthy". [61]
- Cygnet Wast Hills private hospital in Birmingham.[62]

3.30 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.30.1 Since the Serious Case Review on Winterbourne View hospital was published, it has been acknowledged that specialist mental health inpatient units for people with a

[55] https://www.lincolnshire.gov.uk/downloads/file/5079/sar-long-leys-court-overview-report
[56] https://belfasttrust.hscni.net/2019/02/15/summary-of-a-review-of-safeguarding-at-muckamore-abbey-hospital-a-way-to-go/
[57] https://nursingnotes.co.uk/news/mental-health-learning-disability-services-deterioratingcqc/
[58] https://www.bbc.co.uk/news/uk-england-essex-54255514
[59] https://www.eadt.co.uk/news/health/cqc-report-on-st-johns-hospital-palgrave-8329912
[60] https://www.independent.co.uk/news/health/cqc-abuse-disabled-hospital-eldertree-b1900277.html
[61] https://www.cqc.org.uk/location/1-136037581
[62] https://www.cqc.org.uk/location/1-894095716

learning disability and/or who are autistic, are high-risk settings. There has been less thinking about the compounded risks faced by people who have been abused in such settings and/or forced to be moved from them at short notice or the needs of the families of patients who experience such closures. The experiences of patients at Whorlton Hall draws attention to the range of ways that risk is escalated for people in these circumstances and the distress experienced by their families. This includes the impact of the abuse suffered by the individual, manifesting as distressed behaviour and damaged trust; the limitations of emergency placement searches; the gaps in information sharing between clinical teams; and finally, the real potential for people who have been 'rescued' from one setting to be abused again in a subsequent one.

3.30.2 The review has also shown that the absence of any ongoing financial responsibility by providers for addressing the harm done to patients by emergency closures, leads to there being an inbuilt imperative towards closure rather than exploring other options. This leaves the commissioners paying for all costs incurred as well as having to find placements in very short timeframes which is not necessarily in the patients best interests.

3.30.3 The absence of national oversight of urgent hospital closures means there is little learning about what is working well and what needs to improve. The closure of a hospital, particularly where there are disclosures of abuse, will always be a stressful situation and learning from previous experiences will increase the chance of achieving joined-up and effective responses from all partners involved. Without effective processes and systems in place to minimise as much as possible the impact on people using services, their families, carers and advocates and to keep them as fully informed and involved as possible throughout the changing situation the closure will become a further abuse to people who are already vulnerable and may have been victims.

FINDING 5. GAPS IN GUIDANCE AND FUNDING RESPONSIBILITIES FOR EMERGENCY SPECIALIST HOSPITAL CLOSURES AFTER ORGANISATIONAL ABUSE OR DEREGULATION

3.25.3 In circumstances where people must be moved quickly after an organisational abuse scandal and/or cancellation of registration by CQC, current national guidance is not well known and does not adequately address the needs of families, require providers to be accountable financially for additional costs incurred, or include national oversight of such closures. This risks insufficient support and follow-up for individuals and their families, statutory agencies taking total funding responsibility and no national overview of how individuals are impacted by such closures or identification of learning to support on-going improvement.

SUMMARY OF SYSTEMIC RISKS

3.30.4 Media exposure of abuse of people with a learning disability and/or who are autistic in specialist mental health in-patient settings simultaneously reduces some risks whilst potentially creating new ones for those individuals. Suspending suspected staff and moving people to new placements whilst closing tarnished institutions, means people are returned abruptly into a system already under pressure with limited alternatives available. It forces a pace that does not allow for gentle transitioning. It ruptures roles and relationships including clinical, care and advocacy. It scatters known-victims and as-yet-unidentified victims and witnesses, geographically. Moreover,

oversight of people's human rights, safety and care is dependent in this situation on the same roles and mechanisms that, in some instances, have just failed them. This finding highlights the importance of providing the people who are responsible for managing such processes with the relevant tools and supports to enable them to undertake a difficult task well. There are obvious difficulties given the wide range of structures known as hospitals and the wide range of patients in them. That very complexity is however the reason there is a need for guidance and systems. Simple processes may rely on good sense but where there is complexity there is a need to learn from others' experience and to systematise that learning in systems and written information.

3.30.5 The current guidance fails to address the needs of family members whose relatives are being moved at short notice. There is also evidence that current guidance is not well known by the relevant agencies. Furthermore, the guidance does not require provider services to take responsibility for funding additional needs required because of the closure giving them an incentive to close rather than find alternative ways to address effectively patients' needs and leaving the burden of funding additional services with health commissioners. Finally, there is insufficient national oversight of emergency hospital closures meaning that there is no systemic learning about the effects on patients of such closures and how their needs can best be met.

Questions for the DSAP to consider:

- Is there agreement about the need for improving knowledge of and developing further, the guidance about the processes involved following emergency closure of specialist hospital units?
- Is there a need for a national oversight role, of such processes where people with learning disabilities and/or who are autistic who have been victims of organisational abuse and/or experienced abrupt closures of places they were living due to cancellation of their registration by CQC?
- Did NHSE/I'S new national Learning Disability and Autism Safe and Wellbeing Reviews[63] highlight all those individuals who are known victims of organisational abuse and/or were in hospitals that closed abruptly because of alleged and confirmed organisational abuse and/or cancellation of their registration by CQC? Can NHSE/I share this information with the relevant Integrated Care Boards (ICBs) to check that this history is on the person's records and appropriate support is in place?
- Where the specialist hospital unit is part of a large organisation, what contribution should that organisation make to the closure process and how?
- What are the forums/opportunities that DSAP can use to raise these issues at a national level?

[63] NHS England, Monitoring the quality of care and safety for people with a learning disability and/or people who are autistic in inpatient care

3.31 FINDING 6. NO CLEAR NATIONAL APPROACH TO ABSORB LEARNING, COORDINATE AND RESOURCE ACTION TO TRANSFORM CARE

3.31.1 Finding 6 **Headline:** There is currently no clear national approach or governance mechanism that pulls together the national strategy of Building the Right Support[64], with other initiatives, as well as learning from all sources, into coordinated and adequately resourced action. Without such a responsive, whole systems approach, increased ambition and activity, risk not translating into real change and fulfilling lives for people with learning disabilities and/or who are autistic, who are in or at risk of being admitted to specialist hospitals. It risks the promise to 'transform care' continuing to lie beyond reach, at significant cost financially and an incalculable cost to the individuals whose lives are impacted.

