



Joint Committee on Human Rights

Oral evidence: [Detention of children and young people with learning disabilities and/or autism](#), HC 1861

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Members present: Ms Harriet Harman (Chair); Ms Karen Buck; Baroness Lawrence of Clarendon; Jeremy Lefroy; Scott Mann; Baroness Prosser; Lord Trimble; Dr Sarah Wollaston; Lord Woolf.

Questions 42–50

Witnesses

I: Ian Trenholm, Chief Executive, Care Quality Commission; Dr Paul Lelliott, Deputy Chief Inspector of Hospitals (lead for mental health), Care Quality Commission.

Examination of Witnesses

Ian Trenholm and Dr Paul Lelliott.

Q42 Chair: Welcome to this session of the Joint Committee on Human Rights. We are a Joint Committee. Half of us are Members of the House of Lords; half of us are Members of the House of Commons, and as our name suggests we are concerned about human rights. We have been conducting an inquiry into the human rights relating to detention and inhuman and degrading treatment, focusing particularly on young people with autism in assessment and treatment units. Our inquiry has been under way and we have been hearing evidence for some time. I am grateful to Paul Lelliott from the CQC, who came at an earlier stage to give us evidence as part of that.

In today's session, I am delighted that we have here Sarah Wollaston, Chair of the Health and Social Care Committee, who has a big interest in these concerns. She has asked to be a guest at this session, so welcome, Sarah. That is a new procedure where Chairs of other Committees can take part in a session when it covers a number of areas.

Oral Evidence: Detention of children and young people with learning disabilities and/or autism



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I am very grateful to you, Ian Trenholm, chief executive of the Care Quality Commission, for coming to give evidence to us today. That is a post you have held since 2018.

Dr Paul Lelliott, you have come back today and you are the lead for mental health inspections in the Care Quality Commission. That is a post you have held since 2014.

Dr Paul Lelliott: That is correct.

Chair: Thank you very much indeed for coming to give evidence to us. We have invited you back, because after you came to give evidence and we were already under way with our inquiry, the BBC broadcast a "Panorama" programme about Whorlton Hall, which showed shocking abuse, inhuman and degrading treatment, and cruelty to vulnerable people there. Anne-Marie Trevelyan MP, who gave evidence to us last week and is one of the officers of the All-Party Parliamentary Group on Autism, said it was very hard to watch. You were on that programme and you said afterwards that that was sickening abuse.

Dr Paul Lelliott: I am very happy to repeat that statement. What I saw there was horrifying. I have worked in mental health now for 40 years, and more than 30 of those as a clinician, as a consultant psychiatrist. I am glad to say that in my entire career I have never seen anything like that. Yes, all I can do is echo your words that it was horrifying and sickening.

Chair: Indeed, you said in your statement, which was published on 22 May: "'Panorama' shows sickening abuse of vulnerable people. As soon as the BBC told us that they had evidence of abuse we alerted the police". You went on to say in your statement: "It is clear now that we missed what was really going on at Whorlton Hall".

I want to test that assertion because, looking at the papers you have kindly given to us, it seems quite evident to me that you did not miss what was going on at Whorlton Hall, that you knew what was going on, arising out of an inspection that was carried out in 2015, four years ago.

I cannot square the surprise you showed in your interview on "Panorama" with the papers we have here, which show a report of an inspection in 2015 that talks about patients accusing staff of bullying and using inappropriate behaviour. Patients did not know how they could protect themselves from abuse. A statement in a patient's records said that, when an allegation against staff was made, the first step was just to ignore it. How could you have been surprised when you saw "Panorama", or were told by "Panorama" what had been found, when it matched what you had found in 2015 on the inspection of Whorlton Hall?

Dr Paul Lelliott: First, I would like to repeat the fact that this was a surprise to me. I had no idea that abuse of that type was happening at that hospital. Had I had any inkling that it was happening, I would have taken action. We would have taken action then and we would have taken



action in 2015. The 2015 inspection was a routine inspection. It was undertaken as part of the programme of inspections that we do.

You have taken information from the draft report. We sent you five versions of it. It talks about allegations made by patients and staff's response to that. The summary, which is the conclusion the inspection team came to about what they found and the judgments about weighing up the evidence, contains no statement that the team concluded that patients were being abused.

It is our expectation that if an inspection team believes that patients are being abused, they do not wait until they write the report; they take action immediately. Had that team concluded that abuse was happening, I would have expected them to alert the police. Safeguarding would have been informed. Following that inspection, there should have been a review meeting at which urgent enforcement action was taken to stop any abuse that was happening.

Also, on that inspection in 2015 there were a number of healthcare professionals: a psychiatrist, clinical psychologist and a nurse. If any of those people had suspected abuse happening, their professional code of practice would have caused them to raise concerns immediately, either with us or with the police. None of those things happened.

The report contains conflicting statements about what patients say about the care. The conclusion in the summary is that patients said that staff treated them with dignity and were caring. There were conflicting statements in the report, which is one of the reasons we questioned the report and the evidence behind it.

I come back to my first point: I had no idea that such a thing was going on. The inspection team in the north of England also had no idea that it was going on. If they did, they would have taken action immediately. We have a track record of taking decisive action when we have evidence of abuse, malpractice or poor care. We have done that on many, many occasions.

Chair: The allegations in the 2015 report are there and they stand: that patients had accused staff of bullying and using inappropriate behaviour, among a number of things. You talk about the expectation of the team of inspectors who went in. One of the expectations was that the report would be published. Incidentally, we have looked at the different versions. You talk about five versions of the 2015 report. In none of the rewrites or edits of that report, which ultimately was not published—we will talk about that in a moment—was there a challenge to the idea that patients were making allegations about bullying and inappropriate behaviour. That does not change in any of the iterations of the report. That 2015 report was never published, was it?

Ian Trenholm: I am determined to get to the bottom of exactly what happened during that time. We have shared with you the information that



we have to hand. We are in the process of collecting together other paperwork as part of an independent review to look at exactly what happened.

The production of a report is part of a broader process, which includes a quality review process, and there will be notes to that quality review process. We are in the process of collecting those things together. We have appointed an independent chair and we will report publicly on the outcome. We are all at the CQC devastated by what we have seen. We want to understand exactly what has happened. There is more to this than simply draft reports, which you have in front of you. We do not yet have that paperwork to hand. When we have, we hope the report will demonstrate that chain of events and we will be able to unpack some of the things that happened here.

Chair: A certain amount of unpacking was already done at the time, was it not, in 2015 and 2016? When it appeared that the report was not going to be published, the lead inspector made a complaint about the fact that the CQC was not going to publish this report. Therefore, there was a consideration about this report, and particularly about whether it should be published. The finding in response to this complaint was that the 2015 report should be published. This complaint was made by the lead inspector. He basically said: "I have conducted this inspection, but my report is not being published and I am complaining". That is quite a big step to take: to make an internal complaint.

Adrian Hughes, who considered the internal complaint, said that the report should be published and that you, Dr Lelliott, had said that it would be, but it was not. Instead, a new inspection team was sent in, a smaller less experienced inspection team, which said there were no allegations of bullying. It was only 10 months later that they produced their report, and they rated the institution "good".

I have to put this to you quite bluntly, Dr Lelliott. It looks like there was a diligent inspection in 2015. It looks like they discovered what we then saw, to our horror, on "Panorama" on our televisions. It looks like the CQC did not publish that 2015 report. It was suppressed. There was a row about it and a strong complaint from the lead inspector, and then it was suppressed, despite a commitment to publish it.

Then, a new team was sent in and they produced a report, which was a whitewash and said Whorlton Hall was "good". We know that Whorlton Hall was not good, because I am afraid we have seen what those staff were doing and that young woman screaming on the television. I have to put it to you that that is what happened.

Dr Paul Lelliott: I do not accept that that is an accurate description of what happened. Mr Trenholm has said there will be an investigation of this. All this information will be put into the hands of an independent person, who will form a view about it. I can account for my part in this, and I am very happy to do that. I received the draft investigation report that you are referring to into the grievance by the inspector on, I think, 2



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March 2016. The day after that, the comprehensive inspection of Whorlton Hall began, so it was the day after I first saw the draft report with that recommendation.

