CQC inspections and regulation of Whorlton Hall 2015-2019: an independent review.

1. Terms of reference

In the summer of 2019, following a televised Panorama programme showing abusive care of people with learning disabilities and/or autism in Whorlton Hall (an independent hospital in the north of England), the Care Quality Commission, CQC, requested an independent review of its inspections of Whorlton Hall. Professor Glynis Murphy was appointed to conduct the review, for which the terms of reference were to:

1. Consider and report to the Board of the CQC on the regulation of Whorlton Hall between 2015 and May 2019 and form a view as to whether the abuse of patients that has been identified could have been recognised earlier by the regulatory or inspection process;
2. Make recommendations for how CQC can improve its regulation of similar services in the future, including in relation to:
    - The way risk is considered in these settings, such as when planning inspections;
    - Inspection methodology and practice, and the monitoring of services, in order to increase the likelihood of detecting of harm or abuse, or the risk of harm or abuse;
    - The protection of the human rights of service users;
    - Any other aspect of the regulatory process, including the way in which CQC works with other agencies, where lessons can be drawn from the experience of Whorlton Hall.
3. The Review will limit its recommendations to those actions which can be taken immediately and do not require changes in legislation.
4. The Reviewer will present the Report to the CQC Board for publication, and will complete the review as soon as is practical.

Alongside this regulatory review, CQC commissioned David Noble QSO to conduct a review of concerns raised by Barry Stanley-Wilkinson (a previous CQC inspector), in relation to the regulation of Whorlton Hall. This is referenced here as the two reviews were tackling somewhat different issues but were running alongside each other for some months. There were some shared pieces of information that were relevant to both reviews (for example, transcripts from interviews in the review by David Noble were shared with the Professor Murphy, with the interviewees' agreement). David Noble's report was published in January 2020[1].

2. Background

Until the 1970s and early 1980s, there were very large numbers of people with learning disabilities and/or autism living in hospital settings, mostly adults but some children. A series of scandals, such as in Ely hospital in 1967[2], provoked a vigorous deinstitutionalisation movement, and government reports followed, such as *Better Services for the Mentally Handicapped (1971).* Alongside a series of Community Care Acts, there began to be major changes to services for people with learning disabilities an/or autism, such that during the late 1970s and 1980s, many hospitals closed. People with learning disabilities and autism were more often living in the community, and community services for people with learning disabilities increased apace, such that every area had community teams for adults with learning disabilities, typically consisting of social workers, psychiatrists, psychologists, occupational therapists, speech and language therapists, and nurses. A variety of forms of supported housing and supported living emerged, alongside the development of day activities and supported employment. However, most children with learning disabilities and/or autism still lived with their families and, although support was provided through Child and Adolescent Mental Health Services (CAMHS), there was often insufficient expert advice available for supporting families, especially when the young person had learning disabilities and/or autism alongside behaviour that challenged. As a result, families who experienced inadequate support and felt unable to continue caring for their children sometimes saw them transferred

[1] https://www.cqc.org.uk/sites/default/files/20020122_noble-report.pdf

[2] https://api.parliament.uk/historic-hansard/lords/1969/mar/27/ely-hospital-cardiff-inquiry-findings

to settings (including hospitals), often a very long way from home. A charity, called the *Challenging Behaviour Foundation,* was set up in 1997 by Viv Cooper (herself a parent of a young man with severe learning disabilities). Its aim was to provide support, information and training for families, and it documented the accounts of many families of this kind[3].

However, despite a strong deinstitutionalisation agenda, increasing family protests, and growing self-advocacy movements (both in the UK and in a number of other countries), who protested that institutions often harboured abusive practices, a small number of people with learning disabilities and/or autism continued to be admitted to hospitals. Often these were people with behaviours that were challenging, and many of them were detained under the Mental Health Act 1983. Some were children.

Despite the beliefs of some professionals and politicians, that scandals like that in Ely hospital were unlikely to be repeated, a whole series of similar events emerged. Increasingly, although abuse was occasionally documented in social care settings, most evidence of abuse seemed to arise in hospital settings. One of the most shocking, in recent years, was that of Winterbourne View, a 24-bedded assessment and treatment unit, exposed in a Panorama programme, which showed abusive treatment of residents with learning disabilities and/or autism, by staff, in May 2011. The service, which was in South Gloucestershire, was operated by Castlebeck Care, an independent provider.

There followed a CQC review of the service in late May and early June[4], which concluded that:

- The registered provider, Castlebeck Care (Teesdale) Ltd, had failed to ensure that each person living at Winterbourne View was adequately protected from risk, including the risks of unsafe practices by its own staff. The registered provider did not take proper steps to ensure that people who use the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe as the planning and delivery of care did not meet

[3] https://www.challengingbehaviour.org.uk

[4] https://www.cqc.org.uk/sites/default/files/documents/1-116865865_castlebeck_care_teesdale_ltd_1-138702193_winterbourne_view_roc_20110517_201107183026.pdf

people's individual needs.

- The registered provider did not protect the people who used this service against the risks of unsafe care and treatment due to the ineffective operation of systems. The registered provider did not have robust systems to assess and monitor the quality of services provided in the carrying on of the regulated activities.
- The registered provider did not identify, assess or manage risks relating to the health, welfare and safety for the people who use this service. The registered provider had not responded to complaints and comments made and had not considered the views, including the description of their experience of care and treatment, expressed by people who use the service, and those acting on their behalf.
- Investigations carried out by the registered provider into the conduct of persons employed at Winterbourne View were not robust and had not safeguarded people.
- The registered provider did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred; and did not respond appropriately to allegations of abuse. Where a form of restraint was used the registered provider did not have suitable arrangements in place to protect the people who used this service against the risk of control or restraint being unlawful or otherwise excessive.
- The registered provider did not operate effective recruitment procedures and did not take appropriate steps in relation to persons who were not fit to work for the purpose of the regulated activity, for example by failing to inform the appropriate regulatory or professional body.
- The registered provider failed in relation to their responsibilities by not providing the appropriate training and supervision to staff, which would be required to enable them to deliver care and treatment to the people who use the service.

There was also a serious case review regarding Winterbourne View, conducted by Margaret Flynn, and commissioned by South Gloucestershire Safeguarding Adults Board[5]. The conclusions and recommendations from this report were as follows (taken from the summary at the front of the report, pages x to xi):

[5] https://hosted.southglos.gov.uk/wv/report.pdf

- **NHS commissioners** believed that they were purchasing a bespoke service for adults with learning disabilities and autism. There was no overall leadership among commissioners. They did not press for, nor receive, detailed accounts of how Winterbourne View Hospital was spending the weekly fees on behalf of its patients. Even though the hospital was not meeting its contractual requirements in terms of the levels of supervision provided to individual patients, commissioners continued to place people there. Families could not influence the placement decisions. There was limited use of the Mental Capacity Act 2005, most particularly concerning adults who were not detained under the provisions of the Mental Health Act 1983. Although some commissioners funded advocacy services, Winterbourne View Hospital controlled patients' access to these.
- The **whistleblowing** notification was not addressed by Winterbourne View Hospital nor Castlebeck Ltd, irrespective of the fact that it was shared with Castlebeck Ltd managers with responsibility for the hospital. Although connections were made in terms of safeguarding and patient safety, the inter-organisational response to the concerns raised by the whistleblowing email was ineffective.
- The **volume and characteristics of safeguarding referrals** which were known to South Gloucestershire Council Adult Safeguarding were not treated as a body of significant concerns. South Gloucestershire Council Adult Safeguarding had only an edited version of events at Winterbourne View Hospital.
- The **existence and treatment of other forms of alert** that might cause concern confirmed the complexity of safeguarding adults from both local authority and regulatory perspectives i.e. had both been aware of: patients' limited access to advocacy; notifications to the Health and Safety Executive; the hospital's inattention to the complaints of patients and the concerns of their relatives; the frequency with which patients were restrained and the duration and authorisation of these; the police attendances at the hospital; and the extent of absconding; then both may have responded appropriately in terms of urgency and recognition of the seriousness.
- The **role of the Care Quality Commission** as the regulator of in-patient care at Winterbourne View Hospital was limited since light-touch regulation did not work.

- On paper, the **policy, procedures, operational practices and clinical governance of Castlebeck Ltd** were impressive. However, Winterbourne View Hospital's failings in terms of self reporting, attending to the mental and physical health needs of patients, physically restraining patients, assessing and treating patients, dealing with their complaints, recruiting and retaining staff, leading, managing and disciplining its workforce, providing credible and competency based training and clinical governance, resulted in the arbitrary violence and abuses exposed by an undercover reporter.
- The recommendations include investment in preventing crises; a commissioning challenge concerning ex-Winterbourne View Hospital patients; outcome based commissioning for hospitals detaining people with learning disabilities and autism; rationalising notifications of concern; establishing Registered Managers as a profession with a code of ethics and regulatory body to enforce standards; NHS commissioning organisations prioritising patients' physical health and safety; and discontinuing the practice of t-supine restraint i.e. restraint that results in people being placed on the ground with staff using their body weight to subdue them - in hospitals detaining people with learning disabilities and autism.

The Government's response to the abuse exposed at Winterbourne View was: *Transforming Care: A National Response to Winterbourne View Hospital*[6], published in 2012. Their plan was to set up a work stream, which aimed to drastically reduce the number of hospital beds for people with learning disabilities and/or autism. The task was harder than expected and the pledge to reduce hospital beds and to move people back into the community, by June 2014, was not met. NHS England then commissioned Sir Stephen Bubb to make recommendations on how to progress the action and his report, with 10 recommendations, was published in 2014[7].

By 2015, the revised target was to reduce from approximately 3000 to 1500 beds, which seemed a modest aim and was much less of a reduction than a number of groups representing families (such as the *Challenging Behaviour Foundation*) wished

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6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

7 https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

for. The associated NHS-England document, *Building the Right Support* [8], published in October 2015, was described as a 'national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition'. The intention was to achieve change through 49 Transforming Care partnerships, involving clinical commissioning groups, NHS England's specialised commissioners and local authorities. In the event, it proved very difficult to reduce the numbers of people with learning disabilities and/or autism who were resident in hospital settings: there were thought to be over 3000 at the start of *Transforming Care*, of whom 150 were children, and by the end of the period of *Transforming Care* in spring 2019, there were 2270 resident in hospitals and proportionately more were children.

It was clear in 2017 and 2018 that *Transforming Care* was struggling to reach its targets of discharges from hospitals and, during this period, there were a number of other programmes on national radio and TV about people with learning disabilities and/or autism, in hospital settings, highlighting the shortcomings of hospital services and the shocking treatment of some people detained there:

- A Channel 4 Dispatches documentary called "Under Lock and Key" about high levels of restraint, the long term segregation of one individual, and the death of a number of other individuals in St Andrews hospital [9] (1st March 2018)
- A 'File on Four' programme on Radio 4 featuring Bethany, a patient at St Andrews Hospital (2nd October, 2018).

Given the fact that the programme of work was clearly not finished, it was a disappointment to families and professionals that the *Transforming Care* work stream halted in March 2019. The NHS Long Term Plan, published in early 2019, declared that the work would continue, however, and set new reduction targets. But data released recently from NHS Digital indicated that there were still 2,185 people in hospital, of whom 230 were children, in December 2019. The data also indicated that restraint had been used over 3000 times in one month, 910 times with children. Families of children and adults with learning disabilities and/or autism (and complex

[8] https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

[9] https://www.challengingbehaviour.org.uk/cbf-articles/c4dispatches.html

needs) felt strongly that the use of hospitals was inappropriate and they repeatedly called for a much more radical reduction of hospital beds, a major improvement of community-based services and better commissioning of person-centred services for their family members[10].

Meanwhile, in 2018, following the publicised concerns of a relative of a person with learning disabilities and/or autism who was being cared for in segregation, the Secretary of State for Health and Social Care asked CQC to carry out a review of segregation and other restrictive interventions for people with learning disabilities and /or autism, in in-patient settings and residential care. Their interim report drew on information about 39 people who were being cared for in these circumstances (out of the 62 of whom they were notified). They described their paths into such care, as well as the care itself and the difficulties preventing their leaving[11]. Typically, the individuals had autism (31 of 39), and had had very unsettled childhoods, with multiple placements. They were not being offered high quality assessment, care and treatment. Staff working with them often did not have the necessary skills for such work and those involved in direct hands-on care were often unqualified. In about two thirds of the cases, there was no plan to re-integrate them back into the main care environment, and in about one third of the people they were experiencing a 'delayed discharge ….due to there being no suitable package of care available in a non-hospital setting'. The conclusion was that the current system of care had failed the people who were being cared for in conditions amounting to segregation, and there were five recommendations in their interim report, which was published on May 21st 2019, immediately before the Panorama programme was aired:

- Recommendation 1: Over the next 12 months, there should be an independent and an in-depth review of the care provided to, and the discharge plan for, each person who is in segregation on a ward for children and young people or on a ward for people with a learning disability and/or autism. Those undertaking these reviews should have the necessary experience and might include people with lived experience and/or advocates.
- Recommendation 2: An expert group, that includes clinicians, people with

[10] https://www.challengingbehaviour.org.uk/cbf-articles/latest-news/december-2019-nhs-data.html

[11] https://www.cqc.org.uk/sites/default/files/20191118_rssinterimreport_full.pdf

lived experience and academics, should be convened to consider what would be the key features of a better system of care for this specific group of people (that is those with a learning disability whose behaviour is so challenging that they are, or are at risk of, being cared for in segregation). This group should include experts from other countries that have a better and/or different approach to the care for people with complex problems and behaviours that challenge.

