social care
institute for excellence

Learning from the Safeguarding Adults Review (SAR) on Whorlton Hall

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Whorlton Hall In Barnard Castle, County Durham

Registered with the Care Quality Commission (CQC) for two regulated activities:
1. Treatment for disease, disorder or injury
2. Assessment or medical treatment for persons detained under the Mental Health Act 1983;

"Assessment & Treatment Unit" (ATU)
"Specialist Hospital"

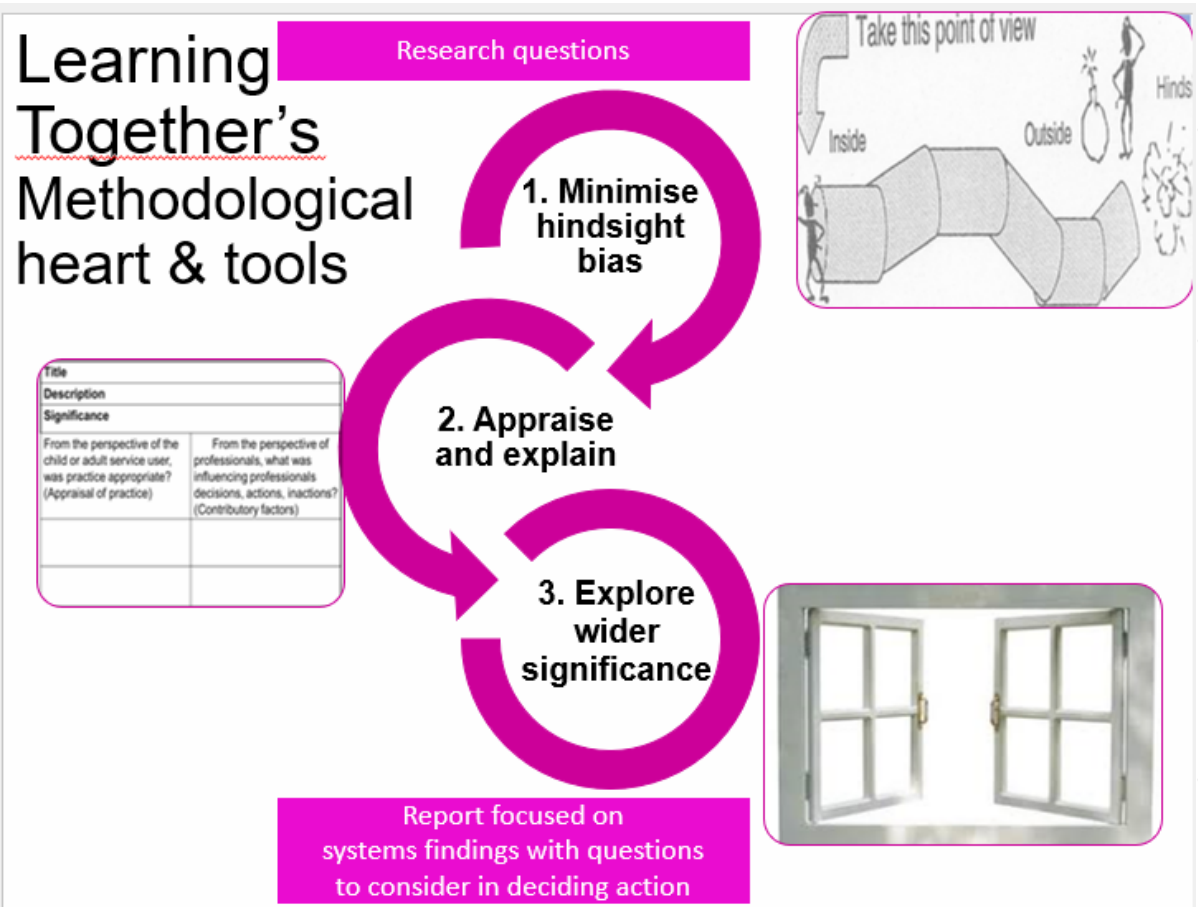
- run by Cygnet Healthcare
- acquisition of Danshell services in August 2018
- took operational responsibility from January 2019

- BBC Panorama 22 May 2019, after an under-cover reporter worked there for over two months
- Alleged* psychological and physical abuse

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

- May 2019, 13 patients,
- commissioned by 10 CCGs
- two people recently discharged

Durham Safeguarding Adults Partnership commissioned a mandatory SAR



- Drew on independent reviews conducted by key agencies involved
- Engaged with
  - Commissioning CCGs
  - Some practitioners and managers
  - Only individuals and families not involved in the on-going trials
- Supported by
  - A local review team of senior leads
  - A national expert panel