I decided that the thing to do, because of ongoing concerns about the evidence in the 2015 report, was to ensure that the report included the findings from 2015. I have looked at the 2016 report, and there are 17 mentions in it of what the team found in 2015 and the situation in March 2016. The key findings from the 2015 inspection report were published in the 2016 report.

Chair: Can I stop you there and say that they were not? The abuse and bullying had vanished and the rating had gone up to "good". The 2015 report said that there was abuse and bullying. That was not in the 2016 report and they were given a "good" rating, when you would not have given the institution a "good" rating, far from it, from the 2015 report. You say that the 2015 report elided into the 2016 one, but that is simply not the case, and clearly not felt to be the case by the lead inspector, who goes on in his complaint to say very clearly, "This fails in our duty to protect people". This is when he is complaining about the failure to deal properly with the 2015 report.

He says that the culture in the CQC, "is only what can be described as toxic". He says that the inspection report was not published, "despite significant findings that compromised the safety, care and welfare of patients". He says that is what happened with the 2015 report and why he is making a long complaint about it not being published. Then he says, "I am raising these issues, because I believe something serious could happen that will put CQC under the spotlight, and I also believe core values of our organisation are not being followed". He was right, was he not?

Ian Trenholm: I disagree with your characterisation of Mr Stanley-Wilkinson's view. In his report, as you will see, he rated every one of our five questions as "requires improvement". In the event that he felt there was any significant abuse going on, he would have recommended an "inadequate" rating. We would have acted immediately, as Dr Lelliott said, called the police, and it would have been closed down. We have done that on three separate occasions in other institutions.

Chair: But the 2015 report does categorise it as "inadequate".

Ian Trenholm: It does not. It categorises everything as "requires improvement".

Chair: I beg your pardon—"requires improvement", yes.

Ian Trenholm: We have four ratings, which run from "outstanding" to "good", "requires improvement" and "inadequate". "Inadequate" refers to institutions that one would describe as unsafe. "Requires improvement" refers to institutions where there are some things that, left unchecked, will lead to unsafe practice.



The report does not characterise the institution as unsafe. That is a really important point. When we went in in 2016, as Dr Lelliott described, the team looked again. Although the overall rating was “good”, they rated the location “requires improvement” for safety on specific drug handling-related matters.

Later on in 2016, we followed up with another comprehensive inspection. That ultimately rated the location “requires improvement”. The following year, it became “good” again. Later in 2016, we went in following a police investigation into allegations of safeguarding concerns, so we followed up with the police. The police did not charge anybody and did not find evidence of abuse.

I appreciate that there is understandable anger and dismay about the 2015 report, but there is an important context here. A number of professionals were working in Whorlton Hall and none of them found any evidence of abuse. At this stage, it is something of a leap to suggest that abuse was going on in 2015 in Whorlton Hall, because nobody found that. The only thing we can say with certainty is that abuse was filmed by “Panorama” in 2019.

Chair: We can also say with certainty that the report said that patients had accused staff of bullying and using inappropriate behaviour. Patients did not know how they could protect themselves from abuse. That is a fact. That is in the 2015 report.

Ian Trenholm: That same report also says that patients spoke positively about the interactions between themselves and staff. There are definite contradictions in the report, which is why the quality panel that reviewed it had some concerns about the coherence of the narrative. That is why the report was not published.

The reason I am so keen to focus on the investigation is because there is more to all this than simply the reports you have in front of you. We need to make sure that all the documentation is sought and properly looked through. Then we can have a proper discussion about this. I am very happy to come back and talk to the Committee about the report once it is written.

Dr Paul Lelliott: The report summary says, “Patients told us staff treated them with dignity and respect”. It also says, “Patients told us they knew how to complain and the service received only one formal complaint from a patient in over a year”. That is in the summary of the 2015 inspection report, which is where the inspector puts their judgments.

From the information we have gathered so far, all of which will be in the hands of the people doing the independent review, the earliest version of the first-draft report we could find was 16 weeks after the inspection. I would have thought that, had those concerns been so pressing, there



would have been action in the 16 weeks that intervened between the end of the inspection and the first-draft report.

Finally, the 2016 report contains a statement about patients making allegations against staff, and it goes on to talk about how those allegations have been dealt with. The suggestion that the 2016 report says nothing about patient allegations is not correct. It is in the 2016 report.

Chair: Coming to the action after the Panorama programme, what happened to Whorlton Hall then?

Dr Paul Lelliott: The first time I saw the actual footage was when the programme was aired. When we first saw the transcript of the programme, we notified the police and linked up with NHS England, the body that would co-ordinate the action. The priority was to ensure that people were safe, so NHS England asked staff from a neighbouring NHS trust to go into the service to ensure that people were safe immediately. NHS England then worked with the provider to ensure that people were moved, either discharged from the hospital or transferred to other hospitals. That was NHS England's responsibility. My understanding is that the last person left the hospital before the Panorama programme was aired and the hospital is now boarded up.

Chair: Going back from 2015 to where we ended up in 2019, how would you characterise how you carried out your responsibilities for the inspection and protection of vulnerable people in the institution, Whorlton Hall?

Dr Paul Lelliott: I would repeat what I said on the "Panorama" programme, which is that clearly we did not detect what was going on. I am deeply sorry about that, because it could have saved people from continuing abuse. We did not give the hospital a clean bill of health. As Mr Trenholm has said, at a subsequent inspection we rated it "requires improvement".

We went back to follow up on the actions the hospital had taken. Although it was rated "good" at the time of these events, the last inspection before the "Panorama" programme had been in March 2018, when, in response to concerns, we went in. There, we had worries about staffing: high use of agency and bank staff, staff who were working overlong shifts, poor supervision and monitoring of those staff.

We found them to be in breach of two regulations and issued requirement notices about staffing and governance. That was the situation, but in March 2018 it was not our practice to revise the ratings of a provider on the basis of a partial inspection, so the rating of "good" persisted. That was from an inspection in September 2017.

We are part of a wider system that is responsible for assuring quality in learning disability hospitals. As well as us, as the regulator, every one of those places in the hospital would have been commissioned by a clinical



commissioning group. By the nature of the hospital, because it is a long way from people's homes, there would have been a number of CCGs, each commissioning a place. You would have expected oversight from the person co-ordinating the contract with the hospital. The local authority would also receive safeguarding notifications from the hospital. You would expect them to respond to that.

Working with NHS England, we put together a timeline. We know that dozens and dozens of people from outside that hospital went into it during the 18 months leading up to the "Panorama" programme, including our inspectors and Mental Health Act reviewers. None of them detected what was going on. None of them was able to get under the skin of this closed and abusive organisation.

Chair: How does that make you feel about your rating of "good"? On the one hand, you have said, "This is a good institution". On the other hand, we see what was happening on "Panorama". Is the issue not that if you issue a "good" rating it is worse than no rating at all? Far from protecting people from the abuse we saw on "Panorama", it shields the abusers by saying, "You are good", so they can get on with it. The people we saw on Panorama must have been delighted to be described as and rated as "good". That enabled them to get on with abusing, taunting and cruelty to vulnerable people, while your authority had stamped it as "good".

Dr Paul Lelliott: Yes, that is a very valid point. I said that in March 2018 that it was our custom and practice not to rerate services following a focused inspection. That has subsequently changed and we now change ratings on the back of a focused responsive inspection. Because we found them in breach of two separate regulations, we would have rated them "requires improvement" on the back of that 2018 inspection.

Ian Trenholm: Our experience is that commissioners will place people in locations that are rated "requires improvement", "good" or, indeed, "outstanding". What will dissuade them from placing people in a location is an "inadequate" rating. Even with the breaches we found, we still do not believe that we would have rated that location "inadequate".

In terms of protecting people, it is a point well made. It opens a broader question about our methodology. The second review I have commissioned is going to look at our entire regulatory history from 2015 to 2019, with the specific intention to look at how our regulatory method actually works. It concerns us deeply.

On "Panorama", we saw individuals who appeared to commit crimes—I use my language carefully, given that this is an active police inquiry—of the worst possible sort, and they appeared to collude in a way that deliberately thwarted our methodology. We need to reflect on that. We must change our methodology to think differently about these things.