- Recommendation 3: Urgent consideration should be given to how the system of safeguards can be strengthened, including the role of advocates and commissioners, and what additional safeguards might be needed to better identify closed and punitive cultures of care, or hospitals in which such a culture might develop.
- Recommendation 4: All parties involved in providing, commissioning or assuring the quality of care of people in segregation, or people at risk of being segregated, should explicitly consider the implications for the person's human rights. This is likely to lead to both better care and better outcomes from care.
- Recommendation 5: Informed by these interim findings, and the future work of the review, CQC should review and revise its approach to regulating and monitoring hospitals that use segregation.

Lastly, a parliamentary Joint Committee on Human Rights had been considering the detention of people with learning disabilities and/or autism in hospitals, partly as a result of its earlier enquiry into restraint for children (later published as *Youth Detention: Restraint and Solitary Confinement* in April 2019) and partly because of the *File on Four* programme (see above). They called for evidence from people with learning disabilities and their families and as a result they decided that:
"Fundamental questions needed to be asked about why these young people were being detained, often for long periods, causing their situation to worsen rather than improve". They therefore launched an inquiry on 10 January 2019 and sought views on the following issues:

- Whether the Government's Transforming Care programme, which aimed to significantly reduce the number of those detained inappropriately, had been successful and if not, why not.
- If it had not been successful what needed to be done to ensure that the numbers detained were reduced more rapidly.

- Whether the human rights of children and young people with learning disabilities and/or autism who were detained in mental health hospitals were being breached.
- If, so how were they breached and what needed to be done to better protect them?

After a call for evidence, the committee received 50 written submissions and held 5 oral evidence sessions. The committee reported in October 2019[12]. Their recommendations are given in Appendix 1.

It was against this background that events in Whorlton Hall took place.

3.0 Whorlton Hall

Whorlton Hall was an independent hospital, for people with learning disabilities and/or autism, originally operated by Castlebeck Care, but later transferred to The Danshell Group. During most of the period considered in this review, Danshell owned and operated Whorlton Hall. However, in August 2018, all of Danshell's 25 different facilities (with 288 beds) were acquired by Cygnet Health Care, a subsidiary of the US company Universal Health Services. The CEO of Cygnet at the time said the "Danshell network of facilities has a strong reputation for providing compassionate behavioural health care…. as evidenced by high quality ratings deemed by CQC. Like Cygnet, Danshell is a brand that portrays quality and confidence" [13].

Whorlton Hall admitted men and women, with a learning disability and/or autism, who were aged 18 years and over, and who also had additional mental or physical health needs, and behaviours that challenged. According to the Care Quality Commission, Whorlton Hall had been registered with CQC as an assessment and treatment unit since 3 September 2013, to provide the following regulated activity:
• Assessment or medical treatment for people detained under the Mental Health Act 1983

[12] Joint Committee on Human Rights: *The detention of young people with learning disabilities and/or autism*. Second report of Session 2019. Published October 23rd 2019.
[13] https://healthcarebusiness.co.uk/cygnet-healthcare-acquires-danshell-group/

• Treatment of disease, disorder or injury

The hospital had been originally registered to accommodate a maximum of 24 service users, and this had been reduced to 19, as a result of some changes in layout. At the times of its CQC inspections between 2015 and 2019, as a result of patients being discharged, there were a smaller number of residents, only between 7 and 9 service users. This number fluctuated somewhat and, at the time that CQC was alerted to the Panorama programme (just before it was aired), there were 13 service users (1 of whom was on leave) at Whorlton Hall. They were relocated to other services very rapidly.

3.1 Panorama programme

On May 22nd 2019, a BBC Panorama programme, using film from Whorlton Hall made by an undercover reporter, showed a staff team engaged in what appeared to be abusive behaviour, threatening, goading and provoking people with learning disabilities and/or autism into very distressed states, often leading to restraint by staff, often for long periods. The Care Quality Commission (CQC) had visited several times over previous years and in its most recent comprehensive inspection had rated the service as 'good'. The events, on the surface at least, were remarkably reminiscent of events at Winterbourne View.

3.2 Independent reviews

Following the release of the Panorama programme, in the early summer of 2019, CQC commissioned two independent reviews

- The first was from David Noble QSO. He was asked to review the CQC's handling of the concerns of Barry Stanley-Wilkinson (a previous CQC inspector). Mr Stanley-Wilkinson had conducted the first inspection of Whorlton Hall in August 2015. The report had been critical of the service, but had never been published, despite Mr Stanley-Wilkinson complaining about this. The review by David Noble was published in January 2020 (see footnote 1, page 2). The recommendations are shown in Appendix 2.
- The second independent review was commissioned from Glynis Murphy, Professor of Clinical Psychology & Disability. She was asked to conduct an independent review of all of the CQC's inspections and regulation of Whorlton

Hall between 2015 and 2019. The current report details the findings of this second independent review.

3.3 The process for this review

Immediately the Panorama programme was released, a number of staff who were employed in Whorlton Hall, were suspended, and a police investigation was begun into their possible criminal behaviour. The service users and their families were potential witnesses in this investigation. Consequently, as the police investigation was still on-going, service users and their families have not been interviewed for this review.

However, the review received full cooperation from CQC, including access to its processes and reports. A series of interviews took place with CQC inspectors, inspector managers, specialist advisors and mental health act reviewers involved in visiting Whorlton Hall, as well as CQC senior staff (17 CQC staff altogether). The local CCG commissioner and the previous lead for Adult Safeguarding from Durham Social Services were also interviewed.

The organisation operating Whorlton Hall at the time of the Panorama programme was Cygnet Health Care. Concerns were raised by them concerning the application of the terms of reference, and the context of on-going criminal investigations, and so proposals to interview Cygnet staff members did not proceed. Nevertheless 5 ex-Danshell staff and two advocates who had previously worked in Whorlton Hall did volunteer to talk to the independent reviewer.

4.0 Care Quality Commission (CQC)

4.1 What they do

CQC is the independent regulator of all health and social care services in England. According to their website www.cqc.org.uk, they 'monitor, inspect and regulate (care) services to make sure they meet fundamental standards of quality and safety'. They publish what they find, including performance ratings, to help people choose care.

CQC's exact processes are up-dated every so often, sometimes radically, but during the 2015-2019 period with which this review is concerned, the main processes that were in place are described below.

4.2 What inspections consider and rate

CQC say that they 'set out what good and outstanding care looks like and make sure services meet fundamental standards below which care must never fall.' CQC examines care in hospitals and other care settings under 5 headings to ensure that it is: *Safe*, *Effective*, *Caring*, *Responsive* and *Well-led*, and CQC defines the essential questions as:

Safe: are service users protected from abuse and avoidable harm?

Effective: do care, treatment and support services provided achieve good outcomes, help to maintain quality of life and are they based on the best available evidence?

Caring: do staff involved treat service users with compassion, kindness, dignity and respect?

Responsive: are services are organised so that they meet the needs of service users?

Well-led: the leadership, management and governance of the organisation make sure the service is providing high-quality care that is based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Each of the 5 domains is rated in comprehensive inspections, and these ratings may be 'inadequate', requires improvement', 'good' or 'outstanding'. There is also an overall rating for the service. In focused inspections, not all domains are considered and ratings are not necessarily given. This issue will be returned to later.

Services are also given instructions on what 'should' and what 'must' be improved, alongside information regarding the precise breaches of regulations found.

4.3 Inspectors

Each inspection is led by a CQC inspector, and overseen by an inspector manager. Inspectors in the mental health sector of CQC have a variety of professional backgrounds. Those engaged in inspecting Whorlton Hall had training and experience in a number of fields, including mental health/learning disability nursing, substance abuse, probation, disclosure and barring services, other regulatory services (such as immigration). Typically CQC inspectors see a number of different types of mental health services and, prior to comprehensive routine inspections, they receive data about the setting they are about to visit, following a Provider Information Request. This information request is sent out by CQC, to the organisation operating the service (often this is the NHS but sometimes it is a private provider), and they reply detailing a considerable number of aspects of their service. The analytics team at CQC examines the information returned on the PIR, and provide inspectors with very detailed analyses of the data, usually in the form of a powerpoint file. The inspectors then plan their inspection, so as to be clear which of the team members will examine which aspects of the care provided. Team members may include other inspectors, as well as Specialist Advisors (with relevant experience) and experts by experience.

Inspectors and assistant inspectors, when they join CQC receive an induction that, for the hospitals sector, covers topics such as the Key Lines of Enquiry (see below), CQC powers, the Health and Social Care Act, regulations around medicines, the Mental Health Act, the Mental Capacity Act and DoLS, mental health awareness, dementia awareness, safeguarding, and a variety of other topics. Some of the learning is on-line, and some is by video.

4.4 Specialist Advisors

Inspectors are not necessarily experienced in the type of service that they are inspecting and therefore one or more Specialist Advisors (SpAs) accompany the inspection team. Specialist Advisors may be from a variety of disciplines, including nursing, psychology, speech therapy, psychiatry, OT, pharmacy. They would always have experience of the type of client group using the service being inspected.

Specialist Advisors also have an induction on joining CQC. It focuses more on CQC procedures and less on clinical issues, given that they are already clinicians.

4.5 Key Lines of Enquiry (KLOEs) and Core Service Frameworks

CQC inspection teams have a framework guiding all inspections in health and social care. The framework, called Key Lines of Enquiry, lists the issues which inspectors need to consider under the five headings of *Safe, Effective, Caring*, *Responsive and Well-led*.

The 2015 KLOEs were varied for different types of services, but this involved considerable duplication, so it led to the KLOEs being updated in 2017 in order to cover all services. These new KLOEs, which were rolled out to all types of inspections between 2017 and 2018, consisted of a series of key points to consider for each domain (6 for Safe, 6 for Effective, 3 for Caring, 4 for Responsive and 8 for Well-led). Each key point entailed a series of examples of questions (38 for Safe, 34 for Effective, 16 for Caring, 27 for Responsive and 47 for Well-led). The KLOEs are also accompanied by examples for each line of enquiry/prompt, to clarify the characteristics of 'outstanding', 'good', 'requires improvement' and 'inadequate' ratings.

In addition to KLOEs, there are detailed Core Service Frameworks for specific types of setting, such as wards for people with learning disabilities/autism. For Whorlton Hall, the relevant Core Service Framework (2017/8, over 100 pages long) includes: a list of key quality themes for such services; references to relevant tools and brief guides (for example, to functional assessment; good communication; positive behaviour support; restraint, the Mental Capacity Act and Mental Health Act; relevant NICE guidance quality standards). There are recommended assessment activities for inspections (such as touring the ward, interviewing members of the team, talking to patients and families, reviewing records, attending meetings) and guidance on writing reports. Finally there are evidence tables providing advice to inspection teams on the topics to be covered, and linking them to the recommended assessment activities.

4.6 Relationship owners

Inspectors in the mental health hospital sector of CQC may be called to inspect any service registered as a mental health hospital, such as those for people with mental health needs, substance misuse services, services for the elderly, and those for people with learning disabilities/autism and behaviours that challenge. The lead

inspector in any inspection may never have visited that hospital before. Each service however has a ‘relationship owner’ within CQC, i.e. an inspector who has a long-term relationship with that service and gets to know it well. They receive notifications of concerns about the service from the National Call Service Centre (see below) and can trigger an inspection following such concerns. The ‘relationship owner’ may be part of the inspection team that inspects the service with whom they have a relationship, but they are not necessarily involved in inspecting their ‘own’ services.

4.7 Processes after inspections

After inspections there are a series of CQC processes designed to ensure that the inspection results are carefully considered, properly rated, clearly reported and consistent. In management review meetings (MRMs), the information collected by the inspection team is considered by the inspector, with the relevant inspector manager and a legal advisor. The meeting lists decisions and actions required.

Once the inspector has drafted his/her report, following the MRM, the report may be submitted for peer review, and/or for assistance from writing coaches. If any ratings of the five domains are ‘inadequate or ‘requires improvement’ or ‘outstanding’, the report then goes to a subsidiary quality assurance group (SQAG) and/or the national quality assurance group (NQAG) for consideration (typically this is chaired by the CQC head of mental health for services like Whorlton Hall, with representatives from policy, intelligence, pharmacy, legal advice and others). The original ratings given for the five domains can be changed at all of these stages.

Draft reports are also sent to the provider organisation for factual accuracy checks. In response to any subsequent provider comments, inspectors can adjust the wording in the report, provided that they accept the organisation’s arguments, in relation to specific parts of the inspection reports.

