Safeguarding Adults Review

Atlas Care Homes

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Section 1: Introduction

The Circumstances leading to the Safeguarding Adults Review

1. The conclusion of criminal court proceedings against Atlas Project Team ("Atlas") Ltd founder, directors, managers and staff of seven Atlas care homes during June 2017 enabled this Safeguarding Adults Review (SAR) to begin. Atlas was commissioned to provide specialist care for adults with learning disabilities whose support needs were described as "complex" and "challenging." Two of the homes which received media coverage during the trial, Veilstone and Gatooma, were geographically isolated, former farmhouses.
2. The criminal court proceedings revealed that Atlas residents were subjected to:
    - systemic neglect
    - seclusion in rooms without food, drinks, heating or access to toilets
    - physical assaults and
    - orders from staff to undertake housework and gardening tasks which were "tests" to establish their compliance.
3. The court proceedings created a precedent since they embraced the owner directors[1] and managers and not just the direct care staff. The legal proceedings spanned five years and a Serious Case Review (SCR) was commissioned at the outset.[2] This was based on "Individual Management Reports" (IMRs) provided by: Bath and North East Somerset; Devon NHS and Devon County Council; Plymouth City Council; South Devon and Torbay Shadow CCG; Surrey County Council (which did not place people in Atlas' Devon homes but in Atlas homes elsewhere); Torbay and South Devon Health and Care NHS Trust; West Berkshire Council; West Berkshire PCT Quality Team; Wiltshire Council, Wokingham Borough Council;[3] and the Care Quality Commission.
4. The SCR was submitted to Devon's Safeguarding Adults Board during February 2013. It was not published because the criminal proceedings had not concluded, and families were advised to remain silent so as not to compromise the criminal justice process. After the trial, the Safeguarding Adults Board undertook to set out its findings and bring the 2013 SCR up to date. Also, it re-visited and brought up to date the SCR's action plan by comparing the commissioning processes which prevailed when placements were made at Atlas homes with those of 2017-18, five years later.

The Terms of Reference

5. The Safeguarding Adults Review addresses:
    1) Pen-portraits of the former Atlas residents (of Curlews - where there were five residents), Gatooma (five), Kingsacre (two), Stone Cottage (three), Santosa (five), Teignmead (five) and Veilstone (eight), and one person supported by Hilltop Atlas

[1] This had been attempted by Gwent Police in "Operation Jasmine" which began in 2005

[2] It was commissioned by the previous Safeguarding Adults Board and pre-dated the Care Act 2014

[3] The commissioning bodies have changed since the 2013 SCR. For example, South Devon and Torbay Care Trust has replaced South Devon and Torbay CCG and South Devon NHS Trust

Personal Care Agency, prepared with people's families which summarise their support needs and personal (occupation, health and care) plans.

2) Information that the former residents of other Atlas homes and their families are willing to share.
3) Fact finding to date about how professionals and agencies went about their work so that any action still required to improve practices is put in place, that is:
    (i) the organisations placing people at Atlas' residential homes
    (ii) the people responsible for overseeing the contract
    (iii) the people responsible for undertaking periodic reviews of the homes' progress in remaining true to their stated purpose
    (iv) care managers
    (v) those responsible for dealing with complaints and with safeguarding alerts.
4) A summary of the implications of the prosecutions of Atlas' Directors, managers and staff
5) An assessment of the progress of the Action Plan arising from the SCR.
6) An analysis of the practices of (i)-(v) during 2010-2011 and those of 2018;[4] and drawing from the experience and ideas of the relatives of former residents, setting out how the practices of (i)-(v) may ensure that accountability to people with learning disabilities, their families and the public is consistently prioritised.

The Review Process

6. There were six sets of activity:
    1) Developing the Terms of Reference with the Independent Chair of Devon Safeguarding Adults Board
    2) Summarising the information provided by the commissioning bodies/organisations responsible for placing people and the CQC for the 2013 SCR (see Appendix 1)
    3) Summarising the 2013 SCR's Action Plan which the Safeguarding Adults Board had updated during February 2017
    4) Engaging with the families of six former Atlas homes' residents, setting out their experience and ideas in a paper negotiated with them (see Section 3)
    5) Summarising and organising the information provided by the commissioning organisations and the Review Panel as it became available
    6) Discussing emergent sections of the Review at meetings of the Review Panel.

[4] Addressing the principal interests of the SCR rather than reproduce the 72 questions posed to the commissioning agencies as part of the SCR's methodology

7. The review author met with the Independent Chair of Devon's Safeguarding Adults Board and the Board's Administrator during **September 2017**. Copies of the Individual Management Reports (IMRs) for the 2013 SCR were shared and a listing of the organisations "involved in Atlas." The Chair wrote to the commissioning bodies requesting (i) funding to undertake an updated Review, and (ii) nominations for membership of the Review Panel.
8. The IMRs for the 2013 SCR were summarised during December 2017 to set out (i) the history of Atlas and (ii) the activities of commissioners, contract monitors, reviewers and inspectors. A draft paper setting out the principal findings was circulated during **January 2018** for (i) discussion with the Review Panel the following month and (ii) for distribution to the commissioning bodies responsible for placing the 33 people at Atlas' homes.
9. During **February 2018**, the Review Panel was advised that "Individuals and their families are yet to be invited to participate in the Review as Commissioners are still ensuring that arrangements are in place for the appropriate best interest assessments and taking into account individual previously expressed intentions by individuals and families in relation to further participation."
10. During **March 2018**, all of the families whose relatives had been placed in the seven Atlas homes and/or received a service from Hilltop Atlas Personal Care Agency received a letter about the SAR from the review author.[5] This was sent via commissioning organisations in contact with (i) former Atlas residents and (ii) their families inviting them to contribute to the SAR if they wished to do so. Devon CCG coordinated the responses from health bodies in Devon and Torbay concerning commissioning, contracting and reviewing practices.
11. During **April 2018**, the commissioning bodies were sent questions[6] to update the information which had been provided to the 2013 SCR.[7]
12. During **May 2018**, the review author met three families with the support of the Challenging Behaviour Foundation. There were also email exchanges and telephone conversations with three other families whose relatives had received Atlas services. This led to a set of email exchanges with six families in total to ensure that their quotations and their ideas for improvements were accurately represented. The resulting paper features in Section 3 of this review.

[5] Two of the six families which came forward did not receive any correspondence due to changes of commissioners

[6] What actions have been undertaken since the Action Plan arising from the 2013 SCR? What is the current process for engaging with safeguarding allegations and complaints which relate to contracted placements? What is the current process for communicating the expectations of providers for people with learning disabilities with complex support needs? How are current commissioning arrangements reviewed for this population? Please describe examples /approaches to procuring time-limited contracts characterised by a high degree of specificity for this population? What is the current process for determining whether or not to recontract with the same provider? What current arrangements are in place to manage and develop placements within the commissioning area for this population?

[7] The Review Panel meeting of 13 February 2018, "noted that the questions asked in the previous SCR were incredibly complicated and thought that there should be 5-6 questions at most asked of stakeholders in this SAR"

13. There were six Review Panel meetings. The initial meeting of the SAR Panel took place during **February 2018**. This considered a summary of the information gathered for the 2013 SCR and confirmed "the approach" of the SAR. The second meeting took place during July and considered (i) the paper which had been agreed with families and (ii) Devon Safeguarding Adults Board's:

> "…summary of responses received/actions taken, 13 people/families where commissioners have advised that best interest decision made and documented not to involve them in review and no known family/contact to contribute to the review; 5 people where family/contact identified and asked by commissioners if they wanted to be involved but they do not wish to be involved in the review; 3 families met with [review author]; 1 family provided written feedback; 2 families expressed a wish to meet [the author] but have not yet advised[8]…1 advocate written to." [9]

14. It was reported to the Review Panel meeting of 3 **July 2018** that the intention to include "pen portraits" with families proved unduly ambitious since only one family offered to do so (see Appendix 2). Other families observed that the prospect of writing about their relative prior to the rapid deterioration associated with Atlas and subsequent, just as damaging placements, was "too painful" to contemplate.
15. The Review Panel meeting of 1 **August 2018** considered the draft SAR and the Panel advised that the review should clarify that:
    1) "Devon's Safeguarding Adult Board contacted all 10 commissioners of placements to ask them if the individuals have mental capacity in relation to contributing to the SAR process. If they didn't, they were asked to confirm that a Best Interests decision has been reached, completed and documented with regard to their involvement. Or if relevant, do they have a representative or family member who should be invited to contribute to the SAR.
    2) The recommendations from the families are from six families' perspectives and that there were 34 people living at the Atlas Care Homes.
    3) Families should be "aware" of any changes in commissioning arrangements and 'who they should approach with their current concern.'"
    4) Two of the six families in contact with the review author reported that they had not been informed that there was to be a Safeguarding Adults Review. Devon's Safeguarding Adults Board established that these arose from (i) a delay in communication and (ii) a change of Commissioner.
    5) Considerable improvements in practice have taken place since the concerns raised in respect of Atlas Care…it is important that these are reflected."
16. It was noted that "Commissioning speak" was prevalent in the **February 2017** update of the SCR. That is, the processes referred to are neither readily understandable nor suggestive of

[8] A telephone interview was conducted with one family on 8 July 2018

[9] From summary shared at the Review Panel meeting of 3 July 2018

improved arrangements. For example, the update referred to a "Risk and Sufficiency Profiling Tool…used by multi-agency sub-groups on a bi-monthly cycle…as part of quality collaborative work a dashboard will be developed… to capture soft and hard intelligence and an escalation process…improved intelligence log…commissioning relationship managers act as a contact point for issues regarding strategic providers and link with our procurement team……enhance the current links between the commissioning of the delegated budget and quality improvements…performance data of reviews will be provided via contract monitoring of providers and performance templates. This will also be visible to commissioner by data of all placements on care track register…intelligence systems link safeguarding/DOLS and Care Governance to maximise efficiencies…with our transforming care partnership work there is a co-production group of customers who scrutinise what we do and feed into the commissioning process…"

17. Although the Review Panel discussed the importance of addressing professionals' language, "commissioning speak" characterised responses to the invitation to commissioners to answer the questions concerning contracted placements during 2018 (see footnote 6). For example, "a variety of multi-agency forms operate at local and STP level to review exiting (sic) arrangements and plan for the future…integrated commissioning has awarded longer term contracts to service providers through a framework agreement. Individual packages are called off from the framework…the integrated commissioning team is working as part of the STP to develop TCP, housing and market development strategies…undertake whole service review of specialist providers when need is identified through recorded indicators of concern which do not trigger whole service safeguarding thresholds…"
18. Since the Review Panel believed that the questions asked of commissioners did not enable them to highlight improvements in practice, Devon County Council, North, Eastern and Western Devon/South Devon and Torbay Clinical Commissioning Groups and Plymouth City Council undertook to revise their responses to the questions. These were received during **January 2019**. In addition, the Care Quality Commission drafted "Atlas Safeguarding Adults Review: What is different in 2018."
19. During **September 2018**, the Review Panel highlighted "some significant features not represented in the [draft] report" such as the provision of support to former Atlas residents and their families from the organisation Respond and from Devon and Cornwall Police plus "the role played by the implementation of the Mental Capacity Act and the Deprivation of Liberty Safeguards in leading to the successful multi-agency investigation of the abuse." Since this information had not been provided, on 30 **October 2018** it was agreed that "further information" should be added "which throws light on where things are now."
20. A Review Panel meeting of **22 January 2019**, which was to have been the final meeting, was cancelled. Additional information from the Review Panel was forwarded during **January** and **May 2019**.

Section 2: The Facts

21. Atlas was a founder-managed company which drew its legitimacy from Paul Hewitt's association with the 1993 Mansell Report.[10] Paul Hewitt established the organisational identity and character of Atlas. It became a "family business" and although it was sold by Paul Hewitt and his wife for £3m to their sons and other directors during **2006**, Paul Hewitt retained a significant management role.[11]
22. Atlas' care homes were situated across the south of England – seven in the South East and eight in the South West. Atlas Project Team Limited's services were registered under (i) the Care Standards Act (2000) as care homes and domiciliary care agencies (ii) the Health and Social Care Act (2008) as care homes without nursing, with one location providing a supported living service.
23. During **February 2010**, the CQC noted of one Atlas home that "concerns had been expressed by the CQC inspector to the registered manager [RM] about the use of restraint…particularly when [one staff member places] someone in the 'prone' position. The RM said it had all been reviewed…The quality rating remained three star excellent."
24. During **2011**, Atlas Project Team had a turnover of £6.5m. The company was paid many thousands of pounds per week per resident.[12]
25. Between **January 2011** and **July 2012**, the CQC received ten reports of concerns.
26. Between **May 2011** and **July 2012**, the CQC received seven whistle-blowing alerts. A CQC inspector was contacted "on numerous occasions" by a resident who had made allegations of abuse while at Veilstone.[13]
27. The Care Quality Commission noted that accommodation was in single rooms with en-suite facilities. The exception was Veilstone which had five en-suite bedrooms in the main house, a single self-contained flat and a three-bedroom bungalow in the grounds. Since nationally there are very few care homes serving people with learning disabilities and autism, the homes in Devon were attractive to authorities elsewhere. Most of Atlas' residents were placed by authorities other than Devon County Council. Of the 35 beds available in the Devon homes during 2011, 34 were occupied. Of these, six were occupied by people placed directly by the Devon authorities. Thirteen were placed by Berkshire authorities, Six by Torbay Care Trust, plus one supported living client, seven by Plymouth Social Services; one by Wiltshire and one by Bath and North East Somerset.[14]
28. The Devon and Cornwall police investigation began in **October 2011**. It focused on (i) the experience of 10 adults over a two-year period who were the residents of three Devon care homes and (ii) the use of "quiet rooms" in which residents were placed for prolonged periods of time. The investigation identified 2,600 incidents of seclusion with some residents falsely

[10] Paul Hewitt was a member of the committee that produced *The Mansell Report* (1993), "Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs" London: HMSO. At the time he was employed by Exeter Health Authority

[11] R v Paul Hewitt [2017] EWCA Crim 1726, 26 October 2017

[12] North Devon Gazette, 28 November 2017

[13] Timeline of events

[14] 2013 SCR

imprisoned up to 400 times. Having seized documentary materials from Atlas, the investigation was hampered by the poor organisation of the company's paperwork. The investigation involved eight full-time officers. The officers worked with an interview advisor from the National Crime Agency and a forensic psychologist to promote a "welfare-focused" approach in their dealings with residents – many of whom were no longer living in Devon.

29. The Crown Prosecution Service and the police initially sought to prosecute senior managers and directors but subsequently assessed all staff for potential criminal conduct. This resulted in four trials instead of one.
30. Since the trial was held in Bristol and there were "many changes to dates and times," the Witness Care staff and Family Liaison Officer had to ensure that information was rapidly communicated to everyone involved. The police held regular meetings with partner organisations which undertook to update the families whose relatives were not part of the police investigation.
31. The organisation Respond was commissioned by Devon and Cornwall Police, Devon County Council and the CCG to support the adults with learning disabilities and their families and facilitate their representation during the trial. Some families opted to be supported by Mencap and the Challenging Behaviour Foundation.
32. During **June 2012**, Atlas entered into administration.
33. During **May 2016**, 24 ex-employees of Atlas were prosecuted during four trials at Bristol Crown Court. Thirteen were convicted of offences ranging from conspiracy to falsely imprison, false imprisonment, ill treatment and neglect.[14]
34. Paul Hewitt and his son Russell Hewitt (Atlas Directors) were cleared by jury of conspiracy to false imprisonment of residents, but Paul Hewitt was found guilty of a health and safety offence.
35. During **October 2016**, Jolyon Marshall, an Atlas Director, was sentenced to 18 months for conspiracy to falsely imprison residents. This was increased to 28 months by the Court of Appeal.
36. During **October 2017**, Paul Hewitt's conviction was quashed by the Court of Appeal. Ultimately his fine of £12,500.00 and payment of £105,000.00 towards the prosecution costs were set aside.[16]
37. The police investigation concluded in **2017**.

[14] Re ill treatment and neglect - S.127 Mental Health Act 1984

[16] R v Paul Hewitt [2018] EWCA Crim 63, 19 January 2018

Section 3. The Families' Experience and Ideas for Change

38. This section sets out the experience and views of six families who chose to contribute to the review - a portion of the 34 people placed at Atlas Project Team's (Atlas) homes in Devon. The italicised texts are the quotations of the former residents' close relatives. Unknown to each other at the time of Atlas' exposure as a harmful business, they had arrived at their own versions of ideas for change independently. They recognise the importance of telling their stories of injustices and injuries and the poor stewardship of public finances. They want others to know about the compromised practice of commissioners' place-hunting for people whose support needs are not met locally. Separated from all that was familiar, their relatives' behaviour – that is their resistance - merely confirmed the necessity of successively more secure placements.
39. The six families live with the knowledge that their relatives have been harmed. It has shaken their faith in professionals responsible for providing care and treatment, inspectors, contract monitors, those responsible for identifying the placements and in the criminal justice system. It has required them to ask and to keep asking hard questions about
    - the life-altering consequences of requiring care and support
    - their intuition about services and their employees
    - and life-long family advocacy and unacknowledged expertise because, in their experience, these do not trump the views of untrained support staff, their managers and all professionals who were associated with their relatives' placements at Atlas' seven homes and all subsequent placements.
40. The families know that **the contexts** in which people are harmed and/or neglected are highly pertinent. It is important to explore these with the alleged victims and their families since the latter can provide crucial information which their relatives may not be able to describe or recall. This is most particularly so when it takes five years for a criminal trial to begin.

