Safeguarding Adults Review on Whorlton Hall

Commissioned by Durham Safeguarding Adults Partnership

Executive Summary

This is a summary of the Safeguarding Adults Review report on Whorlton Hall.

Whorlton Hall was an independent hospital in Barnard Castle, County Durham, run by Cygnet Healthcare who took operational responsibility from January 2019 following acquisition of Danshell services in August 2018[1]. Whorlton Hall was registered with the Care Quality Commission (CQC) for two regulated activities, namely:

1 Treatment for disease, disorder or injury
2 Assessment or medical treatment for persons detained under the Mental Health Act 1983; and

Whorlton Hall admitted men and women with a learning disability, and/.or who were autistic, who were age 18 years and over and who may have had additional mental or physical needs and behaviours that challenged.

In May 2019, there were 13 patients at Whorlton Hall, their placements commissioned by 10 Clinical Commissioning Groups from different areas. Two other people were discharged from the hospital just months earlier.

What triggered this Review

This Safeguarding Adults Review (SAR) was triggered by concerns raised following the British Broadcasting Corporation (BBC) Panorama Programme on 22nd May 2019 which alleged[2] psychological and physical abuse of people living at Whorlton Hall by people who should have been caring for them. Following the programme, staff were immediately suspended, all the 13 people living there were moved to other care settings and Whorlton Hall was closed. Individuals have been charged with criminal offences (ill-treatment or wilful neglect of an Individual by a Care Worker) and currently await trial. Precautions have therefore been taken in writing this summary to avoid prejudicing the criminal proceedings.

The Transforming Care Programme that was established over 10 years ago in response to the 2011 Serious Case Review into the abuse of people with learning disabilities and autism at Winterbourne View Hospital in South Gloucestershire, pledged to stop people with learning disabilities and/or who are autistic being inappropriately 'placed' in mental health settings or 'Assessment and Treatment Units' (ATUs). The Panorama programme therefore raised urgent questions about why people with learning disabilities and/or autistic people were in Whorlton Hall at all.

[1] Cygnet Healthcare is a subsidiary of the United States (US) company Universal Health Services Inc, they do not have an operational role/responsibility for Cygnet Healthcare
[2] This phrasing is used because the allegations are denied and a criminal court is seized of determining the facts.

The alleged abuse of patients at Whorlton Hall caused shock, upset and anger. Listen, for example, to the voices of ***We Are Human Too***,[3] a campaign group of self-advocates and people from three self-advocacy groups from the North East of England who came together after hearing about what is purported[4] to have happened at Whorlton Hall.

Using a SAR to better understand what the barriers are

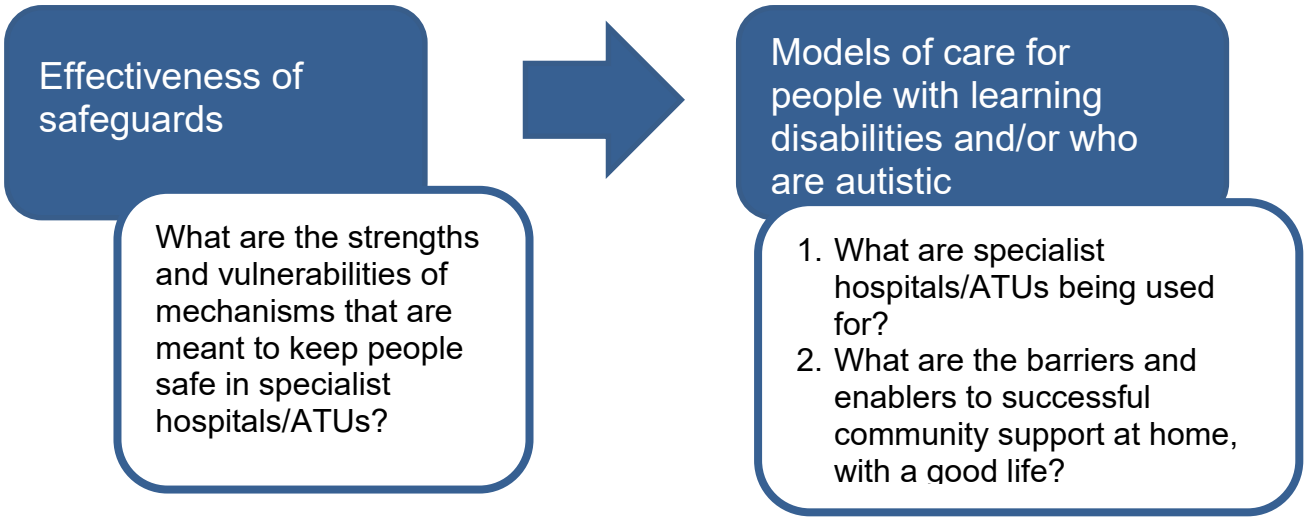
The purpose of a Safeguarding Adults Review (SAR) is to provide findings of practical value to organisations and professionals for improving the reliability of safeguarding practice within and across agencies (Care and Support Statutory Guidance Para 14.178), in order to reduce the likelihood of future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

