MEETING	**PUBLIC BOARD MEETING** **19 June 2019**
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Agenda Title	**Whorlton Hall**
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PURPOSE OF PAPER:

This is for the Board to **note**.

Following the Panorama investigation into Whorlton Hall it is essential that the right questions are asked to make sure the necessary change happens to prevent the mistreatment and abuse of people in care settings.

It is clear that we, the provider, and other professionals failed to detect the abuse being carried out at Whorlton Hall. Every one of us at CQC is devasted by our part in that failure. We have repeatedly apologised and are determined to improve our practice.

We are looking into the specific concerns which have been raised by former CQC inspector, Barry Stanley-Wilkinson in relation to our regulation of Whorlton Hall in 2015 and 2016 through an independent review. We are also commissioning a wider independent review which will look at how our regulation of similar services can be improved. The outcome of the independent reviews will also build on the interim recommendations of our recent report on restraint, seclusion and segregation, enabling us, alongside partners to develop and regulate a better system of care for people with a learning disability and/or autism.

Action following BBC Panorama investigation into Whorlton Hall

The footage captured by Panorama shows sickening abuse of vulnerable people. As soon as the BBC told us that they had evidence of abuse we alerted the police and they are now investigating.

Working with NHS England and the local authority and we have acted urgently to protect the people living at Whorlton Hall. Sixteen members of permanent staff were immediately suspended by the Providers, and subsequently patients were either discharged or transferred to other services to ensure that people are safe.

We also wanted to assure ourselves that people were safe in other services operated by this provider. We have carried out unannounced inspections of a number of services for people with a learning disability and/or autism operated by Cygnet (OE) Limited. We are also undertaking a review of all locations operated by this provider looking across safeguarding, whistleblowing, incident reports and complaints to explore whether there are any areas of concern.

As there is an active police investigation which we do not want to compromise, we need to ensure that we do not publicly release information that would reduce the likelihood of individuals being prosecuted.

Independent review into regulation of Whorlton Hall

CQC's review into Whorlton hall will encompass two parts:

1. an independent review into how it dealt with concerns raised by Barry Stanley-Wilkinson in relation to the regulation of Whorlton Hall. The review will focus in particular on concerns raised about the draft report prepared in 2015, and how they were addressed through CQC's internal processes. David Noble QSO has been commissioned to undertake this.
2. A wider review of our regulation of Whorlton Hall, which will include recommendations for how our regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm.

A further update will be provided verbally on the very latest position.

Next steps

We committed to learning from all aspects of our regulation of Whorlton Hall and will act on the findings of the independent reviews.

We are urgently exploring ways in which we can better assess the experience of care of people who may have impaired capacity, or even be fearful to talk about how they are being treated because of the way that staff have behaved towards them.

Furthermore, we are committed to working with partners to implement the five interim recommendations from our review of Restraint, Segregation and Seclusion[1]:

- Over the next 12 months, there should be an independent, in-depth review of the care provided to, and the discharge plan for, each person who is either 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.

[1] https://www.cqc.org.uk/publications/themes-care/our-review-restraint-seclusion-segregation

- An expert group, that includes clinicians, people with 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.
- 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.
- 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.
- 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.