> *I was told that the place had a very good reputation…the staff thought they were the best and the NHS and CQC backed that up…They hadn't a clue*[15]
>
> The *home was staffed by untrained and inexperienced staff who lacked the skills to meet the needs of the residents. It was extremely remote and isolated…It was located too far away from relatives and the care managers involved*
>
> *Looking back* [that kind of provision] *scares the daylights out of me…it was too insular…you can see the fear in your child's face It was like a prison*
>
> *We don't know how long people were locked up for*
>
> *They were imprisoned*

[15] One family emailed many professionals, including the commissioner, in an effort to bring urgent attention to bear on their relative's deterioration: *X is not in the right place and… I desperately want him moved. He has no warmth in his life, no laughter and we are the only ones who can provide him love and human affection. I cannot tell you how angry I am…I am going to take advice on how to deal with this. X is deprived of books, films and things that he loves the most like dressing up and karaoke. Veilstone to me is like a correction centre for naughty adults for whom the staff have no respect whatsoever*

There are a lot of flaws in the system

There's no public view of the environment. We'd get as far as the kitchen and down to the lounge and that was it

I despaired at why this company [Atlas Project Team Ltd] *seemed to want to discredit me particularly with regards to my relationship to* [my relative]

Having had a breakdown many years ago, I recalled [being] *escorted everywhere by two people and I clearly have that memory of 'confinement' and loss of independence, but I felt disempowered to stop it for* [my relative]

[Our relative] *hasn't had enough therapy through this and wondered how it would be if I asked someone to get more help.* [Relative] *sits there now and says things like "If I tell someone what they did to me will they get told off?" … then reels so much off in a matter of fact way*

We were never allowed to see [our relative] *on her own*

[Our relative] *was there for 15 years. As far as we were aware the home had issues with Deprivation of Liberty Safeguards but never any physical harm as far as we knew…There were restrictive practices and…possessions were locked away because* [relative] *breaks things…there might have been mental abuse in taunting*

I never went to [relative's] *bedroom…always waiting for me at the front door*

[Our relative] *was only with Atlas for a short time but there were some odd things such as saying that* [relative] *didn't get up until late in the morning. Well we knew that that was incorrect! It turns out* [relative] *was locked in*

No one tells you about some of the things that our relatives are is alleged to have done or tried to do

It had seemed to be a positive move because it had been recommended by the Additional Support Team. Veilstone was the only place available and we didn't like it. It was too dark and bleak.

Families propose the following ideas for change:

1) *Unannounced visits should be allowed by parents, carers and social services and others who hold responsibilities – and more frequent use of CQC's powers to enter*
2) *A national awareness campaign aimed at care staff. This should emphasise the primary duty of care to clients which should not be compromised by loyalty to an employer. It might also provide examples of the consequences of* [them] *having a police record e.g. curtailed work opportunities and travel opportunities abroad. Such a campaign, supported by unions, might include presentations to care home staff meetings and YouTube clips*
3) *Body worn cameras for the staff working with the most "at risk" clients*
4) *Evidence of trained staff instead of constant reassurance that they know what to do*

5) *The primary responsibility for closely monitoring a service should transfer to the authority in which the service is based when clients are placed "out of area" and too far from their families - funded by the placing authority. This should include "experts by experience"*[16]
6) *Undercover staff*
7) *CCTV*
8) *Non-verbal people should not be placed anywhere in the back of beyond.*

41. Although **a specialism** may imply the provision of professional expertise and familiarity with evidence-based practice, in the experience of these families and former Atlas residents it was a misnomer which could not be challenged. Paul Hewitt was the "guru of Atlas" who was responsible for developing the "Atlas approach." Although this involved the deliberate exclusion of families, it was not perceived as a breach of the *right to respect for private and family life.*[17] At the criminal trials it was reported that the "Atlas model"[18] hinged on staff acting in accordance with the requirements of "experienced managers." Yet neither their practice nor the "Atlas model" were challenged by the commissioners, the inspectorate, social workers or psychiatrists. The limited training received by staff was "in-house" and delivered by Paul Hewitt and other managers. During the trial the service was described as "inward looking…a closed culture resistant to external advice" in which staff used "Atlasspeak" as they exerted power over residents. For example, visitors were not invited to see the "Garden Room" (at Gatooma) and the "Quiet Room" (at Veilstone) in which it was alleged that residents were unlawfully deprived of their liberty.[19] It was also reported at the trial that neither relatives nor professionals were advised of the existence or purpose of these rooms. This service, and for some residents, and subsequent services did not address the larger aims of people's lives and those of their families.

[16] That is, those with experience of requiring the type of support that the service being inspected claims to provide

[17] Under S.6 of the Human Rights Act 1998 it is "…unlawful for a public authority to act in a way which is incompatible with a Convention right"

[18] If residents exhibited challenging or disruptive behaviour, the Atlas model was a) ignore the resident; b) restrain the resident; c) place the resident in the seclusion room; d) test the resident's compliance with a request to undertake a household chore – compliance meant that the resident did not have to remain in seclusion; e) if the resident's behaviour persisted there was a withdrawal of favoured activities such as a family visit

[19] A psychiatrist informed one family: *to safeguard X's Human Rights within such restrictive practices, it is <u>essential</u> that we are all compliant with the legal safeguards afforded by the Mental Capacity Act and Deprivation of Liberty Safeguards; the regulatory frameworks set in place by the Care Quality Commission; and that our practice within these frameworks follows Good Practice Guidance as set out by British Institute of Learning Disabilities and the Royal College of Psychiatrists. This is the advice that I have consistently presented to all involved, and should form the basis of any service that is commissioned for X…we did not agree with your conclusion to pursue an urgent move without making some attempt to resolve both your concerns and my demand that proper decision making processes be followed* (dated September 2010)

They didn't let me see X for three months and said that he had an "attachment disorder"

I was kept away for semi-plausible reasons

They said X is always worse after you visit…it makes you feel bad because you get to see that it's not like the NHS or even as the inspectors suggest

I worried me that they kept me away

Relatives were kept away by obstructing and cancelling visits and also by intercepting phone calls. When relatives re-dialled there would be no reply

X was told that unless [X *did as told*] *X would not have a family visit…so they lied. Controlling access to our relatives was punishment*[20]

We never expected to be able to speak to X [on the phone] *in the end. When we rang we could only hope… This is hell on earth. Instead of working together we are drowning in this madness…it has become impossible to trust people that show such contempt towards a family. No matter what, that is what we are for X and that will never change. Trying to edge us out will not work and we will be in this situation again if X is not moved to a placement that understands autistic spectrum disorders and family values more*

It used isolation, over-medication and abusive practices

My X was put on antipsychotic medication without my consent and by just a phone call from carer to GP. No capacity assessment was carried out [and] *no best interest meeting, all because my X's anxieties were raising prior to X's birthday and Christmas. My family and I felt it was excitement although it was interpreted by carers as "anxiety." A very thin borderline! Health professionals…all poo pooed my concerns*

Atlas did not want us to be there when she moved in and we had to fight that knowing, our daughter and what would be best for her. We were told we would need to always let them know when we intended to visit, as "We are her family now and you would not expect family just to turn up unannounced." Which is exactly what does happen in normal life! So we started to wonder about them. We often felt that they would like to have severed our contact with [our daughter]. *Due to the* [electric] *gated entrance, no one could get in without them being aware of it*

The *staff disbelieved medical diagnoses and put all emphasis on behaviour. Staff at all levels were not open to input from outside agencies or the relatives of residents. The culture was controlling and manipulative toward residents, their relatives, junior staff, outside agencies and, it seems, the CQC*

[20] A psychiatrist advised one family that, [since] *relationships* [with the family] *have broken down further… this is a significant barrier to the success of the* [care] *plan*

They're paid for failure. It can all go badly wrong; our relatives can be abused and they're still paid

I've never been totally happy with X's care. There have been numerous safeguarding issues but never anyone to corroborate

They'd say "X is always worse after you've visited" – it's a powerful way of putting you down

You so want [the placement] *to work, I almost colluded. On the times when I challenged, they wouldn't answer, or they'd put the phone down and when I re-dialled there was no answer*

Geographically the place was out on a limb – the middle of nowhere set back off the road with an electric gate. It had a prison atmosphere

When we spoke to X they put it on loud-speaker so they could listen in. I could hear what they were saying in the background…you're so helpless

It was explained that X was given black bedding, so it didn't over-stimulate him

It was mean. X told me that they said "say goodbye to your balloon" [that is, a helium balloon which accompanied family birthday gifts]

Everything was taken from him because they said his things were not age-appropriate. His room was like a cell – without pictures or even a chair. They said he smashed his TV…

Paul Hewitt's son said that his father had written most of the Mansell report and didn't get the credit for it. The arrogance of them!

We also had concerns when during a meeting with Paul Hewitt he lost his temper with us and began shouting at us while his staff tried to quieten him. It made us wonder if he "lost" control at the home

We were told that Atlas had the skills and knowledge. Their attitude was "Because we're rated by the CQC as excellent we don't need to be monitored for three years"

These people have no training or if they do it's not in the right areas

X was supported by two members of staff who were inexperienced and untrained

You can be happy with a placement for a while, but you never know. People who abuse will head for work in that kind of care

I believe the next abuse scandal will be where individuals are supported 1:1 or 2:1. Abusers will have free reign as there will be no way of safely protecting clients in this situation

As families you understand their needs and you have to hope that the staff do to…we learned that [one staff member's] *previous job was in a petrol station*

My X doesn't have carers. He has bouncers with no ideas about how to motivate someone

There's no sense that the public sector is being defrauded! It is spending millions on the care of adults with a lot of support needs but has no idea what poor services it's getting. One time there were only two staff on duty when there should have been eight I had no one to talk to. It has broken my family up

I went into a depression trying to fight for X's safety…I feel very isolated. You can get really overwhelmed because everything is stressful…I don't have many friends because when you have children with challenging behaviour it limits the contacts you have, even with your family. Mine says to me "You have X because you have the skills to manage X – so even family shy away"

It went into receivership and the bailiffs even took X's couch – I got it back! Everything was done with such undue haste…I identified a care provider and was told that it would take approximately four weeks for X to be assessed. I was then advised by the care provider that they would not be able to help as they were told by the NHS Nurse Assessor that X would have to be rehoused within 10 days because the social worker was going on a course

The behaviour of the [Commissioning] *team…responsible for X during this nine-month period is worse than lax; it is reprehensible. We would have thought that as the Commissioner responsible for ensuring safe transfer of care for X,* [the senior manager] *would have insisted on a plan…given X's levels of difficulty and challenging behaviour. We have stressed this…at every meeting, yet…not one visited* [the Atlas unit] *and asked the staff there of how best to plan a transition given X's difficulties. In addition, no heed was paid to our concerns; our advice and experience with X's behaviour was disparaged and trivialized. As a result, no decisive plan was formulated, and X has suffered enormous trauma*

The closure resulted in an *inadequate and inappropriate emergency placement resulting in another safeguarding incident, an acute mental health crisis leading to a twelve-month admission to mental health unit, the requirement of ECT and finding yet another new placement*

No one wanted to take X because of the autism and challenging behaviour...they haven't commissioned anything better

That totally inappropriate placement nearly destroyed X

The Commissioners have pushed X away from who he is

Atlas only recruited staff who had never worked in the care sector before. Paul Hewitt and Russell always said they could train and mould them to their way of working. This was probably because they would not challenge some of Atlas' practices!

It's so sad that that they didn't do their job

Most of the staff had no training…X kept having strange accidents and things went from bad to worse…we had to liaise with a team of people who didn't know X because

none of them ever visited him and yet the Commissioners constantly assured us that the service would know what to do/how to work with X

Our hopes for X to have as full a life as possible in a caring environment with his best interests at heart have never materialised

If we hadn't kicked up a fuss, he would have remained with untrained staff

Most of us are afraid to speak out. When we do it seems we are just ignored

We did exactly what they expected us to do – we gave up. We'd attended meetings, written letters, made complaints – we fought long and hard…the Commissioners hadn't planned very well…they made some ill-advised decisions when our focus was to keep X in an area with which X was familiar…with other people…now X lives alone…we have been pushed and bullied by the Commissioners and the complaints team

I learned a lot from the service that X was in before Atlas where there were safeguarding issues. A member of staff had written on an Incident Form "I got X before X got me." The lesson was that staff were advised not to be so explicit in what they put in writing…So what staff tell you is not what you see as a parent. You are so aware of the shortcuts taken…there are lots of issues across the country…whether it's about responsibility for taking bloods for people who have been prescribed medication, or the hush-hush surrounding a care industry that's getting worse. People are untrained and even those that are trained are paid very little and they may not even get sick leave.

With reference to "specialist services"

Families propose the following ideas for change:

1) *Honesty about what a specialist service means*
2) *Transparency about the specialism that is in place, how it impacts on the delivery of care and the qualifications and experiences* [of managers and staff] *which underpin this*
3) *More intrusive checks on specialist services to ensure that practices are non-aversive*[21] *and remain up to date*
4) A question for commissioners: *Why is it ok…for a specialist service…not to let you see your relative?*
5) That families keep a log (i) of events in homes…*because you can't trust anyone* (ii) of every person and agency you have told that there is something wrong…*there's a belief that we should be alerting professionals – as if we hadn't been worn down doing so*
6) That *relatives* [should not be] *made to feel 'fortunate' when* [a placement] *is found making it difficult to raise concerns for fear of losing it*
7) *Adequately resourced, national provision based on the known percentage of the population with high support needs*

[21] That is, "without punishment" – it was defined by Professor McGill during the trial of the Atlas employees

8) *Commissioners who visit* [our relative's] *service, who make judgements against key performance indicators, who monitor what is happening at placements, who are interested in a service's compliance with staff training for example - and who listen to families*
9) No more '*services' provided by random individuals, seeking profit and claiming to provide 'specialist care', unevenly distributed around the country*
10) More local services, that is, *within reasonable distance of families who. after all, provide the only genuine continuity of knowledge of the needs of their loved ones. It is also only sensible that such provision is within reasonable distance of care managers so as to facilitate their monitoring of the adequacy of a placement. Perhaps such provision would prove cost effective because it would reduce the unsatisfactory frequency of placement breakdown as well as benefitting the individuals concerned*
11) Honesty about funding - *we were assured that the financial cost of X's placement would not come into play…it's clear that that's not the case*
12) *That individuals who have such challenging needs that their relatives can no longer meet…require and deserve care from appropriately trained and experienced staff. It is therefore obvious that staff require specialist training and experience.*

42. There was no credible understanding of **people's biographies** – yet a **life course perspective** is essential. It takes time and trust to gather information about a person's life. In deliberately creating distance between residents and their families by mandating or discouraging contact, the possibility of synthesising what is in records with what matters in terms of people's biographies, their personal qualities and resources, social circumstances, interests and "at home support," for example, is limited. Knowing residents as family members, with roles within and outside the family is essential to promote valued care and support.

> *It took us approximately a year to get our daughter released from* [a pre-Atlas placement]*, where she had been for three years – which was even worse than Veilstone. They caused her immense damage and had no idea how best to care for her. I truly would not leave a dog in their care. Her deterioration was immense. We have to say that within weeks of moving to Atlas, she started to improve…There were some good staff and X did greatly improve until near the end of her time there when we were looking for somewhere else due to a sense of unease. We had concerns about her being placed so far from home as we are then not able to check on her regularly*
>
> *When X was due to leave* [Winterbourne View Hospital] *we were told there were two choices of home, Veilstone and one in Swansea. We, of course, chose the one closest to us*
>
> *After Veilstone, X spent almost another three years at* [another "specialist service in the South West] *which was also appalling, and which took years to be closed down, only to shortly reopen with the same staff and company* [owners and shareholders] *for*

children with mental health problems. I could not believe it. That too had to be closed down...eventually. So this seems to me to be pretty much "the norm"

X moved into institutional care in his late teens/early 20s. Then he moved into residential care, then a small holding – a service run by a carer from an institution which grew too big, the expertise was diluted and then there were allegations of abuse…X was used to being with people – there was a person X had been with since leaving the family home – and now he lives alone in "assisted living." There's a photo of X with us on a beach flying a kite. Now X is a completely changed person. X is in a wheelchair…had all his teeth removed, his head is misshapen and often bruised and he went down to 7.5 stone in weight. He had lots and lots of falls which the staff said were "for attention." It took months for them to send us a record of all the falls…what the Commissioners saved in accommodation costs was spent on the NHS to make him better…it's been - and continues to be - a catalogue of horrors

X had a social worker known to us for many years so there's no excuse for not knowing about their lives

Why doesn't anything link together?

When X is happy, he roars and when he's sad he roars and he was placed in a semidetached house where the noise level was unacceptable. The neighbours petitioned to have him evicted and as he was leaving [for the last time] *they cheered. Now he can't open the door and step out. He doesn't have any life*

X is really good at problem-solving and yet his behaviour is not seen as a problem solving response to what was happening to him – even getting his own back

They've had so many placements…it doesn't make sense. What's it like for someone who doesn't understand?

After the challenges of commissioners' securing more "emergency" placements *They get moved at such short notice…X even had wet washing in bin bags*

You tell them as much as possible because you want it to work out and then, there's no sign that anyone knows anything

From the date he went into that place there were no records. No records were sent to the social worker or the commissioners…it's as if they don't matter. We had a terrible time and I had no one to talk to

You have to channel your energy. It dilutes your fight

There's no national responsibility – things seem to be done backwards. We manage for as long as we can and then a "last resort" placement is needed

To ensure that people's biographies are known

Families propose the following ideas for change:

1) People's life stories, written with the assistance of their families, to be known to commissioners and shared with service providers
2) *Listen to families! Nobody visited X…they talked a lot but there was no action. They haven't commissioned anything better*
3) *People with learning disabilities and mental health problems should not have to move to receive a service. This should not happen because families are not able to check on their relatives* and their history is lost
4) *Due diligence processes need to include getting to know the person's history and background with the person and their family.*

43. The **abuse** of adults with support needs hurts families too. It prompts a hunger for justice and a more realistic consideration of what safe and responsive care is. Families' skills and expertise have developed over time and yet they have no experience of being regarded as having skills which would complement those of professionals. Their confident knowledge that things were not right began at the outset of their relatives' placements when they were marginalised.