In many senses, we are saying what we already knew. Dr Lelliott's report on restraint, seclusion and segregation makes the very clear



recommendation that we review the model of care, because these closed environments are very, very difficult to regulate using an inspection model of care. We need to work with the people who use services, commissioners, charities, advocates and a range of other people to see what a new model of care looks like, so that we can create an environment that is as easy to regulate as possible.

We need to be very honest with ourselves. We can never create a situation where we can inspect these services to such an extent that we can guarantee that no abuse takes place. All those partners, working as an alliance, can work together to try to reduce the risk of abuse. That is the issue here.

Chair: You have mentioned seclusion. This is just by the by, but in terms of terminology it would be good if it was referred to as "solitary confinement". With "seclusion", we are not talking about the roof terrace on "Love Island", we are talking about solitary confinement.

Can we turn now from an institution you rated as "good", Whorlton Hall, to one you rated as "inadequate", St Andrew's, which we have also had some evidence about?

Q43 Ms Karen Buck: As the Chair has just said, on the basis of the evidence it appears that you were aware of problems at St Andrew's over many, many years.

I wanted to ask you to confirm what I understand to be the story. The first report was prior to the current rating system. The Care Quality Commission found that there were a number of very serious issues and allegations, including an accepted statement that the seclusion rooms on the John Clare unit did not have access to toilet facilities. One patient said that a member of staff informed them, "I'm leaving my shift and you're not going to the toilet". Staff had offered them a bowl to use instead of having access to a toilet, and during the inspection visit CQC inspectors were told that patients were not always given access to food and drink in the seclusion room. Can you confirm to us that that was in the 2013 report?

Dr Paul Lelliott: No, I cannot. It was a long time ago, even before my time, so I cannot confirm that, I am afraid. I probably have not read it at all.

Chair: Perhaps you could just take it from Karen that it is.

Dr Paul Lelliott: Yes.

Chair: That is exactly what was said in 2013.

Ms Karen Buck: We just heard from you, rightly, that you would act immediately in cases of abuse or bullying. It seems to me that they are examples of abuse or bullying. Would you agree?



Dr Paul Lelliott: It is absolutely inappropriate behaviour towards patients, yes.

Ms Karen Buck: That does not quite answer my question.

Dr Paul Lelliott: I would agree, from what you have read out to me, yes.

Ms Karen Buck: In the history of this—I will come on to some of the other stages in a second—would the Care Quality Commission not normally have referred back to look at the past inspection reports for that institution?

Dr Paul Lelliott: Yes, we would. In our most recent inspection report of the child and adolescent mental health services that we recently rated “inadequate” and put into special measures, we refer back to the number of times we have expressed concern to the provider about the use of seclusion.

St Andrew’s is a big institution. I think it has four separate hospitals and we inspect a number of services at different times. This did not relate to one environment, but it is true to say that a theme runs through both our inspection reports and our Mental Health Act review visits of poor practice in restrictive interventions. That has culminated in us rating it “inadequate” and putting the CAMHS into special measures.

Ms Karen Buck: I will come on to that in a second. The point is that the Care Quality Commission was aware of allegations that were that serious going back to 2013, yet it does not appear that that record was acted on in a way that is consistent with what you have just told us, which is that there would be zero tolerance of bullying and abusive behaviour.

Dr Paul Lelliott: It is difficult, because I do not know the complete context in which the 2013 inspection happened. On an inspection, if the team identify what they believe to be an isolated incident, I would expect them to raise that immediately with a manager. They have an obligation. If they find something that is really troubling and has to be sorted then, they would raise it with the managers of the hospital and we would expect the managers to do something about it and account for why it has happened. It is quite possible to come across an isolated incident that is not part of a general pattern, and therefore would not result in a rating of “inadequate” or other action.

Ms Karen Buck: Indeed, but the examples I have just given you are, by definition, not isolated, because there were more than one. Would you accept that?

Dr Paul Lelliott: I would. The basic premise is that, if we identify abusive and bullying practice, we should take action. That action would depend on the context, but I cannot argue with that premise.

Ms Karen Buck: I appreciate that this is unfair, because you tell the



Committee that you are not familiar with the content of that report. There does not appear, does there, to have been any serious action or follow-through on a report that included incidents of that gravity.

Dr Paul Lelliott: Could we go back into our records and respond to that in writing?

Ms Karen Buck: Yes, that would be very helpful. Those incidents were in 2013.

The next stage is that there was an inspection report in 2016, which required improvement. Is that right? That was three years later.

Dr Paul Lelliott: Yes, I do not have the complete timeline, but I will accept that is accurate.

Ms Karen Buck: Slightly later than that, in 2016, our parliamentary colleague Helen Hayes took up a complaint about one of her constituents, who was detained in St Andrew's, and raised it in a House of Commons debate. In her letter of complaint, which was very powerful, she expressed concern about the behaviour of the constituent's lead clinician.

Following the meeting, she said that she had left the meeting very concerned indeed about the welfare of her constituent: "I had the impression that his clinical team had no real interest in him and seemed to regard his behaviour as a problem to be managed rather than a condition to be treated". She was concerned about the clinician's aggressive approach, lack of engagement and lack of willingness to engage with fellow professionals. Almost all the elements of that very comprehensive complaint were upheld either wholly or in part. Are you familiar with that complaint?

Dr Paul Lelliott: No, I am not familiar with that precise complaint.

Ms Karen Buck: That surprises me. Would you not expect to have been familiar with a complaint about an institution that had previously had grievances of the type I have referred to in the 2013 report, which led to that institution being rated "requires improvement"?

Dr Paul Lelliott: Yes, but you are referring to a letter that was sent three years ago. There are a very large number of services and reports. Probably thousands of reports would have come over my desk in the intervening period.

Ms Karen Buck: I completely understand that.

Dr Paul Lelliott: I know we have had long-standing concerns about St Andrew's, and that is mirrored in the number of inspections we have done of the service. We have rated a number of elements of their provision as "requires improvement". Recently, we rated two important parts of their provision "inadequate" and placed them into special measures.



Ms Karen Buck: If you do not mind, we will come on to that. The point is that we started in 2013. We have now moved on to 2016 and 2017 with another “requires improvement” rating and a very serious complaint. I would have hoped that prior to this you might have been aware of that complaint and the cumulative impact. The chief executive officer, responding to the complaint, said, “We will learn and take steps to improve care to our patients”. That was in 2017.

After that, we move another year forward to the “File on 4” programme, which focused on the case of Bethany. Bethany’s father gave evidence to our Committee. In “File on 4”, Bethany’s father talked about the conditions Bethany was experiencing, locked in a seclusion cell, unable to have the treatment and support that would have managed her condition. We heard some really powerful evidence from him and from another parent who talked about St Andrew’s being somewhere where people die. That was a year later. We have already now had the chief executive telling us that they were going to learn from the complaints. What learning would have taken place between 2013, 2017 and now 2018?

Dr Paul Lelliott: Now you are moving into territory that my memory encompasses. I recall those inspections and the events around the care of that young woman. We went in there and undertook pretty intensive inspections in late 2017, 2018 and this year. We expressed significant concerns, particularly about the use of restrictive interventions, a term to describe seclusion, segregation and physical restraint. We expressed concern about that. We have expressed that concern repeatedly.

We have a vital role to play, as the regulator. Our job is to inspect, regulate, pick up these concerns and take the actions that we have at our disposal, but there are other parts of the system that we work together with. Every one of those places in St Andrew’s would have been commissioned, either by NHS England or by a clinical commissioning group, so there is shared responsibility for oversight of that hospital.

I know exactly what tools we have in our toolbox and what powers we have to enforce and take action. I am very happy to provide a complete timeline of the inspections we have done and the actions we have taken, because some of the actions would not necessarily be evident from the report. There would have been enforcement action that is not necessarily reported in the reports.

Your central premise that there have been long-standing concerns about the use of restrictive practices at St Andrew’s is true. My recollection is that we go in there and inspect. After we pick up on issues, things get better. Then either they slip back or there are problems in another part of this big organisation. We find that they have sorted out something in this part, but not in another. That seemed to be the pattern. That is the pattern in my head, but over the last six months or so we have taken very decisive action against two important parts of this provider.

Ms Karen Buck: Indeed, so we now go to the latest inspection report,



where we find that the overall rating for the location is “inadequate”. Then you rank on particular issues. Are services safe? Services are ranked as “inadequate” for safety. Are services caring? Services are ranked as “inadequate” for being caring. Are services well led? Services are ranked as “inadequate” for being well led. Is that right?

