Summary of the Health Care Commission’s Investigation into Sutton and Merton Primary Care Trust Learning Disability Services

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Key Decision Report

Summary
This report summarises the Health Care Commission’s Investigation into Sutton and Merton Primary Care Trust’s Learning Disabilities services, the 25 recommendations and implications for Council governance, policy, and practice. It also notes the consequent Inspection by the Council for Social Care Inspection (CSCI) of Services for People with Learning Disabilities in Sutton.

Recommendations to Strategy Committee
I recommend Strategy Committee to:

a. Note the Report and Background
b. Note the 25 recommendations
c. Note the implications for Council governance, policy, and practice
d. Note progress made by the Council over the last 6 months
e. Note the planned Inspection and agreed additional funding to support the inspection process.

1. Background
1.1 In January 2006, The Health Care Commission (HCC) was invited by the Interim Chief Executive of Sutton and Merton Primary Care Trust (SMPCT) to undertake an investigation following several serious reported incidents of concern in the Learning Disability Service. This included allegations of physical and sexual abuse of patients by nursing staff. The South West London Strategic Health Authority supported the request. The aim of the investigation was to establish whether ways of working at the Sutton and Merton Primary Care Trust were adequate to ensure both the safety of people using the service and the quality of the service provided.

1.2 The Investigation Team comprised members from the HCC and external advisors, including a person with a learning disability and a representative from the Commission for Social Care Inspection (CSCI). The British Institute for Learning
Disabilities and the Department of Health’s ‘Valuing People’ Team also provided expert advice to the Investigation Team.

1.3 The investigation team commenced in February 2006 and concluded in June 2006 with the publication of its findings on the 17th January 2007. An Action Plan is being developed to support the recommendations of this public report.

The National Context

1.4 The Health Care Commission and the Commission for Social Care Inspection undertook an investigation of learning disabilities services within the Cornwall NHS Trust and in July 2006 delivered a critical report on the failure of the NHS and Cornwall County Council to deliver safe services and implement ‘Valuing People’. A joint statement accompanied this report on learning disability services across England from Anna Walker, Chief Executive of the Healthcare Commission, and David Behan, Chief Inspector of the Commission for Social Care Inspection.

1.5 The statement said:

“Our Cornwall investigation report highlights unacceptable standards of care. People with learning difficulties and their families have been let down. We hope they are reassured that what we have put in place has stabilised the situation and will improve services in Cornwall for the future.

In light of these events, it is right to ask about the state of these services around the country. Both our organisations have serious concerns that the quality of care is not always what it should be. Let us first be clear we are not saying that the abusive behaviour we found in Cornwall is happening everywhere. But sadly Cornwall is not the only service where serious allegations have been made in recent months.

In Norfolk, the Healthcare Commission has intervened at a privately run unit for adolescents with learning disabilities, which the owners subsequently closed down.

In South London, Sutton and Merton Primary Care Trust have asked us to investigate allegations of physical and sexual abuse. Instances of abuse can be symptomatic of services that have been neglected for too long. They are the most serious sign of a problem, but our concerns are much broader.

We detect a widespread lack of understanding about the rights and needs of people with learning disabilities. Much has been achieved since the Government introduced a framework for these services, called "Valuing People". Self-advocacy is growing and communication is provided in ways that is accessible for people with learning disabilities. Now we must ensure that those running services well can share knowledge with those who need to improve.

It is very important to identify all of the things that are going well, as well as those that are not. This is why the Healthcare Commission, working with CSCI where appropriate, is to embark on a national audit and inspection programme of all NHS and independent healthcare providers. We aim to publish our findings later in 2007. Providers will be asked to declare they are meeting expected standards and we will check what they have said through inspection. If within the audit, services are identified that should be registered under the Care Standards Act, the Healthcare Commission will work with CSCI to ensure that this happens. With this comprehensive picture of what is going on, it will be possible to assess whether the system has the right levers in place to drive improvement. We can assess improvement against the baseline we have established."
More than a million people in England (2% of the population) are estimated to have learning disabilities. It is not acceptable to overlook the needs of these vulnerable people because they rarely capture the headlines or in some cases are unable to champion their own rights.”

1.6 This findings of the report described below need to be understood within the broader sentiments of the joint statement above. It is within this context that the findings of the HCC investigation into SMPCT’s learning disabilities services will help inform the development of national policy. The central principle of ‘Valuing People’ is that people with learning disabilities have the same rights as any other citizen and services should be designed to ensure social inclusion, promote independence and develop choice and control over their lives. The HCC investigation of SMPCT learning disabilities services will be viewed within this broader context as well as a judged against the delivery of local health care standards.

1.7 The HCC report mentions a reference to CSCI to undertake and inspection of social care services for people with learning disabilities. On 11 January 2007 the Strategic Director of Adult Social Services and Housing was notified by CSCI of its intention to inspect services for people with learning disabilities provided and commissioned by LBS. The dates for this inspection is 16 – 27 April 2007.