> *You expect that when abuse is suspected or uncovered that a process will spring into action. It doesn't*
>
> *It can happen anywhere – even in a "specialist…end of the tunnel…very expensive" placement*
>
> *You expect and want to be told. I saw it in a national newspaper and had to be quite assertive to get any information*
>
> *X started telling me about how they had kicked him between the legs – demonstrated it. You wonder why they aren't looking more closely It's always the same. There's no one to be a witness*
>
> *There were times when we had concerns about there being two male carers on with* [our daughter] *as she used to soil herself or fully strip off. This was hard to monitor as we were not told when that happened. We were unhappy about her being given a double bed and could not see why. We were told it was for her comfort. She had previously always been comfortable in a single one*
>
> *We know now that he spent hours locked in a room, that he was verbally, emotionally, physically and sexually abused, and that he is yet to reveal the full horror of what he experienced*
>
> *There has been sexual abuse in some way because of some of X's behaviour. When I raised this during a review, I was told by the Chair that unless X's behaviours are negative it is unlikely that something happened. Yet X was wanting to pull my trousers*

down and kiss my bottom…It follows that if you are non-verbal people don't take you seriously[22]

We were offered support [from an agency] *that couldn't handle it. They even cancelled the first family meeting…that's not support*

[There are such limited choices of appropriate placements] *which is also very stressful for families who already feel dreadful with many on anti-depressants due to the hopelessness of the situation*

[Even at a time when this service's personnel were subject to potential prosecution] *X's dressing up clothes were returned to us slashed and packed with pens without their tops*

I visited just before it closed, and X was the best they had been

Looking back, I think the staff sought out the people they could dominate

There was a constant turnover of staff

My X has had over one million pounds paid to private providers and it is only this newest one, who listen and take on board the information. X now only has one carer and is verbally more interactive [and using] *simple words. It took me two years to get him off the medication, and lots of stress.* [There are times] *when I am just so overloaded with stress and worry about my X's future. I will never be 100% secure that X won't ever be abused again and fully understand why some families keep their children at home with them. I felt, and still do, that I had to sacrifice my son for the health and safety of* [his family] - *by not being able to keep him at home with us. He would target* [us] *if he did not understand information*

When X left Winterbourne View Hospital, clearly with Post Traumatic Stress Disorder…was told "We concentrate on the here and now." X was silenced with PTSD - that is abuse. X still feels…doesn't know who to trust to talk to without being punished. When they told X that I was dead[23] *he was punished for grieving - locked up and beaten for grieving*

I was told that I couldn't make a complaint because I was "only X's mum"

[I am] *reminded…of issues that I had tried to forget, e.g. X would refuse to drive past* [an Atlas home] *for many years and would write in his book no* [Atlas home] *and show it to anyone who was driving. After he had left - bearing in mind that he was only there for* a short time - *and moved to his own shared ownership bungalow, it took 5-6 years before he understood that* [the former Atlas home] *was no longer a danger to him.*

[22] Since families were advised that the evidence concerning residents' false imprisonment was more compelling, the matter of allegations of sexual assaults was set aside. The former residents and their families have been offered no effective remedies at the time of writing

[23] This may amount to civil tort of` *wrongful interference*`, i.e. an act or statement that it is intended and does cause physical harm - shock and distress. The precedent for legal action was established in the case of Wilkinson v Downton [1897] 2 QB 57, a case concerning a practical joke that went awry. The circumstance described above is no joking matter

Because we live in the same village as [the former Atlas home] *my son took me by the hand, and walked to* [there]*, with me reassuring him that it was now safe and no longer a care home. He plucked up enough courage to walk through the electronic gates - the Hewitt's had installed them…and up to the house and ring the doorbell. The new owner came out and I explained that my son needed to see that it was no longer a care home. She allowed us to see that it was a normal house with cats and we now call her "the cat lady"*

You have no idea what the best next steps are. What should happen? No one has a clue

Once we were unable to contact X for five days. We were later told it was because X had been moved into the main house

X went to a holiday park when it closed.

To reduce the likelihood of abuse

Families propose the following ideas for change:

1) *Investment in keeping people (i) out of Assessment and Treatment units (ii) in making Assessment and Treatment units safer* [24]
2) *An authority that dictates what is needed for X as a human being with Human Rights*
3) *Greater attention to what happens to individuals in service settings because abuse can happen anywhere, in any setting*
4) *Small places which are available in emergencies which are near to home and close to families so they can still visit*
5) *What about the people without parents and siblings? The ones whose parents are too elderly?* They too require attentive support
6) *Recognition that when people have been abused the care system has no track record in looking after them,* that is, *there is no trauma support*
7) *Acknowledgement that families are traumatised by the system too, particularly when abuse happens. What supports are available to them?*
8) *Regulating commissioners so that they may be brought to task when placements harm people*[25]
9) *Supported living services should be inspected by the CQC*
10) *Recognition that when people have been abused the care system doesn't look after them*

[24] The 2012, Winterbourne View Hospital SCR recommended *inter alia* that (i) the CQC should have characteristics akin to HM Inspectorate of prisons in terms of monitoring standards since it was such a high risk setting and (ii) that inspectors should be qualified and competent to carry out inspections…demonstrate that they have sufficient knowledge about the services they inspect and the abuse of vulnerable adults. Further, it stated that there was no place for "out of sight, out of mind" commissioning

[25] Since the consequences of being placed at Atlas homes were wholly disproportionate to the reasons for people's admissions, families want to see commissioners held to account. Commissioners are part of public authorities bound by the Human Rights Act 1998

11) *Since things are so much worse now for* [our relatives] *they should* be prioritised and *receive support to help them* make sense of these bleak experiences in their lives
12) *Families should be kept informed of significant changes in their relatives' lives*
13) Particular attention to the observations and reflections of the families of people who are non-verbal.

44. There was no credible **monitoring** or **inspection**. The CQC did not seek out the families' experience of visiting (or being discouraged from doing so) and did not 'hold the ring' in terms of having an overview of the complaints, the safeguarding referrals and contract compliance monitoring for example. It was unaware of the existence and use of the "Garden Room" and the "Quiet Room." It is not news that the actions of private care companies have wide-ranging public consequences.

> *The oversight wasn't there. It wasn't anyone's priority*
>
> *NHS Continuing Care's approach seemed to be - find anywhere that will get them away from the parents*
>
> *We have met* [the Commissioners] *several times to discuss the issues, but what has not changed is the need for appropriate accommodation and care for X. While* [they] *were happy to commission Atlas as the provider for X,* [they] *failed to monitor the quality of the service and neglected to visit X for three years. It is arguable that* [the Atlas home was] *not convenient but a 90-minute car journey once a year* [was] *not exactly onerous*
>
> *The CQC hadn't a clue. They didn't even insist on gaining access to X when the staff were inside shredding documents. Two inspectors sat outside for 30 minutes because the home told them that they "weren't ready!" Things got so desperate I went on hunger strike*
>
> *Continuing Health Care was not geared up for this. Once they're placed, that's it. It's as though they fall into a big hole*
>
> *You'd think there'd be more scrutiny because surely, they last thing they want is another placement? It's easier if they don't want to think that there's a problem*
>
> *Doesn't the CQC consider location and what a place looks like? Do they ask themselves "Is it appropriate to have barbed wire fencing on one side of a hidden location?"*
>
> *I can't let it go. Over a cup of tea we were sold this package and now I live with that guilt*
>
> *All the Continuing Healthcare people were interim. There were no full-time people. I was even emailing one person months after he had left. There was no message*
>
> *There's no accountability. People move on and get promoted*
>
> *The CQC reports were superficial – then suddenly there was a 180 degrees' turnaround, and everyone had to be removed immediately*
>
> *X was always waiting for me at the front door. He's so black and white*

X had an outreach service from Atlas for over two years. I raised issues with the commissioners, but nothing was done[26]

[Re pre-placements] *We are greatly concerned that the infrastructure that* [Commissioners] *aim to build around X to safeguard him involves a resource with little experience in dealing with learning disabilities. X's inability to communicate his fear or concern can result in violent behaviour to both himself and others. He has to be surrounded by skilled staff capable of dealing with such behaviours to prevent harm and anything less than this is blinkered and short sighted*

There was an occasion when X threw [an object] *through a window…I am convinced it was his way of showing that he was not happy…They never showed me any incident forms…*[at another placement] *it means that you're not surprised when you're told, "Sorry, but we've got concerns about X and we need to move X on"*

We made complaints and they proposed that the investigators should be [the Commissioners] *we had complained about! We gave up when we got the letter saying, "I have reviewed the file and note that you…have declined to clarify your complaints and the outcomes you would be looking for from an investigation on several occasions. It is very difficult for the Local Authority to undertake an investigation where a complainant does not work in partnership in order to ensure a robust investigation can take place. I have carried out a full review of your complaint and feel that the Local Authority has acted reasonably and in accordance with the relevant statutory legislation and guidance…"*

How could [Atlas] *get away with getting rid of documentation?* Also, since, *the placing authorities didn't take or keep notes there were no records! This made it possible for Paul Hewitt to state at his trial that he did not recall being present at a particular review meeting.*

Families want reform in regulation and enforcement

and propose the following ideas for change:

1) *Knowledgeable local people involved in inspections. People willing to listen to us and to our relatives*
2) *Funded local authority oversight – more than safeguarding responses*
3) *People with knowledge and expertise in learning disability and mental health problems*
4) *That high-risk environments…funded to high levels…are subject to extra scrutiny*
5) *That a locked unit with a barbed wire fence should raise a red flag*

[26] Hilltop Atlas were registered with CQC for personal/domiciliary care in addition to residential care, allowing it to care for people in their own home - see https://www.cqc.org.uk/location/1-309952740/inspectionreport/1-332048253 (accessed on 9 July 2018)

6) *Reviews which are thorough…which check out what people are getting, including whether or not people are receiving 2:1 or being falsely imprisoned for example*
7) Acknowledgement that *having a family run a service is risky.* There should be a presumption against husband – wife – son – daughter Director companies and/or an expectation of independent members of a company's Board. With the exception of smaller companies, at least half of the Board, excluding the Chair, should comprise independent, non-executive directors
8) There should be a presumption of information disclosure with the responsibility lying with the service to show that it does not have to disclose. *The failure to take minutes of meetings with families, withholding information about routine practices and, separately, the destruction of records* should be grounds for registration cancellation
9) *Incident Forms should be shared with families* – most particularly if these constitute evidence that a resident may not remain at a particular service
10) *Evidence of abuse in a service which is part of a wider group/business, should result in scrutiny of all services in that group/business*
11) The practice of paying services irrespective of how they care for people is stopped. *Because anyone with money can set up a service and staff it with underpaid, inept and untrained staff, commissioners should be required to ensure that staff who are effective in securing valued results with residents and their families receive enhanced remuneration – and begin to provide a ladder of opportunity and responsibility. This should involve external training, NVQ standards which involve more than restraint*
12) Credible scrutiny of the human outcomes of funding anomalies. For example, *Whilst X was placed in Devon, her funding was split, and* one *care manager* was *in Windsor and Maidenhead and the other in Hampshire*. X is *now placed in Hampshire and the care manager is placed in Devon. How can this* be or *result in good practice?*
13) *There's no option but to undertake unannounced visits – most particularly when commissioners such as the Devon Partnership Trust tell you that Atlas has "such a good reputation."*

45. Finally, the **criminal justice processes** were experienced as bewildering and highlighted some alarming shortcomings. Adults with learning disabilities and mental health problems are likely to be perceived as *vulnerable witnesses,* eligible for special measures,[27] since their evidence may be diminished on account of their *mental disorder* or significant impairment of intelligence and social functioning. Certainly, witness vulnerability in a general sense is likely to be more acute for adults with learning disabilities and mental health problems. Although special measures were invoked to enable former Atlas residents to enhance their testimony, in the form of video-recorded evidence, their families had been hopeful that they also might be witnesses.
46. The families recalled hearing glowing character references of the former staff employees, yet there was no parallel means of describing the essence and vitality of their relatives' lives. They

[27] Youth Justice and Criminal Evidence Act 1999, s.16

matter a great deal to their families and yet, during the trial, their individual qualities were reduced to accounts of aggressive behaviour, how they gave expression to their distress and to their *challenging behaviour.* Crucially for families, the trial was silent on the implications of the European Convention on Human Rights[28] for Atlas' residents:

> *We were told that the trial was going to result in a huge change in care*
>
> Some *relatives received no notification about the case going to Court but were left to come across it by chance in the national press and then had to resort to searching the internet and eventually contacting the Police via 101.* My family's *approach to Devon Social Services for information took almost three months and a follow up assertive email before any response was received. It added insult to injury to read in a national newspaper how victims and residents were receiving support when we had not even been informed![29]*
>
> *Victims are always on the back foot. We were reassured that at least the Director was convicted and fined – but he appealed, got off on a technicality, the case was dismissed, and he got damages of £4k[30]*
>
> *The CPS said that there'd be a retrial and we've heard nothing…no information is forthcoming. They didn't even bother sending a letter. We were told it was not in the public interest*
>
> *It took five years for it to get to court*
>
> *X's evidence was inadmissible/inherently suspect because he became confused.* [He had been subject to more than a single abusive episode at more than one service] *…stress and the fact of being a repeat victim were at play. X was harmed*
>
> *You start by having hope that you are going to get some justice*
>
> [The defence] *barrister spoke about "the disease of autism"* [and] *we were relying on people who didn't know anything about our relatives. They didn't know to challenge the staff who fabricated stuff about* [our relatives]
>
> *I didn't have any hope. Previous experience meant that I knew there was no point…I had no faith in it even at the beginning. It makes you very cynical*
>
> *The police took too long. They did what they could, but they took too long and the investigation was too wide. They should have gone solely for the directors and not just the menials*

[28] A civil trial or a judicial review may have provided better options in terms of securing answers from the home and its staff about harms in addition to false imprisonment

[29] *It felt that* [this] *scenario was repeated when despite having made it clear that we wished to contribute to the SAR, we were only alerted to being able to do so by another resident's relative and again having to seek out the appropriate channel to do so and again, via the Police*

[30] The former Managing Director was acquitted of the conspiring falsely to imprison residents and was convicted of a less serious offence under S.3(1) of the Health and Safety at Work etc Act 1974. He received personal expenses of £4762.25 for hotel and travel to and from Bristol Crown Court

The trial was a shoal of red herrings. I kept wondering how the jury would cope with all of this…it went on for four months

I was naïve. I thought that our relatives were the victims but the staff and directors, the people on trial, were portrayed as victims

Everything was weighted against [our relatives]. *There must have been about 10 barristers defending the service's directors and staff.* [Our relatives] *had one! Their barristers seemed to make a great deal of the fact that these people chose to work with unpredictable and challenging people*

They didn't just demonise [our relatives] *they demonised us*

[The judge did not appear to question the use of either the quiet room or the garden room since one family recalled him saying] *What else were* [staff] *supposed to do with them? The behaviour* [of ex-residents] *was reprehensible…no real harm was done"*

There's no question X can be challenging and difficult, but X was demonised during the trial

They made so much about the behaviour of the victims – our relatives. They didn't seem to understand that if you looked more closely at some of the behaviours, they were understandable – victim blaming was rife

It was shocking that the Director, his family and staff [gave evidence which was contrary to the experiential knowledge of families]. *Paul Hewitt was present in lots of meetings and yet he denied it,* [claiming that] *he might have "popped in but I wasn't the Director at the time." There were no minutes to confirm what we knew*

The lack of support hurts – for us and for our relatives…X's parents are in their 80s and in very poor health

I have been subjected to five years of trauma, with a devastating outcome, where those involved in assaulting my son were not taken to court as it was not deemed to be in the public interest

You wonder how a jury will cope with all this information. The trial went on for four months

There was a sense that being imprisoned, because that is what happened [to residents]*, was somehow not shocking*

The judge concluded and there was no suggestion that Witness Impact statements were required even though Atlas residents were known to have been harmed *Comments from the judge and barristers were despicable.*

In terms of achieving justice

Families propose the following ideas for change:

1) *A realistic view of what's going to happen in court*

2) *A quicker process – why on earth did it take five years to get to court?*
3) *Judges and barristers with specific knowledge and training in learning disability and challenging behaviour so that, minimally, they know what effective and humane support is*[31]
4) *Recognition that people who are being abused express their distress in different ways – ways that may appear to be challenging*
5) *Never again are distressed adults portrayed so disrespectfully by a judge, that is, "displaying canine tendencies," in trials of this nature*
6) *Proper support for our relatives and for us…we told people we need proper support…We didn't get it*
7) *Advocacy*[32] *should not be as rare as rocking horse poo*
8) *Training for the CPS, the judiciary, for solicitors and barristers which includes training from people with learning disabilities and their relatives who have had experience of the Criminal Justice System* so that the credibility and humanity of witnesses' is not sacrificed before a jury.

47. More broadly, families want the criminal justice system to cease to 'explain' abusive practices as a by-product of residents' distressed behavioural pattern, the onset of mental health problems or even their age. People with learning disabilities and mental health problems are not the problem. There was no sense that people's relatives had difficulties in making themselves understood and were likely to be frustrated and upset by not being able to communicate directly what had happened to them. These populations are too easily stigmatised and considered unreliable.
48. Families wonder why it was necessary for barristers to present people with learning disabilities and mental health problems in such a negative and harmful manner. Hanging undue relevance onto the behaviour of people with learning disabilities and mental health problems eclipsed the duties and responsibilities of the employees, managers and Directors of a "specialist service" which was so wanting.
49. The short-lived publicity surrounding the trial heralded the fact that directors and managers of the Atlas homes were held to account and not just the staff. However, the conviction of Paul Hewitt of a failure to discharge a duty under the Health and Safety at Work Act for which he was fined £12,500 and ordered to pay costs of £105K was ultimately set aside. So from the families' perspective, justice has not been realised.
50. At the time of writing the families of people who had no option but to be placed at Atlas homes want to influence the conduct of future criminal trials toward a realisation of the essential humanity of people with learning disabilities, autism and mental health problems.

[31] Ministry of Justice (2011) *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses and guidance on using special measures*

[32] That is, "…a person who is independent of the authority (an "independent advocate") to be available to represent and support the individual for the purpose of facilitating the individual's involvement" S.67(2) the Care Act 2014

How were the residents of Atlas' homes supposed to make sense of their unlawful detention? That is,

1) being forcibly taken to the Garden Room or Quiet Room where they were not fed or offered drinks
2) the trivial reasons for being put into a cold, bare and inhospitable room without access to a toilet[33]
3) the arbitrary duration of being in the room
4) untrained staff determining when they should be released
5) the subsequent imposition of "compliance tests" in the form of household tasks.

51. The harmful punishments and events families' relatives endured, shaped by the "Atlas model," have had enduring consequences. It is possible that some patients have memories of previous events at unknown times which they are resistant to forgetting. It is also possible that some behaviours are "trauma-specific" yet the traumas themselves are not known.
52. Three families who have shared their experiences have not been able to identify compassionate support for their relatives even when allegations became known. Most have not been able to halt successive placements since 2012, at increasingly high cost, some of which have also been abusive. All families are grieving and aggrieved.