3.32 CONTEXT

3.32.1 It is now over ten years since abuse was exposed at Winterbourne View hospital. The government of the day promised to 'transform care' for people with learning disabilities and/or who are autistic; and thereby stop the normalised practice of admitting people to institutional settings (often mental health hospitals) where they are detained under the Mental Health Act, often without sensory adaptations and at significant distances from their homes, families, and communities. This formed the latest step in the deinstitutionalisation agenda that began in the 1970s and 1980s. However, targets proved difficult to achieve and numbers of people in inpatient provisions remained stubbornly high. Over the lifetime of Transforming Care there was a net reduction of just 125 people living in such institutions and in July 2019, 2,270 people were reported as remaining in institutional care.

3.32.2 March 2019, saw the last phase of the Transforming Care programme officially ended. In January 2019, revised targets for reducing the numbers of people with learning disabilities and/or who are autistic, in inpatient settings, were set in the NHS Long Term plan. The 2019 NHS Long Term Plan set a target that by 2023/24 the use of inpatient beds for autistic people and people with a learning disability would be reduced by half, compared to March 2015 levels.[65]

3.32.3 During this time, a further tranche of reviews and reports and recommendations were commissioned due to significant concerns about the experiences of people with learning disabilities and/or who are autistic detained in mental health hospitals and specialist units, and concerns about the violation of their human rights. These include:

- The House of Commons and House of Lords Joint Committee on Human Rights (JCHR) report on 'The detention of young people with learning disabilities and/or autism', published 01 Nov 2019.[66]
- CQC's review of the use of restrictive practices for people with mental ill health, autistic people, and people with a learning disability. An interim report was published

[64] NHS England - National plan – Building the right support
[65] Health and Social Care select Committee report (July 2021) Treatment of autistic people and individuals with learning disabilities (parliament.uk)
[66] https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/121.pdf

in May 2019, and the final 'Out of sight. Who cares?' report was published in October 2020.[67]

- This was followed by Baroness Hollins' Interim Report on Seclusion and Restrictive Practice for People with a Learning Disability and Autistic People.[68]

3.32.4 The JCHR report detailed above recommended the establishment of a Number 10 unit, with cabinet level leadership to ensure that reform was driven forward. Such a body would have had the authority to direct all government departments and would have provided a broad oversight of the issue. The response by the DHSC was to establish a Delivery Board with responsibility for delivering the Building the Right Support Programme 2021. This reactive response does not have the authority of a body directed from Number 10 and thus provides less broad oversight.

3.32.5 The response by Government to the CQC review and Baroness Hollin's interim statement was to support the continuation of an independent review process which provides necessary scrutiny in the care and treatment of people who are subject to segregation. The reviews, chaired by independent experts, are aimed at developing bespoke recommendations, offering advice on implementing person-centred care plans and, where appropriate, moving the individual to less restrictive settings.

3.32.6 The CQC followed up with the publication in October 2020 of 'Right support, right care, right culture How CQC regulates providers supporting autistic people and people with a learning disability'.[69] This guidance is supported by NICE guidance (CG142) on the definition of 'small' services for autistic people with mental health conditions and/or behaviour that challenges. This states that residential care "should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation). The guidance continues to say that it is probable that this will require commissioners and providers to develop bespoke services.

3.32.7 In October 2021, as part of the NHS response to the Safeguarding Adults Review (SAR) concerning the deaths of Joanna, Jon and Ben at Jeesal Cawston Park, a national review, is being undertaken to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting.[70] The expectation is that individual reviews of care will be completed early 2022.

3.32.8 The overall context is therefore that there is a plethora of different reviews and initiatives concerning people with learning disabilities and/or who are autistic.

3.33 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.33.1 Whorlton Hall was registered with CQC for two regulated activities: 1. Treatment of disease, disorder or injury; 2. Assessment or medical treatment of persons detained

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[67] https://www.cqc.org.uk/publications/themed-work/rssreview

[68] https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/baroness-hollins-letter-to-the-secretary-of-state-for-health-and-social-care-about-the-independent-care-education-and-treatment-reviews

[69] https://www.cqc.org.uk/sites/default/files/20200929-900582-Right-support-right-care-right-culture-FINAL.pdf

[70] https://www.norfolksafeguardingadultsboard.info/assets/documents/NHSE-NHSI-response-SAR-08.09.21-FINAL-SIG.pdf

under the Mental Health Act 1983. Whorlton Hall admitted men and women, with a learning disability and/or who were autistic, who were aged 18 years and over, and who also had additional mental or physical health needs, and behaviours that challenged.

3.33.2 The hospital was originally registered to accommodate a maximum of 24 patients which was later reduced to 19. At the time of the Panorama programme there were 13 patients (1 of whom was on leave) at Whorlton Hall. The age range of patients spanned 19 years to 56 years with 7 patients aged under 30, 4 of whom were 22 and under, and 5 patients over 40. There were 11 patients who identified as male and 4 who identified as female.

3.33.3 Most of the patients had a learning disability (only 2 did not) with 9 assessed as having mild or moderate learning disability, and 4 assessed as severely learning disabled including 3 patients with significant communication difficulties. 9 patients were autistic with one further patient where there was a lack of clarity about diagnosis. Another 2 patients had been described as autistic when admitted to Whorlton Hall, but this diagnosis was changed, in both cases, to an assessment that the patients, in fact, had a personality disorder. 8 of the 15 patients were autistic and had a learning disability, 2 of them had a severe learning disability.

3.33.4 One effect of the lengthy periods patients spent in hospital was that contact with family members was made difficult. Few of the patients had family who lived locally and whilst most (10) had ongoing contact there were five patients who had minimal or no contact with their families and 2 more, where that contact ceased whilst they were at Whorlton Hall albeit that it has now resumed. None of the patients had families that lived near to Whorlton Hall with the most distant being one patient whose only family lived in Northern Ireland. Other relatives were scattered around the country, and it was evident that few family members attended CTR reviews with distance being the most common reason given for absence. A repeated request in CTRs was for patients to be placed nearer to family members.