4.8 Mental Health Act Reviewers

CQC also provide Mental Health Act reviewers, who come from a variety of professional backgrounds, such as doctors or other health professionals or lawyers, and are independent of the service providing care. They visit patients detained in hospital and meet with them in private to find out about their experiences. They check MHA paperwork, can raise issues with ward managers, listen to service users

and can support patients to write letters or complain. They write reports and request improvements from providers (the reports are not published on the CQC website).

4.9 National Customer Service Centre

CQC also runs a National Customer Service Centre, which responds to queries and concerns from providers, health and social care professionals, and members of the public across the country. The web page (https://www.cqc.org.uk/contact-us) invites phone calls, letters and emails from the public and others, and provides a 'Tell us about your care' link. The NCSC team is based in the Newcastle office and in 2014, for example, had 400 team members. In 2013/14, they received over 238,600 calls and 72,000 emails.

Information coming into the NCSC is considered using a complex decision-making tool. It is then rated for priority, and can be passed on to the relevant Local Authority safeguarding lead. Information is also passed on to the CQC relationship owner for the relevant service. The relationship owner may then seek further information from the provider and may decide to make an unannounced focused inspection of the service.

4.10 Registration

According to the CQC website, 'any person (individual, partnership or organisation) who provides regulated activity in England must be registered with CQC, otherwise they commit an offence'. There are 14 different regulated activities, such as personal care, nursing care, substance misuse services, diagnostic and screening procedures, surgical procedures, maternity services, and so on. Some organisations may provide more than one of these. In the case of Whorlton Hall, it was registered to provide:

- Assessment or medical treatment for people detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

The registration process is rigorous and is designed to ensure that those setting up services have the skills and knowledge to do so.

5.0. CQC's inspections of Whorlton Hall

There were seven inspections in all, between 2015 and 2019. The last took place in May 2019, after CQC had been notified about the Panorama programme, but just before the programme was aired on TV. All of the inspection reports are available on the CQC website and so they are not given here in full, but are summarized (with links to the full reports on the CQC website for those who wish to read the full versions)[14].

It is striking that at each inspection:

- There were only 7 to 9 patients present (although, at other times, there were apparently somewhat more patients in Whorlton Hall, but never as many as 19).
- In all inspections, access to a multi-disciplinary team at Whorlton Hall is mentioned. Each time, they are said to visit on Tuesdays only, although there is provision for access to psychiatry at other times if needed.
- In every single report (apart from inspection 3 where patients' views were not mentioned and inspection 7 where they were unavailable), in the section 'What people who use the service say', patients and carers are said to be positive about the service. For example, 'Patients told us they were generally happy with the care and treatment provided' (inspection 1, see below); 'Patients told us they felt safe and liked staff' (inspection 2); 'Patients told us they felt safe…. They liked the staff and thought they were caring' (inspection 4); 'Patients and carers told us staff treated them well' (inspection 5 and similar wording in inspection 6).
- In the sections on *Caring*, where this domain was considered, all of the inspection reports say 'staff spoke to patients in a kind and respectful manner' (inspection 1), or 'we observed staff being kind and respectful to patients' (inspection 2) or use similar wording (inspection 5, 6 and 7).
- Three of the seven inspections (1, 2, and 5) were comprehensive, in which all 5 domains were inspected and rated. The other 4 inspections (3, 4, 6, and 7) were responsive and focused on particular domains. Some of these focused inspections did not provide ratings of the domains (in inspection 6 no domains

[14] https://www.cqc.org.uk/location/1-894121431/reports

were rated; the others rated some but not all, even of the ones they were focused on).

These points will be returned to later.

5.1 Inspection 1 (August 2015)

Prior to the first CQC inspection in 2015, there had been three whistleblowing alerts regarding Whorlton Hall. The first was reported by a senior member of Danshell staff (on 6/3/15), who advised that Danshell head office had received an anonymous letter saying that a member of Whorlton Hall staff had talked about putting a patient's head down the toilet, then flushing the toilet[15]. The investigation by Danshell highlighted poor practice by the member of staff mentioned, and a second member of staff, and both were investigated by Danshell via the disciplinary route (one was sent to a different service for some months but later allowed to return).

The second whistleblowing alert (19/6/15) came from a staff member (of a non-Danshell service) who was visiting Whorlton Hall, prior to offering one of the residents a placement in the community. A series of inappropriate remarks by staff were reported, alongside confrontational handling of a dispute. The provider was informed and an internal investigation apparently followed.[16] The service user involved, several months later, made allegations that a staff member hit him, telling his mother 'You've got to get me out of here'[17] (he later retracted his statement).

The third whistleblowing event involved the NHS Improving Lives team who visited in June 2015 for two days to look at the service for one particular informal resident (due to a dispute about funding for this resident, who was due to be moved to another setting). The team of four included the Deputy Lead of the Improving Lives Team, and they interviewed a number of staff

[15] ENQ1- 2024865759
[16] ENQ1- 2223209107
[17] ENQ1- 2280019470

members at Whorlton Hall, as well as a representative of the local CCG and the resident's LA. They had the following concerns[18]:

- A distinct lack of meaningful engagement between staff and patients over the two days
- High use of agency staff
- A lack of therapeutic/professional involvement in patient care. Including (low) frequency of visits from responsible clinician/ psychiatrist as well as Speech and Language therapist, O/T and behavioural specialists etc.
- Blanket policies being adopted and followed rigorously despite individual needs and circumstances (for example, in relation to the person the team reviewed, this became apparent on her access to the community and hospital vehicle).
- Segregation used routinely as a policy of admission/induction to the service for all patients.
- People/patients left alone and over reliance on room/door sensors with no obvious care planning, risk assessment or meaningful structure. Observed and questioned by the team, as staff were observed running from an outside smoking area to support a patient who was reportedly on 2:1 staffing and likely to be targeting another patient.
- Inappropriate use of the Mental Health Act. Seen in relation to the person/patient being reviewed. She was an informal patient who had repeatedly had nurses holding powers used when she wanted to leave the building and go shopping. This caused her considerable distress and confusion as the practices seemed to be undertaken only by staff she had a poor relationship with and wanted to avoid.
- Sparcity of official paperwork available to the team to review and take a view on care planning/interventions etc patient records had inconsistent and intelligible daily entries/running records.
- There was also considerable debate as to the future of the service as The Danshell Group had begun changing their models of care from Hospital status to Registered Care Homes with Nursing. Many staff spoken to expected Whorlton Hall to be the next in line for this request

[18] ENQ1-2151587261. This detailed list is taken from communication by email from the Improving Lives Team to David Noble and is covered in DN's report

> for a change of use/registration, reference being made to a sister service near Hexham where this had occurred when similar access to professional and hospital infrastructure was problematic for the organisation to consistently provide.

Against the background of these three whistleblowing events, the first inspection of Whorlton Hall took place, in August 2015. It was a comprehensive inspection, led by Barry Stanley-Wilkinson.

There had been a Provider Information Request prior to the inspection and, according to the data pack (of 38 powerpoint slides) sent to the inspector, a number of concerns were recorded about Whorlton Hall. For example, there had been 17 serious incidents over the previous year (June 2014-May 2015), including one service user stating that 'Im sick of you knocking me about', another saying 'I hate (X, a staff member), he hurts me for no reason, he picks on me'. A number of other complaints had been made about the service (see also above). There were 129 incidents of restraint in six months, across 10 different service users. Nevertheless, the provider reported over 80% satisfaction levels in their service user survey. The provider values included statements that they would 'respect the human, legal and civil rights of the individuals using their service' and 'provide care and support that is safe, evidence based and outcomes focused', using 'positive and strengths based approaches'.

As regards staffing, there was a high vacancy rate of 37% in June 2015, with turnover of 17% across the year, and a very high sickness rate of 25%, with about 60 shifts/month covered by agency staff in each of several months. There were very poor levels of training on MCA and DoLS (12%) and mental health (5%).

When the inspection took place in August 2015, the inspection team was large (one lead inspector, two inspectors in training, one inspection manager, one psychiatrist, one psychologist, one OT, one pharmacist, one expert by experience and their support worker). There were only 7 people with learning disabilities/autism in Whorlton Hall at the time. Subsequently, the CEO, complained about the size of the inspection team (though not all members were present on each day and they had specific tasks to carry out), and their

occasionally disrespectful language, amongst other issues. The inspection report was not initially published by CQC, though it went through a series of drafts (this is discussed in detail in David Noble's report)[19]. The drafts were not substantially different from each other and so the findings of the report are summarized below from the latest version (post-IM).

The inspection found some positive points in the care regime at Whorlton Hall (for example, staff reported incidents of abuse, residents said they were treated with dignity and respect, they had access to advocacy, they had health action plans) but the inspection team also found a whole series of difficulties: they listed 22 issues that caused them to rate the service as 'Requires Improvement' on all five domains. For example, there were serious environmental concerns, which made the setting unsafe; staff training in mandatory subjects was inadequate; staff had limited understanding of patient's communication needs; there were no discharge plans; there were insufficient night staff. A series of breaches of regulations were identified and Whorlton Hall was rated as **RI on all 5 criteria,** although the final report was not published[20].

The inspector did meet with the provider a few days after the inspection to discuss the outcome with him. As a result the provider developed a 35 point action plan (see David Noble's report for details).

5.2 *Inspection 2 (March 2016)*

This was described as a comprehensive inspection, and according to CQC it took place because 'not enough evidence was gathered to give an accurate assessment' in the August 2015 inspection. Despite it being a comprehensive inspection, no Provider Information Request was made (presumably the PIR from the previous inspection was relied on). The final report was published in June 2016.

The inspection team consisted of two inspectors and one Specialist Advisor (a nurse). Since the August 2015 inspection, the provider's senior managers

[19] https://www.cqc.org.uk/news/stories/cqc-shares-previously-unpublished-findings-2015-inspection-whorlton-hall

[20] The reasons for this are covered in David Noble's report

and registered manager (who had been in post since 2015) had developed a detailed action plan and there had been some marked improvements. For example, the safety of the environment was considered good, staffing levels were adequate, staff training in the MHA (97% completed) and MCA (95% completed) had improved, as had residents' assessments (e.g. of communication needs, of mood, and of mental capacity) and care plans (including formulations and treatment plans). Residents were positive about staff and they had access to advocacy. **The overall rating in the final CQC report was 'Good', with four of the criteria rated as 'Good' (*Effective, Caring, Responsive, Well-led*) and one rated as Requires Improvement (*Safe*)**, mainly due to the lack of emergency medicines and other medication issues.

There had been some discussion at SQAG and NQAG about the ratings: originally the overall rating had been RI (with *Effective* and *Safe* rated as RI), but NQAG altered *Effective* to 'Good', as the deficits were minor, and hence the overall rating was 'Good'.

There had been 188 restraints in 6 months and seven serious incidents in the previous year. Staff turnover was not given; agency rates were not given; sickness rate was 9% in the previous 12 months.

5.3 Inspection 3 (August 2016)

Prior to this inspection, Durham Safeguarding alerted CQC that they had received a referral (on 11/8/16) from an advocate at Whorlton Hall, who had major concerns about staffing[21]: there had been four managers in 3 years and the 4th had just resigned after only a few months in post, leaving an interim manager in place. Seven staff had gone off sick, some new staff had worked a couple of shifts but then not returned to work, and police had been called to several incidents. Some staff had worked 24 hr shifts, there were staff working in dual roles, and some staff had worked 31 days in a row. These events seemed to have followed the admission of two new residents with very high support needs. The Durham Practice Improvement officer and a CQC inspection team visited Whorlton Hall on 15th August (see below). The issues

[21] ENQ1-2844757156

were discussed at an Executive Strategy meeting on 24th August 2016, led by Durham County Council (with a CQC inspector in attendance), which concluded that 'at present Danshell were failing to meet their duty of care to both residents and staff'.[22] This was the first Executive Strategy meeting concerning Whorlton Hall.

The CQC inspection took place on 15th August and was responsive, unannounced and focused. The inspection team consisted of two inspectors and one specialist advisor. The inspection focused on *Safe* and *Effective* and the team identified a number of problems with both. *Well-led* was not inspected, though this is very surprising, given the staffing issues identified by the advocacy service and the concerns about the resignation of the manager.

The inspection team found that, in relation to *Safe*, there had indeed been staffing shortages over the previous months, such that some staff were working in multiple roles, and staff and patient safety had been put at risk. There were also parts of the hospital that were not clean. However there was an action plan in relation to both of these issues. In relation to *Effective*, the service had not identified one patient as in long-term segregation, despite that fact that the person's care met the Mental Health Act definition for this. ***Effective* was thus rated as RI; *Safe* was not rated** 'because (we) did not carry out a full inspection'. It was not unusual for focused inspections to result in no ratings, the rationale being that if only part of the care has been inspected it is not reasonable to provide a rating. It was also argued that the action plan obviated the need for a rating of RI for *Safe*. In this case, there appear to have been several SQAG meetings, which had discussed whether or not *Effective* should be rated, and it was concluded that it should be.