[33] The trial confirmed that there were no records concerning the use of the Garden room; there was no evidence that residents put into the Garden Room were offered food and drink; being placed there was known to distress some residents; it was not a calming place; the windows were boarded up; it had two doors – the one leading to the garden was locked and staff remained outside the other door so residents were "monitored from the lounge;" a resident recalled that there was "no handle on the inside;" it was not "a place of safety;" some residents were required to remain in the Garden Room overnight; and, according to former residents, it was a cold room

Section 4. The Serious Case Review of 2013

53. The 2013 SCR detailed what was known about the organisations which commissioned Atlas to provide specialist care.

The Commissioners of Atlas Project Team Ltd

54. A perspective on commissioning care home placements for adults with learning disabilities and autism before 2013 is revealed in Appendix 1.
55. The police investigation and prospective trial meant that the SCR could not engage with residents' families. However, it glimpsed the experience of some Atlas residents. For example, one resident had been placed at an Atlas home for seven years prior to being transferred to another Atlas home. The resident had become "settled" and behaviours which had once been challenging to manage were no longer in evidence. Atlas had claimed that because this resident's "potential had been reached" they could move to an Atlas flat. After 12 months the resident requested a move because they wanted company. The resident wrote to the case manager and rang occasionally. They did not make any allegations or complain about staff practices and neither did their relatives. One commissioner stated that "Progress was seen with individuals coming off [Mental Health Act] section and reduced package costs."
56. In addition to people whose challenging behaviours were overwhelming their families and/or community services, long-stay hospital closure programmes accounted for people's placements. Atlas also benefitted from S.117 placements;[34] those which were geographically close to people's families; the success of time-limited "trial placements;" and pressures to identify urgent placements against the backdrop of a "small number of specialist providers." Atlas' willingness to accept emergency placements resulted in a reputation for being a service of "last resort." It was perceived as "being able to cope with residents with challenging behaviours and complex needs."
57. The commissioning bodies accepted that the absence of "local options" for some adults with learning disabilities and autism resulted in the necessity of Out of Area placements. These relied on contracts with the providers. Each commissioning body undertook their own scrutiny processes without the benefit of a repository of "intelligence" about providers. The dispersal of Atlas' homes lessened the possibility of multiple commissioning bodies collectively assessing the adequacy and quality of individual placements.
58. While approaches to personalisation varied across commissioning bodies, to different degrees these involved people with learning disabilities and autism and their families in individual assessments, the development of pre-placement support plans and residents' reviews. One commissioner reported that families were also involved in the process of tendering for services for their relatives. However, as one council acknowledged, "crises severely inhibit planning and decision-making."

[34] Also known as "section 117 aftercare" is a duty to provide accommodation and other community care services for people who have been detained under the Mental Health Act 1983 or admitted to hospital under one of the criminal provisions or transferred under a transfer direction and then cease to be detained

59. Compliance with generic contracts and service specifications were cited by most commissioning bodies as the overarching means by which the quality of a service was determined. One commissioner noted, "we know from Atlas that it is extremely difficult to rely on contractual remedies." The responsibility for monitoring Atlas residents was undertaken by nominated practitioners, locality and specialist provider teams. Their reviews were complemented with consideration of placement agreements, generic contracts and assurance meetings.
60. The reviews of some residents did not occur because of "workload pressures." One commissioner noted that the development of local provision, "may have been to the detriment…on those who could not be easily moved back."
61. It appears, from the drafting of the 2013 SCR, that the limited pool of specialist providers was likely to result in Out of Area placements for which pre-placement assessments could be cursory. People placed out of area were disadvantaged because their circumstances did not feature in commissioning strategies; there was no guarantee that the host authority would be informed of their arrival; and because reviewing processes were underdeveloped there was no agreed means of determining the quality of specialist services.
62. The ten commissioning bodies did not know whether their experience was familiar to other commissioners concerning: the absence of residents' support planning; Atlas' use of restrictive practices; its reluctance to negotiate the fees for placements; its failure to report significant events to the Care Quality Commission; and its compromised engagement with people's families for example. At one review, the "attitude" of the Managing Director was perceived as "overbearing" by a commissioner who resolved to identify an alternative placement for the resident they were funding.
63. The public interest associated with the care of adults with learning disabilities and the income from individual fees of around £4k per resident per week had no impact on the corporate governance of a family-run business. People with learning disabilities and autism were disadvantaged by commissioners being occasional buyers of specialist services and their placements being contingent on vacancies.

The Care Quality Commission

64. During October 2010,[35] Atlas applied to register under the Health and Social Care Act (HSCA) 2008. The CQC's Quality and Risk Profile indicated that all 14 locations were rated as "good" or "excellent." The CQC acknowledged that at the relevant time, inspectors had little intelligence with which to assess the level of risk when planning inspections and "provider level intelligence" was limited. During September 2011, the CQC noted that having registered managers registered for more than one site was not identified as a potential risk factor.

[35] Between April 2010 and October 2014, the HSCA 2008 (Regulated Activities) Regulations 2010 and the Care Quality (Registration) Regulations set out the essential standards of quality and safety that people had a right to expect. There were 16 standards that CQC inspectors assessed. Previously Inspectors did not specialise in a particular type of care.

65. The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) were inspected at three Atlas homes and found to be compliant. The CQC acknowledged that its analysis of the inspection reports revealed "some inconsistencies" in the inspection approach and response to findings. The findings of inspectors and those of the commissioners were conflicting, that is, the inspectors did not identify "serious concerns" about residents' care. Inspectors made additional corroborating visits which resulted in "significant delays."
66. The CQC stated that its pre-October 2014 inspection methodology was heavily weighted towards seeking people's views and making observations with inspectors focusing less on the documentation relating to people's care – which is where the strongest evidence of noncompliance was eventually found. Its own review of inspection reports indicated that some inspectors were unable to communicate effectively with people using the services. It was not clear what steps were taken to ensure the safety and welfare of people using the service between October 2011 and August 2012 when the Notice of Decision was issued. There was a high level of monitoring by the commissioners of services and a feedback system was established through care quality monitoring and safeguarding meetings. With reference to provider action plans, the CQC looked at the provider's response to the inspections and found that action plans had not been returned in all cases where concerns had been identified. It does not appear that the CQC challenged Atlas about this.
67. Under section 20 of the HSCA, Regulation 18(1) and (2), registered providers are required to notify CQC of certain events relating to the running of the service or to people who use the service. The reportable notifications include incidents resulting in serious injury. It is not clear that the CQC followed up notifications of significant incidents. The use of restraint did not fall in the scope of reportable incidents. Although Veilstone was on the CQC's Risk Register it had received a single notification.[36] Similarly, Gatooma had a single notification.
68. The CQC acknowledged that it should have adopted a more focused and coordinated approach to "provider-level" regulation and should have followed up on non-compliance and poor action planning.[37] The response to a resident who alerted a CQC inspector "on numerous occasions" was a series of emails to and from Devon's safeguarding personnel. Although the SCR confirmed that commissioners relied on CQC inspection reports, the CQC reflected that it "did not receive information from commissioners about people's care and welfare. Our intelligence did not highlight any risks."

[36] Under s.20 of the HSCA, Regulation 18 (1) and (2) (assessing and monitoring the service provision and notification of further incidents), providers are required to notify CQC of certain events [relating to the running of the service and to people who use the service] including abuse and allegations of abuse, an application to deprive someone of their liberty for example. Since October 2014, the CQC's Key Lines of Enquiry asks: "Do staff recognise when people aged 16 and over, who lack mental capacity, are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?"

[37] The CQC's current approach produces ratings for all adult social care services based on key lines of inquiry addressing the questions: is the service safe, effective, caring, responsive and well-led? See www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection#core-services (accessed 21 May 2019) for information concerning its current intelligence gathering and inspection methods. Also, the CQC is part of the DHSC - led MCA Steering Group which seeks to "drive improvement in the implementation of the MCA, including DoLS

69. The CQC's regulatory activities were in transition during 2010-12. Since Atlas self-reported its compliance with key outcomes – and inspectors had to take this into account when planning inspections – the CQC had no indication that earlier inspections were required. It accepted that its inspections and monitoring had no knowledge of the potential risks such as Atlas' inattention to Deprivation of Liberty Safeguards across its homes, or the implications of Registered Managers being registered for more than one site.

The Lessons Identified during 2013

70. The SCR concluded that "there was little evidence to support a needs-based approach for placing [people. Placement decisions] would have been based more on who could provide the service…annual reviews…either did not take place or were irregular…[they] were not always very thorough…some were carried out over the telephone… [and the reviewers] tended to be on their own, possibly without the confidence or experience to challenge or explore areas of concern…"
71. There was no evidence that Care Managers followed up the questionable methods deployed by Atlas, for example, discouraging family visits to enable a new resident to "settle in;" monitoring and discontinuing phone calls between residents and their relatives; or using seclusion. The expertise of Atlas was assumed rather than evidenced. The SCR drew attention to the "variable" provision of primary care to Atlas residents.
72. SCRs were regarded as a means of setting out the lessons learned. This purpose was made explicit in the Care Act 2014.[38]

Table 1: The 2013 Lessons Identified by the Commissioners

Agency	January 2010-11
Bath and NE Somerset	More scrutiny of a provider before a placement is made – including its history; contact with host safeguarding to establish their experience of a service
Bracknell Forest Council	Bracknell Forest has instigated a review of its approach to supporting people who live outside the Borough. This will focus on how the Council develops relationships with host LAs and NHS partners. It is unlikely that the Council would be supporting new, out of Borough placements
Devon NHS and Devon CC	Just as at Winterbourne, there was a controlling figure and negative culture…there is little resource investment in effective monitoring… asking about the methods used to achieve the results…improving understanding of placement systems, management controls, the role of the CQC and improved Care Planning Approach by those geographically closest

[38] S.44 (5) Each member of the SAB must co-operate in and contribute to the carrying out of a review…with a view to (a) identifying the lessons to be learnt from the adult's case and (b) applying those lessons to future cases

Plymouth City Council	Need to monitor providers to ensure that individual support plans/care plans are reviewed annually
S Devon and Torbay Shadow CCG	Reviewers of people with complex support needs should be specialists; there is a gap in provision which allows a single provider to become the "go to" provider of choice; positive risk enablement should be supported; risk-based approach to review frequency? Since "Atlas management… were the (self-proclaimed) experts" – this should have been tested. The expectation that providers will cooperate with scrutiny should be embedded in contracts…many of the actions in the Winterbourne View report…good contracting, clear service specifications, clarity re lead commissioning arrangements, good quality monitoring of providers
Surrey CC	There should be clarity on each LA website on how other LAs can contact the relevant commissioning, procurement, contracting or QA team to discuss particular placements or concerns; there should be a requirement for registered services to advise the host LA area which other LA has placed people; the regulator should ask the provider to confirm the LAs which have made placements and their reports should state the contact details of the lead commissioner; the regulator should state the LA area the service falls under and identify the key people in the CQC who should be contacted regarding emergent "themes" from inspections
Torbay and S Devon Health & Care NHS Trust	Commissioners and contract managers are in a difficult position where concerns are based on subjective impressions…particularly where CQC have approved the service. If action is taken against a provider there is a risk of legal action – which is why many commissioners/contract managers are reluctant to provide advice when Care Managers request information about services in their LA; Atlas was good at reassuring families…which reassured CMs; reviewers should be skilled; not all concerns reach the safeguarding threshold; where reviews do not take place at the home, the risk should be recorded; CMs should record when providers fail to deliver requested information. Providers should have contractual obligations to address this; there needs to be active contract monitoring…All services have the potential to become desensitised with poor practice escalating if there is not sufficient outside question…are providers alert to custom and practice becoming poor custom and practice; should undertake pre-placement checks for all Out of Area placements…need to be clear about the level of monitoring of the host authority

W Berks Council	Will be re-assessing all Out of Area placements and undertaking annual reviews; the review document will be revised to provide more information about the quality and safety of the placement; reviewing staff will be trained and residents' views captured; long term Service Users should have a multi-disciplinary assessment every 3 years; robust commissioning for Out of Area placements is required; reviews should establish that staff are aware of safeguarding procedures and that commissioning authorities should be informed of referrals; ditto Health Action Plans; where there are concerns re mental and physical health, a MD review is indicated; the community team will advise the host LA of placements and seek feedback on care quality
W Berks PCT Quality Team	Every effort should be made to find placements as close as possible to the service user's home
Wokingham BC	It is difficult to discern how abusive behaviour management techniques evolved in a remote location; CMs require training to carry out rigorous placement reviews; once the concerns came to light the leadership of Devon's Safeguarding Service – which resulted in effective collaboration – was "helpful and responsive." The CQC only shares information when there are safeguarding concerns

73. During December 2018, the Review Panel stated that, "Many of the learning points identified by the SCR were like those identified by the Winterbourne View SCR. The recommendations from the SCR focussed on commissioning and quality and safety monitoring arrangements. These were used to create a multi-agency action plan for Devon Safeguarding Adults Board members and for all other organisations from other parts of the country involved in commissioning placements and overseeing services provided by Atlas including the Care Quality Commission. A number of these actions were also in line with the national Winterbourne View Action Plan and subsequent Transforming Care national programme…Completion of the Winterbourne View Action plan in Devon was reported to the DSAB [and] Department of Health."

'The placing bodies' recommendations for themselves

74. Information about events and practices at Atlas homes exerted an influence on the commissioning bodies. The following Table captures what the contributors to the 2013 SCR recommended for their own organisations/placing bodies.

Table 2: The recommendations proposed by the Individual Management Review authors for the 2013 SCR authors to consider

Agency	2013
Bath and NE Somerset	(1) Examine the way in which a very clearly defined care/support plan setting out the objectives by any service will be measured is prepared (2) Review the way in which relatives are enabled to participate meaningfully in reviews
Bracknell Forest Council	(1) Clarify the roles and responsibilities of 'host' authorities regarding quality/ contract monitoring and how the outcomes are shared with commissioning authorities…may be appropriate for ADASS to consider this (2) Guidance regarding sharing the outcomes of annual health checks between the host provider and the commissioning NHS/ LA (3) The role of CQC and how "local intelligence information" is shared with commissioning authorities (4) Contact all host authorities to establish appropriate information sharing arrangements
Devon NHS and Devon CC	*In the original table presented to the Reviewer this was left blank. Panel Members reviewed why this was the case and found: The Implementation programme was in progress to meet the national requirement to implement recommendations from Winterbourne View, (this was superseded by transforming care programme) and that organisations were awaiting recommendations of the initial Atlas SCR in order to apply the findings.*
Plymouth City Council	(1) Timely, face to face joint reviews of individual placements monitored by commissioning (2) Quality review all learning disability providers through 2013
S Devon and Torbay Shadow CCG	*In the original table presented to the Reviewer this was left blank. Panel Members reviewed why this was the case and found: The table refers to IMRs prepared in 2011 and Winterbourne View recommendations were being implemented at that time. Organisations were awaiting recommendations of the initial Atlas SCR in order to apply the findings.*
Surrey CC	Keen to receive the recommendations of the [SCR] and apply the findings where appropriate, particularly given that we have a large number of individuals placed outside our area

Torbay and S Devon Health & Care NHS Trust	(1) Improve information sharing protocols and systems for user level information for staff employed by different organisations in the CLDT and AST (2) Clarify systems and accountabilities for joint commissioning between health and social care (3) Improve systems for sharing and collating concerns about providers (4) Ensure that staff are skilled in identifying potential causes for concern within services supporting people with complex behaviour
W Berks Council	(1) Reassess all people living in Out of Area placements (2) Review and revise the Review/Reassessment document so that the quality and safety of services are addressed in much more detail as part of the individual review (3) Specific training will be given to staff who are reviewing Out of Area placements (4) People who are long term Service Users will have a full multidisciplinary assessment every 3 years (5) Develop a robust commissioning process for Out of Area placements
W Berks PCT Quality Team	(1) Continue to prioritise placing Service Users in area (2) CHC to audit current placements and review the quality of services in respect of those Service Users who remain Out of Area and to review protocols and practice with all Out of Area specialists responsible for Service User welfare (3) Produce an audit tool for gauging the quality of services for Out of Area Service Users for beneficial reasons (4) Produce a programme of short notice visits to residential homes using Audit tool scorecard during the visit (5) Review commissioning for personalisation diagnostic tool
Wokingham BC	(1) Consider recommendations from this SCR as part of its review of: Care Governance and Quality monitoring arrangements; customer reviewing process; and commissioning strategy (2) Retrain workers who will be reviewing customers in care homes and supported living placements (3) LAs and CQC to review their information sharing processes to ensure that concerns about service quality and practice of organisations is collated locally and nationally (4) Review procedure for placing people with complex needs (5) Care Governance Team to follow up any concerns raised by individual customer reviews or providers' reluctance to engage with the care fund calculator

75. The CQC's recommendations addressed "strengthening its systems" to: identifying locations where there may be vacancies or changes in registered managers; seeking assurance that managers registered for multiple placements are able to do so effectively; collating intelligence about corporate providers and individual locations; developing guidance and

methods for effective, consistent management and reporting; developing its QA systems; raising awareness of the tools and internal resources available to inspectors; ensuring that action plans are returned and that the quality is adequate; ensuring that all notifications are followed up and a record of the outcomes is kept; considering action to be taken when provided with information that indicates the provider is not complying with the regulations; ensuring a full audit trail of internal management review meetings; acting promptly when considering representations against enforcement actions; following the enforcement policy and procedures when considering what action should be taken regarding ongoing noncompliance; and maintaining a register of locations where risks have been identified to ensure monitoring and regulatory action.

Section 5: What is different in 2018

76. The commissioning authorities[39] which had contributed to the 2013 SCR reflected on their progress in terms of (a) the actions identified by the SCR and (b) their current monitoring processes and arrangements for dealing with complaints and safeguarding alerts. Beginning with safeguarding, the processes for dealing with **safeguarding allegations and complaints** have changed.

77. The Care Act 2014 confirmed the local authority's lead role in making whatever enquiries are necessary if there is reasonable cause to suspect that an adult is at risk of abuse or neglect.[40] Where allegations involve adults in Out of Area placements, cooperation with the host authority is required. Safeguarding enquiries are undertaken in line with the host's safeguarding procedures. Typically, a multi-disciplinary, multi-agency overview meeting determines whether a "whole service" response is required. Devon CC's referral pathway is via its three safeguarding hubs which triage within two days, according to "the level of risk." The triage process includes contact with the person concerned or their advocate/relative, with the lead professionals involved in their care and with the service provider. A decision about whether to undertake a S.42 safeguarding enquiry follows "immediate protection planning." If there is to be an enquiry this will be led either by the health and social care community team or a partner agency. The safeguarding "hub" will inform the police if a crime is suspected. A "whole service" response may run in parallel with an individual safeguarding enquiry. If the County Council decides that a service is not meeting people's needs, improvement plans are developed with the provider, with the help of the Quality Assurance Improvement Team. If no improvements result, then Devon may cease to commission the provider's service and will identify alternative services. Devon has an Out of County Reviewing Team which, since 2013, has supported 34 people to return to Devon or their chosen location. Some 65 people remain out of area, 15 of whom are in hospitals. See Appendix 3 (a) for an example of the Reviewing Team's practice. Appendix 3 (b) provides an example of a safeguarding intervention.