3.33.5 The mean length of patients' stay at Whorlton Hall was 2.5 years, but 6 patients had been resident for 1 year and under (2 for only 3 months); and 5 patients had stayed 4 years or more with the longest stay being thought to be 10 years (although this cannot be fully substantiated due to changes in provider and difficulty accessing earlier records). There were only 4 patients who had been at the hospital for between 1 and 3 years.

3.33.6 Most of the patients had recently arrived for assessment (as would be expected in an ATU) but one third (5) were long-stay patients of whom only one was being actively treated prior to discharge. The other four were all ready for discharge but without future placements and in most cases with discharge difficulties having been raised unsuccessfully in the CTR process. The patient who was assumed to have been at WH for 10 years was receiving no active treatment. This man was the subject of a secure order because of a sexual assault, he was not autistic but had learning difficulties and could be aggressive. His placement at Whorlton Hall seemed to be mainly concerned with protecting the community. Following the Panorama disclosures, he was moved to an NHS hospital where he remains placed alone in a separate unit. Some of the patients ostensibly placed at Whorlton Hall for 'assessment' remained in placement for longer than those receiving 'treatment', it was also hard to identify clear distinctions in the formulations of those apparently being 'assessed' and those who were being 'treated'.

3.33.7 All of the patients at Whorlton Hall were the subject of 'Compulsory powers under the MHA', 9 were subject to Section 3 'treatment' orders; 5 were subject to Section

37 treatment orders, meaning they had been convicted of a crime requiring their detention in hospital and 1 patient was subject to a Section 37/41order, which required him to be detained in hospital for treatment rather than serving a custodial sentence in prison. There was no obvious correlation between the nature of the order and the level of risk of violence posed by the patient as some patients subject to Section 3 orders seemed to present a similar or greater risk of harm than others who were the subject of Section 37 orders. One explanation given for this was that on occasion criminal proceedings could be dropped if someone was admitted to hospital after committing an offence. Whilst this may be a laudable effort to avoid criminalisation of people with disabilities this can lead to them being detained for longer periods than if they had been charged with an offence. It is relevant to note that Clinicians did indicate that where patients were the subject of Section 37 or 37/41 orders there was more likely to be delay in discharge because of the potential risks that needed to be addressed prior to discharge, despite this risk assessment also being required for patients subject to section 3 orders.

3.33.8 A significant feature was the large number of patients who were admitted to hospital either as children or soon after they were 18. 10 of the 15 patients had been in hospital since they were children or were admitted soon after their 18th birthday. Some of these patients (5) were older and had spent most of their life in hospital so had no real experience of living in the community making discharge planning even more complex. Clinicians working with these patients indicated that they felt that it was extremely unlikely that they would ever move to a community setting. Most worrying however was that a significant number of patients (6) who were aged under 30 who also had been in hospital either since childhood or when they were 18. This was despite the Transforming Care agenda requiring that community provision should be the preferred option. It is clear this raises questions about the effectiveness of transition planning currently in place and highlights the danger that young people now are becoming institutionalised in hospital settings rather than it being a historic feature.

3.33.9 There were two patients where there were disputes over who was the 'Responsible Local Authority' and in both cases this resulted in delays to discharge. One of these patients was thought had been at Whorlton Hall for ten years for assessment. The issue of which Local Authority was responsible is now resolved, following the intervention of NHS England. In both cases the issue of delayed discharge were raised at CTR meetings repeatedly.

3.33.10 8 patients remain in hospital settings two years after the Panorama disclosures. 6 are placed in NHS hospitals and 2 are in secure units in private hospitals. 3 of the 6 in NHS hospitals are in bespoke units that have been developed to meet their specific needs. 1 patient has been in 3 separate hospitals for assessment which has still not been completed. 1 is in an NHS secure unit with no immediate plans for discharge. 1 is in an NHS ATU and is about to move to a bespoke placement in their hometown. The remaining 7 patients are living in the community. 5 of them are in bespoke placements in the community. The other 2 patients are in private sector community placements run by the same private sector group that owned Whorlton Hall. (For more detail see table below)

3.33.11 Discussion with CCGs about why placements were made at Whorlton Hall and what led to delays in discharge included a few common features. In most cases where the patient was younger or had not previously been in hospital there had always been attempts to place in the local ATU which were unsuccessful because there were no beds available. For some of the older patients, who had been in alternative hospitals previously, Whorlton Hall was chosen as it was seen as providing a specialist service for patients

whose behaviour other hospitals had felt unable to manage. Areas without local ATU facilities were more likely to choose Whorlton Hall as a first option. Such areas also struggled to find suitable placements on discharge. However, in some cases the lack of local NHS hospital facilities did mean that there was creative commissioning of bespoke community placements. When Whorlton Hall closed, those commissioning areas with larger NHS hospital facilities available placed the patients in the hospital and universally those patients now remained there.

3.33.12 The next finding provides greater detail about the differences between the CCGs and the effectiveness of more proactive CCGs in facilitating discharge planning. It was apparent that if the commissioning CCG was not proactive the discharge plan often led to a patient being moved on to another facility that was run by the Whorlton Hall provider. In part this was because the multi-disciplinary team at Whorlton hall would be aware of the services available and in the absence of the commissioning CCG offering alternatives this became the default move. These placements often were not local to the patients family and therefore increased the patients' isolation.

3.33.13 Discussion with CCGs identified that there was significant competition for national funding to develop suitable local provision, whether bespoke to an individual, or more generic provision which meant that significant time was spent in making bids for development which were often unsuccessful. CCGs spoke positively about the opportunities being made available by NHSE but were clear that overall, there were insufficient resources to develop appropriate facilities.

3.33.14 A further difficulty that was identified was the precarious nature of the workforce with insufficient people available within the local area to provide adequate levels of staffing across all social care and health settings. This pressure meant that social care and health providers were competing for a limited resource which again limited the CCG ability to develop and improve local facilities. One CCG reported that in the previous week (November 2021) the Local Authority Chief executive had been considering whether the staffing shortfalls should be declared as a local emergency.

3.33.15 In summary Whorlton Hall was being used for a range of purposes; some patients were there for assessment, some for treatment, and some to safeguard self and community, a holding place in the absence of other more suitable accommodation. Assessment and Treatment was not always timely and whilst there were some examples of clear formulations and actions where there was timely, realistic treatment there were other examples where discharge planning appeared to be driven by expediency.