Dr Paul Lelliott: That is correct.

Ms Karen Buck: The question I am struggling with is this. That is a pretty devastating report on an institution that, according to Bethany’s father, received something like £15,000 a week for the services it provided.

Dr Paul Lelliott: I know that the cost of the care of some individuals is extremely high.

Ms Karen Buck: We now have a report that fails this institution on safety, being caring and being well led, six years after you went in to inspect and found reports of what I would consider to be abusive behaviour. Is that right?

Dr Paul Lelliott: That is a fact from what you are saying, but I am not sure about the interpretation. In my experience, hospitals do not have a constant level of quality over time. They fluctuate. One of the features of an organisation such as Whorlton Hall is that its quality can change quite quickly, depending upon two critical things. One is the quality of the front-line staff providing the care. The second is the quality of the middle managers. I do not know whether it is correct to characterise this as six years of continuing awful care. When we visited on different occasions, you will find that we rated some of the services provided by St Andrew’s as “good” during that period.

Ms Karen Buck: That slightly worries me, because if that is the case it begs the question: what is the point of an inspection? I completely take the point of what you are saying. If you were to say, “We inspect an institution and find it good, but in between inspections there may be times when the service quality will dip”, that would seem to be fair and unarguable.

I struggle to understand it where you have an institution into which a huge amount of money is going and where in 2013 there was evidence of quite serious failings, yet years later, following a consistent pattern of complaints and inspections, these particular services are still failing.

Ian Trenholm: I understand the point you are making. I guess you will invite NHS England to come and talk to the Committee. That feels like a question you should better ask them.

During that period, there was public domain information in our reports, which commissioners would have looked at, so commissioners are still commissioning services in an institution of the sort you have just described. We can go so far, but it is worth remembering that we get



three to four challenges a week to our ratings process, so it has to be very carefully controlled. I know that sounds like I am playing the civil servant.

Chair: Could you explain who the challenges are from?

Ian Trenholm: They are from providers.

Chair: They are from the institutions themselves.

Ian Trenholm: Yes. A range of different providers will challenge our ratings process. That is why we have this quite complex quality assurance process. It is why we produce these reports. It is why we make such a big deal out of making sure that we can triangulate evidence and all these things.

Dr Lelliott's point is well made: performance will rise and fall over time. We try to reflect that in the report in a way that cannot be challenged, because there is no point in getting into a position where a rating is challenged. A range of different people will have been involved in placing these individuals in this setting. That will take place over time. I suspect those those professionals will have had to take a view as to whether the disruption from moving a person from an inadequate setting outweighs the benefits of doing that. It is very difficult to make that judgment without being the clinician who is treating them.

Ms Karen Buck: That is all fair, and I will finish on this point. I am not sure that is entirely consistent with your strong opening remarks that, when there is evidence of bullying or abuse for example, you will act immediately.

Ian Trenholm: It is entirely consistent. If we find there is an offence we can prosecute, or a criminal offence, as there was in Whorlton Hall, we will call the police or take enforcement action. There is a history of taking enforcement action at St Andrew's. We can only operate within the law that exists.

Chair: Is it a question of you worrying about challenges from institutions, which after all are businesses that get a lot of investment from the public purse? Basically, you are looking over your shoulder, due to the issue of legal challenges. Of course, there was a threat from the institution of Whorlton Hall about that 2015 report. That is what triggered all the edits on that report. There was a challenge from Whorlton Hall about the way the inspection had been conducted. That was one of those cases where the institution challenged the process of the inspection. The answer to that is yes.

Ian Trenholm: No, it is not actually. It is no. There are two questions there. First, there is the general one. We are not afraid to close institutions down. We take on world-class names on a daily basis. We do 75 inspections a day across our portfolio. We take on world-class brands, we take enforcement action, and in some cases we close them down. I



am not afraid of legal action. We need to recognise that there is sometimes a balance to strike as to the likelihood of challenge, and we need to make sure there is evidence there. Specifically on Whorlton Hall, from the information I have seen today, there was no threat of legal challenge.

Chair: But there was a challenge. I did not say whether it was a legal challenge. There was a complaint by the institution about how the inspection had been provided. They complained about the inspection.

Ian Trenholm: From the information I have seen, there was a complaint email, but I would not describe it as a challenge. From what I have seen so far, it does not relate to the process of the inspection.

Lord Trimble: What did it relate to?

Ian Trenholm: It related to the behaviours of the inspection team.

Lord Trimble: They were saying that the inspectors had acted improperly.

Ian Trenholm: That is right.

Lord Trimble: Was it true?

Ian Trenholm: I do not know.

Lord Trimble: Would that have resulted in the rewriting of the report?

Ian Trenholm: From what I have seen, I do not believe so, no.

Dr Sarah Wollaston: Could I clarify a point? Was the non-publication of the report because of the complaint—or the challenge, however we refer to it?

Ian Trenholm: No, that is not correct.

Dr Sarah Wollaston: Why was the report not published?

Ian Trenholm: The report was not published, because we had concerns that there was insufficient evidence to back up the statements that were in the report.

Dr Sarah Wollaston: It was not as a result of the challenge you had received.

Ian Trenholm: No, I have seen no evidence to date that links the non-publication of the 2015 report and the complaint. I would describe it as a complaint, not a challenge, to be clear.

Chair: Can I help you here? You are saying it is just a coincidence that they did not publish the report after the complaint from Whorlton Hall. The core of the complaint from Whorlton Hall about this inspection was that the number of inspectors, compared to the number of residents in



Whorlton Hall, was disproportionate and heavy-handed. Can I put it to you that the inspection team in 2015 that Whorlton Hall said was disproportionate was the lead inspector, one inspection manager, one psychiatrist, one psychologist, one occupational therapist, one pharmacist and one person with learning disability who is an expert by their experience?

That amounts to a number of people, but they are all the appropriate people, are they not, to look at an institution? They have the relevant expertise in psychiatry, psychology, occupational therapy, or have experienced that setting. Therefore, is it just a coincidence that the next inspection team was slimmed down and only comprised three people, or does it look like Whorlton Hall said, "We do not want all these people coming and inspecting us. It is unfair and feels disproportionate"? Then that report is not published. They do a new inspection with three people and—blow me down—they are "good".

Ian Trenholm: I do not recognise that characterisation. There is more to the complaint than what you have just described.

Chair: But you do not know what that is. You cannot tell us.

Ian Trenholm: I do.

Chair: It is not evident from the papers we have seen that are on our website.

Ian Trenholm: No. I said right at the start that I would like to do an independent review that enables us to look at all aspects of what went on in 2015. We are concerned that we do not necessarily have all the paperwork. Some of it is on email systems. Some of it is in our main system. It is the inspector's job to file the paperwork and to plan the number of people who go on the inspection. It is then their job to make a judgment and to take action subsequently.

The complaint itself touches on a number of issues. I would describe it as at the complaint feedback end of the spectrum, rather than a challenge. Some issues about behaviours on the inspection were contained within that complaint.

Q44 **Dr Sarah Wollaston:** Could I ask a question about the role of experts by experience? As you will know, the follow-up inspection did not have an expert by experience, and that was later in 2016. As you will know, in February 2016 there was a change to the contracting arrangements for experts by experience. How much of a role do you think that could have played? You could argue that having experts with lived experience adds a huge amount of value to an inspection. I would definitely argue that. Could that have been relevant here?

Dr Paul Lelliott: It is difficult to tell at this remove. Like you, I am a great supporter of having experts by experience on an inspection. In this context, it could be either a person with a learning disability, who would



probably be accompanied by somebody, or a carer of someone with a learning disability.

Whether that inspection team did not have an expert by experience because one was not available, I would not know. It is public knowledge that there have been difficulties with the contract for experts by experience.

Dr Sarah Wollaston: They have had a very significant cut in pay, have they not?

Dr Paul Lelliott: Yes.

Dr Sarah Wollaston: What has happened now, looking forward, to the number of people who are available to be there as experts by experience, bringing the tremendous value they do to inspections?

Dr Paul Lelliott: The hospitals directorate, of which I am a part, has identified those types of services where it is more vital to have experts by experience than others. Learning disability is top of the list. We prioritise finding an expert by experience who can participate in the inspection in a learning disability service. That would be a priority, regardless of the problems with the contract or the pay.