78. In the light of an increase in the numbers of people presenting with highly complex pictures of substance misuse, physical and psychiatric co-morbidities, Plymouth has created a Creative Solutions Forum, including commissioners, to provide an additional multi-agency, multidisciplinary response. During 2017, the Forum addressed the support needs of 20 adults, 15 of whom presented with "high risks." The risks concerning 12 adults were reduced, workers responsible for these adults reported feeling more supported with a reported reduction in accessing emergency services" for example.

[39] Bath and North East Somerset, Bracknell Forest Council, Devon CC, NEW Devon CCG, Plymouth City Council, Royal Borough of Windsor and Maidenhead, Surrey CC, South Devon and Torbay CCG, Torbay and South Devon NHS FT, West Berkshire Council, Wiltshire Council and Wokingham BC/ CCG

[40] *where a LA has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) (a) has needs for care and support (whether or not the LA is meeting any of those needs); (b) is experiencing, or is at risk of, abuse and neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it –*

79. NEW Devon CCG and Devon Partnership Trust have a process in place for supporting applications to the Court of Protection for those requiring an authorisation for a Deprivation of Liberty working with local authorities. A mental capacity lead professional has oversight of all DoLS applications. The Transforming Care Partnership supports people with learning disabilities and people with autism to return to their local communities from secure hospitals and seeks to ensure that children, young people and adults don't get placed out of area unless this is necessary. See Appendix 3 (c) for a case study which reflects the outcome of NEW Devon CCG's revised approach.
80. Plymouth has an integrated health and care provider which supports people with learning disabilities and their families. Its multi-disciplinary learning disability team has responsibility for specialist individualised assessment and service design, planning and reviewing person centred support for those living locally and out of area. See Appendix 3 (d) for a pen picture of a former Atlas resident.
81. Devon County Council has a Customer Relations Team that handles feedback about the council's provided and commissioned services. When **complaints** are received the Team will assess whether immediate action is required. Some complaints may be transferred directly to the safeguarding enquiry process once the Team has sought advice from safeguarding personnel. Complaints concerning a commissioned service may be directed by the Customer Relations Team to the provider or to the relevant commissioning body. The Team will identify the complainant's desired outcome and provide "an active case management role" to ensure the effectiveness of the complaints process. The Team may offer local resolution meetings if this is acceptable to the complainant and provider to promote the earliest possible resolution of a complaint. The Team monitors learning and actions following each complaint.
82. Complaints teams across [NEW Devon and South Devon and Torbay, now NHS Devon CCG will liaise with the team/provider responsible for the placement; and Devon Partnership Trust's Complaints Team works closely with the DPT safeguarding Team, the Local Authority Safeguarding Team and the CCG" to secure timely responses.
83. The commissioning authorities reported to the 2013 SCR that without a mandated notification system for LAs and the NHS to share information about people being placed out of area, the process relied on information being volunteered. Accordingly, the numbers of all **placements of vulnerable people with complex and challenging needs in an area** may be underestimated. Devon CC noted that it is estimated that over half of residential beds in Devon for adults with a learning disability were the responsibility of other placing authorities and Devon CC did not have the resources to collate or update such data.
84. Geographical remoteness is critical because, as Wiltshire Council noted, "the council always undertakes reviews for out of council placements, so we maintain close oversight…the only exception has been for one customer placed in Scotland…the LA there are asked to conduct the review on our behalf." Similarly, the Royal Borough of Windsor and Maidenhead noted that [it] "would refer to the local CTPLD" for its Out of Area placements. However, notification information was basic and did not "denote levels of complexity" for example.

85. The intention of the Care Act 2014 in terms of strategic planning, commissioning and market shaping[41] creates a general duty for local authorities to promote diversity and quality in the market of care and support providers for people in their local area. Key messages are the requirements for variety, high quality information on which to base choices. The Act places a duty on local authorities to plan for the demand and supply of care provision.

86. In **2017**, Devon CC undertook a supply and demand analysis to set out current and future needs and gaps in provision. This involved work with providers to explore how pathways to employment and independence might be developed. It has an all-age approach, aspires to people to living in their own homes, where possible, for care and support to be provided in their homes and for people to be as independent as possible. This is complemented by NEW Devon CCG's scoping of existing provision and future demand. Plymouth City Council established a *crisis management* group to plan for and develop services to meet the housing and support needs of those who go into crisis to help prevent out of area placements. It is also bidding for funds to develop step down, bespoke accommodation for people returning to the locality. Also, a Complex Needs professionals' group meets regularly to discuss system, client and provider issues and identify solutions [and] a Bluelight collaborative conference call problem-solves when a person may be at risk of being removed from their home. Care and Treatment reviews are supported by (i) people with lived experience and (ii) clinical experts. These determine whether a person is safe and that a good treatment plan promoting discharge is in place. Across Devon, training is taking place to establish a bank of staff who can lead and develop individualised planning with individuals and their families.

87. Other ex-Atlas commissioners reported similar developments. In addition to contract review meetings and monitoring, Bath and NE Somerset commissions a minimum annual review of all individual placements. It operates a "single panel process…to ensure good practice is evidenced [and that] budgets are controlled and monitored." Also, its oversight of young people with challenging and complex needs is facilitated by regular meetings with children's commissioners. West Berkshire Council is managing and developing places within its commissioning area through annual reviews, care quality visits and contract management. Wiltshire Council reports that commissioning leads are identifying "gaps in the market… [and assessing] individual placements. It uses provider forums, joint commissioning boards, joint strategic needs assessment and has a strategy for Learning Disability and autism. The Royal Borough of Windsor and Maidenhead similarly has a multi-disciplinary approach to reviewing, monitoring and working proactively to support people to remain living locally. The development of its Intensive Support Service is ongoing, and the Borough is working with neighbouring councils and the CCG to build, manage and develop placements locally.

88. The Care Act 2014 requires local authorities to: "(a) keep under review generally care and support plans, and support plans, that it has prepared and (b) on a reasonable request by or on behalf of the adult to whom a care and support plan relates or the carer to whom a support plan relates, review the plan."[44]

[41] Section 53

89. In addition to these requirements, commissioning authorities acknowledge the influence of the Transforming Care programme.[42] Devon County Council confirmed that risk assessments are carried out where "urgent need" is evidenced. Its repatriation programme is regularly reviewed and monitored by the Quality Assurance Consultant Nurse for Learning Disability and Joint Commissioner for Learning Disability. Social workers undertake social care reviews with multi-disciplinary team involvement. NHS care coordinators invite social workers to attend the reviews of Continuing Healthcare Funded people [Plymouth City Council]. South Devon and Torbay CCG host six monthly Care and Treatment Reviews for inpatients with representation from the care coordinator, the provider and independent "expert by experience" and independent expert clinical lead. Torbay and South Devon NHS Trust reported that it was reviewing on a home by home basis and aligning these with CHC reviews.

90. Elsewhere, Bath and NE Somerset has a Risk Register identifying the people at risk of hospital admission. The Royal Borough of Windsor and Maidenhead's care reviews were "in line with need" and more frequently "if there are concerns." People from Surrey who are placed in SW England are allocated to a single care team to enable more coordinated assessments and social workers accompanied CCG staff at Care and Treatment reviews. Wiltshire Council has a review team…and its guidance promotes "every contact counts." Also, commissioners worked with the providers, the contracts team and discussed safeguarding matters [Wokingham Council/ CCG].

91. Having **a system for bringing together information about care homes for commissioning purposes** – without risk of litigation - is a long-standing aspiration of commissioners. Before 2013, most commissioning authorities placing people with learning disabilities and autism cited the CQC's inspection reports. For example, these "are automatically sent to the Safeguarding Team for scrutiny…interventions are then put in place where required" [Bracknell Forest Council]. Tools and processes were described such as Devon CC's Risk and Sufficiency Profiling Tool; the Care Treatment Review process [NEW Devon CCG]; the QA Framework [Plymouth City Council]; the work of a Contract and Monitoring Team [Royal Borough of Windsor and Maidenhead], a Quality Assurance Team [Devon CC], and a Care Quality Team [West Berkshire]. Reference was made to meetings of the South East ADASS Learning Disability network [Surrey CC]; and to Quality Surveillance [Wiltshire Council].

92. By 2018, having relied on the review of the care and support plan to monitor the performance of services, Devon CC remodelled its Quality Assurance and improvement procedures and "all available intelligence" is used to produce a provider quality/risk profile. A Devon, Plymouth and Torbay review of all placements has been undertaken. The overarching intention is that people will be supported to live in their own homes. Residential and nursing care will only be used when people can no longer be supported. Supporting people to acquire skills so that they may have fulfilling lives and providing timely information

[42] https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf (accessed 1 March 2019)

and advice to individuals and their families are at the heart of a Joint Commissioning Strategy.[43]

93. Across Devon, Torbay and Plymouth an analysis of the range and cost of service provision for people with learning disabilities, backlit by population projections and prevalence information, has identified gaps and such priorities as ensuring a sufficient supply of community-based provision for young people in transition.

94. The supported living and residential care markets are changing as a result of national investors purchasing care homes for deregistration to supported living for example. The model involves leasing the properties to registered housing providers with care companies delivering the necessary support to individuals. Devon CC's market oversight involves ensuring alignment with its Joint Commissioning Strategy. In addition, it is placing fewer people in care homes; developing (i) a model of housing with care to meet people's changing needs over the lifetime; (ii) accommodation with new providers; (iii) a more flexible, Carer Households/Shared Lives offer;[44] supporting providers to reconfigure their business models in favour of supported living for example; seeking to increase the supply of accessible housing in collaboration with health, social care, housing authorities, District Councils and local communities; and it is refreshing its Market Position Statement.

95. Plymouth City Council's integrated commissioning team has contract monitoring systems in place, multi-agency forums, system design groups and market oversight processes which are attentive to service quality. Market development through the Transforming Care Partnership is underway to enable people to return from Out of Area placements. It is seeking to develop the skill base and improve recruitment and retention within provider services and improve the sustainability of commissioned support to people with complex needs. It has a Positive Behaviour Support network.[45]

96. Bath and NE Somerset relies on contract review meetings with local providers, contract monitoring and liaison meetings with the CQC. It uses a Joint Strategic Needs Assessment to inform its projections of future need. West Berkshire Council's Care Quality Officers visit providers and a review team conducts the scheduled annual reviews and unscheduled reviews. These include assessments of the quality of care. Wiltshire Council has convened a Transforming Care Partnership[46] Board to gather feedback from CCG funded hospital inpatients. The Royal Borough of Windsor and Maidenhead is reviewing its commissioning arrangements. A Joint Operational Group meets on a monthly basis to review the action plan to develop more local provision. A Berkshire-wide Intensive Support Service has been developed resulting in "a reduction in the number of in-patient assessment and treatment hospital beds." The Borough and CCG were successful in bidding for NHS capital funding to

[43] *Living well with a learning disability in Devon 2018-2021*

[44] Shared Lives supports people from 16 years to live in a family environment

[45] https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf (accessed 12 May 2019)

[46] Resulting from the Winterbourne View Hospital SCR

purchase a property in Berkshire to support "people who were living in an in-patient hospital bed ensuring that they can continue to live locally."

97. All commissioning bodies had **contract monitoring systems and processes** in place in 2017. Although there were reviews outstanding and challenges in monitoring the performance of over 400 providers, the Acute Trusts were carrying out care and treatment reviews [Devon CC and NEW Devon]. NEW Devon used a dynamic risk register alerting it to the providers supporting people with complex needs. Plymouth City Council's Quality Assurance and Improvement Team worked with the CQC in undertaking "quality reviews" and the Trust arranged, quality assured and monitored placements [South Devon and Torbay CCG]. In Bath and NE Somerset "Quality Checkers" - adults with learning disabilities - assist with monitoring and review" activities. The Royal Borough of Windsor and Maidenhead's Quality Assurance Team monitors in-house and out of area placements and in West Berkshire a Care Quality Team led reviews and responded to concerns about service quality.
98. In the light of Atlas' inattention to the **Deprivation of Liberty Safeguards** and the House of Lords Select Committee on the Mental Capacity Act 2005,[47] most commissioning authorities have invested in Mental Capacity Act and DoLS training programmes as a means of ensuring that people's human rights are not infringed. Accordingly, DoLS applications feature in contract monitoring.
99. An array of overarching arrangements was in place to strengthen the scrutiny of contracts and escalate emerging concerns. These included appointing Practice Lead professionals; conducting "whole home reviews," hosting governance board meetings and meetings focusing on safeguarding referrals, complaints and improvement actions. Also, posts have been created with specific responsibility for care homes supporting people with learning disabilities and domiciliary care home providers.
100. So in 2018, there is **new specificity in contracting** most particularly in re-contracting services for people with learning disabilities and autism. Devon CC reported that it aspires to people having access to short term services that promote a return to independence. Its recommissioning exercises resulted from the suspension of new placements and/or cancelling contracts, even though it is not easy transferring people from one service to another. Devon CCG's work involves writing outcome statements for each individual which are reviewed by senior operational managers. Devon's Transforming Care Partnership has started an independent quality review programme which seeks assurance concerning In and Out of Area Locked Hospitals. It is intended that the results of this will inform commissioning arrangements.
101. A 2018 review of commissioning processes for people with learning disabilities revealed a a wide range of innovative approaches according to the Review Panel. NEW Devon CCG's decisions to re-contract are made on an individual placement by placement basis, unless there are safeguarding/quality concerns. These require formal contract management processes for high cost placements and escalation for CCG approval is always required. Placement proposals are considered by a Quality Assurance Lead Nurse with knowledge of

[47] https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

the local market and area. Where the QA lead nurse does not believe the placement would be appropriate, they will seek clarification/challenge the proposed placement. In Torbay, the QA process is undertaken by the local specialist teams. Plymouth and Torbay's model of contracting enables flexibility and client choice. Torbay Health and Social Care has coproduced a Supported Living Service Specification and framework with 14 providers successfully appointed. These providers offer assured short hold tenancies to people placed.

102. Plymouth City Council shares care plans with providers and requires higher levels of assessment and fuller explanations from providers seeking to support people with more complex needs. For supported living services, Plymouth has awarded longer term contracts which are reviewed by health/social care staff at appropriate intervals and packages adjusted to meet changing needs. These are considered more appropriate and support market stability since they enable the retention of specialist provision. Its integrated commissioning takes account of, whether the organisation or senior person had been convicted of criminal activity; grave professional misconduct; the adequacy of economic and financial standing; technical and professional ability; insurances; Health and Safety; equality and diversity; quality management; data protection; contractual disputes; business capability, including evidence of experience of delivering the service in question; safeguarding compliance;[50] and where individual packages are being placed with organisations; individual clients will be offered a choice of service provider where this is exists.
103. Elsewhere, West Berkshire Council has spot contracts with local providers of respite and short-term care. It notes, "if a provider meets our care quality standards for accreditation, we will continue to contract with them. For block contracts it will be as per tender." Wiltshire Council states, "If someone is on a short-term contract there is always a plan to try to bring them back to county… if a provider is not red alert and is accredited, we will re-contract…the CQC and other LA input will also be sought." The Royal Borough of Windsor and Maidenhead "utilises the full range of expertise to design contracts" and "…it works with partners to define the specification…to ensure they are fit for purpose…the dataset…[to be] reported by providers are agreed prior to the start of the contract in order to track that services meet the intended outcomes for the population." Bath and NE Somerset audits and analyses information from its contract and quality monitoring, safeguarding activity and outcomes, CQC intelligence, compliments and complaints information, suspensions and restrictions information and information from the risk and contingency planning register. The Royal Borough of Windsor and Maidenhead uses, contract monitoring information to inform its view of the performance of providers. "If provision is viewed to meet at least the expected terms, it may be extended for a fourth year on a three-year contract…any current provider is expected to compete alongside other providers, regardless of how well they have delivered the contract."
104. In order to manage and develop placements**,** a number of themes emerge in the work of commissioning bodies: their vision of enabling people to be part of their communities; working with individuals, their families and providers to promote diversification and reduce reliance on residential provision, most particularly for younger adults; forecasting future

support needs; and understanding the implications of service ownership and management for people's lives. For example:

1) Investing in a purpose-built, multi-occupancy home with three individual front doors to provide short term, intensive support before people move into their own homes
2) Fortnightly updates are received on people moving back to Devon
3) A Provider Development Plan is a self-assessment undertaken with providers about their ability to promote the independence of people they support. It is a tool to support shifts in models of care, describing how the business will change and how they will support the workforce
4) Progressing a more flexible Carer Households/Shared Lives offer of accommodation, care and support provided in the family homes of carefully selected, trained and supported Shared Lives carers. This may provide short term respite or the longer-term promotion of independent living skills.
5) Working to increase the supply of accessible housing to support people to live independently. This work includes improving health, care and housing collaboration and being involved in local housing and planning
6) Working to ensure that our funding models support personalisation.

105. Finally, since the health of Atlas residents did not appear to have been prioritised, in 2013 the SCR recommended that **Healthwatch England** [48] should have a role in providing independent scrutiny on the quality of care of services. This and other forms of advocacy were shaping practices in 2017, by which time, most commissioning authorities reported having designated **lead safeguarding professionals**.[49]

[48] https://www.healthwatch.co.uk/what-we-do (accessed on 13 December 2018)

[49] See NHS England (2015) *Safeguarding Vulnerable people in the NHS: Accountability and assurance framework* Leeds: NHS England

Section 6: Analysis

106. When the SCR was commissioned and ready for publication in 2013, it was not envisaged that it would take five years for the trial of the Atlas directors and employees to begin. Although that review could not take account of the perspectives of Atlas' residents or their families, it revealed that the fundamental shift in commissioning anticipated by "Valuing People" and "Valuing People Now" (Department of Health, 2001; HM Government 2009) had not impacted on their lives.

107. The Care Act's new provisions concerning safeguarding would suggest that the test of safeguarding and scrutiny processes is their responsiveness to the allegations of people with learning disabilities and autism, their families, visiting professionals and whistle-blowers. The former Atlas commissioning bodies have processes in place which, in 2018, they assert are more responsive to the allegations arising from people placed out of area. In order that people making a complaint do not feel disadvantaged, perhaps the interface between **complaints and safeguarding** requires attention if the safeguarding procedure is invoked on behalf of an individual making a complaint.