3.33.16 Significantly there was a cohort of younger people who could easily become older institutionalised patients without more radical intervention. There was also some evidence, both prior to their placement at Whorlton Hall and after they had left, of patient's plans being changed at short notice because of unexpected closures of hospitals and/or changes in registration status meaning that much commissioning/spot purchasing was crisis driven rather than planned.

3.34 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.34.1 Input from the Expert Panel supporting this SAR provided further evidence about the experience of both providers and patients and their families. A provider described reviewing and increasing the pay that was provided to their staff only to find that it was still lower than that paid by an international on-line shopping supplier. There

was agreement that the precarious nature of staffing was national and that there was a need for a national workforce strategy to address the problems. Voluntary sector organisations confirmed the absence of coherent planning as experienced by patients and families, and that often it seemed that placements were identified at a point of crisis, which meant that factors important to the family, such as location, were ignored.

3.34.2 There are two recent reports that document progress against recommendations for people with learning disabilities and/or autistic people, in or at risk of admission to specialist facilities. These evidence that the issues highlighted for people living in Whorlton Hall were not exclusive to those individuals, or their placing CCGs. These factors include the lack of sufficient resources to fund community options and the absence of a sustainable workforce to provide support in the community. This means that people are admitted to specialist hospital facilities and often stay there longer than is needed for assessment or treatment. These reports are detailed below:

3.34.3 **CQC Out of sight – who cares? progress report** In December 2021, one year after publishing Out of sight – who cares? an urgent review of use of restrictive practices, CQC published a progress report against the recommendations they had made. This report includes findings from published data sources and from their own regulatory work, about the health and care experiences of people with a learning disability and/or autistic people. Key points highlighted were:

> *"much still needs to be done to improve the health and care experiences of people with a learning disability and autistic people:*
>
> - *there are still too many people in inpatient hospital wards*
> - *when admitted, some people are spending too long in hospital and discharge can be very slow*
> - *well over 2,000 mental health inpatients were reported to have been subject to restrictive interventions in August 2021*
>
> *These findings indicate that we urgently need more appropriate housing provision, with a workforce in place who have the right skills to support people"*[71]

3.34.4 From this they concluded:

- The commitment around increasing community support needs to be converted into real change
- Commissioning the right support and services for people with a learning disability and autistic people is not happening quickly enough
- People are still being placed in services which are not able to give them the right care

3.34.5 CQC comment on the importance of the Building the Right Support Delivery Board, chaired by the Minister of State for Care and Mental Health, as a lever for change in this area. However, they also underline the need for the forthcoming Action Plan to better capture how recommendations will be practically delivered to ensure they will make

[71] Restraint, segregation and seclusion review: Progress report (December 2021) | Care Quality Commission (cqc.org.uk)

a difference.

> *"Without coordinated action and a whole systems approach, that utilises the breadth of expertise available across the sector, we risk missing an opportunity to deliver real change for people with learning disabilities, autism and a mental ill health."*[72]

3.34.6 **House of Commons Health and Social Care Committee report** Five months earlier in July 2021, The House of Commons Health and Social Care Committee report on the treatment of autistic people and people with learning disabilities found that the target for reducing the number of people in inpatient beds had not been met because there was inadequate care available in the community and said it was concerned that support levels were significantly below that which was required:

> *"Community support and provision for autistic people and people with learning disabilities, and financial investment in those services, is significantly below the level required to meet the needs of those individuals and to provide adequate support for them in the community. Fixing this must be a greater priority for both the Department of Health and Social Care and NHS England & Improvement"*

3.34.7 They recommended that the DHSC set out the costs of providing care in the community for all current inpatients, and then provide the funding to meet those costs. Alongside this, they recommended the DHSC assess the cost of providing community support for all autistic people and people with learning disabilities, funded by both the NHS and local authorities. In addition, they asked the Department to redesign the funding incentives in the health care system so that local authorities were not incentivised to pass responsibility to the NHS. The above would represent what they called a more radical approach to unlocking funding for community provision which ten years of missed and delayed policy targets suggest is urgently needed.

3.34.8 On the Building the Right Support Delivery Board their view had echoes of CQCs later comments,

> *While we welcome the vision set out by Helen Whately MP (Minister of State, Department of Health & Social Care), we believe this is a matter of delivery and not a matter for further review. At present, the work and output of The Building the Right Delivery Support Group is unclear and risks repeating the previous mistake of focusing on a "voluntary" approach to supporting autistic people and people with learning disabilities rather than addressing the fundamental flaws in funding flows that prevent community provision being adequately provided. The Group does not appear to have a clear plan for improving the practical support autistic people and people with learning disabilities receive when living in the community in order to avoid future admissions or readmissions to inpatient units.*[73]

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[72] **One year on from Out of Sight – what's changed? | Care Quality Commission (cqc.org.uk)**
[73] **https://committees.parliament.uk/publications/6669/documents/71689/default/**

3.35 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

3.35.1 The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings. All these people would be potentially affected by this finding about the inadequacy of advocacy provision.

3.35.2 The finding will also affect a wider group of people with learning disability and/or who are autistic, who may not currently be in an inpatient setting, but may have previously been in hospital, or may be at risk of a hospital admission.

3.35.3 There does not appear to be any reason this finding would have geographical limits. It is therefore likely to be a national issue.

3.36 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.36.1 The model of care represented by Whorlton Hall has been described as a clinically and morally incoherent model and method of care for people with learning disabilities and/or those who are autistic.[74] Missed and delayed policy targets for another decade, and predictable consequences of organisational abuse in these settings, cannot be justified.