Dr Sarah Wollaston: I am glad it is a priority, but my question was whether there has been a change since then. If we look forward to future inspections, do you have enough experts by experience, and do you need to change the contracting arrangements accordingly?

Dr Paul Lelliott: I would never say that we have enough experts by experience. I know that the number of days that were allocated this year is slightly higher than last. The anticipation is that in 2021 it will be slightly higher still. There were significant problems with the contracting arrangements for experts by experience.

Dr Sarah Wollaston: We have had correspondence, as you know, with the Health and Social Care Committee on this, and the concerns about how we value people with experience within inspection teams. Perhaps we could continue that correspondence. It is an important point.

Dr Paul Lelliott: Yes, and how you reimburse people is a measure of how much you value them.

Dr Sarah Wollaston: It was a very significant cut.

Ian Trenholm: It is worth noting that the procurement process for a new contract for experts by experience is in process at the moment. We expect, in the next 12 months, to have a new contract in place, which I am determined will address some of what I know are long-standing concerns.

Q45 **Lord Woolf:** Your task, collectively, is to avoid what was eventually found and shown on the "Panorama" programme. It happened, and I

Oral Evidence: Detention of children and young people with learning disabilities and/or autism



know you want to do further research and have further inquiries. At this stage, at any rate, it looks as though the procedures exercised by the commission were not achieving their purpose. Do you agree with that?

Ian Trenholm: I would agree with that. The way in which an inspection methodology works is to inspect a normal institution and form a view as to how well run or otherwise it is, and how safe it is.

On this occasion, as I said right at the start, we had some individuals who were deliberately setting out to thwart that inspection methodology, so the methodology did not work well. I would echo Dr Lelliott's view that we in the CQC are all deeply sorry about that. We are determined to do something about it. That is why I have commissioned a second, longer review to start to look at whether our processes, our procedures, our approach, could be improved, particularly to target individuals who are seeking to thwart us.

Lord Woolf: What happened is evidence that you were not able previously to find out what was going on. There is a great need for a very steep learning curve to make sure this never happens again.

Ian Trenholm: Yes, absolutely. From our point of view, I hope the review will deliver that. I do not think anybody can give you a guarantee that this will never happen again. If people are seeking to behave in this way, we can reduce the risk of it happening to the absolute minimum, but I do not think I can honestly, hand on heart, sit here and promise you it will never happen again.

Q46 **Scott Mann:** I have a preliminary question and one that I have written down.

You mentioned earlier on, Mr Trenholm, that local commissioners are still allocating places to people in inadequate facilities. What the hell is going wrong if that is happening across the country? What is the problem? Is it a lack of facilities, a lack of people? Why are there people being allocated to inadequate facilities?

Ian Trenholm: You have probably answered your own question to some extent. A challenge we see is that people are placed significant distances from home. A lot of people do not go to assessment and treatment units in a particularly planned way. They have a placement that may break down. They may be living at home, and suddenly they are in crisis and are placed wherever the nearest available bed is. That may be some significant distance away.

This is a service where people are placed in suboptimal ways. It would be a useful conversation for the Committee to have with NHS England. We have a perspective, but I am sure they will have a perspective on this. As other people have said, that leads to pretty expensive placements. I do not necessarily think this is just about money. This is probably about provision as well.

Scott Mann: I would definitely like to see us do that, Chair, at some



later stage.

The evidence that we have received in this inquiry suggests that Whorlton Hall is just one example of more widespread, systematic abuse that has not been picked up by your organisation. I will give you some examples. We have been given evidence from a parent about the Willows in Wisbech: physical injuries untreated, segregation, deprived of clothes, watches not adhered to, staff asleep when they should be on watch. Does this sound like an organisation that you are familiar with? Is this something that you have anything to say about?

Dr Paul Lelliott: Since the “Panorama” programme, and before the “Panorama” programme, we have received many notifications, from members of the public, carers or people working in services, raising concerns about services. Last year, CQC received about 10,000 whistleblowing notifications from staff. I think the figure is right: about 1% of those related to learning disability hospitals, so there are many, many other areas of concern. We listen to those concerns. We take them seriously and we act, by bringing inspection forward when we need to. In passing, if you have any information that we do not already have, we would be very happy to receive it.

The challenge for us, which Mr Trenholm has alluded to, is how you get to the truth about these organisations. It is partly through the thematic review, but also through reflecting on Whorlton Hall, talking to whistleblowers—staff members who come to us—and asking, “What was it like?”

In these types of institutions—Whorlton Hall is almost certainly one, and Winterbourne View was one—not every staff member is a bad person who is conducting abuse, but there is a group of staff, or clique, that seems to set the culture for the organisation. That group of staff is inward-looking. They exclude others. They will abuse patients deliberately out of sight of other staff who are not part of that clique. They also take active steps to cover up what they are doing. We saw descriptions of that at Winterbourne View. If you have CCTV cameras in place, they know the places there are not.

It is very difficult to get under the skin of that and gather the evidence you need to prove it. When you say to staff, “We have had this allegation”, people do not tell you, “Yes, absolutely right, that happened”. They cover up. I went on an inspection myself a couple of weeks ago to a learning disability hospital where we had had a whistleblower saying, “We are worried that something like Whorlton Hall has happened here”. I talked to a large number of staff and I looked at CCTV footage. Gathering the evidence that turns an allegation into something we can act on is really difficult. I go with Mr Trenholm and say that although it is difficult we have to think how we can get closer to this.

Scott Mann: I have another example for you. This one is from Oaktree Manor: a mother saying that her son was physically, mentally, chemically



and verbally abused; had broken arms, leg, hand, finger and clavicle bruises; was restrained in straitjackets and was kung fu-kicked, leaving shoeprints with horrendous bruising. I know we have talked a lot about Whorlton Hall, but it seems to me like it is a lot wider than that. Would you agree?

Dr Paul Lelliott: That sounds appalling, and I hope that has been reported to the police, because that is a matter for the police rather than a regulator.

The Committee suspended for a Division in the Commons.

Scott Mann: We mentioned the case of the Willows in Wisbech. This is the second one. Would you expect this to be part of a normally run facility?

Dr Paul Lelliott: Absolutely not, no. What you are describing there should be reported to the police as well as to us, as a regulator. If you do not mind passing those on, that would be great.

Chair: You have them already.

Dr Paul Lelliott: Can I comment on the context for this? We talked about these hospitals being open and people still being admitted, even if they are rated "requires improvement". I suspect there are hospitals that we rate "inadequate" where people are still admitted.

Scott Mann: These two were both rated "good", actually.

Dr Paul Lelliott: These hospitals are not pulling people in. People are being pushed into these hospitals from local areas, often from distant parts of the country. The problem is that as long as we have these hospitals, often in out-of-the-way places—Whorlton Hall was certainly in an out-of-the-way place—admitting people from all over the country so they are a long way from home, there is always the potential for that type of abusive practice. We as a regulator can go in and, we hope, identify any bad care. As I said earlier, we have rated eight of these hospitals "inadequate" over the last three years. As long as people continue to be pushed into these hospitals, this risk persists.

We need a change to the system and the model of care so that, first, people are helped in the community and do not think they need to be in hospital. Secondly, if people would benefit from a period of in-patient care, it has to be close to home and for the shortest possible time. The absence of alternatives is the reason these hospitals are still open.

Ian Trenholm: As a general plea, I personally sign off all letters and all correspondence with people from both the Lords and Commons, so I would encourage all MPs and all Members of the Lords to write to us if they have any concerns from constituents. I can guarantee that they will receive a response.



Scott Mann: The point I was trying to make is that we, the general public, place your organisation in a role to protect vulnerable people from this kind of situation. How can we as a Committee, and the wider public have confidence that the same failings uncovered at Whorlton Hall are not going on at any other institutions? We cannot be confident that your failure to pick up on the problems at Whorlton Hall or St Andrew's is an aberration, can we?