There had been 233 restraints in 6 months, and 17 serious incidents in 6 mths (police had been called in 6; in 10, one patient had accused another of abuse; and in one there was an allegation of abuse by two staff against one patient). Staff turnover was not given but seven permanent staff had recently resigned; sickness rates were not given; agency staff use was not given. The final report was published on 15th February 2017, about 5 months after the inspection.

[22] ENQ1-2897161719

5.4 Inspection 4 (November 2016)

This was a focused inspection, undertaken in order to check that actions from the last inspection had taken place and to ensure that staffing problems had been alleviated. Just prior to it, there had also been an anonymous complaint about the provider (31/10/16), alleging that two members of staff were taking cocaine (it was not known if this was during working time)[23]. It was unclear what action followed this complaint.

The inspection concentrated on *Safe* and *Well-led* (it was surprising that *Effective* was not questioned, given it had been rated as RI in the previous inspection). The inspection team consisted of two inspectors and one specialist advisor (nurse). The inspection found that there was a new manager in place who had been in post less than a week. There was an improvement in resuscitation equipment but anaphylaxis medication was still not available. There were gaps in the domestic staffing, meaning some areas were not as clean as they should have been. The long-term segregation issue had still not been completely resolved and paper records were not easy to locate and sometimes very short (in the case of governance meetings). However, the inspection team recognized various improvements since the previous August inspection, including to numbers of staff and their morale, and it was considered that the new manager would continue these. Overall the rating was **RI**, **with *Safe* rated as RI and *Well-led* as Good.**

There were 32 restraints over 2 mths and 5 serious incidents in 2 mths. Staff turnover was 46%; long term sickness was 3%; agency staff use was 'regular' but exact figures were not given. Mandatory training levels were below 72% on average, with 6 of the 14 areas below 75% (eg training on the MCA was 56%).

The report was published on 17th February 2017 (only two days after the previous inspection report was published).

[23] ENQ1-3028474594

5.5 Inspection 5 (September 2017)

During early 2017, there were a number of safeguarding concerns. For example, four different residents alleged that they had been hurt, punched, kicked, or had their hair pulled by staff. All four later retracted their (sometimes multiple) allegations. In another safeguarding referral, an ex-member of staff alleged that two staff members had carried out serious assaults against two residents[24]. It was decided by Durham Adult Protection that this should be investigated by police. The police found no corroborating evidence and it was concluded that the allegation was malicious.

In September 2017, a routine comprehensive inspection was planned and it was preceded by a Provider Information Request. The provider information that was returned was analysed by CQC analytics department and passed to the inspectors in the form of a very detailed powerpoint file (with 73 slides). The data showed that there were 8 different CCGs purchasing care at the time, for 9 patients, and there was an average length of stay of one year. Over the previous 12 months there had been a 4% sickness rate and a 54% staff turnover rate, with 370 shifts covered by agency staff over the last 3 months. Mandatory training was above 75% compliance, apart from Mental Health Act awareness (67%), for which training was booked. A number of audits were undertaken in relation to e.g. the MHA, MCA. Three staff had been dismissed over the year and two were reinstated after 'false allegations made by a colleague'.

The provider reported having completed a patient satisfaction survey in September 2016, using Talking Mats for 5 patients and staff observations for 4 patients (as they were unable to use Talking Mats). The results were very positive. In relation to safeguarding over the previous 12 months, there had been no safeguarding alerts and 15 safeguarding concerns, all now 'closed'. There had been 23 notifications, 3 in error, 12 related to abuse or allegations (all closed), 4 police incidents (all closed) and 4 DoLs applications. They recorded 128 incidents of restraint in the last 6 months (with 6 different patients). As part of their Duty of Candour statement they said 'We recognize this requires us to ….. act with honesty, integrity and transparency at all

[24] ENQ1-3495516821

times'. They added that 'Danshell is committed to promoting a culture that encourages candour, openness and honesty at all levels'. They reported 36 serious incidents over the previous 12 months, the vast majority of which were allegations by patients of abuse by staff (n=33), almost all of which were noted as 'retracted'. Danshell gave details of how all such incidents were dealt with in the company.

The inspection team consisted of 2 inspectors, a pharmacy advisor and one specialist advisor (a nurse). The inspection team reported that there were clear improvements in a variety of areas, including to the cleanliness of the environment, staffing, staff supervisions, staff mandatory training (84% in the MHA; 84% in the MCA), and there had been a staff survey with positive results. There was provision of easy read information for patients. There were a range of assessments undertaken, and positive behaviour support plans. There had been a patient satisfaction survey with positive results (over 80% said they were happy with the service overall) and carers were sent weekly newsletters specific to their relative. The patient in long-term segregation engaged in some group activities (in the garden) and there was a plan for reintegration. All five domains (Safe, Effective, Caring, Responsive, Well-led) were rated as 'Good' and t**he overall rating was 'Good**'. The report was published in December 2017.

5.6 Inspection 6 (March 2018)

This unannounced inspection took place in March 2018, and was in response to two pieces of whistleblowing information (see below), concerning 'staffing, patient safety, culture and incident monitoring' (see page 5 of the inspection report).

One anonymous whistleblowing letter, of 6 pages, dated 5/2/18, described a 'deterioration in the culture of Wholrton Hall' and requested a full investigation by an outside agency, as he/she had reported the problems previously within Danshell (10/11/17) but had received no response[25]. The letter detailed a 'culture of bullying', with an 'obvious clique of management and support staff

[25] ENQ1-4834659995

who consider themselves the alpha group'. The letter went on to say this group also referred to themselves as the 'Cunts Club', and he/she named 6 members of staff, of whom two had been 'investigated in the past for this same reason'. The whistleblower reported that the deputy manager threatened staff with the sack if they complained and showed 'no regard for the service users'. The letter went on to detail very poor treatment of service users, inappropriate use of staff (some of whom were allowed to sit in the office all day, some were allowed 100s of hours of overtime), overuse of agency staff who were inexperienced, and a number of other matters.

Another whistleblower contacted CQC on 8/2/18 and complained that there was a high turnover of staff at Whorlton Hall because 'the unit is poorly managed and maintained' [26]. The unit was said to rely on agency staff who were poorly trained, often slept at night and did not follow care plans. The only time any effort at improvement was made, according to the whistleblower, was before the CQC inspection in September 2017.

The completion of the CQC decision tool following these whistleblowing events led to senior Danshell staff being contacted for their explanations, and then CQC decided to conduct an inspection. The inspection was a focused one, looking at *Safe, Effective, Caring* and *Well-led*. The team consisted of two inspectors and one specialist advisor (a nurse). **None of the criteria inspected were rated**, but there were major concerns over staffing (for example, 25 shifts of 24 hours length in the last 3 mths; overuse of agency staff whose training was not monitored, and poor supervision). There were no plans to mitigate the extended shifts. Nevertheless, the report records that staff said 'morale was positive', 'they felt happy in their roles' and 'felt supported, respected and valued by management'. Staff 'told us there was a culture of openness within the service and the wider Danshell group'.

There were 190 restraints over 3 mths (92 of these related to one resident). Staff turnover was 28% in the previous 12 months; sickness was 3 %. Two staff had been suspended in relation to an issue about inappropriate restraint (this had been observed on reviewing CCTV on 26/1/18) and a number of staff reported that relationships had improved since then. However, there

[26] ENQ1-4839461816

were a large number of vacancies (one nurse and 34 HCA vacancies) so that staff worked a great deal of overtime, and agency staff had covered 821 shifts in 3 months. In one month, for example, 41% of shifts were covered by bank and agency staff. Ancillary staff were sometimes involved in restraints. The full inspection report was published in May 2018.

The original whistleblower then complained[27] (22/5/18) that they had undertaken 'a minimal flawed inspection' and taken 'the word of the service manager that there was no abuse'. He doubted that they had spoken to 13 staff members outside of the cartel of abusive staff he had named and did not believe they had interviewed 6 service users and two carers.

Further allegations also arose. For example, in May 2018, a member of staff alleged that a Health Care Assistant had assaulted a resident, and this was investigated by police[28]. There was no further action, as the CCTV in the resident's area was insufficient to show the event had occurred. Some months later another whistleblower contacted CQC (7/8/18) concerned about the restraint that one particular service user was experiencing (involving holds by 8 staff) [29]. There followed further whistleblowing messages (16/8/18 and 10/10/18) regarding the lack of staff, overuse of untrained agency staff, under-reporting of incidents, care plans not being followed[30]. These were followed by discussions with the provider and a series of meetings (24/8/18, 4/9/18 and 17/10/18), in which it was decided that further action was not required because of the provider's response, which had included involvement of the police in relation to one incident, agreement to install CCTV, promises of alterations to Ulysses (allowing all staff to insert details of events such as those leading to restraints), closer attention to staff supervision, including for agency staff, and assertions that there was no problem with the staff culture. Follow up meetings were planned for January 2019.

4.7 Inspection 7 (May 2019)

This inspection took place in May, just before the Panorama programme was

[27] ENQ1-6904653152
[28] ENQ1-5199579345
[29] ENQ1-5585533840
[30] ENQ1-5623989932 and ENQ1-5868651968

aired (but after CQC had been informed about the programme). The inspection team included three inspectors and a pharmacy specialist.

The domains *Safe, Effective* and *Well-led* were all rated inadequate; insufficient information was said to have been collected on caring and responsive for them to be rated. At the time of the inspection, there was a police investigation on-going, relating to the alleged abuse, and a number of staff had been suspended, including the registered manager and deputy manager. These staff could not therefore be interviewed. Service users and family members could also not be interviewed, due to the police investigation. Overall the service was rated as Inadequate.

At the time, restraint was being very frequently used and rapid tranquilisation had been used 3 times in the previous year, sometimes without physical health observations. Staff training records could not be located at first, and patients had several different case files making retrieval of information difficult. Care plans were observed as not always being followed. Nevertheless, staff were said to provide ' a range of care and treatment interventions suitable for the client group'.

As regards staffing, the establishment was for 7 registered nurses (no vacancies), and 90 support workers (49 vacancies), with 7511 shifts covered by agency staff over the year, about 50% of shifts. The turnover was 51.8% in 12 months and sickness rate 2.45%. Recruitment procedures 'to ensure staff were of good character or had the necessary qualifications, competence, skills and experience …. were not operated effectively'. However, staff spoken to said 'they felt respected, supported and valued'.

Despite staff having apparently received positive behaviour support and reducing restrictive practices training, over the previous year, there were 1348 episodes of restraint, of which 755 of these were floor-based holds and 593 were non-floor based holds or other interventions. Fifteen different patients were restrained during this period of time.

6. Interviews with CQC staff

Interviews were held with Inspectors, Inspector Managers, Specialist Advisors, and a Mental Health Act reviewer, all of whom had been involved with inspections and/or visits to Whorlton Hall. In addition, representatives of CQC's National Customer Service Centre, Intelligence and Analytics department, and Registration section were also interviewed. Interviews undertaken by David Noble for his review were also made available (see his report for details - these mostly related directly to the first two inspections).

6.1 Inspectors, Inspector managers and SpAs

The inspectors interviewed were asked about their impressions of Whorlton Hall, as well as about the details of their inspections. All had followed CQC procedures and were committed and thoughtful in their interviews.

All of the inspectors said that they felt the building was inappropriate for an assessment and treatment unit, and that the building was part of the problem: it was large, old, with many complexities, including multiple staircases, and nooks and crannies. Line of sight was very limited in many places in the building. Moreover, the building was 'in the middle of nowhere' so that staff recruitment was problematic and this meant that agency use was likely to be high. It also meant that there was limited access for family members, whose sons/daughters/loved ones were resident, particularly because the family members often lived a long way from Whorlton Hall (a large number of different CCGs were purchasing places at Whorlton Hall).

All of the inspection reports that considered the *Caring* domain noted that service users had been spoken to during inspections. None reported that service users were unhappy with the service. However, inspectors and SpAs explained that service users were mostly spoken to in the presence of staff, since many of them were on 1:1 observations. Nevertheless, staff were reported to be treating service users with dignity and respect, in the inspection reports. *Caring* was never rated as RI during any inspection, apart from the first one.

Most of the inspectors said that they noticed nothing problematic about the atmosphere in the home. This was confirmed by at least one Specialist Advisor who visited quite often, including for Care and Treatment Reviews. Nevertheless, 3 inspectors, all of whom had done unannounced inspections at Whorlton Hall, said that they felt 'uneasy' in the service, or said that the service was 'very unsettled' and 'there was a lot of undercurrent with the service …. it was one of those places when you went in there, you got a feeling about it'. Another said 'You go in and you get a feeling and you look at the evidence… and you think there is something not quite right'. They all found it difficult to put into words why this was, though they could give examples (eg tea stains on the wall; dirty conditions; food on the floor; poor maintenance of areas; lack of activities; 'arrogant' and 'defensive' attitudes of the manager and some other staff members who were interviewed; attempts to 'baffle' the inspectors when paperwork could not be found). At least one inspector felt that 'staff never seemed to be comfortable talking to us'. When asked how this was reflected in their inspections, they reported that the material signs had been included (eg dirty conditions), but as one commented 'you can't write a report based on a feeling, can you?'