> "As with Winterbourne View, it was the abuse [at Whorlton Hall] which was shocking but what we should be focusing on is the model of care we saw which fostered that abuse."[75]

FINDING 6. NO CLEAR NATIONAL APPROACH TO ABSORB LEARNING, COORDINATE AND RESOURCE ACTION TO TRANSFORM CARE

3.36.2 **There is currently no clear national approach or governance mechanism that pulls together the national strategy of Building the Right Support[76], with other initiatives, as well as learning from all sources, into coordinated and adequately resourced action. Without such a responsive, whole systems approach, increased ambition and activity, risk not translating into real change and fulfilling lives for people with learning disabilities and/or who are autistic, who are in or at risk of being admitted to specialist hospitals. It risks the promise to 'transform care' continuing to lie beyond reach, at significant cost financially and an incalculable cost to the individuals whose lives are impacted.**

SUMMARY OF SYSTEMIC RISKS

3.36.3 Policy issues marked by a lack of consensus as to the problem, conflicts of values and profound disagreement and a nature that defies solution, are known as

[74] https://www.threecs.co.uk/wp-content/uploads/2020/08/AW_ATU-Report_MM_SCREEN.pdf
[75] https://alexfoxblog.wordpress.com/2019/05/23/horror/
[76] NHS England - National plan – Building the right support

'wicked issues'. They are notoriously difficult to tackle.[77] The issue of people with learning disabilities and/or who are autistic with behaviours that challenge the system being routinely admitted to specialist mental health hospitals or ATUs, appears in contrast to be a 'tame' policy issue. The problem is not contested and there is a clear consensus about the solution. One-off examples of alternative homes, lives and communities supported by appropriately skilled, kind, and dedicated teams of staff are becoming available[78] There is ambition and concerted activity across all national partners. Yet the case of Whorlton Hall highlights how far from a sustained solution we are; a next generation of young adults who are autistic and/or have learning disabilities and distressed behaviours of concern are losing years of their lives detained in hospital settings that the Winterbourne View SCR suggested should always be considered as high risk services. This finding highlights that there is no national approach to pull together all efforts, including the national strategy of Building the Right Support, into coordinated and adequately resourced action. This would include a mechanism for integrating new learning and recommendations from successive reviews, and evidence from other relevant initiatives.

3.36.4 Without such a responsive, whole system approach, that articulates and refines the costs of providing and sustaining people with homes in communities and provides funding to meet those costs, we risk seeing a succession of reactive responses to successive individual cases, e.g., deaths and/or to particular issues e.g., long-term segregation. While individually legitimate, a national approach to absorb learning, coordinate and resource action is needed to achieve alternative models of care The Secretary of State for Health and Social Care risks a legal challenge if the cycle of failure is not broken, for the repeated failure to move people with learning disabilities and/or autistic people into appropriate accommodation.[79] A national, whole system approach could help avoid this, articulating the resources required and providing a clear mile-stoned delivery plan.

Questions for the DSAP to consider:

- Does the DSAP recognise the finding as a valid interpretation of the issues?
- Is this finding one that needs to be escalated to the DHSC via the National SAB Chairs network's new escalation mechanism?
- Are there other ways that the DSAP can ensure this issue is promoted effectively at a national level inclusive of the Reviewers and the DSAP linking with DHSC?

[77] http://www.demos.co.uk/files/Connecting_the_dots_-_web-2.pdf
[78] https://www.cqc.org.uk/publications/themed-work/home-good-successful-community-support-people-learning-disability-mental
[79] https://www.equalityhumanrights.com/en/our-work/news/health-secretary-faces-legal-challenge-failing-patients-learning-disabilities-and

3.37 FINDING 7. NO EVIDENCE-BASE FOR WHAT MADE A CCG EFFECTIVE AT 'MICRO' COMMISSIONING AND QUALITY ASSURANCE OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES AND/OR WHO ARE AUTISTIC, TO INFORM ICSS

3.36.5 Finding 7 Headline: Before the establishment of integrated care systems (ICSs), across England there were a wide range of different structures for commissioning, managing and quality assuring individual placements for people with learning disability and/or who are autistic. This resulted in variations in service provision with some CCGs appearing to have more effective systems for commissioning and quality assurance. There did not appear to be any guidance or knowledge base about what made an effective structure, within a CCG, for this work. The establishment of ICSs since 01 July 2022 provides an opportunity to learn about best practice from CCGs and through this enable the future development of improved commissioning and quality assurance in ICS commissioning teams across England.

3.37 CONTEXT

3.37.1 When CCGs were first established in 2012 it was not intended that they should be responsible for directly commissioning individual packages of care, so they had limited systems for administering or scrutinising such arrangements. The Transforming Care agenda and increasing requirements for jointly funded, bespoke, individual packages of care for people with learning disabilities and/or who are autistic, has meant there is a need for systems to be developed to enable better commissioning, quality assurance and scrutiny by the CCG. These systems seem to have developed in an ad hoc fashion and therefore reflect local resources and systems.

3.37.2 Historically health and social care services have been established and delivered separately with responsibility for deciding what and how these services should be provided, sitting within the separate agencies. The Transforming Care programme developments have focused on increasing integration between health and social care. This has created a need for agencies to develop new, joint mechanisms for commissioning, managing, and delivering care packages where needed. There is a requirement that CCGs develop and maintain a Dynamic Support Register (DSR). The purpose of this register is to create a dynamic process for risk stratification of the local population of people with a learning disability and/or who are autistic, who are most likely to be at risk of hospital admission

3.37.3 The 'Framework for commissioner oversight visits to inpatients' strengthens the responsibilities of CCGs as placing commissioners both regarding the commissioning of placements and the oversight of the individual's placement and pathway of care back into the community. The guidance places specific responsibilities for undertaking regular commissioning reviews of the individual patient including oversight visits. The guidance also reminds placing CCGs of their responsibilities for safeguarding and the need to raise concerns when noted with the local authority for the area in which the individual is placed.

3.37.4 A further development is Integrated Care Systems (ICS) which will bring together NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners to collaboratively plan and organise how health and care services are delivered in their area. The ICS will then take over the CCG responsibilities for directly commissioning individual packages of care and for ensuring that such

placements are adequately scrutinised and that safeguarding is prioritised appropriately.

3.38 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.38.1 As part of the SAR the Lead Reviewers met representatives of the 10 CCGs who were responsible for commissioning the placements for the 15 patients who were resident at Whorlton Hall. The CCGs were asked to identify for themselves the professionals who had greatest involvement in the placements and who could therefore assist the Lead Reviewers in better understanding the rationale for and the supervision of the individual placements. In practice this meant that the staff interviewed from each CCG were very different, but it is probable that they were a fair representation of the professionals involved in the commissioning and oversight of the individuals placed at Whorlton Hall.

3.38.2 The interviews the Lead Reviewers conducted identified a marked variety in the quality and rigour of the commissioner roles across the different CCGs. These differences related both to the oversight of the placement and the energy put into identifying and commissioning an alternative placement. Interestingly, despite these functions requiring quite dissimilar skills, those CCGs which showed the greatest commitment to visiting and engaging with the patient at Whorlton Hall were also the ones that seemed to have the greatest success in planning and developing alternative placements.