Durham Safeguarding Adults Partnership (DSAP) following commissioning activity decided to use the Social Care Institute for Excellence (SCIE) Learning Together model for reviews to conduct this SAR on Whorlton Hall.[5] Learning Together is a 'systems' model designed to draw out wider learning about what is getting in the way of keeping people safe.

Improving the safeguarding of people with learning disabilities, and/or who are autistic, who are in, or at risk of being admitted to, a specialist mental health hospital, needs to address two elements:

1) why people with learning disabilities and/or who are autistic are still being admitted to specialist hospitals and Assessment and Treatment Units, such as Whorlton Hall;
2) as well as examining why the mechanisms that should identify any 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 drawn on independent reviews conducted by key agencies involved. The exception is

[3] https://www.youtube.com/watch?v=fbFRu6VRov0
[4] This phrasing is used because the allegations are denied and a criminal court is seized of determining the facts.
[5] Fish, Munro & Bairstow 2010 https://www.scie.org.uk/publications/reports/report19.asp

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.

There has also been collaboration with a local review team of senior leaders as well as being supported by a national expert panel. The various National Health Service (NHS) bodies (Clinical Commissioning Groups or CCGs) who placed people at Whorlton Hall have also contributed.

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. However, the Durham Safeguarding Adults Partnership intend to engage with everyone in a meaningful way once the criminal process concludes.

Using Whorlton Hall to give a 'window' on the system'

Whorlton Hall was, and the people who were living there are, of course, unique in many ways. However, there also appear to be many commonalities with other specialist mental health facilities for people with learning disabilities, and/or who are autistic. We have therefore used the Whorlton Hall example to give us a 'window on the system'[6] of provision for people with learning disabilities and/or autistic people more widely.

This is important because, while Whorlton Hall was closed shortly after the BBC Panorama Programme, reports of abuse and neglect, elsewhere, have continued. September 2021 saw the publication of a Safeguarding Adults Review report into the death of three people with learning disabilities, Joanna, Jon and Ben, at Jeesal Cawston Park, in Norfolk[7] which, like Whorlton Hall, was an ATU. At the end of 2021 BBC and Sky reported the case of a Brighton man Tony Hickmott, a 44-year-old man, detained in a specialist hospital for 21 years[8]. In December 2021 a Review was published into the death of Clive Treacey (who died in a Nottinghamshire ATU). The review found that Clive's death was 'potentially avoidable' and that 'there were multiple, systemwide failures in delivering his care and treatment[9]. Finally, 2022 opened with the Sunday Times featuring the story of "A", a 24-year-old man with learning disabilities and autism locked in a small room in a specialist hospital in Cheshire since 2017[10]. Meanwhile, the Care Quality Commission (CQC), with an inspection methodology revised following Whorlton Hall reviews, has shown a step change in their identification of poor care for people with a learning disability, autistic people and/or with mental ill health, leading to enforcement action. The number of inpatient services for people with learning disabilities and/or autistic people that were rated 'inadequate' more than tripled between 2019 and 2020 – from 4% to 13%.[11]

Tackling national systems findings to enable change

Below we present the seven 'systems findings' identified in the review. These capture what currently hinders a) efforts to keep people safe while detained in specialist mental health facilities and ATUs and b) efforts to keep people with learning disabilities and/or who are autistic out of such services in the first place and discharged in a timely fashion if they are admitted.