Inspectors were shocked by the Panorama programme. Even where they had rated aspects of Whorlton Hall as RI, none had witnessed abuse. Many felt responsible for missing putative signs and said they were really worried about missing such signs in other services too. However, looking back none felt they *had* missed signs, rather they felt that staff had deceived them deliberately.

In preparation for inspections, all of the inspectors commented that they had found it difficult to access information, such as previous notifications and abuse alerts, on the CQC system, including when they were relationship owner. Some had constructed their own spreadsheets so as to keep track of such issues. Moreover they felt there were far too many changes in relationship owner, so that it was difficult to really get to know a service.

Inspectors generally felt that they had insufficient time in inspections (usually 2 or 3 days, though some focused inspections were shorter), and they thought that abuse would be easier to spot with longer inspections, especially if they were unannounced. However, as one inspector commented, he/she

had seen the Winterbourne View programme on TV and thought ‘Oh I wouldn't have missed that’. He/she said that it was profoundly shocking when it transpired in May 2019 after the Panorama programme on Whorlton Hall, that he/she had done just that.

When asked, inspectors had a number of suggestions for improving inspections and these will be discussed later.

6.2 Mental Health Act reviewer

The Mental Health Act reviewer explained that she worked in a different way from the inspectors. Her job was to go, about twice a week, into wards, unannounced, where people were detained under the Mental Health Act. During those visits ‘my priority is to speak to the patients and find out from them their views or thoughts, perceptions, to check that the Mental Health Act is being used correctly’. Mental Health Act reviewers also check paperwork, such as care plans, or restraint records, but their actions are led by what the patient tells them. After the visits, there is a report written which is sent to the provider but is not published. Typically, the report will refer to the MHA Code of Practice, relevant sections, and ask the provider to explain what they plan to do to improve their practice.

Each MHA reviewer may cover a large number of wards (for example, over 100), and some of their work will involve whole mental health trusts while some will involve single ward services, like Whorlton Hall. When asked about the links with inspectors, for the services they were reviewing, the MHA reviewer commented that these were very variable. Ideally he/she thought the MHA reviewer should be considered part of the local team, and should have good relationships with all the local inspectors. Until recently, though, MHA reviewers did not get alerts about abuse, nor did they have access to these on CRM, and alerts would only go to the relationship owners for the service in question. MHA reviewers typically would call or email the relevant relationship owner, prior to going to visit a particular service, in order to find out whether there had been recent concerns. However, inspectors may be out on visits and not all of them returned the calls or emails.

The Mental Health Act reviewer had been on four visits to Whorlton Hall since 2015, approximately once per year, the most recent time being in April 2019 (shortly before the Panorama programme was aired). S/he felt that the setting was a difficult building for such a service because it was impossible to know what was going on everywhere. However, his/her experience was that Whorlton Hall was operating their responsibilities under the Mental Health Act properly. They sometimes had no actions to do following MHA visits, which in his/her experience of other services was very rare. However, s/he was concerned about the volume of staff changes there, and the fact that s/he was taken everywhere by staff when there.

Service users in Whorlton Hall had limited communications skills and were often on 2:1 staff observations, limiting the privacy that the MHA reviewer had. S/he also felt that s/he had limited experience in learning disabilities, so that although s/he had some Makaton from a previous job, s/he was often unsure whether the person s/he spoke to really understood the questions, and was sometimes unsure if s/he understood their responses. In general their conversations could not go much further than talking about their basic needs and, for example, their recent activities, the food, the staff, and sometimes the only responses they could make were a thumbs up or thumbs down.

The MHA reviewer did not feel that staff tried to stop him/her talking to particular service users, but s/he did feel very heavily supervised. S/he was not left to go around on her own (c.f. in medium secure services). Sometimes s/he was advised that someone was ‘too unsettled’ but s/he would usually leave that person til later and try again. At times s/he was unable to see a service user because s/he was there on her own and staff insisted there needed to be two people to conduct the interview. On one occasion, s/he did interview the young woman (A.) who was later shown on the Panorama programme, very distressed. She had been calm when the MHA reviewer arrived and was being shown around the building, but became upset later, screaming. The MHA reviewer was then able to see her on her own in her bedroom and asked her about what was upsetting her. The woman was only able to say ‘I don't want to be here’; ‘I shouldn't be here’; ‘Im not sectioned’ (she was sectioned but believed she was not). She also said she did not want to come out of her room and this seemed to be more because of the other

patients than staff. She appeared to have a good relationship with the female staff member who was outside her room at the time.

The MHA reviewer also managed to interview the person in segregation (in April 2019, because s/he was with colleagues) but he became upset at the end of the interview, when s/he went to leave, punching the doors and walls. The young man was not happy there but was positive about the staff, and in the MHA reviewer's experience this was typical of those at Whorlton Hall. This was also often the case with people in other hospitals s/he visited (about 70% would want to leave). Only the more able people in her experience, in mental health wards, and only when they were recovering, were able to say that they did not want to be there but recognized that they needed to be treated at the time.

At times, the MHA reviewer would meet people who had been at Whorlton Hall, after their discharge to other services. They would often recognize him/her but s/he was not always able to speak to them (as s/he was in a setting for other purposes). On the occasion when s/he was able to have a conversation they would complain more about their current service than their previous one.

6.3 National Customer Service Centre (NCSC)

The National Customer Service Centre takes all the calls, emails and web-based contacts about health and care services. These can come from anyone, including staff, family members, service users, and members of the public.

The lead for NCSC was interviewed in order to understand the processes followed in NCSC, since 2015, particularly in relation to Whorlton Hall. Essentially during the period 2015-2019, the same 3 routes were available for contacting CQC (calls, emails and web-base contacts). When calls came in there were 4 options offered: the general enquiries line, the mental health line, the safeguarding line, and registration. Where callers were uncertain they would be put through to general enquiries and could then be allocated to the appropriate line.

Whichever ways calls came in, the advisors followed a complex decision-making tool, allowing them to triage the information. The tool guides the advisor to ask the caller a series of questions in order to decide the priority level of the information. There are four possible levels: a safeguarding or whistleblowing alert, priority 1; other safeguarding concerns, priority 2; medium concerns, priority 3; and low level concerns, priority 4. Each priority level rating leads to a set of actions. For level 1, if the caller said that CQC was the first to know about the concern, the local authority would be contacted on the same day 'to alert them to the situation and ensure that there is action being taken'. The NCSC advisor would also contact the CQC inspector who was relationship owner for the service in question.

All concerns, however they came in and however minor they seemed, were recorded, and if the service named by the caller was Whorlton Hall, then they would have been recorded against Whorlton Hall in the system, on CRM, and shared with the relationship owner. The NCSC takes thousands of calls a year and has a considerable number of advisors, so it may be that a series of minor concerns come in about the same service, to different advisors. In such circumstances it is clearly important for all the calls to be logged, as while they may each be minor, together they may indicate that something is happening to a provider, that is making it fail.

However, the NCSC lead said that the CRM system that logged all these contacts was difficult to use. He agreed with the inspectors' view that it was not easy to pull up a list of concerns that had come in, over the last few months for example, in relation to a particular setting. He thought that, were it possible, it would also assist call advisors, as it would help them when a complaint came in about a particular setting to be able to quickly call up the last series of complaints, whistleblowing episodes and abuse alerts about the same setting.

6.4 Other CQC interviews.

A number of other CQC staff were interviewed in order to understand the following issues:

- ***Training***

The lead for Learning explained the induction and training programmes for inspectors, assistant inspectors and SpAs

- ***Registration***
  A senior staff member in Registration explained the process that was required in order to register services like Whorlton Hall. The interview also covered how services change their registration, whether they can expand once registered, and how registration requirements were changing.
- ***Intelligence and Analytics***
  Two staff in Intelligence and Analytics were interviewed in order to understand the work they do to analyse provider information returns for inspectors. They also explained the new Insight tool and the focused analysis of several independent health care providers.

7.0 Local Social Services and CCG interviews

A representative from Durham Social Services and a local CCG representative were also interviewed about Whorlton Hall. They said that neither the local Social Services nor local health commissioners had placed service users in Whorlton Hall in the last 6 months.

Both asserted that there had been no deliberate decision to stop using Whorlton Hall. They had had no serious worries about its quality of care (prior to the Panorama programme). They both noted that they felt the building was very unsuitable for an assessment and treatment unit, in that it was old and rambling, with many corridors and staircases, miles from town, so that it was likely to have staff recruitment issues. They also noted that there were some problems, such as occasions when the police had been called in, and abuse alerts, but they both felt that the following four factors meant that they did not feel unduly worried:

- There were numerous visits to Whorlton Hall by outside agencies (see Table below)
- Police had not been concerned about the service when they were called in

- The provider appeared to be being transparent and reporting abuse responsibly
- The service managers had action plans to improve matters.

The Health commissioner commented that one of the problems was that so many different commissioners used Whorlton Hall. Each of them was focused just on their own service users. The local CCG (ie. Durham) had no particular coordinating role at the time and would not typically have received information about issues such as repeated changes of manager at Whorlton Hall.

The local CCG commissioner interviewed had listed the visits by CCGs, Local Authorities, and Mental Health and Learning Disability Partnerships to Whorlton Hall in the last 9 months (June 2018 to Feb 2019). These are summarized in the Table below. The numbers of GP visits from residents of Whorlton Hall over the last 9 months (June 2018 to Feb 2019) were also listed: there were 106 visits to the GP by service users and 15 visits by the GP to Whorlton Hall.

Table 1 CCG and LA and other professional visits to Whorlton Hall

Date	Who came	Purpose
12 visits across June, July, August 2018 (2 of these were done jointly between two organisations, these are counted separately in next column)	4 visits Durham LA Practice Improvement Officer	3 Monitoring visits plus one visit to collect info
	5 CCG visits (3 different CCGs)	I to collect info, 1 admission, 1 CPA, 1 CTRs & 1 complex case preparation
	4 Mental Health & Learning Disability Partnership visits	1 meeting re discharge, 1 assessment visit, 1 Tribunal meeting, 1 CTR

13 visits across Sept, Oct, Nov 2018 (2 of these were done jointly between two organisations, these are counted separately in next column)	4 visits Durham LA Practice Improvement Officer	3 monitoring visits, 1 visit to reflective practice meeting
	8 CCG visits (4 different CCGs)	4 CTRs, 1 monitoring visit, 1 re admission, 1 discharge meeting, 1 visit to reflective practice meeting
	3 Mental Health & Learning Disability Partnership visits	1 CPA, 1 discharge, 1 section 117 meeting
12 meetings across Dec, Jan, Feb 2018-2019	1 visit Durham LA Practice Improvement Officer	1 monitoring visit
	2 visits Derbyshire care managers	2 visits to MDT meetings
	7 CCG visits (4 different CCGs)	1 admission, 4 CTRs, 1 visit to MDT meeting, 1 discharge meeting
	2 Mental Health & Learning Disability Partnership visits	1 mental capacity assessment, 1 CTR/CPA meeting

It seemed therefore that, in addition to any CQC visits, there were a considerable variety of other health professionals visiting Whorlton Hall, none of whom had voiced concerns about abuse. Occasionally professionals had concerns about (for example) their service user's care plans and had gone back for a follow-up visit, or concerns about staffing, but the provider appeared to be responsive and typically had action plans in place.

At the request of the independent reviewer, the Durham Local Authority representative summarized its Executive Strategy meetings, monitoring visits and all abuse alerts (adult protection and section 42 enquiries) at Whortlon Hall over the (almost) three years from August 2016 to mid-May 2019. A summary of these is given in the Table below.

Table 2: Durham Local Authority Executive meetings, Planning meetings, Practice improvement visits, Adult Protection and section 42 enquiries relating to Whorton Hall between August 2016 and May 2019

Date	What type of event	Number
Year 1 (Aug 2016 to end of July 2017)	Executive Strategy or Planning meeting	4
	Monitoring visit Practice Improvement	1
	Adult Protection	1
	Section 42 enquiry	7 (5 retracted by 3 different clients)
Year 2 (August 2017 to end of July 2018)	Executive Strategy or Planning meeting	2
	Monitoring visit Practice Improvement	7
	Adult Protection	2
	Section 42 enquiry	20 (6 retracted by 2 different clients)
Year 3 (August 2018 to mid-May 2019)	Executive Strategy or Planning meeting	3
	Monitoring visit Practice Improvement	9
	Adult Protection	4
	Section 42 enquiry	40 (11 retracted by 5 different clients)

From the Table it seems that there were an escalating number of concerns being generated by Whorlton Hall over that three year period. A large number of concerns in a short time, or concerns where the provider seemed not to be taking action, would tend to lead to an Executive Strategy Meeting. In the

case of Whorlton Hall, it seems that there were Executive Strategy meetings or Planning Meetings every few months. Nevertheless, the Durham representative said that Whorlton Hall was not particularly unusual: he estimated that around 10% of their settings would be going through Executive Strategy meetings each year.