3.38.3 Positive examples of scrutiny and oversight of placements included one CCG where the commissioner, when visiting the placement, always stayed overnight to be able to spend time with the patient alone in the hospital, as well as meeting the MDT as part of the review process. This compared with other CCGs where there was a strong reliance on the CETR process and the contact with the patient was limited to a formal interview prior to the meeting.

3.38.4 Another example of proactive monitoring included one CCG who were unhappy with the progress of recommended treatments at Whorlton Hall, so they commissioned an independent expert psychiatrist who attended the CETR and challenged the treatment programme. This compared with another CCG who when questioned as to why it had taken almost five years for their patient to move from Whorlton Hall presented extremely passively with deference to and uncritical acceptance of the Danshell/Cygnet decisions and plans.

3.38.5 The differences in approach to commissioning alternative/moving on placements showed a similar range. Some CCGs had well-developed arrangements with the Local Authority and had agreed 50/50 funding formulas to avoid unnecessary delay and these CCGs often also had developed close working with Housing providers to develop bespoke placements. By contrast other CCGs relied on commissioning from known providers which often led to delay in discharge and there also seemed to be a pattern of patients moving on from Whorlton Hall to other placements provided by the Danshell/Cygnet group. These placements may well have been appropriate but the delay in patients moving may well have been avoided if other options were considered. Such placements also rarely accommodated family desires for a more local placement.

3.39 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

3.39.1 When the Lead Reviewers discussed with the CCGs and the Review Team the rationale and reasons for the differences in the CCG commissioning team structures it

was clear that within CCGs these teams were developed in response to local need and custom and practice. There was no central guidance about the expertise and knowledge that a commissioning team should contain, and the history of CCGs was that there were very different levels or knowledge and expertise across the country. Furthermore, there was a perspective that team structures should develop organically in response to local resources and need rather than by proscribed national standards. It was also clear from this feedback that there was no evidence that the different structures had ever been evaluated or their relative effectiveness compared.

3.39.2 When we explored further with the CCGs what helped and hindered people in their roles within the range of different team structures and roles the following themes emerged: -

- The importance of there being someone in the team with casework expertise, sometimes this was a social worker, but other professionals had the same skills.
- The significance of there being professionals in the team with a passion and commitment to people with learning disability and/or who are autistic. This was relevant at an operational level but was also important in other roles such as finance teams.
- That it was essential for case workers in the team to have protected time to allow them the capacity to do their work in depth and to have the tenacity to follow things through even when faced with significant challenges.

3.39.3 The teams that were less effective were often less well-resourced, with staff under pressure because of the volume of work and who seemed to approach the task as being primarily about commissioning in general without a specific commitment to the wants and needs of people with learning disability and/or who are autistic.

3.40 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

3.40.1 As of April 2021, there are 42 ICSs covering every area in England. All 42 are expected to be fully operational by June 2022. There is no evidence that the teams commissioning individual placements will be different from those in operation in the CCGs. Furthermore, since those CCGs will have been incorporated into the ICSs it is probable that the teams will continue to function as previously albeit over larger geographical areas and with the additional complexity of having to relate to a number of Local Authority areas meaning that reaching agreement regarding joint funding of placements may be more challenging.

3.40.2 The Assuring Transformation data set at the end of September 2021 shows that there were 2,085 people with learning disabilities and/or autistic people in inpatient settings. All these people would be potentially affected by this finding about the inadequacy of safeguarding investigations.

3.40.3 The finding will also affect a wider group of people with learning disabilities and/or who are autistic, who may not currently be in an inpatient setting, but may have had and/or may be at risk of a hospital admission.

3.41 SO WHAT? WHY SHOULD THE DSAP AND PARTNERS CARE?

3.41.1 Given the known levels of risk when people are placed in specialist hospitals and given the importance of such placements having skilled and effective oversight, it is important that such teams are composed of highly skilled and dedicated staff. It is essential therefore that going forward there is greater knowledge and understanding of the best composition of teams that commission and oversee individual placements. This requires that there is some co-ordination and oversight of the different models of delivery and that the new ICS systems learn and develop their services based on those that are most effective. This is required to ensure that the most vulnerable patients in specialist hospitals will be fully protected.

FINDING 7. NO EVIDENCE-BASE FOR WHAT MADE A CCG EFFECTIVE AT 'MICRO' COMMISSIONING AND QUALITY ASSURANCE OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES AND/OR WHO ARE AUTISTIC, TO INFORM ICSS

Before the establishment of integrated care systems (ICSs), across England there were a wide range of different structures for commissioning, managing and quality assuring individual placements for people with learning disability and/or who are autistic. This resulted in variations in service provision with some CCGs appearing to have more effective systems for commissioning and quality assurance. There did not appear to be any guidance or knowledge base about what made an effective structure, within a CCG, for this work. The establishment of ICSs since 01 July 2022 provides an opportunity to learn about best practice from CCGs and through this enable the future development of improved commissioning and quality assurance in ICS commissioning teams across England.

SUMMARY OF SYSTEMIC RISKS

3.41.2 Clinical commissioning groups (CCGs) were established as part of the Health and Social Care Act in 2012, and replaced primary care trusts on 1 April 2013. On 1 July 2022, integrated care systems (ICSs) became legally established through the Health and Care Act 2022, and CCGs were replaced.

3.41.3 The structure and staffing within commissioning teams in CCGs was variable with most having developed organically over time in accordance with available skills and expertise. This review found little evidence that there was sharing of best practice about what skills were needed or what systems worked best, meaning that there were significant differences in the quality of commissioning and oversight of placements in specialist hospitals.

3.41.4 These commissioning teams have a key role in safeguarding patients and that function is strengthened with the introduction of the 'Framework for commissioner oversight visits to inpatients'. To avoid there being significant variations in the quality of services provided by different ICS commissioning teams there needs to be some minimum standards agreed, based on the learning from the most effective CCGs.

Questions for the DSAP to consider:

- Is there agreement that there is a need for consistency in the structure and skill base within commissioning teams within the ICS areas?
- Is there a need for an evaluation of past CCG arrangements to determine which structure and skill set provides the optimal basis for effective commissioning and oversight of placements?
- Which organisation is best placed to achieve such changes?
- What are the forums/opportunities that DSAP can use to raise these issues at a national level?