Using SCIE's Learning Together approach

Timeline: Feb 2018 to May 2019

Learning Together a highly pertinent methodology

It was vital to use the Whorlton Hall example to give us a ‘window on the system’ of provision for people with learning disabilities and/or autistic people more widely

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

- Whorlton Hall closed shortly after Panorma
- The Assuring Transformation data set at the end of September 2021 showd that there were **2,085** people with learning disabilities and/or autistic people in inpatient settings.
- Since the SCR on Winterbourne View Hospital (2012) it is widely accepted that these are inherently high risk settings for people with LD and/or autistic people
- Reports and SARs into abuse elsewhere have continued
- The number of inpatient services for people with learning disabilties and/or autistic people, rated inadequate more than tripled between 2019-2020

SAR WH needed a dual focus

Effectiveness of safeguards

- What are the strengths and vulnerabilities of mechanisms that are meant to keep people safe in specialist hospitals / ATUs?

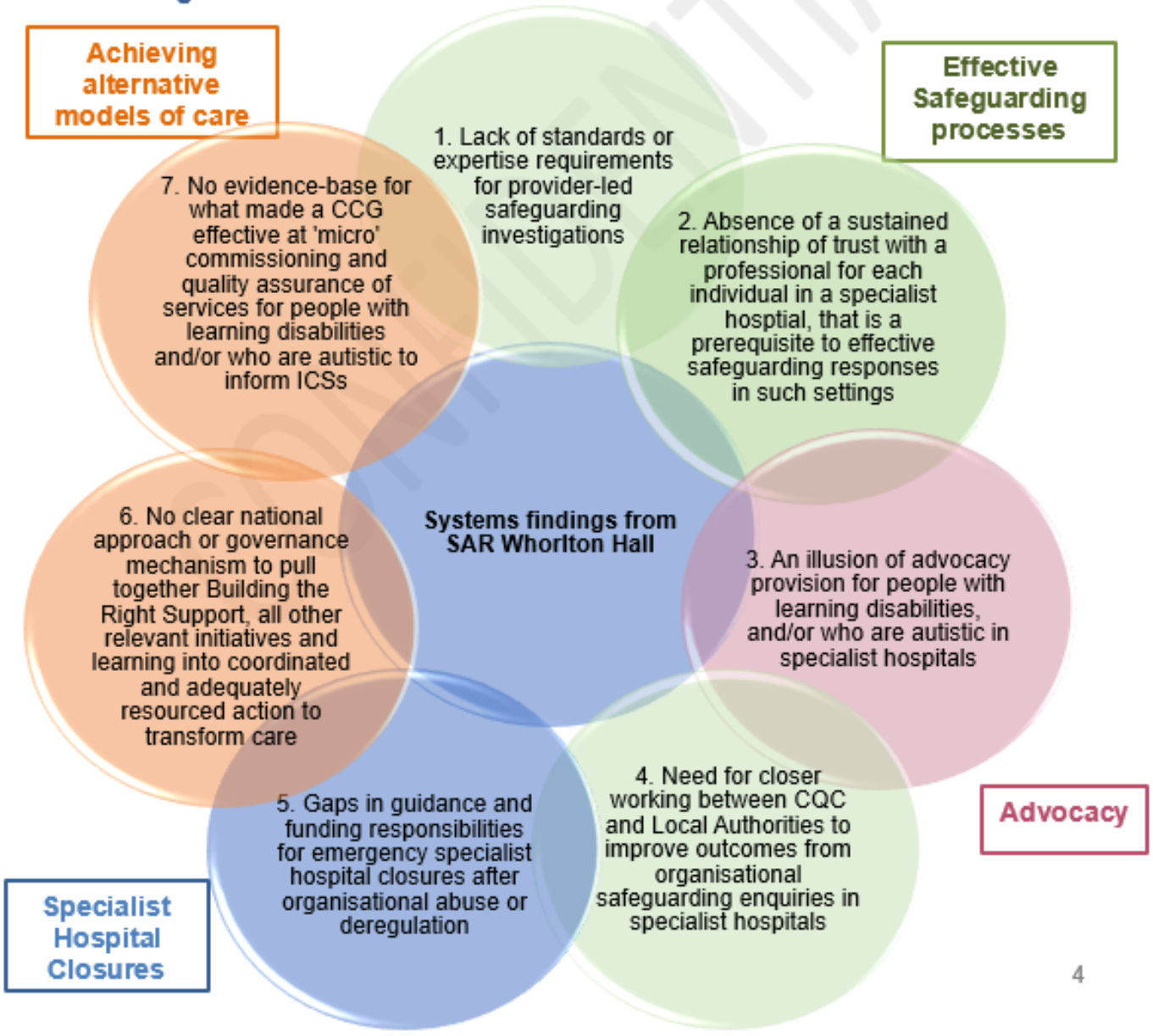
Models of care for people with learninng disabilities and/or who are autistic

1. What are specialist hospitals / ATUs being used for?
2. What are the barriers and enablers to successful community support at home, with a good life?