It appeared that the computerised recording system in Durham allowed some data to be easily extracted (eg. records relating to a particular service user, or records relating to services Durham commissioned), but other data, such as that related to Whorlton Hall, a health provision Durham was not commissioning, was much harder to extract. Moreover, 'whilst the local authority had lead responsibility in terms of coordinating safeguarding, it did not have the same power, influence and control as it would do over a service it commissioned'. The fact that Whorlton Hall was a health provision and a whole variety of different area's CCGs were involved in commissioning places at Whorlton Hall, added to the complications when safeguarding issues arose, since the relevant local authority would normally be the one where the service user had originally come from (so Durham LA would have to pass the information on to the relevant Local Authority).

8.0 Whistleblowers, Advocates and previous Danshell staff

Interviews did not take with Cygnet staff, following concerns raised by that organisation, concerning the application of the terms of reference and context of on-going criminal investigations.

However, interviews were conducted with two ex-Danshell staff who were whistleblowers; and several other staff who had worked in Danshell during the 2015-2019 period but had since left to work in other organisations. In addition, two Advocates previously employed by Vocieability were interviewed.

8.1 Advocates

The two Advocates had been frequent visitors to Whorlton Hall, one or other being there all day for one day per week (or two half days), over a period of

some years (they stood in for each other during periods of leave). Both thought Whorlton Hall a very unsuitable building for a hospital, given its numerous corridors, stairs and several floors. They felt that, when they were there, it was difficult for them to be sure what was going on elsewhere in the building and they considered this would have applied to the manager too, who was mostly in his/her office during the time the Advocates were in the building.

When asked what they had thought of Whorlton Hall, as a service, prior to the Panorama programme, they reported feeling that they had not thought it was abusive. Their view was that some staff were very good, empathic and caring, while some staff seemed less so, but that the biggest downfall in the service was a lack of activities for residents (despite there being two activity coordinators). This criticism applied especially to activities outside in the community, but also to activities inside the building. For example, they both had experienced times when they saw service users sitting watching TV, at the point when they (the advocates) went in to lengthy MDT meetings, and hours later, at the end of the meeting, they would emerge to find the same service users watching the same TV. As regards trips out of Whorlton Hall, to the community, both advocates reported these were often cancelled, usually because the vehicles were said to be not working (service users were thought too disturbed to use public transport, so the service had two vehicles of its own). Moreover when residents requested particular activities, these were often not provided on the grounds that the person had 'only asked once'.

The Advocates spoke to all of the residents, sometimes on their own (with staff around). They always tried to see the person who was in segregation, though he was sometimes said to be too disturbed to speak to them on their visits (on such occasions they would watch him on the CCTV instead and check through his notes). They did find that some residents reported wanting to leave the service, but they would say, for example, that they 'wanted to move on', which the Advocates felt was quite understandable, for people living in a hospital. Occasionally, residents would accuse staff of harsh or abusive behaviour (for example, they remembered one young man saying staff had pushed him down the stairs, a small flight of about 3 stairs). In such circumstances, the Advocates then always checked with staff what had happened (in this example, staff said he had been running and had fallen

down the steps). They also checked the events had been properly reported: the staff member in charge could always find the safeguarding report and would show it to them; they had no reason to doubt it had been passed on to the local Safeguarding authority.

The Advocates felt that some residents' communication difficulties would have made it impossible for them to explain the treatment they were receiving (as seen on Panorama). They did talk to one resident about what had been shown on the programme, after it had been aired, and asked her why she had not reported the staff behaviour, but the resident had not understood what was happening. The Advocates did know that sometimes resident's possessions were removed from their rooms but this was never described as a punishment, only as a precaution, in case the person broke his much-valued i-pad, for example, when in a rage. They were aware of at least one female resident who had asked staff to remove her possessions in such circumstances.

Similarly, they were aware of the high level of restraint and always queried why people had been restrained, but the staff always gave ' a credible reason'. They did occasionally see restraint occurring while they were there, but rarely saw the whole lead up to it; they tended to just see the immediate precursor (such as a resident trying to attack staff), so it was unclear to what extent de-escalation techniques were being appropriately used.

The Advocates commented that they were only present between 9 and 5 approximately, one day per week. They had no keys for independent access to the building and were not in the service every day and, as they said, they were not there in evenings and weekends.

The Advocates were asked for their recommendations for improving inspections and their suggestions are considered later.

8.2 Whistleblowers and ex-Danshell staff

Both the Whistleblowers and some of the ex-Danshell staff interviewed had worked in Whorlton Hall on a daily basis, often for years.

Staff who had been on the ‘shop floor’ talked about the ‘toxic’ culture amongst a small group of staff in Whorlton Hall. This so-called ‘alpha group’ of staff (this is what they called themselves) had worked in Whorlton Hall for many years and it seemed that Danshell senior staff had recognized that they behaved inappropriately in various ways, engaging in conversations that were unsuitable between themselves, and socialising closely outside of work as well as in work. According to the whistleblowers, two staff members, who had been considered to be the ringleaders, had been moved out of Whorlton Hall by Danshell senior managers to different Danshell services on two occasions, between 2014 and 2016, each time for a period of months. Those interviewed reported that the service had improved in their absence, and yet they were allowed back each time, after being disciplined, apparently because there were insufficient grounds to sack them.

Perhaps as a result of what the whistleblowers called this ‘toxic culture’, there were frequent changes of manager. In some periods, for example, there were four different managers in a short time. In addition, in mid 2016, a service user was admitted who was extremely challenging and those ex-Danshell staff who were interviewed for this report, and were there at the time, felt that this resident was admitted inappropriately, as the service was unable to meet his needs. Indeed an ex-Danshell senior staff member interviewed said that he had advised against admission of this particular individual on a number of occasions, but during a period of his own absence from the service, the individual had been admitted. He felt that there were financial reasons for this admission and that because of the difficulties providing a service for this individual, Whorlton Hall had ‘gone into crisis’.

The whistleblowers reported that staff were often subjected to shift patterns as a means of control, so for example one nurse was put on 3 months of night shifts after he/she spoke up to safeguarding/ commissioners about the unsuitability of the extremely challenging client. Similarly, staff would be put on 12 hour observation shifts with one resident (as opposed to a shift with changes in activity every few hours) as a way of controlling them. In addition, the whistleblowers felt that far too much restraint was being used, but they rarely saw the start of incidents. Moreover, incident reports on Ulysses (the in-house incident reporting system) could only be entered by qualified staff, so Health Care Assistants had to give a verbal account of events and these

would then be entered onto Ulysses by a third party (the qualified staff member). The whistleblowers thought they would often down-grade the events from major to minor incidents, so that senior managers would not see the seriousness of incidents.

When planned CQC inspections took place, the whistleblowers reported that there was careful organization of what happened. For example, some staff would simply not be on the rota, some were sent out for the day on community activities with residents, so that they were not interviewed by CQC inspectors. The whistleblowers confirmed that interviews with service users were typically arranged to occur only in the presence of staff, so they suspected the service users felt intimidated by the staff presence. Also a number had relatively limited verbal skills, or insufficient to express what was going on. Carers were not usually present during CQC visits so they were only contacted by telephone and frequently they had no knowledge of the reality of care in Whorlton Hall as they often lived a long way away and, when they did visit, staff behaved in a welcoming way.

One other ex-Danshell staff member, who was a senior manager, and had worked in Castlebeck, helping to turn the organization around after the Winterbourne View scandal, stayed on when Danshell took over in 2013. S/he left in the summer of 2015 because s/he felt that Danshell were not really interested in caring for patients but were interested in profits. She felt they were stripping out the parts of the organization that ensured good care quality (such as the governance team, the training team, the HR services), in order to make the company more profitable. Another senior staff member who had worked in Danshell later on, based in SE England, did not share this view, but had joined the organization late in 2016 and left very early in 2018 (for family reasons).

9.0 Analysis and interpretation

9.1 The views of inspectors and the inspections themselves

Inspectors felt that they were often rushed on inspections and would have liked more time. They took their work extremely seriously and worried about

missing abusive practice. While they appreciated the flexibility of home working they missed the support of other colleagues, with whom to discuss their work, and some would have liked longer team meetings as a consequence. Some of them wanted more training on aspects of the work, such as safeguarding; breakaway training; communication with people with learning disabilities/autism.

The six inspections between 2015 and 2018, of which two were comprehensive and four were focused, produced variable ratings. In summary:

- On two comprehensive inspections, Whorlton Hall was rated as good overall (inspection 2 in March 2016 and inspection 5 in September 2017)
- In two focused inspections it was rated as RI overall (inspection 1 in August 2015 and inspection 4 in November 2016),
- In one focused inspection (inspection 3 in August 2016) there was an RI rating in one domain (Effective), but no rating for the other domain (Safe)
- There were no ratings at all in one (inspection 6 in March 2018) but the criticisms in the report make it clear that the service required improvement.

The Table below summarises the inspection reports (the final inspection in May 2019 is excluded since by then the inspectors knew what was going to be shown in the Panorama programme, and the inspection was post hoc). It is striking that the comprehensive reports more often rate ‘Good’ than the focused reports, which were unannounced. Together with information from staff who worked in Whorlton Hall, this suggests that being given warning about an inspection, makes managers, and possibly other staff too, change their behaviour, alter work rotas, up-date their paperwork, and generally make an effort to attain the rating ‘Good’. Much of the work of inspections involves checking paperwork, such as care plans, positive behaviour support plans, restraint records, training records, and so on, and these can all be improved with sufficient warning, even if the experience of service users has not changed. The danger, of course, is that the quality ratings on such comprehensive inspections, of which services had notice, do not properly reflect the practices that normally go on, in that setting.

Nevertheless, unannounced focused inspections were not always helpful, in relation to Whorlton Hall, since they often produced no ratings. The inspection reports may have asserted that there was no rating for a domain because there was not a full inspection of the domain, but sometimes the findings seemed serious enough to produce an RI rating despite this (for example, in inspection 3, the very high rate of restraints and the number of times the police were called was surely suggestive of an unsafe service; likewise in inspection 6, the high number of 24 hour shifts in the previous few months were surely an indication of an unsafe service).

Moreover, RI ratings trigger re-inspections, so without them, there may be large gaps in time without any kinds of inspections. For carers or professionals searching for information on a service, who may only look at comprehensive inspections, a service may appear to have been rated 'Good', despite there being concerns about it later. This is indeed what happened in Whorlton Hall.

Table summarizing inspections

Date & type	Findings (7-9 patients each time)	Ratings
1. August 2015 Comp-rehensive inspection; final report not published.	5% trained in MHA 10% trained in MCA Staff turnover: 25% in 12 months Sickness rate: 17% in 12 months Agency use: high (200 shifts covered by agency staff in the previous 3 months). 129 incidents of restraint in 6 months, 4 serious untoward incidents; one formal complaint and 5 allegations from patients against staff, none substantiated after investigation.	Whorlton Hall was rated as **RI on all 5 criteria**
2. March 2016. Comprehen-sive inspection, report published June 2016.	97% trained in MHA 95% in MCA Staff turnover not given Sickness rate 9% Agency rates not given 188 restraints in 6 months and seven serious incidents.	**The overall rating 'Good'**, with four domains rated Good, & one rated as RI (*Safe*).

3. August 2016. Responsive unannounced and focused. Published February 2017.	Response to high staff turnover (incl managers). Staff training levels not given Staff turnover not given Sickness rates not given Agency staff use not given 233 restraints in 6 months 17 serious incidents in 6 mths (police had been called in 6; in 10, one patient had accused another of abuse; one had involved an allegation of abuse by two staff against one patient).	*Effective* was rated as **RI**; *Safe* was not rated 'because (we) did not carry out a full inspection'. SQAG had discussed whether or not *Effective* should be rated and concluded that it should
4. November 2016: focused inspection Published in February 2017	Mandatory training levels were below 72% on average, with 6 of the 14 areas below 75% (eg training on the MCA was 56%). Staff turnover was 46% Sickness was 3% Agency staff use not given 32 restraints over 2 mths and 5 serious incidents in 2 mths.	Concentrating on *Safe* and *Well-led*. Overall the rating was **RI**, with *Safe* rated as RI and *Well-led* as Good.
5. September 2017: Routine compre-hensive inspection. Published December 2017.	MHA & MCA training 84% Staff turnover was 54%; Sickness 4% Agency staff covered 370 shifts over the previous 3 mths. 128 incidents of restraint in 6 mths, no use of rapid tranquilisation, 33 allegations of abuse in the 12 months	**Overall rating was 'Good**', with all the five domains rated as 'Good'.
6. March 2018: Unannounced, focused inspection. Report published end of May 2018	Major concerns over staffing (eg 25 shifts of 24 hours length in the last 3 mths; overuse of agency staff whose training was not monitored and poor supervision). There were 190 restraints over 3 mths (92 of these related to one resident). Staff turnover was 28% Sickness was 3 %; Agency staff 821 shifts in 3mths	In response to whistle-blowing, looking at *Safe, Effective, Caring* and *Well-led*. No ratings given.

It was not always clear from the inspection reports in Whorlton Hall whether findings in one inspection were followed up in the next (for example, *Effective* was rated as RI in inspection 3, but not focused on in inspection 4).