4 Appendix One

4.1 METHODOLOGY

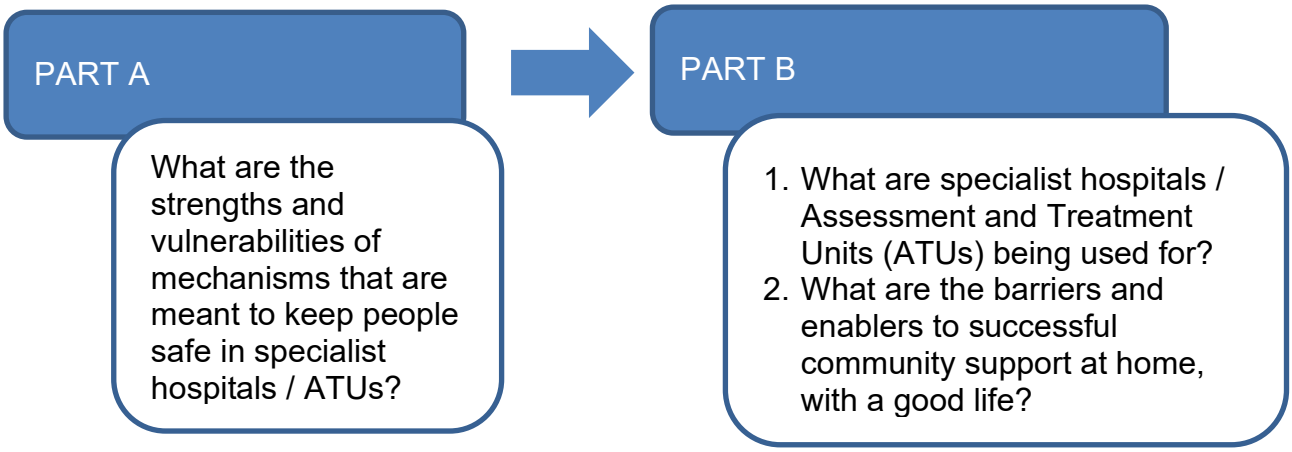
4.1.1 The purpose of a SAR is to provide findings of practical value to organisations and professional for improving the reliability of safeguarding practice within and across agencies (Care Act Guidance Para 14.178), to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect. Durham Safeguarding Adults Partnership (DSAP) used SCIE's tried and tested Learning Together model for reviews to conduct this SAR on Whorlton Hall (Fish, Munro & Bairstow 2010). Learning Together provides the analytic tools to support both rigour and transparency to the analysis of practice in the case and identification of systems learning.

RESEARCH QUESTIONS

4.1.2 The Learning Together approach uses the setting of 'research questions' as a mechanisms to agree on the areas about which generalizable systems learning that is sought. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable more generally, in the present and into the future, as is the nature of systems Findings. The research questions provide a systemic focus for the review, seeking generalizable learning from the single 'case'.

4.1.3 For this case of Whorlton Hall a two-part focus was agreed. The focus of Part A was to be on existing mechanisms designed to assure safety and pick up deterioration and indicators and/or allegations of abuse. This includes mechanisms within Whorlton Hall management, advocacy provision; the wider Danshell/Cygnet Health Care organisation, Adult Social Care (ASC) quality; ASC safeguarding; CCG oversight as well as Care Quality Commission (CQC). What could be learned from Whorlton Hall about barriers and enablers to these mechanisms working in a timely, effective way?

4.1.4 The focus of Part B in contrast was on what could be learned about why Assessment and Treatment Units were still being used for autistic people and people with learning disabilities and what was helping and hindering their timely discharge to more suitable homes.



METHODS PART A

4.1.5 The methods used for Part A were standard to the Learning Together model, adapted for use in a case of organisational abuse of several individuals, rather than the abuse of a single individual.

4.1.6 The timeline was broken down into several sequential chunks, called Key Practice Episodes. The judgement about the nature and length of the KPEs was informed by the research questions for Part A. Each of these was then analysed using a standard Key Practice Episode table layout.

4.1.7 Early analysis drew on information and insights from relevant review reports that had already been completed (see below). Members of the Review team and national Expert Panel were then involved through a whole day meeting respectively, in evaluating what went well and where there could have been improvements in practice in the case through each episode. Crucially, they are also be involved in identifying from a range of different social and organisational factors, what could have or did help and hinder practitioners in their work at the time. This analysis was later refined using supplementary data from additional conversations and documentation.

4.1.8 From the KPE analysis, the lead reviewers drew out suggested underlying systemic issues that helped or hindered the identification and response to abuse beyond the case of Whorlton Hall. These generalizable systems findings were further discussed with the review team and national expert panel in whole day meetings respectively.

METHODS PART B

4.1.9 The focus of Part B fitted less well with a standard Learning Together case review approach, premised as it is on a single chronology of events. We considered creating a smaller sample from the 15 people living at Whorlton Hall as is common in organizational abuse reviews. However, the full group provided a useful range in terms of people age, gender, life experiences, care and support needs and 'placement' history. We then used a three-step process to generate the data needed to speak to the research questions of Part B.

4.1.10 Firstly, using documentation provided we created individual 'pen pictures' to explain the rationale for the placement of everyone at Whorlton Hall, which included understanding their assessment and treatment regime and the plans that were made for discharge. Secondly, through conversations with relevant professionals for each person respectively, we added further understanding of CCG team set-ups, commissioning contexts and experiences of the CCGs respectively, both in the past and more recently, for the individuals and more widely. Lastly, we drew out some systems findings about seems to be helping and hindering a clear, brief, and well managed use of ATUs as well as barriers and enablers to achieving for everyone a place to call home.

4.1.11 There was also overlap between the parts. In the meetings with CCGs, we also sought to hear their experiences of communication with Durham County Council about safeguarding concerns, during the time they had people placed at Whorlton Hall, and to better understand their responses to these.

TIME PERIOD

4.1.12 It was originally agreed that the review would focus on the period between 22 May 2018 and 22 May 2019 (airing of the BBC Panorama broadcast). The timeline was

later expanded to start in February 2018, with the end-date later in 2019 to encompass additional information which had been shared with the Reviewers.

A PROPORTIONATE, COLLABORATIVE APPROACH.