Dr Paul Lelliott: As I said earlier, I could give you numerous examples of where we had picked up on poor care. We have taken action that has resulted in either improvement or the hospitals closing. You are quite right: as Whorlton Hall illustrates, there were occasions when we missed what was going on. Part of the reason for that is the closed nature of these organisations and the abuse that happens. It is a wake-up call for us, but not just for us. It is for the whole system, the people who commission these services, and the local authorities that support safeguarding. We all have to work together to make the likelihood of this happening as low as it can possibly be. But, like Mr Trenholm, I cannot look you in the eye and say that this is not happening somewhere else, or it might not happen again. I am afraid I cannot do that. I wish I could.

Ian Trenholm: My appeal to people who work in the sector is to come and talk to us about what is going on, because they are the eyes and ears on the ground. Many of the doctors, nurses and other care workers are registered professionals. There is an expectation on those professionals to call out poor behaviour when they see it. As Dr Lelliott said, when we talk to whistleblowers we find that these things are not entirely straightforward. There are in groups and out groups, as there are in any place of work. The difference here is the consequence of being in the out group.

Scott Mann: Could you change your CQC inspection routine to include some way of breaking through the barriers you have described?

Dr Paul Lelliott: We are very actively thinking through that. In our thematic review report, we made recommendations about what could be done to improve safeguarding. One is strengthening independent advocacy, so an independent person is assigned to somebody in this type of situation whose job is to spend significant time in the hospital, looking at the world from the patient's perspective. That could be one safeguard. If that is happening it might deter abusive behaviour. Also, having someone there as a regular feature might increase the likelihood of that being picked up.

The law would allow us to do covert surveillance, but CQC has chosen not to do that. We need to go back and revisit that. Even if we did covert surveillance, talking to whistleblowers, and actually talking to the journalist who did the "Panorama" programme, it takes time; it took a while to get in with the group so that the group displayed the behaviours they were showing on the "Panorama" programme in front of her.



There is more that we can do such as observing care and trying to find ways of getting other people who can be the eyes and ears into those organisations. We will look at all these things, as well as finding better ways of talking to patients and carers so we can elicit their experience. We have a lot of thoughts, and we hope the person leading the other review that we are conducting about our regulation of Whorlton Hall will have the expertise to help advise us on how to do that.

Scott Mann: On that, you mentioned at the start, Mr Trenholm, that you were going to review the evidence from Whorlton Hall. Can I suggest that this review might need to be much more strategic and be about the processes that are in place within the CQC in order to eliminate some of the challenges we have heard about in the evidence session?

Ian Trenholm: Maybe I was not completely clear. We are doing two reviews. One is focused specifically on Whorlton Hall, to get quite quickly behind the allegations that the former colleague has made. The second, as you describe, is a much strategic review. Although it will be focused on Whorlton Hall as an example, the expectation is that the report that comes out at the other end will start to look at a range of different interventions and will potentially lead to a change in our methodology.

It will draw very heavily on the lessons from Whorlton Hall. It will pick up issues like CCTV and so forth. This is where I hope the Committee can contribute, on the human rights dimension of that. Some of the interventions that some voices call for directly impact on people's human rights. Expert voices in that debate would be really helpful.

Chair: You asked about the issue of reporting to the police in relation to the complaint about Oaktree Manor, which Scott has raised with you. Apparently it was reported to the police, but the young man concerned was unable to give evidence because of his disability, so the case was dropped. I just add that in for further information.

Q47 **Jeremy Lefroy:** I want to turn to your CQC regulations. Regulation 12 of your 2014 regulations talks about preventing people from receiving unsafe care and preventing avoidable harm or the risk of harm. I do not know if that regulation was as is in 2014, or whether it was amended as a result of the Health and Social Care (Safety and Quality) Act 2015, which amended Section 20 of the 2008 Act.

Whatever is the case, either in 2014 or in 2015 those regulations stated that was the case. Those are your regulations and you must inspect in accordance with those. I wondered whether those regulations are communicated directly to all those whom you inspect, and whether you check that all the staff in those organisations are fully aware of those regulations. If they were and they followed them, none of this would have happened.

Dr Paul Lelliott: Every provider has a registered manager, who is our link with the CQC. We would expect that registered manager would communicate to staff what these regulations mean, in a form that they



could understand, because these are legally worded regulations. For our inspectors, we have key lines of inquiry and prompts that have turned those regulations into not standards but meaningful statements about what we would expect to find when we inspect a service.

We have a body of guidance, much of it in the form of brief guides, which is primarily to inform our inspectors about what they should be looking for, but also is publicly available. On the mental health side, we have 61 brief guides. All of those would be accessible by providers, so they should jolly well know what we are looking for and what we expect.

Jeremy Lefroy: I will give you an example. When I started work as a foreman in Ford in 1980, the Health and Safety at Work Act had come in in 1974. I was required to go through a detailed training course, which made it quite clear that if I did not follow this and anybody who I was responsible for was injured, I could face up to two years' imprisonment. I would expect that kind of level of induction to be given to at least those at supervisor level, if not every member of staff. Does that happen in all the places you inspect?

Dr Paul Lelliott: I would not have thought that it does in that form. Training and induction would not be couched in terms of the regulations, but we expect that every member of staff in a service would have had basic training in a set of essential skills that would be relevant to that service. I am not aware that services would train all their staff in the actual regulations in the Health and Social Care Act.

Jeremy Lefroy: Do you not think that is an essential part of working in such an institution? These are your regulations. You regulate them. They are regulated under these regulations, and they are very serious. Under Regulation 12 you can prosecute, and you do not have to serve a warning notice; you can simply go in and prosecute. You have that power. Very few people have that power, but you have the power of prosecution.

Ian Trenholm: I will add two things. One is that we register and prosecute the provider, not individuals, so the consequences for individuals differ from the Health and Safety at Work Act.

In the reports you have in front of you on the 2015 and 2016 inspections, there are a number of references to training not being done. We go in and ask in general terms, "Have people done training?" The area of weakness, particularly at Whorlton Hall, was lack of training for agency staff. Some of these locations have significant numbers of agency staff, which is a potential weakness for some providers. We will go and look at that sort of issue. The legislation is fundamentally different when it comes to the personal liability of what you describe and the health and safety equivalent.

Jeremy Lefroy: It may be to some extent, but not fully, I would contest. If you can prosecute and you are prosecuting the provider, that provider will be an individual, or a company.



Ian Trenholm: It is a limited company, normally.

Jeremy Lefroy: Clearly there is not the legislation here, but would it not be better if there were individuals who could be prosecuted as under the Health and Safety at Work Act?

In many ways, we are talking about a similar thing. As a foreman on a production line, you are responsible for your staff. As a runner of a home, you are responsible for your staff and your patients. They are the people you are there for. If a foreman at Ford or Jaguar Land Rover can be prosecuted and sent to jail because somebody is injured on their production line, surely the same should be the case for the owner or manager of a care home.

Ian Trenholm: In some cases, it is one and the same individual. There is a fairly complex suite of legislation here. There are occasions when individuals can be prosecuted, but that is not universally the case.

Coming back to the events at Whorlton Hall, the events that were shown on the "Panorama" programme were criminal offences. Therefore, individuals are liable. Most of the work that we do in relation to prosecution relates to some form of negligence, usually on the part of the provider; it is about a sort of corporate negligence, if you want to give it a broad term. The sorts of things we are talking about with regard to Whorlton Hall are straightforward criminal offences. They are not things that we, as CQC, prosecute in any event.

Jeremy Lefroy: If a provider cannot satisfy you that they have done the correct training, which in my view is an absolute basic, your regulations themselves, going on with Regulation 12 of 2014, state that you "must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation".

If they are not providing the training to their staff in respect of the safety of those for whom they are providing care, or they cannot prevent the risk of avoidable harm, surely you should refuse registration or discontinue that registration on the spot. It is quite clear that they do not have the systems in place that are going to give you the assurance that they will continue to provide safe care and avoid harm.

Dr Paul Lelliott: Yes, for a new registration, that would be—

Jeremy Lefroy: Sorry, why is it different for a new registration? If I went into a place that was being run poorly, such as a factory that was clearly not training its workforce, even though it had been registered a few years ago, I would expect it to be closed on the spot and the registration to be withdrawn.

Dr Paul Lelliott: If we go into a service and identify a concern, after the inspection there would be a management review meeting. The inspector would present their findings, usually with a manager. If necessary, one of our legal team would be present, too. At that review meeting, they would



go through a decision tree that identifies the severity and the likely impact of the problem. That would determine the level of enforcement action we would take.