Timeline: Feb 2018 – May 2019

Systems findings x7

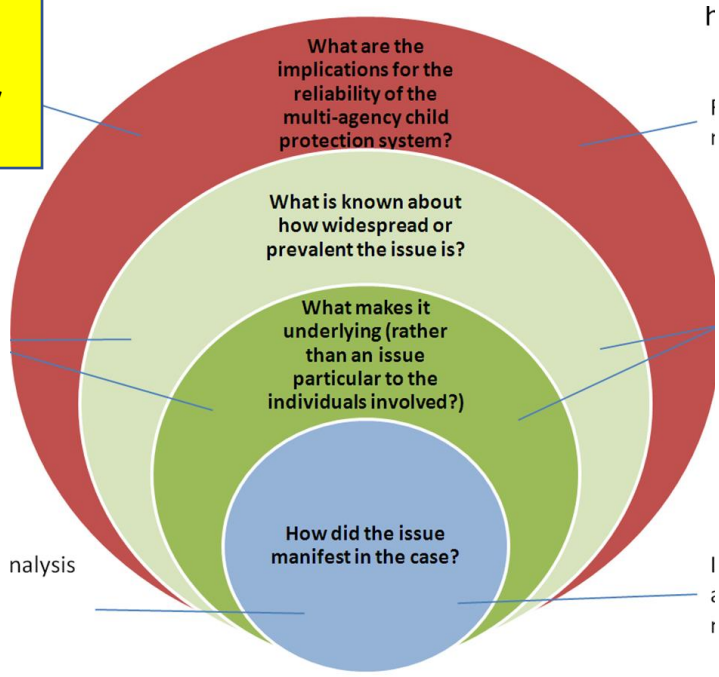
Figure 1.



A common structure to test and evidence systems findings

1. How did the issue manifest in the case?
2. How do you know it is underlying not a one-off, unique to that case?
3. How wide spread is the pattern?
4. How many cases are actually or potentially affected?
5. So what? What effect does the pattern have on the reliability of safeguarding?

In full report, not in Exec Summary



The 'anatomy' of a Learning Together systems finding

A little more detail on each

Barriers to effective safeguarding

- 1) provider led safeguarding investigations of closed cultures - Sheila
- 2) relationship of trust – Fiona
- 4) close working between CQC-LA - Fran

Advocacy

- 3) Illusion of provision - Fran

Emergency specialist hospital closure

- 5) Gaps in guidance - Sheila

Alternative models of care

- 7) Evidence base for effective ICBs - Fiona
- 6) Clear national approach and resourcing - Sheila

What is getting in the way of

EFFECTIVE SAFEGUARDING

Systems finding 1 *Sheila*

- **LACK OF STANDARDS OR EXPERTISE REQUIREMENTS FOR PROVIDER-LED SAFEGUARDING INVESTIGATIONS OF CULTURES**

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

Systems finding 2 *Fiona*

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

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

Systems finding 4 *Fran*

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

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

Quick poll (1)

To achieve a named social worker for every person in or at risk of being admitted to a specialist hospital, which do you think is more critical:

- a) more resources or
- b) a change of priorities and mindset?

What is getting in the way of

EFFECTIVE ADVOCACY

Systems finding 3 *Fran*

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

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

What is getting in the way of

EMERGENCY SPECIALIST HOSPITAL CLOSURES

Systems finding 5 *Sheila*

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

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

Quick poll (2)

Prior to this SAR, were you aware of the guidance on emergency specialist hospital closures?

Yes or no.

What is getting in the way of

ALTERNATIVE MODELS OF CARE

Systems finding 7 *Fiona*

- **NO EVIDENCE-BASE FOR WHAT MADE A CCG EFFECTIVE AT 'MICRO' COMMISSIONING AND QUALITY ASSURING OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES AND/OR WHO ARE AUTISTIC** Before the establishment of integrated care systems (ICSs), across England there were a wide range of different structures for commissioning, managing and quality assuring individual placements for people with learning disability and/or who are autistic. This resulted in variations in service provision with some CCGs appearing to have more effective systems for commissioning and quality assurance. There did not appear to be any guidance or knowledge base about what made an effective structure, within a CCG, for this work. The establishment of ICSs since 01 July 2022 provides an opportunity to learn about best practice from CCGs and through this enable the future development of improved commissioning and quality assurance in ICS commissioning teams across England.

Systems finding 6 *Sheila*

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

Quick poll (3)

To what extent do you agree that there is no clear national approach to absorb learning, coordinate and resource action necessary to transform care?

A) Not at all

b) yes and no

c) fully

Contact details

Any comments or queries, please email:
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