108. The Care Quality Commission's "Registering the Right Support" (2017) is policy guidance on registration and variations to registration for providers supporting people with a learning disability and/or autism. It covers the new and changed registrations of care homes, specialist hospitals and supported living. It serves to regulate the types of services required in the community as result of closing inpatient hospital beds and is based on principles for commissioning good services, that is, "quality of life, keeping people safe, and choice and control."[50] **The CQC is responsible for ensuring that homes remain true to their stated purpose.** The regulator has undergone many changes since the end of the Atlas trial. As the CQC's Chief Inspector of Adult Social Care noted on 7 June 2017,

> "When CQC inspected Veilstone in October 2011, inspectors were so concerned by the treatment they discovered that they quickly extended the inspection to all 15 of the services run by Atlas. We found serious concerns in most of their care homes, including the routine use of excessive restrictive practices which is why we took action which led to the closure of all of these services in 2012.
>
> Much has changed since 2011. When these abusive practices were discovered, CQC took decisive action but we should have responded more quickly to the concerns raised earlier by someone using the service. Since then we have overhauled our regulatory approach; improved the monitoring of services and the way we respond to safeguarding concerns; introduced a new and more thorough inspection process; increased the numbers of people with learning disabilities involved in our inspections; and strengthened our enforcement processes. We have also worked with The
>
> Challenging Behaviour Foundation on the issue of restraint and we now subject

[50] This is used by CQC's inspection teams to ensure that the fundamental principles of care are followed in services for people with learning disabilities and/or autism. Also, inspections focus on consent to care and treatment with particular reference to the Mental Capacity Act and the Deprivation of Liberty Safeguards

services where staff frequently resort to restrictive interventions to much tougher scrutiny than we did five years ago…"[51]

109. The CQC's work with the Challenging Behaviour Foundation is significant. The CBF asserts the importance of involving in reviews and inspections those families with experience of reordering their priorities to manage the additional demands arising from their relatives' challenging behaviours.[52]
110. All commissioning bodies are immersed in efforts to "shape" the market to reduce the likelihood of people across the life span being moved away from their areas of origin. These are significant developments. Commissioning authorities very much wanted **a mandatory notification system** which would advise a local authority that an adult with a learning disability was to be placed. There is a continuing case for commissioning bodies to fund "host" authorities to undertake essential monitoring, supporting via community services, reviewing and safeguarding processes. Notification by placing authorities should encompass information concerning a person's support needs, including their physical health status since this impacts on local generic and specialist services.
111. Although the terminology varies across the commissioning bodies, they all seek to assure the quality, and effectiveness of commissioned services. The activities are not totally independent of resident reviewing processes, but they differ in terms of purpose, focus and personnel involved. Most commissioning bodies have policies and processes that govern monitoring. The results of monitoring, in hand with residents' reviews, are being used to modify or terminate contracts. Devon has invested in dedicated contract monitoring and relationship officers to work with providers in delivering the outcomes for people set out in their care and support plans. They link with the Learning Disability Partnership Board to ensure the voices of people and their families inform and influence commissioning arrangements. The Devon Specialist Placements Team reviews all out of county placements, carries out face to face meetings the person and the provider. Where possible and appropriate, the person's family and/or advocate are also involved in or consulted on how the provider is meeting the person's complex needs. The Team also conducts unannounced visits. The Intensive Assessment and Treatment Teams or the Continuing Healthcare Teams undertake targeted multi-agency support and interventions - including reviewing.
112. The creation of a system for collating **information about care homes** would be complicated – dovetailing the procedural requirements of adult safeguarding with inspections, resident reviews, contract compliance monitoring, professional regulation, law enforcement, complaints and clinical governance. John Kennedy's[53] challenge is pertinent:

[51] https://www.cqc.org.uk/news/stories/cqc-statement-conclusion-atlas-project-trials (accessed 2 February 2019)

[52] On 21 May 2019, the CQC published an interim report, "Segregation in mental health wards for children and young people and in wards for people with a learning disability and autism" as part of a thematic review concerning the use of restraint and long-term segregation in health and social care locations

[53] Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

"Care homes don't and cannot work in isolation: they are in a system. Doing more to them from above won't improve care – it hasn't up to now. Likewise, the inspection system can't, on its own, improve care; it can only tell us what it is measuring. In order to improve the status, consistency and quality of care, we need to make sure that the system supports care homes as well holding them to account."

113. Devon CC, Torbay and Plymouth hold providers to account by setting out expectations in "Living Well with a Learning Disability in Devon." This is premised on:
    1) effective working relationships with providers and commissioners
    2) trained support staff, e.g. training in Individual Service Designs and Positive Behaviour Support and focusing on personalised outcomes which are based on real-life examples
    3) the delivery of valued, safeguarding-conscious and respectful services 4) listening to people and their families about the care they are receiving 5) understanding what good looks like.
114. There are many individuals and teams across health and social care responsible for people in local and out of area placements. **Care Managers** are at the sharp end of commissioning. They are responsible for assessing people's care and support needs and (including those of carers), negotiating the content of a care and support plan - and its oversight. It is the oversight of these lead professionals, their functions and accountability that are critical. They must have clear goals which hinge on understanding the aspirations of people with learning disabilities and their families for ordinary lives. Their role is to understand each family's context and negotiate interventions accordingly. It is important in shaping the contributions of all agencies to set out a vision of the opportunities and support which should be available to people over the life course.
115. There has been progress in ensuring that, in the event of crises, adults with learning disabilities and autism are not placed out of area. Unscheduled reviews, quality monitoring visits and feedback from residents for example are addressing the wish of six families that there should be more contact and more person to person contact with their relatives. Although reliance on CQC reports is undiminished, commissioning authorities' processes and procedures are more attentive to the quality of provider services and the risks associated with particular placements than they were in 2013. The reach of their work underlines the fact that responsibility for the quality control of residential provision cannot be transferred to the provider.
116. However, in the light of six families' experience, the processes and reporting systems described would provide greater reassurance if it could be demonstrated that:
    - individuals who are known to have been harmed or were at risk of harm at Out of Area placements, and/or their families, have been involved in their development
    - the commissioning bodies have evidence that their processes/reporting systems are reducing variability between practitioners in the same authority, and
    - are assured that their processes/reporting systems are indispensable to effective and timely action when allegations of people with learning disability being harmed come to light.

117. The time perspectives of all commissioning authorities are relevant to people placed out of area. It is during the post-award period that poor contract performance is likely to emerge. The test of a contract is how residents and their families experience a service and engage with employees at all levels. Although no commissioning body challenged the necessity of swift intervention, it cannot be asserted that a single process or hierarchy of processes has the most promise in ensuring people's timely protection. There remains an urgent need to reconsider the continuing use of Out of Area placements to localities where:
    a) the commissioning bodies outsource the reviewing processes to the host authority
    b) the importing host authority does not use the residential service as readily as commissioning authorities in other parts of the country
    c) there are no guarantees that GP practices, for example, have the capacity to proactively assist in promoting people's health care
    d) the capacity of host authorities to use notification data and hold providers to the specifications set by the placing authorities is not known
    e) people's families may experience severe difficulties and even financial hardship in remaining in contact.
118. The six families which contributed to this review would seek assurance that inspection, reviewing and scrutiny processes are led by specialists, are intrusive when required and responsive to their own life-long advocacy. They had no significant role in reviewing their relatives' care. Atlas' resistance to family contact had direct relevance to its support of residents. At least one psychiatrist stated that the "broken" relationship with one family negatively impacted on their relative's care plan. The commissioning bodies should consider "testing" their systems to determine how a family might challenge a psychiatrist who appeared duped by Atlas's employees.
119. Guidance in the *Deprivation of Liberty Safeguards Code of Practice* refers to examples of the factors that should in general be considered by decision-makers in considering whether an act taken or proposed may amount to a deprivation of liberty. These include such questions as:

    > *What measures are being taken in relation to the individual? When are they required? For what period do they endure? What are the effects of any restraints or restrictions on the individual? Why are they necessary? What aim do they seek to meet? What are the views of the relevant person, their family or carers? Do any of them object to the measures? How are the restraints or restrictions implemented? Do any of the constraints on the person's personal freedom go beyond 'restraint' or 'restriction' to the extent that they constitute a deprivation of liberty? Are there any less restrictive options for delivering care and treatment that avoid deprivation of liberty altogether? Does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?*

120. Since the punitive purposes of the benign sounding "quiet room" and "garden room" were not known to the commissioning authorities or the CQC, and their use was not recorded, the Code of Practice and the associated processes were untested. This underscores how

imperative it is to work with people's families whose presence in the home as visitors is likely to exceed that of any inspector, contract compliance monitor or reviewer. It is unlikely that visiting relatives would be familiar with the scrutiny arrangements of the commissioning agencies. The onus is on all professionals to demonstrate their responsiveness to potential breaches of people's Human Rights. The trial's findings of unlawful detention in "seclusion" at two Atlas homes may usefully feed into future training concerning DoLS. Although commissioning bodies are responsible for checking the service to an individual - the provider remains responsible for supplying what is contracted for in the care plan within the law and regulations under which they are governed.

121. Paul Hewitt's influence and hands on approach was familiar to families. Atlas was not a oneoff aberration. It was right that the Hewitt family company was subjected to legal scrutiny. However, families' perception of fairness and accountability was undermined by the slow pace of the legal response. The restorative power of speaking out about the implications of their relatives' deterioration was denied to them by **the trial**. In law, company directors have separate and collective responsibility for the management of their company. They have specific statutory duties to exercise independent judgement, reasonable care, skill and diligence.
122. Many developments and considerations are now brought to bear on re-commissioning support. However, these must be viewed against an enduring backdrop of insufficient (i) local provision for adults with complex support needs and (ii) accommodation and support.
123. The experience of Atlas residents concerning primary care is not known although some did receive emergency treatment. It is known that when people with learning disabilities seek help from their doctors and primary care teams, they are very reliant on the knowledge and support of the people who accompany them. It appears unlikely that prior to the 2013 SCR that health promotion activities were available to Atlas residents. Some commissioning bodies acknowledged that they were inattentive to people's health promotion needs, health prevention screening, nutritional habits and lifestyles. A specialist primary care role is a significant investment in the light of the pressures placements made from outside a local authority create for community services.

Section 7: Learning

124. The six families who have contributed to this review have provided a remarkable analysis of the shortfall between the trial process and their experience. Because the prospective trial had kept them apart, they were unable to locate their experience within the testimony of others with similar or parallel experience. Theirs was not just an indictment of the Atlas homes but of an ineffective and inefficient means of commissioning services for the minority of people with learning disabilities, autism and mental health problems. Almost 20 years after the publication of "Valuing People" there were no real options for their relatives other than geographically remote "placements." They could identify no one who was sympathetic to their growing unease that their relatives were at risk of harm or understood that their relatives' behaviour gave expression to trauma, being dislocated and the absence of any sympathetic understanding. Atlas' Directors, managers, staff and clinicians dismissed their questions and allegations. Although the trial determined that Atlas residents had indeed been subject to false imprisonment, it was harmful for families to hear the behaviour of their distressed and traumatised relatives presented as the rationale for the criminal behaviour of Atlas Directors and employees. Their experience is a bracing indictment of the remote commissioning of isolated, specialist, Out of Area placements and a criminal justice process which they do not believe recognised the humanity of their relatives. There are rarely tidy endings. Assurance of improved ways of engaging and working with people with learning disabilities and their families cannot be evidenced from an emphasis on process-driven approaches. Families are not wholly enthusiastic about attentive, if belated, support for their relatives. Services' failures are raw – most particularly when families' questions, doubts and experience were discounted.
125. It has been challenging for the Review Panel members to read about six families' experience and ideas. They had hoped that ex-Atlas residents and their families would have benefitted from their own, firm commitment to offering them all something better and indeed their knowledge of current provision available to the ex-residents known to them. To different degrees, the hurt, disorientation and anger of families is a defining feature of reviews. The complexity and difficulties described by the families weighed heavily in the Review Panel meetings. The six families had sought feasible anonymity and yet willingly assisted when the Review Panel requested information about the names of particular professionals. Although it is outwith the Terms of Reference to detail the ex-residents' current circumstances, the Review Panel shared information about two people's lives post-Atlas which it stated evidenced "their vastly improved lives." Their commissioning bodies are regularly briefed about the detail of their vastly improved lives. The Review Panel regrets that its engagement with all other commissioning bodies has not resulted in confirmation of significant improvements in the lives of other ex-Atlas residents.
126. Language is a way of organising the world. Commissioners have their own language to describe aspects of their work, but their language is not used by people's families. There is a case to be made for being true to the world view of families and using shared language.

127. Atlas provided personal/domiciliary care to a single citizen, in their own home. This service was an addition to its portfolio of residential care homes. It appears anomalous that a location which is registered with the CQC may add services such as domiciliary care by "variations" through a notification rather than via a separate application. The onus was on Atlas to satisfy itself that it could deliver domiciliary care – even though it was not registered to do so. The CQC only intervenes if a notification gives cause for concern which may trigger a safeguarding referral and/or an inspection. The considerable faith that the commissioners of Atlas services had in CQC inspections was unmerited. The inspectorate itself acknowledged that it had "limited provider-level intelligence;" its approach to inspections was inconsistent; the findings of inspectors conflicted with those of commissioners; it did not challenge Atlas' inattention to action plans; some inspectors were unable to communicate with residents; and it is not clear that notifications of significant incidents were followed up. The six families believe that such a system requires shaping by people with first-hand experience of the type of specialist support that the inspected service claims to provide. They want transparency about how the specialism impacts on care delivery and the qualifications and experience of managers and staff. From their perspective it does not appear that high cost, out of area services for people with complex support needs merits searching scrutiny above and beyond that provided by the host locality. It does not appear that the possibility of risks which result from the type treatment offered was ever considered.
128. The ambitions of values-based commissioning [54] signalled part of the search for more efficient ways of closely connecting individual care and support needs with service commissioning – most particularly since there is too much distance between commissioning/place-hunting and people's person and relationship-centred plans. The Department of Health's Transforming Care Programme (costing over £10m - end date March 2019) has not delivered the promised reduction in reliance on inpatient care following the Winterbourne View Hospital scandal.[55] There can be no role for adult safeguarding in remedying the shortcomings of strategic planning, commissioning and inspection practices.

[54] Heginbotham, C. (2012) Values-Based Commissioning of Health and Social Care, Cambridge: Cambridge University Press

[55] During October 2018, NHS Digital confirmed that there were 2,350 people with learning disabilities and/or autism in inpatient units; 250 of these people were under 18 years; there were 125 admissions during October 2018; and the average length of stay in these units is five years and four months

Conclusions

129. Necessarily a review provides a view from a distance within a timeframe. This review presents the findings from a review which was completed during 2013 and it has provided an update.
130. How many specialist services for people with learning disabilities and autism are known to be operating efficiently, where all parties express their content and there is consensus about the future of the whole service system? The 2013 SCR stated that the task of commissioning services for adults with learning disabilities and autism with "complex and/or challenging behavioural needs" merited "tighter systems…[and] outcome-based contracts." At that time, monitoring was under-developed and under-resourced. It noted that there was, "some lack of clarity regarding the responsibilities of the host authority's role with Out of Area placements…" There is still no mandatory notification system concerning people being imported to a service and this warrants attention – most particularly when the "host" commissioning bodies themselves do not refer people to the same service.
131. However, in 2018, there is encouraging evidence of improved approaches to assessing the efficacy of services. Reviewing the circumstances and progress of individuals is a principal means of detecting problems. People with learning disabilities and their families have a crucial role in alerting commissioning bodies to the extent to which specified services are provided.
132. Neither the 2013 SCR nor this SAR concerning the harms endured by the former residents of Atlas' homes include the provider perspective. Atlas' legitimacy arose from the Paul Hewitt's association with the 1993 Mansell Report. However, the culture of Atlas ceased to be credible when it became unresponsive to residents, their relatives, the professionals who questioned its adherence to behaviour modification and non-negotiable weekly costs. It became "inward looking." What is missing in this review is the company's rationale for the succession, governance, estate planning or plans for managing transitions, including that of creating a domiciliary care service within this family business. There appeared to be nothing in place, neither commissioning processes nor questioning shareholders, to apply brakes to what appeared to be an increasingly autocratic business which was resistant to change. Atlas' demise and the associated damage highlights two factors which merit scrutiny, the continuity of values over time in a family business and reputation – Atlas' reputation had outlived its credibility.
133. The six families had struggled to persuade anyone that emergent problems at Atlas principally resided with Atlas and not their relatives. The criminal trial itself perpetuated this myth. Although the families who shared their experiences with this review have made profound contributions to their own families, caring, adapting and continuing to provide their relatives with love and support, their expertise was not and, for some, still is not recognised as foundational to valued service delivery. Processes that are vulnerable to lapsing into formula such as "monitoring" for example, have a poor track record in terms of revealing a service's operating deficiencies.
134. Families very much want **care managers** to be familiar with each person's position in the life course, their own experience of providing and seeking assistance for their relative, and the critical transitions they have faced e.g. securing post-parental care. Only continuing, complex

case management ensures that a family's experiential knowledge is valued – including their experience of visiting their relatives' services. Continuing contact with their relatives is too important to be denied. Services' calendars must be subordinate to those of all families, most particularly those with long distances to travel. They require information about the implications of their relatives' funding – its source and characteristics – which they do not have to request. The contact details of the lead commissioner should be shared with all families, most particularly as individuals and organisations change.

135. The Public Services Social Value Act 2012 requires the commissioners of public services to have regard to how social, economic and environmental benefits might be realised. The six families identified nothing that is value creating about the experiences of their relatives when they were residents at Atlas. Unless the social value of commissioning is rooted in people's real-time experience, it is compromised. Out of Area placements are demanding for families who may not be able to maintain regular and routine contact. The six families described appalling successive placements - this is not suggestive of a vision of public value commissioning which is responsive to a sustained dose of real time feedback from them.
136. The work undertaken by commissioners since the revelations at Atlas warrant a number of conclusions. Commissioning necessitates partnerships – with people with learning disabilities and autism, with families, with partnership boards, local authorities, housing and providers. Case management is at the sharp end of commissioning. The former Atlas commissioning bodies in Devon describe a greater readiness to feed information about individual residents into their reviewing and oversight roles than at the time of that the services were exposed as harmful.

Recommendations

137. The following recommendations complement those of Mendip House.[56] They were developed at the 3 July 2018 Review Panel meeting.