Sometimes this may have been due to the lag between the inspection and published report, which often appeared many months later, and at times the next inspection had taken place before the previous one had been published (this was certainly so for inspection 2, but also for inspection 4). One of the reasons for this appeared to be the large numbers of processes within CQC, prior to publication. There were sometimes as many as 5 reviews of a draft report (peer review, writing coach review, inspector manager review, Subsidiary Quality Assurance Group, National Quality Assurance Group) before a report was published, certainly time-consuming and arguably excessive.

Inspection reports sometimes gave figures for a variety of aspects of care but sometimes did not, making it very hard to compare the state of the service at different times. For example, the figures provided for mandatory training were sometimes given in the reports and sometimes not; the staff turnover figures, which were often very high (46% in inspection 4; 54% in inspection 5) were not always given (eg inspection 3), and agency use which was also often very high (370 shifts in 3 mths in inspection 5; 821 shifts in 3 mths in inspection 6) were not always given (e.g. inspection 4).

The levels of restraint at Whorlton Hall were consistently high, and sometimes very high (for example, 190 in 3 mths in inspection 6). The figures for use of restraint were normally provided in the inspection reports, but often the figures referred to different periods of time, making them harder to compare. Similar points can be made about abuse allegations and serious incidents. Very often allegations were also said to have been withdrawn, and while an occasional person with learning disabilities and/or autism may make false allegations, it would be very unusual for this to apply as often as it appeared to do in Whorlton Hall. The implication of course is that they may have been pressurised to withdraw their complaints by unscrupulous staff.

9.2 The views of service users and their families

In all the reports (apart from inspection 3, where patients' views were not mentioned, and inspection 7 where they were unavailable), patients and carers were said to be positive about the service. Some inspections

mentioned surveys of patients' views (eg inspection 5) and they appeared to be generally positive.

In the section of inspection reports called 'What people who use the service say', there were the following quotations: 'Patients told us they were generally happy with the care and treatment provided' (inspection 1, see below); 'Patients told us they felt safe and liked staff' (inspection 2); 'Patients told us they felt safe…. They liked the staff and thought they were caring' (inspection 4); 'Patients and carers told us staff treated them well' (inspection 5 and similar wording in inspection 6). Similarly, in the sections on *Caring*, where this domain was considered, all of the inspection reports say 'staff spoke to patients in a kind and respectful manner' (inspection 1), or 'we observed staff being kind and respectful to patients' (inspection 2) or use similar wording (inspection 5, 6 and 7).

As a number of the inspectors and the Mental Health Act reviewer from CQC commented, in interviews for this review, their arrival at Whorlton Hall on inspections or visits was always known to staff there. Even in unannounced visits, once they got to the door, they were of course identified as CQC. Moreover, when they asked to talk to service users, they were often accompanied by staff from the service. In addition, service users had limited communication skills, they may have been suggestible and acquiescent if they had not understood questions or information, and may have needed specialist tools (such as Talking Mats) to assist them to give their views. In theory, such skills were available through Specialist Advisors, who accompanied inspectors, but in practice these SpAs were of variable quality and did not necessarily have the skills themselves. This suggests that inspectors and Mental Health Act reviewers, who may have backgrounds that are not in learning disabilities or autism, need to be offered specific training in communication with those whose verbal skills are limited. Moreover, interviews with service users need to take place in a private area, preferably without staff present, and this may take more resources than currently used for this part of the inspection. The inspection reports do not appear to give this aspect of the inspection priority, as the Mental Health Act reviewer said, and yet it needs to be absolutely at the heart of the inspection. Similarly the views of carers are often hardly mentioned in inspection reports, and these also need more focus and more priority. Of course, sometimes, abusive staff

can appear caring, if they know they are talking to family members, but this is not a good reason to omit carer interviews.

9.3 The views of Whorlton Hall staff

Inspections typically involved talking to staff (including managers) about their views of the service, as well as asking staff about service users and their care plans. Nevertheless, inspectors told me that junior staff had not alerted them to the situation at Whorlton Hall and this may well have been because they were not interviewed in a private setting out of earshot of other staff, who they may have feared. Managers also did not alert CQC inspectors. It may be that managers were unaware for some time about what was happening, because they spent most of their time in their offices, according to many of those interviewed. Nevertheless, the high turnover of managers was notified to CQC at times (e.g. prior to inspection 3) and was referred to in some inspection reports. In retrospect, it seems likely that once managers had been in place for some months, they became aware of the problems and, finding themselves unable to solve them, they left. This of course involves speculation, as to the course of events, as we did not interview the registered manages of Whorlton Hall (as concerns had been raised by Cygnet concerning the application of the terms of reference and context of on-going criminal investigations). Nevertheless, it implies that interviewing staff who have left a service, especially if they leave after a short time, is extremely important (as the local CCG representative said).

The whistleblowers who had worked at Whorton Hall, and who were interviewed for this review, said that they had repeatedly reported their worries about a toxic culture to the organisation which ran Whorlton Hall at the time, ie. Danshell. Two ex-Danshell staff in their interviews said that the organisation knew about the small group of staff, who termed themselves the ‘alpha group’, and three ex-Danshell staff said one or two leaders of this group had been sent out of the service on two occasions, between 2014 and 2016, because of the ‘toxic culture’ they were creating. This toxic culture was said by at least one senior manager to involve staff, mainly male, who had worked at Whorlton Hall for many years, who socialised outside work as well as in work, and who had institutional attitudes, engaging in inappropriate

language and conversations while at work. This senior manager did not think they were abusive, but he did view their behaviour as inappropriate. After these staff had been sent away from Whorlton Hall to other Danshell services, on these two occasions, they were apparently disciplined but allowed to return, because there was 'insufficient evidence' to sack them.

Occasionally, Whorlton Hall engaged in staff surveys, and they did report the results of these to CQC (for example, in inspection 5). It is impossible to say whether the results were reported accurately to CQC inspectors, or whether the staff completing the survey were simply too intimidated by the 'alpha group' to give their real opinions. For a number of reasons, this suggests that interviewing staff (including managers) privately is essential, that surveying their opinions needs to occur without this information going through managers, and interviewing those who have left services would be an important way to discover staff's real opinions.

9.4 Safeguarding and whistleblowing

CQC has a clear and consistent process for taking calls, emails and web-based concerns and complaints from staff, service users, carers and member of the public, through its National Customer Service Centre.

There were a considerable number of concerns, complaints and abuse allegations notified to CQC between 2015 and 2019 in relation to Whorlton Hall, and some did trigger unannounced inspections (eg. inspections 3 and 6). NCSC notifies concerns to the Local Authority Safeguarding lead and the list of such events provided by Durham's Safeguarding representative, when he was interviewed for this review, showed that these concerns were escalating over the three years (see Table 2). Moreover, many of the complaints by service users were being retracted (a worrying sign). The Durham Safeguarding representative felt that the numbers of reports coming in indicated that Whorlton Hall was being transparent and taking its responsibilities seriously. The local CCG representative who was interviewed thought the same. In hindsight of course, this was a mistaken view.

All the CQC inspectors who were interviewed for this review reported that they found it very difficult to extract information, of abuse alerts, whistleblowing events, and other concerns, from the CQC system (CRM). According to the NCSC representative interviewed, all of these incoming calls, letters and emails were communicated to the relationship owner for the relevant service. However, relationship owners for Whorlton Hall were very short-lived and there were a large number of changes to the role. What this meant was that, were an inspector to be informed that they would be inspecting a particular service in the coming weeks, neither they nor the relationship owner were easily able to call up all the information held by CQC, which had come through NCSC or through other routes. The same applied to the Mental Health Act reviewers, who covered a very large number of different wards in a variety of services. This poor access to records of safeguarding and whistleblowing events and other concerns was a definite failing of the CQC system. It was similarly problematic in other agencies (e.g. Durham Local Authority).

What is needed by relationship owners, inspectors and MHA reviewers is a system through which they can easily call up a chronological list of such events relating to any particular service. As well as abuse alerts, whistleblowing and other concerns (which mostly come through NCSC), data on restraints over a standardised period (e.g. per month) needs to be accessible, along with other up-to-date information on staff turnover, sickness rates and agency staff use, since any of these may indicate that a service is struggling. These data also need to be available in the form of graphs so that relationship owners, inspectors, and MHA reviewers can see if a service seems to be starting to fail. It would be particularly helpful if, in addition, means and standard deviations could be shown, as this would assist CQC staff in deciding if a service was statistically unusual in its level of, for example, restraints.

Where a service does appear to be failing, CQC needs to be able to gather more in depth data than it usually does in its inspections, perhaps through a ‘level 2’ inspection, where more data is gathered from staff (independently from the service provider), more time is spent observing on the ward, and priority is given to interviewing service users and carers. In addition, most interviewees thought that CCTV or other method of covert surveillance

needed to be considered as a tool in such circumstances, given that as all the inspectors and Advocates noted, once punitive and devious staff know that a visitor is from CQC they may change their behaviour, and this is less likely to be sustainable with covert surveillance in place.

9.5 The service model

The service model in Whorlton Hall was that of a hospital for people learning disabilities and/or autism, in a rambling old building, in a rural setting, a long way from large towns. This meant:

- It was likely to attract out-of-area placements, simply because it was a long way from towns
- It was likely to struggle to recruit staff, for the same reason.
- The difficulties recruiting would be likely to lead to excessive overtime for employed staff
- There would probably be a high staff turnover and heavy use of agency staff
- While these might be regular agency staff, the training that agency staff had would be unclear and they would not get in-house supervision and appraisal.
- It would be difficult to attain good lines of sight in such a building (important in services for people with behaviours that challenge)

In addition, the service model in Whorlton Hall was to employ a large number of Health Care Assistants, who usually had relatively little training and experience, with a small number of qualified nurses and very little multi-disciplinary team input (the MDT were present one day per week).

At the time when Whorlton Hall was registered (2013), NHS-England had already published its document *Transforming Care,* and they were trying to reduce the numbers of people with learning disabilities and/or autism in hospital, especially those in out-of-area placements, with little MDT oversight, since these conditions were already recognized as risky, particularly after Winterbourne View. In hindsight, Whorlton Hall was an unsuitable service and should not have been registered. CQC has resolved not to register further services of this kind (see below for further details).

10. Could the abuse of patients have been recognised earlier by the regulatory or inspection process?

This question was central to the regulatory review conducted. It is clear from section 9 above, that there are a number of improvements that are needed to the CQC process. However, given the inspection and regulatory process in place at the time, it may be that abuse could not have been recognized. None of the CQC inspectors saw punitive or abusive behaviour by staff (though three did say they felt uncomfortable and uneasy in the service). The MHA reviewer from CQC, whose job it was to liaise with service users, also said s/he did not have concerns about the service. Moreover, a large number of professionals went to Whorlton Hall, who were not employed by CQC, including the local GP, representatives of the Local Authority and the CCGs who were placing residents there. In all, the local CCG, who had counted the visits over the previous 9 months to May 2019, found 37 visits had taken place (excluding GP visits) and none of these professionals recognized that abusive behaviour was going on, even though they spoke to staff and service users. In addition, there were two advocates who were regularly in Whorlton Hall, one day per week, over a period of years, who had close contact with service users and yet did not see abusive and punitive practice in place. During inspections, service users generally said that they felt safe and they liked staff, and it appeared that they were not able to describe the cruel behaviour of some staff.

In hindsight, after the Panorama programme, CQC began to consider the issue of a ‘toxic culture’ and how to detect it. Paul Lelliott, head of CQC mental health at the time, drew up a paper alerting inspectors to the characteristics of a toxic culture (see Appendix 3). He listed a series of aspects of services that could be considered ‘red flags’, including many of the characteristics of Whorlton Hall. Nevertheless, were inspectors aware of such ‘red flags’ of a toxic culture, the question remains could they have detected abusive practices?

Where there is a small group of devious staff who deliberately mislead both those engaged in inspection and regulation processes, as well as MDT members, advocates and carers, it is very difficult to detect their actions, especially when service users are very vulnerable and have limited communication skills. In hindsight, unannounced visits, especially at evenings and weekends, may have helped to detect failings in the service. More helpful still would be:

- The use of CCTV, or other covert surveillance method. Even then, abusive and punitive staff may work out ways to avoid being seen (as one staff member described on the Panorama programme)
- The interview of staff who left after short periods of working at Whorlton Hall, once they were no longer employed by the provider
- Much more careful interviews with service users in conditions of privacy where they felt safe, preferably with the use of alternative and augmentative communication tools, such as Talking Mats.
- More thorough interviews with all family carers (frequently inspectors were simply given the contact details for a small sample of chosen carers).

11. Recommendations for how CQC can improve its regulation in the future

The following recommendations arise from a consideration of CQC processes, the events and inspections of Whorlton Hall, and the interviews conducted. The recommendations are limited to the terms of reference for the review. They do not consider related matters, such as why Transforming Care has largely failed to improve services, since such matters are outside the terms of reference. It is recognised that the recommendations echo many of those made before, for example, in the Serious Case Review after Winterbourne View, and the Joint Parliamentary Committee on Human Rights (see Appendix 1), as well as those made by David Noble (see Appendix 2).