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[6] Vincent,Charles(2004)https://www.researchgate.net/publication/8420168_Analysis_of_clinical_incidents_A_window_on_the_system_not_a_search_for_root_causes

[7] https://www.norfolksafeguardingadultsboard.info/assets/SARs/SAR-Joanna-Jon-and-Ben/SAR-Rpt-Joanna-JonBen_EXEC-SUMMARY02-June2021.pdf

[8] https://www.bbc.co.uk/news/uk-england-59733934

[9] https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2022/11/Clive-Treacey-Independent-Review-Final-Report-9.12.21.pdf

[10] https://www.thetimes.co.uk/article/young-autistic-man-confined-in-hospitals-former-storage-room-for-four-years-lcp8pn26p

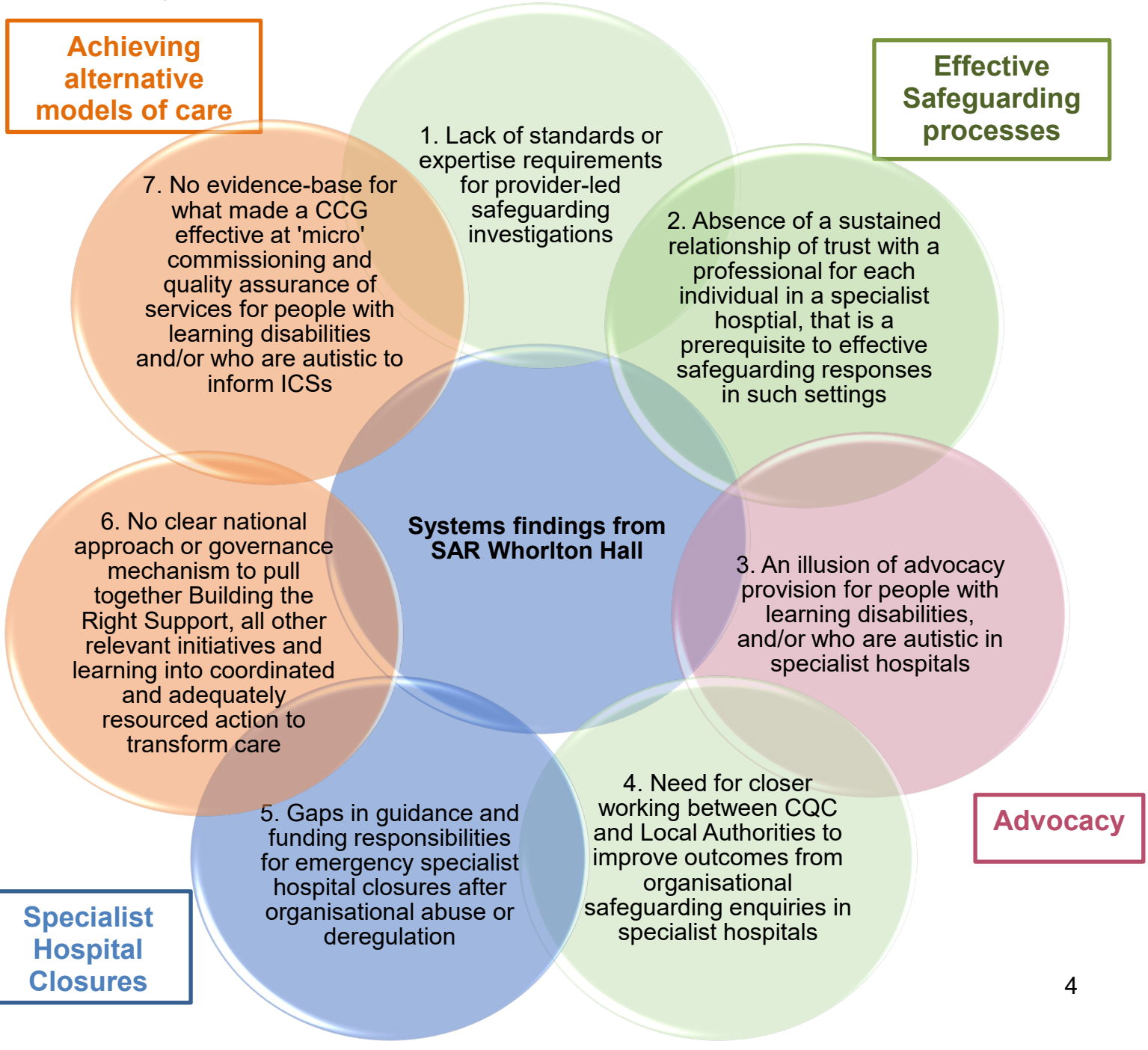
[11] www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf

The findings emphasise a need for urgent action to turn the often-heard rhetoric that 'lessons will be learnt' into reality.

All seven 'systems findings' from the SAR into Whorlton Hall are national findings. They capture barriers that need to be tackled in order to enable improvements in the experiences of people with learning disabilities and/or who are autistic, who are inpatients or at risk of being admitted to specialist hospitals in the current context of provision. Some of these findings have already been articulated by others and are supported by the analysis of this Whorlton Hall SAR. Others are newly articulated systemic issues that need national action, to increase the chances of achieving real change. They are presented separately for pragmatic reasons, to make it easier to address them. In reality, they overlap, with the potential for any individual person to experience the cumulative impact of more than one, or all of them.

Figure 1 below illustrates how the seven systems findings (colour coded circles) cluster around four different areas (in the rectangles): effective safeguarding processes; advocacy; specialist hospital closures; and achieving alternative models of care. The table that follows presents the headline of each finding.

Figure 1.



	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 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.

A brief summary of each finding is detailed below. After the summary of each finding, questions are posed to help Safeguarding Adult Boards, specialist providers including Cygnet Healthcare, Integrated Care Systems, CQC and the Department of Health and Social Care (DHSC) to identify what action best addresses each of the systems findings summarised above. The aim is that all relevant partners can therefore progress action, ahead of publication of the full SAR report which may be delayed due to the on-going criminal process. The full SAR report presents illustrations of how these systems findings manifest in Whorlton Hall.

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

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.

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?

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?

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

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[13] as high risk. Finding 2 has highlighted a pattern of the opposite occurring.

Many safeguarding concerns raised do not trigger a statutory s.42 safeguarding enquiry and are instead closed down after an initial investigation phase.[14] Key here is a lack of

[13] Initial assessment to determine the levels of risk

[14] 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.

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.

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: 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?

FINDING 3. AN ILLUSION OF ADVOCACY PROVISION FOR PEOPLE WITH LEARNING DISABILITIES, WHO ARE AUTISTIC OR BOTH, AND WHO ARE INPATIENTS OR AT RISK OF BEING ADMITTED TO 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.[15] 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?

[15]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 .

FINDING 4. NEED FOR CLOSER WORKING BETWEEN 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.

SUMMARY OF SYSTEMIC RISKS:

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?

FINDING 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.

SUMMARY OF SYSTEMIC RISKS

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.

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[16] 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?

FINDING 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[17], 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

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 'wicked issues'. They are notoriously difficult to tackle.[18] 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[19] 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.

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

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

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

[18] http://www.demos.co.uk/files/Connecting_the_dots_-_web-2.pdf

[19] **https://www.cqc.org.uk/publications/themed-work/home-good-successful-community-support-people-learning-disability-mental**

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.[20] 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?

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

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.

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.

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.

[20] https://www.equalityhumanrights.com/en/our-work/news/health-secretary-faces-legal-challenge-failing-patients-learning-disabilities-and

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?

What next?

Addressing all the findings is vital because improving safeguarding systems alone will not work if people are still being inappropriately 'placed' in 'closed' hospital environments. Equally developing new and better options to allow people ordinary lives in places they can call home will still need improvements in safeguarding processes that can be genuinely personalised and empowering, and effect sustainable change, as otherwise the new and better homes risk seeing the purpose of safeguarding activity ineffective or subverted.