138. Devon's Safeguarding Adults Board should:

i. recommend that the Department of Health, NHS England and the Local Government Association

- incentivise commissioning bodies to engage in "close to home" Regional Commissioning for adults with learning disabilities, autism and mental health problems – a small population whose needs are not being met locally - and determine, for example, how much support at home, supported living, housing with support, care home, care home with nursing and assessment and treatment is required pro rata
- assert a new requirement to discontinue commissioning placements at (a) residential services which would not be registered by CQC in line with 'Registering the Right Support'[57] policy and (b) placements which "take anyone"
- make mandatory the notification by commissioning authorities of prospective placements to the host authority
- assert the requirement for specific funding for essential monitoring, reviewing and safeguarding should this be necessary; and for residents' access to local health services, most particularly community health services

ii. commend the replacement of episodic/once a year reviews with continuing, complex case management with a strong advocacy role. This should be trialled for all former Atlas residents

iii. incentivise the creation of a repository of "intelligence" about providers which is accessible to commissioning bodies. This should include a company's response to complaints, inspections and compliance matters. This will require funding if good data from all parts of the system is considered on a continuous basis (see Section 3 for ideas)

iv. ensure that people receiving specialist care must include their health, wellbeing and need to be protected from harm and danger is explicit in enforceable, individual contracts and support plans (see Section 3 for ideas)

v. review impact on corporate governance of the care of large numbers of adult residents and the public sponsorship involved [58]

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[56] https://ssab.safeguardingsomerset.org.uk/ (accessed13 December 2018)

[57] https://www.cqc.org.uk/files/services-people-learning-disabilities-registering-right-support-0 (accessed 1 August 2018)

[58] Griffiths *et al* (2015) propose that because the corporate duty of directors is to their company, companies owned individually and collectively by a family, independent, non-executive directors should comprise 50% of their Boards. Section 12 "In Search of Accountability" Welsh Government

vi. promote proceedings under the Company Directors Disqualification Act 1986 are considered when residents are harmed and a company's inattention to outcomes for them is recurrent.

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Appendix 1: Information Shared with the 2013 SCR

The following nine Tables set out the information shared by the commissioning bodies associated with Atlas' homes for the 2013 SCR.

Table 3: Commissioning and contracting arrangements

Agency	January 2010-11
Bath and NE Somerset	The commissioning intention was to support people to live in their own homes rather than commission registered care. Also worked with schools and colleges to avoid Out of Area education placements which can lead to residential placements
Bracknell Forest Council	The Joint Strategy states that people will be supported to move from residential care homes to their own homes within the community of their choice. The Council does not support transfers to residential care unless this is in line with their wishes or where there are "specialist" needs and there are no local options. The council notifies host authorities when people are moving; the Council has not always been informed of the outcomes of annual health checks - and was not for the individual at Atlas; the ASC practitioner is responsible for assessing the ongoing suitability of a placement with the individual, the family, support network and other relevant professionals. The Council has a generic contract. A Service User Agreement and support plan specifies the requirements and outcomes for each individual. The contract standards and individual outcomes are monitored via the review process by the ASC practitioner
Devon NHS and Devon CC	It was a *demand led* process of matching individuals with a provider. There was no process to determine success. Devon did not have an accredited list of providers…CHC arrangements tended to check for eligibility for funding rather than quality of placements…placements had to be cost effective
Plymouth City Council	In April 2012, there were 34 Out of Area placements in care homes. Pre2011, reviewing was undertaken by SWs/ operational teams…did not need to place out of the city. Post 2011, SWs required commissioning approval before placing Out of Area
S Devon and Torbay Shadow CCG	There were no measures in place to monitor the effectiveness of commissioning. Pre-placement support plans were developed with families, providers were suggested by the AST and CLDT – based on knowledge of track records and previous family feedback…the CLDT reported difficulty in identifying suitable providers for people with complex needs

Surrey CC	Following assessment or review, practitioners referred people with Learning Disability to the commissioning team…providers were contacted. The providers made their own assessment and the fee was negotiated with the commissioning team
Torbay and S Devon Health&Care NHS Trust	There was no strategic plan for commissioning care home services for people with LD, especially the hard to place…wanted to reduce the use of care home services and move to supported living. Commissioning based on availability and local knowledge…relied on host authorities' contracts and safeguarding to be aware of concerns about providers, plus CQC inspections. Options in area were likely to be based on experience or consultation with the AST. A pre-placement checklist was being used**.** There were no mechanisms for measuring the success of Out of Area placements – processes focus on the individual. *This was clearly flawed in the use of Atlas…*services have to be challenged and monitored and the relationship cannot be too comfortable. With few providers, they may *have a strong hand in the relationship*
W Berks Council	SW undertook initial assessment and consulted with Contracts and Commissioning about availability. If Out of Area, the view of the host LA was sought. The provider would undertake their own assessment. Annual reviews would identify matters about the placement and practice. The Care Quality Board informed ongoing and future commissioning decisions
W Berks PCT Quality Team	The relationship between CM and commissioning assurance
Wokingham BC	Placements were made *on CMs and managers knowledge and experience. Re Atlas, these placements were inherited as a result of transfer responsibilities from the NHS.* Success was determined by *how well the person settled…*family, provider and CM feedback. *In hindsight…Atlas were very well versed in controlling contact between Service Users and their families and at getting the families 'on side.' This was demonstrated by the difficulty we had extracting people from Atlas and gaining family cooperation…*

Table 4: Agencies' involvement with Atlas

Agency	January 2010-October 2011
Bath and NE Somerset	The People and Communities Department included a Learning Disability commissioning and contracting service, led by an Assistant Director with lead responsibility for joint commissioning across health and social care. The majority of residential placements were "spot purchased" using a generic care homes contract. Out of Area single placements were monitored via the individual care management review. Social Work/Care Management reviews were carried out by Sirona Care and Health via a contractual arrangement with the Council
Bracknell Forest Council	The council had a joint strategy with the PCT. Commissioned services follow comprehensive assessments and may include…specialist healthcare assessments. The resulting support plan is reviewed 6weeks after implementation and 12 months thereafter. However, the frequency of review is likely to be greater where there has been difficulty in identifying an appropriate support arrangement. The CLDT and the Challenging Behaviour Advisor are instrumental…in identifying suitable services. The Council supported one person to move to an Atlas home in Devon in 2000. It was one of the last actions of a longstay hospital closure programme…there were no concerns identified until 2010
Devon NHS and Devon CC	The CC and NHS jointly commissioned services for people with LD. An individual service contract sat under an agency agreement. The Care Management system generated a payment process with the provider. Placements were monitored via individual reviews
Plymouth City Council	Pre 2011, commissioning was undertaken on an ad-hoc basis by social workers with little checking of policies and procedures before placement. During 2010/11 all Out of Area placements had started to be reviewed by the commissioning team. Social workers carried out annual reviews
S Devon and Torbay Shadow CCG	Provided time-limited, specialist advice and support to the CLDT via the Additional Support Team (AST). Overall monitoring, including safeguarding, was provided by Torbay and S Devon Health&Care NHS Trust. The Devon Partnership Trust had oversight re Individual Patient Placements. The Trust was *part of a larger MH contract for which NHS Devon was the lead commissioner and NHS Torbay the associate.* The Additional Support Team ended its involvement with Atlas once the placements were made

Surrey CC	Had a commissioning team for people with Learning Disability which worked with the central procurement department and *key strategic providers.* Locality teams were responsible for reviewing and monitoring. Once a placement was agreed an individual placement agreement was signed and required outcomes were monitored by the nominated practitioner
Torbay and S Devon Health & Care NHS Trust	Had a programme to change the way in which its services were commissioned using the Any Qualified Provider (AQP) contract. Outcomes *are defined in co-production…placements which cost over £1k a week are monitored and approved by the complex care panel.* Contracts awarded under the AQP process, which post-dated placements at Atlas, had not been monitored, *a capacity issue has been identified…the current period of organisational flux.* All Learning Disability residential care services in Torbay are visited by the Quality lead
W Berks Council	Services commissioned for individuals whose behaviour challenged were based on multi-agency assessment. Following placement in a residential service there was a 6-week review and a 12 month one thereafter. ForOut of Area placements there was monitoring reliance on the relevant LA and the CQC. It was believed that a special joint LA/ Health group placed 5 people with Atlas as part of a hospital reprovision programme. The 6 LAs across the old Berks assumed responsibility for *a number of these people under a s.28a agreement*[59]
W Berks PCT Quality Team	NHS Berks was the NHS commissioner of Learning Disability placements via Continuing Health Care (CHC), forensic and national specialist services and all others. The NHS commissioners had regular *assurance meetings with the organisations responsible for Case Management…*the annual self-assessment was the vehicle for improving joint working. The specialist provider teams and CHC team were monitoring care via patient reviews and Case Management

[59] *"…formerly known as Section 28A agreements (now agreements under section 256 of the National Health Service Act 2006) are for a CCG to meet the costs of helping local authorities deliver on the duties owed by local authorities to patients or service users. They are designed to be used where the CCG is satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of health services…"* http://www.landmarkchambers.co.uk/userfiles/documents/resources/A%20Guide%20to%20the%20Law%20on%20NHS%20Continuing%20Care%20and%20NHS%20Funded%20Nursing%20Care%20-%20DLQC.pdf (accessed 6 January 2018)

Wokingham BC	Had a long-standing relationship with Atlas and had 4 people in its Devon homes, 2 of whom were joint funded by Wokingham BC and Berks Healthcare Foundation Trust

Table 5: Attention to Out of Area placement in commissioning strategies

Agency	January 2010-11
Bath and NE Somerset	The model was to avoid Out of Area placements. If a rare placement was made, the host area was informed by the CM, the host commissioning and contracting team was asked for local intelligence, and the latest CQC report reviewed. Annual health checks for Out of Area placements were not monitored
Bracknell Forest Council	The Joint Commissioning Strategy does not have a specific section on "Out of Area" placements
Devon NHS and Devon CC	The strategy reported the Out of Area numbers and the needs of children. CLD staff informed the host area – this was not a formal process. Commissioners sought to gather views about local providers and the regional Learning Disability commissioning group shared experiences. Services were not used if they were under notice from the CQC or subject to safeguarding. The Out of Area placements may have meant that annual health checks did not occur. Suitability was determined by looking at the person's needs and how well the provider had demonstrated *its success in this area*
Plymouth City Council	Were only made in extreme circumstances. Hosts of Out of Area placements were routinely notified, and Plymouth Community Healthcare liaises with the host area… *re Atlas, this may not have been undertaken. Commissioners are required to check Out of Area placements…*In social care it was the QA and Improvement team… New suppliers signed T&Cs of contract with the Council. Commissioners and clinicians checked suitability
S Devon and Torbay Shadow CCG	Host areas were not notified; the AST was a Devon and Torbay service and information was shared informally across teams about providers…suitability was assessed on an individual basis. Consideration factors included the purpose of the placement, plans for the person, environment, staff skills and knowledge, individual's/ family feedback re a visit and legal restrictions. Re Atlas, *the feedback re the individual's response…such as reductions in numbers of events when an individual's behaviours challenged would have been provided by ATP Ltd*

Surrey CC	Had 575 Learning Disability Out of Area placements – the majority of which were in the bordering authorities…the commissioning team would discuss a prospective placement with a local authority and seek evidence of contractual concerns. The case holding practitioner would visit a placement – ditto a member of the commissioning team
Torbay and S Devon Health & Care NHS Trust	The commissioning strategy does not reference Out of Area placements. Host areas were not routinely advised of prospective placements…*fluctuating organisational structures make it difficult to identify the appropriate people to be notified.* The pre-placement checklist required consideration of provider concerns but *the response…varies in quality and preparedness to comment on providers.* Health matters should have been addressed as part of the annual review…quality monitoring *was dependent on individual, family and care manager experience with* input from the AST. A personalised approach was expected however, there were *compromises…due to the restricted market and availability of providers or housing*
W Berks Council	During 2008-11, there were 51 Out of Area residential placements. *We have developed some very successful local services this may have been to the detriment of focus on those who could not be easily moved back*. If an Out of Area placement was sought, the SW was expected to produce 3 costed options and visit, generally with the family; ask the host authority and a contract officer would contact the provider. Once agreed, the host authority was informed. The Health Action Plan was reviewed as part of the review. There was not a comprehensive mechanism for reviewing the Out of Area placements
W Berks PCT Quality Team	Personalised services were tailored to meet individual needs by the Berks Health Care Foundation Trust case managers, the 6 unitary authorities and the Continuing Healthcare team
Wokingham BC	Notification to the host authority was a recent development. When preparing a contract the team obtained a reference from the host authority. Devon CC was not informed about 4 people

Table 6: How commissioning met the requirements for personalised services

Agency	January 2010-11
Bath and NE Somerset	The model was to support people in their own homes rather than commission registered care and retain people in the LA. Placements were assessed using a single assessment process and Personal Budgets. Did not operate a preferred provider list – rather a local accreditation process. There was a complex health needs team which included CM

Bracknell Forest Council	The Joint Commissioning Strategy is built on the principles of In Control and Valuing People. The involvement of individuals and their families is central to the strategy; the Council uses the Care Funding Calculator; and it works in partnership with voluntary sector organisations e.g. Mencap, the Ark, Just Advocacy and InnerSense; the integrated CTPLD involves appropriate clinicians in developing or commissioning support arrangements; and the CTPLD works with local GPs to ensure that health checks are provided to all residents with a Learning Disability who want one
Devon NHS and Devon CC	The person and family were involved throughout- especially in relation to identifying needs…expectations were constrained by availability or suitability. There was no maximum cost limit. The AST provided an overview re the provision of clinical support, care planning and Risk Assessments when concerns had been raised…it was unclear who had medical responsibility for people in "independent hospitals." There was a Single Involvement Contract and an Engagement Board for users and others
Plymouth City Council	Consulted with users, carers and families before commissioning services. Tenders were weighed in favour of quality with 30% attributed to the commercial element of the tender. Clinicians provided in-reach support. Health and social care specialists were involved in the commissioning framework and the evaluation of tenders
S Devon and Torbay Shadow CCG	Individuals and families were involved at all stages, including in *core meetings and reviews.* Clinicians were involved in identifying possible services. Re Atlas, there were *letters from local GPs which kept the consultant psychiatrist informed of changes to medication or medication reviews*
Surrey CC	People had *individualised supported self-assessments* which generated a resource allocation. The indicative weekly limit for Learning Disability was £745. A senior manager would agree any sum above this
Torbay and S Devon Health & Care NHS Trust	Torbay had a whole system approach to personalisation which was embedded in the IT system. A Supported Self-Assessment Q'aire was completed with the individual/ circle of support. Torbay had contracts with advocacy services. Social care used the RAS (different from the Devon RAS); people with complex needs *challenge the current RAS.* CLDT members might have visited the provider or advised CMs. Torbay achieved high levels of annual health checks

W Berks Council	SWs engaged with families and they were involved if tendering for a service. Lay visitors were part of service monitoring; the Care Funding Calculator agreed funding levels; information from annual health checks and HAPs was also used
W Berks PCT Quality Team	Personalised services were tailored to meet individual needs by the Berks Health Care Foundation Trust case managers, the 6 unitary authorities and the Continuing Healthcare team
Wokingham BC	Before Personal Budgets there was no limit to a maximum cost…*people with complex needs will require a higher spend than average…there were only a small number of providers in the market and none locally…Atlas put off the use of the Care Funding Calculator…*[It] *claimed their fees were high due to the specialty training…on being asked to evidence this…we experienced more delays…tactics included complaints about the staff member leading on the fee review and sending in paperwork with highly inflated prices…followed by excuse why this couldn't be addressed*

Table 7: Processes for monitoring the effectiveness of commissioning

Agency	January 2010-11
Bath and NE Somerset	Operated a Contract Review Framework to monitor providers. This was not used for Out of Area individual placements. Following individual reviews and CQC inspections, senior manager attention was drawn to any concerns
Bracknell Forest Council	The Joint Commissioning Strategy (2008-13) reflects the input of people with Learning Disability and their families; the Council always reviews policies and practice to ensure that any learning from SCRs is taken into account; and all stakeholders are required to provide regular progress reports to the Learning Disability Partnership Board
Devon NHS and Devon CC	There were insufficient resources and a lack of joint monitoring; there was one contracts officer for Learning Disability services across Devon. There were no measures concerning successful commissioning. CMs were responsible for monitoring their own placements although this responsibility could be transferred to a team local to the individual; and clinicians could raise concerns

Plymouth City Council	Governance was via the Learning Disability Partnership Board and tendering which required services to demonstrate how they were meeting outcomes. Contract monitoring was in place for the Learning Disability framework. Responsibility for commissioning services and placements was that of the ASC commissioning and commissioning at NHS Plymouth
S Devon and Torbay Shadow CCG	See Torbay and S Devon below
Surrey CC	There was commissioning team oversight of relationships with key providers and the Terms and Conditions (T&C) of the latter were regularly reviewed; the safeguarding team shared concerns with the commissioning team; the review and assessment processes provided feedback to commissioning and Quality Assurance (QA); the CQC sent a monthly update of compliance standards
Torbay and S Devon Health & Care NHS Trust	Due to the small size, it was not always possible to provide the range of services required. Numbers of Out of Area placements were monitored and reported to the Learning Disability Partnership Board. The system flagged reviews which were due. Atlas had a standard care homes contract
W Berks Council	Mostly worked with providers who delivered supported living and worked to an outcomes framework. Individual outcomes were monitored. Care Quality Questionnaires were used to gather the views of families, professionals and others. For Out of Area providers, liaison with the host authority and annual reviews were the principal processes – plus complaints and safeguarding referrals
W Berks PCT Quality Team	The CHC service considered the specific needs of individuals and considered providers where CHC funded people were placed. Providers with vacancies were asked to assess people and families would be encouraged to visit. Up to 3 assessments were sought. After placement the CHC visited to monitor progress. A single strategy was not viable
Wokingham BC	Did not have a commissioning strategy when the 4 placements were made, and outcomes required were not set out. Senior managers were involved at the point of placements being made. Contract monitoring was in place