We have powers to take civil action. We can issue warning notices or impose conditions on people's registration, which is something we do quite often. We can ask for a location to be removed from the registration, which would effectively close the service down, or we have the powers to take criminal action. With mental health services, we have prosecuted three NHS trusts in the time I have been here. All three have been related to the safety of patients.

Jeremy Lefroy: I understand that. In my own constituency, you closed down a care home just outside Stafford very rapidly, because you had concerns about care. That was the right thing to do. It was a difficult thing to do. The county council had to find alternative places for many people.

I find it slightly difficult to understand why that could be done in this case of Sister Dora Care Home in Milford near Stafford, but in these cases that has not been done. I am not trying to compare severity, because in all cases of abuse it is extremely distressing, but it seems to me that these would have met the same criteria as was used in the case of the one in my constituency.

Dr Paul Lelliott: Had we known what was happening at Whorlton Hall, that is absolutely what we would have done, without any doubt. Several mental health hospitals have closed down as a result of our inspections. I say that in that rather laborious way, because quite often when the provider sees this is coming, they will close the service down and remove it from our registration system. There have been a number of hospitals that have closed as a result of our inspection, including children and young people's hospitals.

Ian Trenholm: Can I build on that? The other thing to bear in mind is that when there are multiple agencies prosecuting, as there effectively are in Whorlton Hall, the police investigation, as you would expect, takes primacy. When they have completed that investigation, irrespective of the disposal of the matter we would then look at what prosecution we may take against the group. There is a sequence to this, so we may take a different view from where we are today, but we will of course gather evidence, as you would expect.

Jeremy Lefroy: Where I am coming from on this is that I was Member of Parliament during the Francis inquiry into Stafford Hospital, which is now County Hospital, Stafford. One of the problems there was that the Healthcare Commission, your predecessor, did not take seriously enough the warnings that were given by staff, relatives and patients.

I had hoped that the CQC, as the successor body for obviously more than what the HCC did, would learn from that the need to pick up and look at



these things very quickly and to go through with a fine-toothed comb anything that appears, whether from whistleblowers, relatives or any source, rather than allowing it to rest and go through some perhaps fairly lengthy administrative procedures and only then to come back to it at a later stage.

That is why I am really concerned. I had hoped that what we had been through in the Stafford context would have had an impact. Clearly, in some respects, it has. I have seen much better care and much better inspection regimes in hospitals and in other areas, but it still seems to me that we have not fully learned that lesson.

Ian Trenholm: I probably would not agree with that characterisation. I am aware of matters—we cannot talk about the detail publicly—where somebody has contacted us on one day and we were in the next day taking significant action.

That is routine business for us. We will triage a whistleblowing concern or a concern from an individual. We will look at the pattern of complaints in relation to that institution and take a proportionate response. We might know that we are going to do an inspection the next month, so it may make sense, given the nature of the complaint, to package them together and take it as part of the next planned inspection. We might have to assemble a team the next day, and we will go straight in and do something about it.

This is probably not quite as binary as perhaps you were looking for, but we take this very seriously. It is fair to say that we take the lessons from Mid-Staffs very seriously. Sir Robert Francis is on our board, so he gives us a regular reminder of his experience. That is incredibly powerful. It is almost a continuum of action. Sometimes we can act very quickly. Other times, we may choose to do something different. Be assured that we do take prosecutorial action very seriously.

Jeremy Lefroy: Would you perhaps take from this question the need for all staff, particularly supervisory staff, to have that training and understanding on a regular basis, not just when they first are employed? I worked in a care home myself as a young man. This was a long time ago, but I saw things going on around me that were terrible and it was difficult to speak about to others because of my youth. It was quite clear that some people had got into a situation almost by habit. They would be characterised as good people, but they got into a habit of treating patients in a way that was not correct.

I think that there but for the grace of God go an awful lot of people. You can go into a situation that is difficult and your humanity gets tuned out. It should not be, but it is. Regular training and regular reminders of the need to treat people with dignity and respect are necessary probably for all of us here.



Dr Paul Lelliott: It is a very important point for two reasons. One is that a high proportion of people in these hospitals are unqualified workers. They do not have that code of practice and ethics that is put into a doctor and a nurse. They are often the right people in the first place, but it is put into a doctor and a nurse when they go through training. They do not have that, so something else has to replace it.

Secondly, you are quite right about this isolation of a group of staff. For many of them it is their first job, so that culture is not exposed to any other equivalent culture. It is so easy for that to evolve and deviate in a way that then becomes abusive. That isolation is a point.

There are two things. You are right that it is about finding a way of reminding people about their obligations, which are legal, moral and ethical, but, secondly, it is about trying to open up these places so that they are exposed to places where things are done differently and better. That is vital.

Jeremy Lefroy: This comes out of the Health and Social Care (Safety and Quality) Act 2015. The point I made when I was taking this legislation through the House was that it is in the interests of staff that these kinds of things happen. If those procedures, whether in training or anything else, are there, yes, it protects patients, but it also protects staff from perhaps being hauled through the courts at a later stage for having done something that on reflection they wish they had not done, but they did because that training was not there. The procedures were not there and they are the ones in the dock and having fingers pointed at them, when deep down they know they should not have done that, and would not have had they had that correct training.

Q48 **Baroness Lawrence of Clarendon:** We talked about back in 2015 and 2016 and you not seeing a need to follow up on those reports. Had we had those from the person who went in under cover so that it all came to light, would you have taken a different view in 2015? If somebody had gone in and recorded what was happening, would you have taken a different view, rather than what you are saying: that in 2015 there was not enough there for you to take any actions?

Ian Trenholm: I do not think we can speculate on what was or was not going on in 2015. If there was undercover evidence at any point that demonstrated abuse, we would have taken a very different view, if that is the question.

Baroness Lawrence of Clarendon: It seems to me that the only time anything is taken really seriously is when somebody goes in with a camera and highlighted what has actually happened. When somebody has gone in, inspected and written a report, it does not seem to have the same gravitas. If the camera had not gone in, I think you would still think that Whorlton was "good".

Ian Trenholm: In relation to Whorlton Hall, that is probably true. More broadly, as Dr Lelliott said earlier, we have put seven of these types of



settings into special measures in the last few years and we have closed three of them down.

There is an argument that we take significant action and close these places. Each week, we close a range of different settings, so we take enforcement action where we have the evidence. We keep coming back to this point about gathering evidence. In this case, the "Panorama" undercover reporter will have gathered evidence that we would not otherwise have been able to access. Where we have evidence, we very much take action and close places down.

Baroness Lawrence of Clarendon: Would you consider at some point you, the CQC, doing spot inspections rather than letting them know that you are coming? That way, people can always change things. Have you considered doing something like that, where you can see more of the reality?

Dr Paul Lelliott: Yes. Our inspections for independent hospitals are invariably unannounced these days. The team will just turn up, but I think what you are saying is more important—dropping in at night and at weekends, when people are off-guard and a different group of staff is in. That is something we could and should be doing more of.

On the question of CCTV, I spent three hours on this inspection looking at CCTV footage, looking at incidents where staff reported that they had used physical restraint on people. I could see whether the behaviours of staff matched what had been reported. What was very difficult was that it had no sound. Without sound, you could not say what was happening in the minutes before the person became distressed. What were staff saying to the person? There is mileage from CCTV footage, because many hospitals now have it in the common areas. Our inspectors could do more looking at that footage, just to see the quality of interactions between the people receiving care and the people providing it.

All these things have their limitations, especially if staff are trying to cover their tracks. On the "Panorama" programme, there is that dreadful bit where they said, "If CCTV cameras come here, we know they will not be in the bedrooms", so there is that inference that they can abuse people out of sight of the cameras. There were many awful things about it, but that knowingness was one thing that was particularly awful.

Q49 **Dr Sarah Wollaston:** You have referred already to the difficulty of regulating with an inspection model, because you are only seeing a snapshot. When you actually have reports and are triaging them, as you said, are you prioritising the closed institutions where we know this is a much higher risk? In other words, do you have a much lower threshold for stepping in than you would have for reports in other settings?