Recommendation 1: CQC should consider displaying data, for each service, in a user-friendly way, on abuse allegations, complaints and concerns (coming into CQC via NCSC and other routes), alongside data on mandatory staff training, staff turnover, sickness rates, use of agency staff, restraints and segregations. These data should be easy to access, chronological, and graphical, and allow inspectors and MHA reviewers to prepare and plan inspections, and to become aware of 'red flags' indicating failing services.

It may be that CQC could also mine the rich source of data that it already has, on a large number of services, to provide evidence of a series of statistically significant performance indicators to assist staff in detecting 'red flags' for failing services (by, for example, conducting a regression analysis of the extent to which variables listed above influence outcome).

Recommendation 2: For high risk settings which provide hospital services for people with learning disabilities and/or autism and complex needs, CQC should consider using only unannounced inspections, and should include evening and weekend visits. Alongside this, CQC should require Provider Information on a regular basis, every 6 mths (previously these were linked to up-coming inspections), so that PIRs do not signal imminent inspections. All inspections should produce ratings, including focused inspections, and action plans by the provider should not be a sufficient reason for rating a service as 'Good' when it would otherwise be rated as RI. Inspection reports should be published more quickly (with a month to six weeks of the inspection) so that providers can improve services faster and inspectors can better plan re-inspections.

Recommendation 3: CQC should take abuse allegations, safeguarding alerts and whistleblowing events extremely seriously and recognise that they are probably the tip of the iceberg. They should work closely with other agencies on these issues (LAs and CCGs) and should consider these data as a whole for services, and examine their trends over time (rather than just seeing them as a series of individual cases). The relationship owner should access the relevant data (see Recommendation 1) for a service on a regular basis, and work with the Local Authority to ensure there is a proper response to these. Repeated retracted allegations should be very carefully investigated. Where allegations of abuse are escalating, the Local Authority should consult

with CQC about increasing its inspections and surveillance (see Recommendation 5)

Recommendation 4: In all inspections, CQC should prioritise in-depth service user interviews, in private (i.e. without staff from the service that is being inspected), and inspectors should receive training in alternative and augmentative communication tools such as Talking Mats. They should also ensure that as many carers as possible are spoken to, about their views of the service, and inspectors should spend more time observing in the lounges and day rooms to ensure they have seen the every day nature of the service. There are a number of observation tools that could be used.

Recommendation 5: Where the information about a service indicates that it is at risk of failing its service users (see Recommendation 1 and 3 above), for example, if it repeatedly has RI ratings or if its data on restraints or abuse allegations are at worrying levels, CQC should consider conducting a 'level 2' inspection. Level 2 inspections should include more time in the service spent observing and interviewing service users, as well as staff surveys (to be returned to CQC, not to the provider), and interviews with staff who left the service after only short periods. CQC should also consider whether it is possible to rate the atmosphere and/or culture of services and should trial such a measure in inspections. In addition, in a level 2 inspection, CQC should consider whether the importance of detecting abusive behaviour by staff, merits the use of CCTV or other covert surveillance, despite the ethical issues these methods raise.

Recommendation 6: CQC should not register services like Whorlton Hall, that are very isolated, in unsuitable buildings, with out-of-date models of care (difficult for families to access, high numbers of unqualified staff, poor provision of activities, low numbers of qualified nurses, and insufficient MDT presence). They should not allow expansion of such services that already exist and should consider how best to alter those that they have already registered.

12. Next Steps

CQC has been heavily criticised by the media and others, for failing to spot abuse in Whorlton Hall. This review recognised that in completing inspections there, CQC had followed its procedures, but there were a number of reasons why it was unable to detect the abusive behaviour of staff in Whorlton Hall. Furthermore it transpired that there were a large number of other professionals of various kinds who also visited Whorlton Hall without recognising it as abusive.

Of course, it can be argued that the real problem, lying behind the events at Whorlton Hall, is the discriminatory attitude of some people towards those with learning disabilities and/or autism, such that they are not treated with the respect due to them as human beings, and are denied their human rights. It can also be argued that, had there been better community-based services, especially for children and young people with learning disabilities and/or autism, then fewer people would need to be admitted to assessment and treatment units. While both of these points are no doubt true, they were beyond the terms of reference of this review.

Given that services like Whorlton Hall may still exist, CQC is keen to improve its inspections and regulation in such a way as to increase the likelihood of detecting abuse. Some of the courses of action recommended above are already being considered by CQC, for example:

- In relation to recommendation 1, CQC has started to develop such methods and is trialling the *Insight tool* which provides much of what is needed in terms of tracking abuse allegations, staffing issues, and restrictive practices in services.
- In relation to recommendation 4, CQC is considering observation tools that could be used and one (SOFI) is currently being trialled.
- With respect to recommendation 5, CQC is planning a number of conferences and workshops to develop measures of staff culture and service atmosphere over the next few months. It will also be considering the research evidence in relation to CCTV and other methods of covert surveillance, together with the ethical issues these methods raise.
- Finally, for recommendation 6, CQC Registration is drafting a new set of guidelines *Right Care, Right Staff, Right Culture* to guide future registrations,

and is considering how to reduce out-dated service models that already exist.

Certainly, the families of people with learning disabilities and/or autism, as well as professionals, will be watching CQC closely to examine improvements in its methodology over the next few years.

Appendix 1

Recommendations from the Joint Parliamentary Committee on Human Rights

- The establishment of a Number 10 unit, with cabinet level leadership, to urgently drive forward reform to minimise the number of those with learning disabilities and/or autism who are detained and to safeguard their human rights.

• A review to be carried out by the Number 10 unit of the framework for provision of services for those with learning disabilities and/or autism. At a minimum Government should introduce:

- a legal duty on Local Authorities and Clinical Commissioning Groups to ensure the availability of sufficient community-based services.

- a legal duty on Local Authorities and Clinical Commissioning Groups to pool budgets for care services for people with learning disabilities and/or autism.

• Stronger legal entitlements to support for individuals. The Government must act on legislative proposals put forward by the Equality and Human Rights Commission, as well as those made by the Independent Review of the Mental Health Act 1983 and campaign groups.

• Care and Treatment Reviews and Care, Education and Treatment Reviews to be put on a statutory footing.

• The criteria for detention under the Mental Health Act must be narrowed to avoid inappropriate detention. Those with learning disabilities and/or autism must only be detained in situations where:

- treatment is necessary;
- treatment is not available in the community and only available in detention (i.e. the last and only resort);
- treatment is of benefit to the individual and does not worsen their condition; and
- without the treatment, there is a significant risk of harm to the individual or others.

• Families of those with learning disabilities and/or autism must be recognised as human rights defenders, and other than in exceptional circumstances, be fully involved in all relevant discussions and decisions. This should include:

- On every occasion that anyone is restrained or kept in conditions amounting to solitary confinement their families must be automatically informed.
- Young people must not be placed long distances from home as it undermines their right to family life under Article 8 ECHR. Financial support must be

made available to ensure that families are able to visit their loved ones.

• Substantive reform of the Care Quality Commission's approach and processes is essential. This should include unannounced inspections taking place at weekends and in the late evening, and the use, where appropriate, of covert surveillance methods to better inform inspection judgements.

Appendix 2: Recommendations from David Noble's report

Recommendation 1: Security and availability of notes from inspections

CQC must ensure that secure and effective arrangements are in force for the collection and storage of physical notes and electronic records made in the course of gathering evidence at inspections. These arrangements should be capable of producing both the documents/records and a reliable audit trail. These arrangements need to operate both during and at the end of an individual's employment with the CQC and must ensure that data protections requirements are fully met.

Recommendation 2: Improvements to the information provided to inspectors about services.

As part of the wider review being conducted by Professor Glynis Murphy and the work already underway in CQC to improve how they assess learning disability and mental health hospitals, CQC should consider what further improvements can be made to the systems that pull together information about a service. Easy access by inspectors to all the information which CQC holds and receives about services is critical to the quality of inspections and reports.

Recommendation 3: CQC's Quality Assurance Processes for reports

CQC should re-examine the quality assurance processes it has designed and applied to inspections and report-writing to ensure that they are delivering cost-effective, valuable quality assurance at the right points in the system. I recommend this review take place as part of any response to this and the wider review of regulation being conducted by Professor Murphy rather than as part of the immediate work programme of the Whorlton Hall Co-ordination group. The review should examine whether more investment earlier in the regulatory/inspection process might not be a better use of time, money and management input than the current model which seems heavily focussed at the end of the process.

Recommendation 4: Legal advice (and possibly a policy) about non-publication of inspection reports.

CQC should urgently consider the potential benefit in producing legal advice, available across all Directorates about the Commission's duties under section 46(1)(c) and 61(3) of the Health and Social Care Act 2008 to "publish a report". It should also ensure that policy advice on inspection methodology is clear and is consistent with the legislation in all respects. This also should apply across all operational directorates not just the Hospitals Directorate. The Board of CQC may wish to consider whether there should be Board oversight of decisions not to publish.

Recommendation 5: Investigation of provider complaints

CQC should review its current approach for examining complaints to ensure that lessons have been learned from the shortcomings of the Whorlton Hall complaint handling in 2015.

Recommendation 6: CQC Internal whistleblowing process

Recognising that this will be some 3½ years late I recommend that CQC formally write to Mr. Stanley-Wilkinson as recommended (and accepted by management) in relation to the second and third elements of the internal review of his whistleblowing concern: " They should be thanked for taking the time and the energy to raise the concerns affording CQC the opportunity to look and learn from them [and] There should be an apology that the person was not fully involved in the complaints investigation and outcome prior to the outcome letter being sent to the provider."

Recommendation 7:

Noting the up-dated CQC Speak Up policy (September 2018) CQC should consider building more confidence in the process by ensuring wherever possible that reports of the action planned or taken are part of the feedback to the complainant.

Ap**pendix 3:**

Summary of supporting information for inspectors: Identifying and responding to closed cultures

Background

In May 2019, BBC Panorama exposed the culture of abuse and human rights breaches of people with a learning disability at Whorlton Hall. It reinforced how important it is for everyone involved in the care of people with a learning disability or autistic people to identify closed cultures, where abuse and human rights breaches may be taking place.

Protecting people's basic human rights is at the heart of good care. Everyone involved in the care of people has a duty to act where there is a risk that a person's human rights are being breached. As the regulator of health and social care services, we are committed to improving how we regulate services where there is a risk of a closed, or punitive culture.

We have commissioned two independent reviews into our regulation of Whorlton Hall. However, ahead of the findings of these reviews we have also taken practical steps to improve how we regulate these types of services.

About the supporting information

In July 2019, we produced discussion papers for inspection staff to make sure that all our inspectors have a shared understanding of the potential risk factors for abusive cultures and can use this information to take action where necessary. The supporting information document provides further detail to support the identification and regulation of services where there is a risk of a closed or punitive culture. It provides information on:

1. Inherent risks. The likelihood that a service might develop a closed or punitive culture, which could lead to abuse or breaches of human rights, is higher if inherent risks have been identified. For example, this may include:

- people who use the service are highly dependent on staff to meet their basic needs
- risks with how the service is managed
- concerns about the numbers, skills and level of training for staff working in the service.

2. Warning signs. When monitoring and inspecting services, inspection teams need to be alert to warning signs that there may be a closed or punitive culture, or that there is risk of such a culture developing. For example, this may include:

- concerns raised by staff working in the service, by families or others that relate to how people are being treated, incidents involving violence or how complaints are handled
- whether managers know what is happening in the service day-to-day and whether they acknowledge potential signs of poor culture or potential abuse a high proportion of people being cared for in some form of isolation, away from other people using the service

- people using the service being restricted without proper consideration of their human rights. As well as restraint, this includes restrictions on access to food and drink, to using the toilet, to going outside, to visitors and to their own clothes and possessions.

3. Responding to closed cultures. The presence of one or more inherent risk factors is not proof that there is an abusive or punitive culture, but could be a sign that there is an increased chance of one developing. When monitoring, planning an inspection and inspecting services, inspection teams need to consider**:**

- are people able to self-advocate?
- is there a high inherent risk?
- are there any warning signs?

Where there is a high inherent risk in a service and warning signs are developing, there should be a low threshold for deciding to carry out a responsive inspection. We have given inspectors some pointers on how to carry out inspections where there is a high inherent risk and/or warning signs. These include:

- who should be on the inspection team, including using Experts by Experience the importance of gathering the views of people who use services and their families as early as possible, so that their views can influence the focus of the inspection
- how to gather information on inspection, including having a focus on people using the service who might be at highest risk of human rights breaches.

4. After the inspection and enforcement. Following the inspection, if we have identified closed cultures where there is a high risk of abuse, human rights breaches or poor care, inspection teams will consider what the appropriate response is, and if enforcement action is required. This could range from raising a safeguarding alert, to immediately taking action against a provider, to cancelling their registration with CQC.

We will be continuing to review and update our supporting information. If you would like to provide feedback, please email closedcultures@cqc.org.uk.

Appendix: Flowchart for identifying and responding to closed cultures