Table 8: The process errors identified by commissioners

Agency	January 2010-11
Bath and NE Somerset	Although reviews were undertaken there was no support plan; the care plan did not provide clarity on the objectives…[it was] not of sufficient depth to enable a comprehensive review; no evidence on file of the reasons for the placement or how this service was chosen; we are reliant on the CQC and the local commissioning teams to undertake checks and inform us of any concerns
Bracknell Forest Council	Some potential triggers of concern should have been followed up more robustly e.g. the inappropriate application of behaviour modification which, following a safeguarding concern, Atlas was unwilling to change. Its staff were *very defensive* re the 2009 safeguarding concern (raised by Bracknell Forest) which hinged on the use of restraint. This was *not substantiated* by Devon CC which informed Bracknell that there were "no concerns" and that Atlas was "extremely good"
Devon NHS and Devon CC	Processes should be "reasonably adjusted" for people with complex support needs; Atlas should not have led scrutiny processes; replacing the monitoring of the placement team with local monitoring may work; the absence of risk reporting and complaints does not mean that all Is well; all documentation should have been available for scrutiny; should have asked how incidents of challenging behaviour were reduced; should have asked what the provider meant by a "safe place;" in multiple occupancy homes, how can we know that residents are receiving 1-1 support for example? When senior managers attend and lead discussions at all meetings, the views of support staff are unknown
Plymouth City Council	Although the weekly costs were high (between approximately £1900.00 and £2700.00) and this was discussed at each review, the fees did not change; families have reported that "they felt unable to challenge the managers or quality issues as it may have had an impact" on their relatives. One family wanted to visit more than once a month and were told that it would not be possible…it would be unsettling and lead to behavioural difficulties; it was not easy to get information from staff
S Devon and Torbay Shadow CCG	Processes for placements made in emergency were less thorough; Atlas had a reputation for supporting people in crisis; reports which stated "when X becomes anxious staff prompt him to his bedroom" should have triggered questions; the Mental Capacity Act (processes) were not monitored

Surrey CC	Did not place people at Atlas homes in Devon
Torbay and S Devon Health & Care NHS Trust	Atlas' positive reputation arose from its links with the Tizard Centre and the work of Professor Jim Mansell. This provided assurance; ditto a parent who was known to drop into a service…provided assurance that the service was safe; progress was seen with individuals coming off sections and reduced care package costs; there were some accounts of families' access being restricted during the first few weeks of placement. It is not known whether this occurred at other Atlas services; information was sought concerning the use of the "quiet room;" there were problems chasing relevant paperwork; there was a reliance on CQC monitoring system and reports
W Berks Council	Due to legacy of hospital re-provisioning, there are no records re matching people to placements; the reviewing process was not adequate enough to monitor the quality of placements…we would rely on CQC inspections, any notification from the host authority about safeguarding issues or problems with the provider; the review format was not searching enough; one of the Atlas Directors was usually in attendance and "Atlas generally presented a report which gave a very positive picture of how it was supporting X; Atlas refused to engage in the use of the Care Funding Calculator mechanism; there were ongoing concerns about Atlas, including the "strong culture of behaviour control" – which was not deep enough act upon; Atlas never asked for help in managing an individual; one resident was found to have a soaking and stained mattress and an activity programme which was without purpose; medication administration was poor; and Atlas did not notify or report any concerning events. There was no multidisciplinary assessment for one person for 11 years; her behaviour was perceived as more significant than her physical health care; there were no records of Best Interests assessments in respect of people who were restrained; there was a lack of governance
W Berks PCT Quality Team	There were no significant/ untoward events to suggest that "practice could be improved"

Wokingham BC	Initially her support hours were reduced, and the local authority negotiated a reduction in fees. Even though the "costs were so high," Atlas declined to cooperate in reconsidering these; the use of a special "quiet room" was not mentioned; a complaint was not pursued; a parent report that telephone calls were monitored and if the resident spoke about certain matters the staff discontinued the call; when the nature and extent of the garden room became known an independent assessment of capacity was made; after the initial "alert" the case manager visited with an hour's notice…Atlas staff [were] furious…; client's preferred communication was not always respected. Atlas staff gave excuses; no evidence of complaints being followed up; resisted requests to engage in review of fees

Table 9: Contracting for people who were hard to place

Agency	January 2010-11
Bath and NE Somerset	Placements were subject to a generic contract for care homes and an individual schedule for each person – monitored via a local contract review framework. The commissioning and contracting team maintained an overview of contract monitoring and operated a risk rating system
Bracknell Forest Council	The Council rarely commissions residential provision for people with Learning Disability Learning Disability (it has supported 3 people since 2009). It requires agreement in principle from the Learning Disability Commissioning Panel (with senior officer membership) and extensive contractual checks including, against the business, i.e. credit checks; checks to ensure sufficient insurance cover; the most recent CQC report; and checks with the local authority to ascertain if there are currently or have been safeguarding or quality issues. Once competed the proposed support plan is submitted to the Learning Disability Commissioning Panel which agrees or rejects the suitability and cost in the light of identified needs

Devon NHS and Devon CC	All contracts were drafted by the CC. There was a generic contract in place with individual contracts underneath. *Atlas demanded a different payment schedule than that offered by the CC. They required payment in advance that fell outside the routine one week in advance and one week in arrears…an "old style" contract was used…a single sheet of paper outlining the agreement to place with a single fee and dates of application…*this did *not protect the organisation or the individual placed sufficiently.* Atlas engaged in *covert activity operating off the agreed process*
Plymouth City Council	There was a brokerage system in place. Users and carers were informed about the providers which could meet needs. Providers were required to accept the terms and conditions of contract; SWs were required to provide a detailed support plan. Quality Checkers trained Service Users to evaluate their own service and providers could buy into this. SW monitored individual support plans. The Commissioning Team spent 2-5 days with the provider to undertake a whole system quality review. These were completed annually
S Devon and Torbay Shadow CCG	See T&SDH&CT response
Surrey CC	There was a generic service specification and the contract detailed the outcomes to be met. Standards were reviewed at an individual's review, discussion with providers, feedback from families and ad hoc QA visit
Torbay and S Devon Health & Care NHS Trust	NHS AQP and overarching LA residential care contracts were used (as with Atlas); some services were contracted via the provider contract…organisational flux was impacting on the ambition to *move all contracts to standard NHS contracts* and on the monitoring of new contracts
W Berks Council	Drafted own but inherited existing arrangements. There was an overarching contract with individual detail in the care plan for residential placements. A Care Quality Tool monitored standards for residential and supported living services

W Berks PCT Quality Team	CHC contracts were drafted in house but may also have been offered by the provider. Contracts were generic but took account of specific requirements. The contract required that quality standards were achieved. Monitoring included the annual review, CQC reports and fb from the LA. There were no specific processes in place in CHC to monitor contracts…concerns raised were dealt with on an individual basis. In all cases, QA and monitoring were carried out by CMs
Wokingham BC	There was an overarching template and the contract made clear that support plans dictated what was required – CMs give these to the providers. The monitoring looked at outcomes for SUs. Contract monitoring was mostly reactive. CQC reports were checked before contracts were renewed. We also sometimes note services that have been of concern or who are high risk and proactively visit and monitor them, but this is not standard

Table 10: How Atlas was identified

Agency	January 2010-11
Bath and NE Somerset	Do not use brokerage – providers were approved via an Accreditation Framework. People were signposted to a range of services. The person with complex needs and family were involved in the final selection
Bracknell Forest Council	Via the multi-disciplinary Community Team – the lead practitioner will have advice from a number of colleagues including the Challenging Behaviour advisor. Team members will be involved in defining outcomes and identifying suitable placements
Devon NHS and Devon CC	Devon CC had a brokerage scheme – all placements were required to go thro' the process. A shortened pen picture was sent to prospective providers and the latter were shortlisted. However, crises severely inhibit planning and decision-making...there was a formal check re the financial status of providers. There were provisions for placements to be made outside brokerage which required the agreement of the Assistant Director
Plymouth City Council	Via brokerage. The T&C of contracts were drafted by the legal team
S Devon and Torbay Shadow CCG	Consideration was given to providers on the AQP list; providers were selected *for approach based on the circle of support's knowledge of the provider* and the individual's needs

Surrey CC	Providers were chosen who had agreed to work with the CC, meet commercial terms and requirements. Anonymised pen pictures were sent to the provider…providers were allocated a relationship manager from the commissioning team…brokerage was in the process of being commissioned
Torbay and S Devon Health & Care NHS Trust	The CLDT did not use brokers – they used the AQP lists and drew on previous use and knowledge and also asked the AST for advice. It acknowledged that this could *lead to a closed shop for providers…CMs failing to think beyond 'what they know;' it was time consuming; it was hard for providers to change their image; and 'one off' contracts might not have been subject to contract monitoring*
W Berks Council	For supported living, via an initial tender process then on an assessment of need. No brokerage. The Contracts and Commissioning Team held information on a range of services. SWs also visited services
W Berks PCT Quality Team	All care packages and providers were selected by the Learning Disability CMs and/ or the CHC team. Requests for NHS funding were reviewed by senior managers separate from the Berks HC Foundation Trust (the local NHS specialist Learning Disability clinical provider). Providers were selected by the CM or the CHC team. The PCT was consulted on placements which fell above the ceiling level. The Learning Disability patient entered a common point of entry and the pathway was agreed from that point
Wokingham BC	Pre 2010, there was no brokerage or commissioning service. Commissioning for spot contracts was based on CM knowledge…placements with Atlas predated 2010, and 2 post 2010…commissioning did not highlight and of the issues at Atlas…an expression of interest was sometimes advertised

Table 11: How agencies measured the quality of services

Agency	January 2010-11
Bath and NE Somerset	Via the contract review framework which included quality standards around safeguarding
Bracknell Forest Council	All individuals had a personalised support plan that is outcome focused. Success criteria would be identified by the person with support from their family and/ or advocate and their Adult Social Care practitioner

Devon NHS and Devon CC	The contract had 2 parts – an overarching agreement and a spot purchasing agreement. The following aspects were addressed in the standard care home contract used to place people at Atlas: no subcontracting without agreement; insurance; confidentiality; security and safeguarding prioritised over confidentiality; legislative cover; CRB checks; complaints; adult protection; access; declaration of interests; environmental standards; compliance with the CS Act 2000; community equipment; and data protection. CQC reports were *heavily relied* upon and there were pre-placement visits by staff and families which *did not reveal anything suspicious or concerning…there was no developed reporting process…about individual placements. In the NHS* work was *orientated around the larger contract with NHS Trusts. Capacity was not in place to establish these arrangements re complex individual placements…*Since Winterbourne View, regular reporting was in place with the Safeguarding Adults Board and the Cluster Quality Committee
Plymouth City Council	Governance was via the Learning Disability Partnership Board and tendering which required services to demonstrate how they were meeting outcomes. Contract monitoring was in place for the Learning Disability framework. Responsibility for commissioning services and placements was that of the ASC commissioning and commissioning in NHS Plymouth. A person's support plan sets out outcomes by which performance is judged. The Learning Disability service was provided within a Partnership until end March 2012. Key developments related to VP and VP Now targets
S Devon and Torbay Shadow CCG	See T&SDDH&CT response
Surrey CC	Large contracts had a dedicated contract manager who reviewed performance and quality with Commissioning and QA colleagues every 3 months. Re spot contracts, the annual review ensured that needs were being supported against the care plan. The Terms and Conditions required (i) [provider] staff to be CRB checked, (ii) compliance with safeguarding and (iii) attention to the 10 point dignity challenge. The relationship managers kept in regular contact with providers; the CQC website was reviewed; and safeguarding alerts were considered

Torbay and S Devon Health & Care NHS Trust	The AQP was used to create a list of providers. Where contracts were not in place the pre-placement checklist was used to ensure that providers were of good quality before placements were approved. The Care Home Monitoring Tool drew together information from a range of professionals. Torbay and S Devon Health and NHS Care Trust operated its own quality and governance structure. Provision of CLDT services for Torbay was subcontracted to Torbay and S Devon Health and NHS Care Trust which subcontracted to a range of residential providers
W Berks Council	Assessing safety/ quality was a core part of assessment. Standards were specified in T&C, contract specification or individual user agreement; there were regular monitoring visits and surveys of key stakeholders. The Care Quality Board considered all monitoring information on a monthly basis
W Berks PCT Quality Team	CMs and the CHC team were required to review individual placements to address issues of concern and changes. SUI were reported to the cluster's quality team, linking into the Berks safeguarding processes
Wokingham BC	Were not officially monitored…there was a Care Governance Protocol and Board overseeing the quality of services for vulnerable adults…*we know from Atlas that it is extremely difficult to rely on contractual remedies*

Appendix 2: A Pen Portrait

"A is now 27 years old and has spent much of his life in the care system. Despite this, and regardless of the barriers placed between us, he is very much a part of our family, much loved and cared for, and a binding force between us all. A loves singing, music, animals and food - he is and has always been the family comedian.

A is autistic and has a learning disability, he also has a diagnosis of bipolar. His complex needs affect every day of his life, leading him to require support at all times.

In 2009, aged 18, A was admitted to Winterbourne View Hospital. He woke up at school, and by lunchtime was in the most restrictive, and as we later found out, abusive setting we thought he would ever face.

Within weeks, his jaw was broken by a member of nursing staff following what was described by the police officer who attended at the time as 'a punch or kick to the face'. He was overmedicated, restrained and abused for the 11 months that he spent there. We were delighted when he was finally discharged.

But the light at the end of the tunnel that A needed was yet to come. He entered Veilstone, an Atlas Projects Team supported living environment post-discharge, and our concerns were quickly revived. The promises we were given about the quality of life that A would have were quickly broken, and abuse once again became his life. A became a shadow of his former self- terrified, distant, lost and desperate. We thought we would never get him back.

And in many ways, we didn't. It took us a year to fight for someone to listen to the concerns that we had. Concerns that were, unfortunately, proved right. We know now that he spent hours locked in a room, that he was verbally, emotionally, physically and sexually abused, and that he is yet to reveal the full horror of what he experienced. A remains scared, broken and tormented by all that happened to him at Veilstone, the place that we hoped would be his saviour after the abuse he experienced at Winterbourne View Hospital, but which was worse than what had come before.

There were prosecutions in this case, but A never received his justice. Perhaps nothing was ever going to be enough for all that he has experienced, for all the trauma that he suffers but at first, we did hope the legal system would expose the truth and hold people to account. The reality is stark - that in all of this, his vulnerabilities, personality, achievements and voice were lost and he, the victim, was blamed for what had occurred.

A's fortunes finally changed, three years after the end of his time at Atlas. He now lives in his own home, hundreds of miles from all that occurred, in a place that he can finally feel safe. He has a dog, the love of his family and a full and exciting future to look forward to, supported by good staff. A finally has the life that he deserves, but it took far too long, the damage to his life, his future and his mental health has already been done.

Re sexual assaults

After leaving Veilstone, A revealed that more than one member of staff had sexually assaulted him during his time there. This information was shared with the police who carried out an investigation into to the allegations made. Evidence was presented to the CPS who stated that there was insufficient evidence for any prosecutions to take place.

Added after completion of SAR

Further to this, after the review was completed, a solicitor representing the family described to the DSAB evidence of an allegation of sexual abuse described in a police interview. This information, which is not included in the completed review, is being followed up separately.

Appendix 3: Case Studies from the Commissioning Areas

(a) **From Devon CC,** "an example of how we consistently work with individuals in a more person-centred way."

Don has a mild learning disability, autism, epilepsy, a hearing loss and partial sight. He had been at a long-stay hospital outside Devon for five years, against a backdrop of "multiple placement breakdowns."

Don wanted to leave the hospital and have his own accommodation near to his family. This was achieved by (i) understanding what was important to Don, (ii) a focus on Don and his family and (iii) assuming shared accountability across health and social care. The process was characterised by "on-going communication" and welcoming feedback from Don and his family. They contributed to the development of an "individual personalised plan" and "bespoke [support] package." Regular and minuted meetings set out the "plan and action process" which ultimately included the prospective provider service. There was clarity "about…the outcomes we were looking for them to support Don with." Don "has been back in Devon for over six months and is doing well."

(b) **From Devon CC,** a safeguarding case study involving a "welfare check."

An unannounced visit to a residential home revealed that it was "cold and untidy with two agency workers" and no permanent staff available. The agency workers were unaware that one resident, Gill, had recently had hip surgery. Gill has a severe learning disability and epilepsy. The agency workers were also unaware of Gill's epilepsy "or what to do in an emergency." A safeguarding process began. The home's senior manager was notified and the person responsible for the welfare-check remained at the home "until the situation was rectified." Since Gill had been assessed as lacking capacity "regarding her accommodation and support needs" her sibling was informed. The sibling "felt that Gill was happy where she was…if the provider was prepared to make some changes." A review was undertaken with "very clear outcomes identified." Similarly, Devon's expectations concerning the "quality of provision and [provider] responsibilities" were affirmed with the provider. This resulted in an apology to Gill and her sibling and the preparation of a development plan for the home. Subsequent unannounced visits "evidenced a pattern of sustained, continued improvement." The CQC were informed at the outset.

(c) **From NEW Devon CCG and Devon CC** a "joint health case study."

Cara is a middle-aged woman who is "well known" to learning disability services due to her autism and bipolar disorder. As a result of her deteriorating mental health, she "moved from fairly independent living to a residential setting" and "required an in-patient hospital stay" under S.2 MHA 1983. Cara became very distressed, threatening and unpredictable at the Mental Health Unit and "a suitable specialist placement was sought." She was detained under S.3 and was transferred to an out of county placement. "A discharge planning route" was sought at the time of her admission and Devon Partnership Trust's Intensive Assessment and

Treatment Team "remained involved" in relation to Cara's Positive Behavioural Support Plan and discharge planning. An initial increase in Cara's distress including "verbal aggression" at discharge received prompt and effective attention. She has "adjusted to the new people supporting her and the new environment." The focus of continuing work hinges on Cara realising her wish to move "to a supported living environment."

(d) **From Plymouth** – three "pen pictures"

Claire moved into a two-bedroom flat over two years ago. She has "positive contact" with relatives and enjoys holidays. Her "consistent, long-standing" support team has facilitated Claire's "good relationship" with a neighbour; attendance at social events, including a community choir. She uses public transport and goes to local shops and cafes. Her team provides "appropriate support, structure and choice to assist at times of distress."

Bob accepts that he requires help on a daily basis to undertake self-care, household routines and to maintain his tenancy. He does not want to return to either residential care and shared living since these took "away his independence."

James has progressed greatly, gaining greater confidence within and outside his home, learning new daily living skills. James is more settled; however certain periods of the day remain difficult, with which he is well supported. James' communication has developed, using a range of vocabulary, Makaton and together with a communication iPad, has extended his communication. In turn, James is making choices about the people who support him and about sampling new activities. For example, he selected the colour of his mobility car and will sign "car" when he wishes to go out.