4.1.13 Since the alleged abuse of people living at Whorlton Hall was exposed in May 2019, and by the time the SAR began, several reviews had already been completed to learn lessons and improve the ability to keep people safe. These include published and unpublished reports; internally conducted reviews as well as those conducted by independent people. In undertaking the SAR, we could bring all that work together to gain added-value from it, see it all in the round, and identify out-standing gaps that could generate new learning.

4.1.14 The SAR has drawn on data and analysis from the following reports:

Commissioning body	Independent author	Title	Date of completion	Published
Care Quality Commission	Glynis Murphy, Prof of Clinical Psychology & Disability, Tizard Centre, University of Kent.	Inspections and regulation of Whorlton Hall 2015-2019: an independent review	March 2020	Yes
Care Quality Commission	Professor Glynis Murphy	CQC inspections and regulation of Whorlton Hall: Second independent report.[80]	January 2021	Yes
Durham County Council Adult Social Care	Kathy Clark Independent consultant	Review of Durham County Council's Safeguarding activity and actions regarding Whorlton Hall, Independent Hospital.	December 2019	Internal

[80] A systematic review of the international research evidence in relation to the detection and prevention of abuse relating to adults with intellectual disabilities and or autism in residential services, both hospitals and social care settings.

NHSE NHS England: North East & Yorkshire	Internal author	Cygnet/Danshell: Whorlton Hall briefing	May 2019	Internal
External Advocacy Service (Service commissioned by Durham County Council to provide statutory advocacy)	Independent Investigating Officer	Confidential Whorlton Hall Investigation	July 2019	Internal
Internal Advocacy Service (Service commissioned by Danshell then Cygnet to provide a non-statutory advocacy service)	Internal	Advocacy service to people who were resident at Whorlton Hall Hospital: Report to the Safeguarding Governance Committee	July 2019	Internal Also reported to the Charity Commission

4.1.15 In addition, some additional documentary evidence was reviewed and some people who were key to understanding decision making at the time were interviewed. Conversations were held with the following individuals who had operational roles during the time-period under review.

Agency	Role during review period
CQC	• Inspector • Inspector • Inspection manager
Cygnet	• Regional Operational Director
Durham County Council	• Safeguarding and Access Manager/Executive Strategy Chair • Practice Improvement Manager • Practice Improvement Officer • Practice Improvement Officer
County Durham Clinical Commissioning Group	• Adult Safeguarding Lead

4.1.16 The ten CCGs who commissioned the services of Whorlton Hall during the time-period were asked to provide documentary information about all the adults living at Whorlton Hall prior to the Panorama Programme and its closure. This related to the time-period under review and was mainly records of CTR meetings.

4.1.17 In addition, these CCGs were asked to bring together the relevant professionals who were involved with the individuals who were living at Whorlton Hall, such as the Safeguarding lead from CCG, Responsible Clinician from local mental health Trust, and the CCG commissioner. The Lead Reviewers then met with those people to discuss the issues raised in Part B of the research questions.

INVOLVEMENT AND PERSPECTIVES OF THE ADULTS AND FAMILY MEMBERS

4.1.18 Inviting the adults and members of their families to contribute to the SAR had to wait for the conclusion of the police investigation and CPS decision making about charging. At the beginning of October nine former Whorlton Hall staff, six men and three women were charged with ill treatment or wilful neglect of an individual by a care worker. This allowed the Police to advise the Lead Reviewers of the five adults and families who were not involved in the on-going criminal process. Only those adults and their relevant family members who were not involved in the criminal process were invited to contribute to the SAR as well as those who had been recently discharged. Those adults whose alleged abuse was subject of the criminal process were not invited to contribute at this stage. This was to avoid the risk of jeopardizing the criminal process. In addition, the two people who had been discharged from Whorlton Hall shortly before the undercover filming, were also invited to contribute.

4.1.19 Of the seven people who were invited via their respective CCGs, five had family members actively involved in their lives. Three family members accepted the invitation and two of the adults (both of whom had no active family involvement). The Challenging Behaviour Foundation were commissioned to support engagement with the adults and families.

BUILDING OWNERSHIP OF SAR SYSTEMS FINDINGS THROUGH THE PROCESS

4.1.20 To support the identification of systems learning, the Learning Together approach requires engagement with senior representatives from the agencies who were involved in the case. This “review team” plays an important role in bringing wider intelligence to the SAR process to ascertain which issues are case specific only, and which represent wider trends locally. Their ownership of the review findings is crucial. In addition, the SAR of Whorlton Hall was set up by DCSAB to be supported by a national Expert Panel. Four full day meetings were held with both these groups respectively, sharing and progressing together the analysis of the SAR.

REVIEWING EXPERTISE AND INDEPENDENCE

4.1.21 The review was led by Dr Sheila Fish, Head of Learning Together at SCIE, working with independent consultants Fran Pearson and Fiona Johnson. All are independent of all services in County Durham.

4.1.22 Dr. Sheila Fish is a senior research analyst at the Social Care Institute for Excellence. She brings expertise in incident review methodology. She has led national programmes to develop good practice standards for reviews across children’s and adult

safeguarding, provides training and supervision for incident reviews as well as conducting them herself. Fran Pearson and Fiona Johnson are both independent social work consultants accredited to carry out SCIE reviews with extensive experience of writing both statutory child safeguarding and adult safeguarding reviews. Fran is the independent Chair of several Safeguarding Adult Boards.

METHODOLOGICAL COMMENT AND LIMITATIONS

4.1.23 There were several constraints faced in conducting this SAR which included:

4.1.24 A criminal investigation was underway, meaning that Lead Reviewers could not speak to professionals or patients likely or later confirmed to be involved in prosecutions. The individuals and families spoken to were not those who were subject to the alleged abuse that triggered this review.

4.1.25 Whorlton Hall had closed so former staff were no longer employed by Cygnet Health Care and therefore could not be contacted also some were subject to criminal proceedings so could not be interviewed. Cygnet Health Care had only acquired Whorlton Hall relatively recently so held little wider history of the service or its staff. Requests for reports related to the acquisition were refused denied as commercially sensitive.

4.1.26 A key component of the SAR was examining internal reviews already undertaken regarding Whorlton Hall. This was particularly relevant when it was not possible to speak directly to the people who were involved. All agencies were asked to provide the Lead Reviewers with reports of internal reviews that had been undertaken. All provided them with the exception is Cygnet Health Care who engaged with and contributed to this report but did not share details of their internal investigation in light of ongoing legal processes.