Dr Paul Lelliott: Yes, we do, but that has not been formalised. Although we did not pick up the abuse, we inspected Whorlton Hall more times during that period than you would have expected for an independent hospital of another type. One thing we are thinking about is saying,



"Given what we know about Whorlton Hall and Winterbourne View, there are characteristics of certain institutions that should mean they are high risk".

Dr Sarah Wollaston: Yes, these are closed institutions with very vulnerable individuals.

Dr Paul Lelliott: They are closed institutions, a long way from home, with lots of different CCGs buying places; there are certain characteristics of the staff group, with a high proportion of unqualified staff and people from all over the country, so there is no one CCG. There are high-risk groups that we should play closer attention to.

Dr Sarah Wollaston: They are particularly vulnerable individuals. That is the point. They are not able to speak for themselves.

Dr Paul Lelliott: Yes, people who are under the control of other people, either because they have a disability or because their liberty has been taken away from them and every action is decided by another person. One group of people is controlling another. That is a high-risk situation. You then have warning signs. We need to be much more alert to warning signs in high-risk services that give us a much lower threshold for going in.

Dr Sarah Wollaston: Indeed, but you say that it is not formalised. Is this something that you will now look at, making sure that people are particularly acutely sensitive to reports that may be of a lower threshold, so that you do respond to them?

Dr Paul Lelliott: Yes, definitely. That is being actively discussed. We hope that the person doing the independent review will have the expertise in this area that will help us with that. We need a watchlist and a set of clearly defined warning signs that trigger a certain response.

Dr Sarah Wollaston: You will just have an ad hoc response around the country unless this is set out very explicitly to prioritise it.

The other thing I wanted to raise with you is cultures in these organisations. Staff are sometimes worried about raising concerns, because they feel that will reflect badly on them. Do we not need a culture change? An organisation that welcomes complaints and people sometimes raising concerns may paradoxically actually be a better institution because it is not suppressing complaints. Are you actively exploring the culture?

Ian Trenholm: Absolutely, yes. We see this repeatedly, if you take our portfolio as a whole, across adult social care, hospitals and general practice. We see institutions that proactively talk about speaking up, that have speak-up guardians, organisations that have good complaints policies, where they welcome complaints and where they have positive staff cultures and positive engagement.



They are the institutions that typically are outstanding. They are also the institutions that typically want to learn and are never satisfied. You are absolutely right; that is exactly the culture. That is something that we feed back to providers all the time.

Dr Sarah Wollaston: You are looking specifically at staff cultures and whether or not the leadership in these organisations is actively encouraging people to come forward.

Ian Trenholm: Absolutely, yes. As part of our well-led framework, we look at how these organisations are led. We look particularly at how complaints are handled. We follow through individual complaints to look at that process and to see the positive statements and positive culture that there is around complaints, and indeed the negative culture if that is the case. We look at these factors. We look at the engagement surveys for large providers and so forth. We look at all these factors as part of making our judgment of the leadership of these organisations.

Dr Sarah Wollaston: Can I ask you a rather difficult question? Can you honestly say that you apply the same standards to private institutions as you do to NHS institutions? Someone has raised with me a concern that they think that privately run institutions perhaps have an easier ride.

Dr Paul Lelliott: I do not think that is the case.

Dr Sarah Wollaston: I just wanted to put it to you, because that has been raised with me.

Dr Paul Lelliott: Absolutely not.

Dr Sarah Wollaston: Are you confident that you apply exactly the same standards?

Dr Paul Lelliott: I am totally confident. I have heard grumbles from the private sector that say the opposite, so yes, I am totally confident.

Ian Trenholm: It is probably also worth building on that point. The private sector operates in different sorts of services. Private sector services are often smaller, more discrete services, whereas NHS services are often in bigger settings, with multiple services on the same campus. They are just different sorts of services. We are absolutely clear we have a single methodology that applies to everybody.

Dr Sarah Wollaston: One of the other areas I wanted to raise with you a bit further was the role of commissioners. You say that these are often institutions where you have multiple commissioners putting people in placements a very long way from home. The cost of these placements is very high. Do you ever look at whether those institutions are properly using that funding to pay their staff appropriate levels so they have their staffing levels right? They are enclosed institutions with poor training, poor development, low wages, rapid turnover of staff and high levels of locums coming in. These are all recipes for cliques being able to take hold



separately and exhibit these behaviours.

Dr Paul Lelliott: We are looking at that very question in the thematic review of learning disability, people in seclusion, restraint and segregation. One of the key lines of inquiry is directly that: how much is being paid for the care, and whether the quality and quantity of care being delivered is commensurate with that cost. That is one of the key questions in the thematic review. We are ascertaining the cost of these care packages and checking whether what is being delivered matches that cost.

Dr Sarah Wollaston: In other words, so that there is not excess profit-taking at the expense of putting that money rightly towards the care of individuals, staffing and training.

Ian Trenholm: We do not make a value-for-money judgment. We do not look at organisations' accounts, if that is what you are driving at.

Dr Sarah Wollaston: Some commissioners will commission and then walk away. We expect commissioners to take a much closer look at what is actually being provided. It is the quality of commissioning and follow-up that I am asking about as well.

Dr Paul Lelliott: Some of these contracts for these very specific care packages actually state the number and grade of staff who should be working with the person, as well as access to clinical psychology, occupational therapy and speech and language therapist. In the thematic review, we want to see whether that is being delivered. It is not something that we have done routinely in inspections, but it is a very valid point. It is not about profits; it is about whether the care being provided is in line with the contract. That is the question.

Ian Trenholm: To be clear, we do not regulate commissioners.

Dr Sarah Wollaston: I know you do not regulate commissioners, but do you think you should be able to do that?

Ian Trenholm: Certainly the conversations we have had with the Secretary of State about system reviews worked really well last year. We are continuing to talk to the department about doing another round of system reviews, which starts to look at commissioning. It is not about rating and regulating in the orthodox sense, but about looking at how that system is working across the board.

Dr Sarah Wollaston: Finally from me, I take your point about cliques. Cliques can operate in such a way that the criminal behaviour we saw on the "Panorama" programme is not always seen by everyone in the unit, but it is often seen by a number of individuals who hold professional responsibility. Are you making referrals to bodies like the GMC and the NMC as well?



Dr Paul Lelliott: Yes, we would do that. If we come across behaviour or practices that we think should be referred, we do that directly.

Dr Sarah Wollaston: I mean where people know that something is going on but are not reporting it. They are witnessing behaviour in others but are turning a blind eye.

Dr Paul Lelliott: If we found evidence that they were turning a blind eye to abusive practices, that would certainly be grounds for referring someone to the GMC or the NMC.

Q50 **Chair:** On your website, you say that your purpose is to make sure that social care services provide people with safe, effective, compassionate, high-quality care. You say, "We protect the rights of vulnerable people", and one of your values is excellence. When you are going about your work, rating other institutions, you rate them as "inadequate", "requires improvement", "good" or "outstanding". How would you rate the CQC right now? Are you inadequate? Do you require improvement? Are you good or outstanding?

Ian Trenholm: That is an unfair question. We do 75 inspections a day across adult social care, hospitals and general practice, and you are asking about one specific set of events.

Chair: No, I am not. I am asking you about the institution. We are the human rights committee. Throughout your work, you say that you protect the rights of vulnerable people. I am asking you what your sense is of how effective you are at that. You are judging others. I am asking you just for a moment to judge yourself and tell us where you think you are on that rating system.

Ian Trenholm: I would say that we are probably "good". I say that, because if you look at the population of this country, and the health and social care services that are consumed, we have seen a year-on-year improvement in the quality of those services. We are also a learning organisation, and one of our values is integrity. We have been very clear on this occasion that we got it wrong with Whorlton Hall and we will learn from that. I absolutely guarantee that. To suggest that Whorlton Hall is typical of everything the CQC does is grossly unfair.

Chair: Thank you very much indeed for coming to give evidence to us. Thank you for the offer of follow-up papers that you will provide to us as you conduct the audit that will feed into your review. I have one final point. Do you know when these two reviews are going to report?

Ian Trenholm: No, not yet. We are talking to the chair and the potential chair of the two reviews and allowing them to dictate the timescales. I would like them to be as quick as possible. Certainly, with the first review on the Whorlton Hall 2015 report, I would hope that is a matter of weeks rather than months. I want them to report quickly so that we can get on and make any changes that we need to make.



Chair: Thanks very much indeed.