2. Findings of the HCC Investigation into Sutton and Merton PCT

2.1 Quality of Care and Service Delivery

2.1.1 The HCC examined the houses that people lived in and the way in which care was delivered to 186 people with learning disabilities who are the responsibility of the SMPCT. The report found that the model of care was very institutional and largely based on the convenience of the service providers. There was a lack of planning at an individual level for people and a lack of care given on an individual person centred basis. The local authorities of Sutton, Merton, and East Sussex (where people lived) each had arrangements for the protection of vulnerable adults (POVA) and their existing policies met the national requirements. However, in some cases there were weaknesses in the implementation of the procedures such as a poor communication, lack of staff awareness and poor follow-up of actions agreed at meetings. The following is a summary of concerns about SMPCT provision (unless contra indicated):

a. The overall provision of activities was very low;
b. The privacy of individuals was compromised by the physical environment;
c. There were poor services for people with behaviours that challenge including evidence of rigid regimes and a lack of individualised care;
d. POVA arrangements were adequate with weaknesses in identification of abuse and poor follow up (LBS);
e. There was a service from the adult Sutton learning disability team to children in a local school that was not subject to proper contracts or properly funded;
f. There were inadequate arrangements in place to support staff working in the children’s short break unit before management was transferred from the Learning Disability Service to the Children’s' Service in November 2005;
g. Governance systems were very weak with understaffing, poor training, under funding, weak complaints systems, poor delivery resulting in a poor user experience of front line care;

h. Person centred plans (as described in Valuing People) were only available for the minority;

i. Communication with people with learning disabilities was poor;

j. Management and leadership was historically weak;

k. The Strategic Health Authority’s monitoring of quality of services provided could have been more robust;

l. There remains a high level of concern about whether new services can be re-provided for people at Orchard Hospital by 2008 and 2010 because of limited management capacity and insecure financial arrangements.

2.2 Learning Disabilities Partnership Board

The Health Care Commission acknowledged that its findings were mainly historic although there were ongoing concerns about the current capacity of the overall system to manage the change needed in the time required especially in relation to the funding of the hospital closure. As a result of early action, significant progress had been noted in the strengthening of the Sutton Learning Disabilities Partnership Board (LDPB). ‘Valuing People’ describe LDPB’s as having an important scrutiny and support role in major service change and design for local learning disabilities services. The work streams of ‘Valuing People’, of which one is the re-provision of long stay hospitals by 2004, are reviewed and supported by the local LDPB.

2.3 Safeguarding Vulnerable Adults

The HCC also noted that there had been a strengthening of processes and practice regarding Safeguarding Vulnerable Adults as a result of early action. It noted that the Executive lead for Sutton was also the joint Executive lead for learning disabilities across the PCT and the Council in Sutton. It accepted that all complaints and concerns about safety and welfare were now thoroughly and independently investigated. The HCC felt that there had been a significant under-reporting of incidents within Orchard Hill and the Community Health Homes and was indicative of a widespread culture that had high tolerance levels of poor standards of care and behaviour. In some cases these were unacceptable standards.

2.4 Conclusions

2.4.1 The Health Care Commission found no evidence of systematic sexual or physical abuse but found that institutional abuse was prevalent in most parts of the Learning Disability Service. The Commission defined institutional abuse as “occurring when the rituals and routines of a service result in the lifestyles and needs of individuals being sacrificed in favour of the needs of the institution”. The culture was such that staff concentrated on what people could not do rather than on what they might be able to do.

2.4.2 The investigation found that the views of people with learning disabilities were seldom heard. It criticized the fact that Orchard Hill hospital had not been shut in line with the objectives of ‘Valuing People’.
2.4.3 The overall model of care provided by the Learning Disability Service was one that promoted dependency. There was little evidence of clinical effectiveness or up-to-date practice, which was based on relevant clinical and social research. The culture was such that staff concentrated on what people could not do rather than on what they might be able to do. Person Centred Plans were focused on meeting people’s health rather than improving their lives. The management of risk was not effective, and was overall risk averse. Very few SMPCT staff had attended POVA training (prior to April 2006) and there was a low level of awareness of their duty to protect vulnerable adults.

2.4.4 In November 2005, Sutton Council (Sutton Disability Partnership for Children and Young People) took over the management of the short break unit for children with learning disabilities. Since this time it has been well managed.

2.4.5 The interactions between staff and people who lived in the Learning Disability Service were generally kind in nature, but were not in accordance with best practice. It was found that people were cared for, rather supported to be as independent as possible.

2.4.6 There were failures in management and leadership, from Home Managers to the PCT’s Board. The PCT’s Board received information about the proposed re-design of services but did not receive robust information that enabled them to monitor the quality of services for people with learning disabilities. However, continual organisation change (seven Chief Executives in the last decade and four different organisations) combined with two Judicial Reviews means that no one individual was responsible for the poor quality of services for people with learning disabilities.

2.4.7 The closure of long-stay hospitals like Orchard Hill should have happened many years ago in line with government policy, as well as the closure of campus style accommodation like Osborne House (Hastings). The HCC considers that SMCPT are unlikely to successfully modernise the service without adequate transitional arrangements in place.

2.4.8 The key recommendations of the report are intended to bring the SMPCT into line with best practice and national guidelines and SMPCT is expected to publish an Action Plan with timescales for action within nine weeks of the publication of the report.

2.4.9 The report highlights the very important role of Independent advocacy and emphasises the significant contribution made by the local Advocacy service.

2.4.10 This report will be linked to the Cornwall report and National recommendations will be issued in respect of NHS and Social Care commissioning, provision, governance, person centred practice and advocacy.

3. **Recommendations and Action Plan**

3.1 The HCC’s 25 recommendations can be categorised into 6 categories:

- Recommendations 0 – 9 Quality of Care
- Recommendations 10 – 14 Staff Development and Training
- Recommendations 15 – 17 Empowering people using services
- Recommendations 18 –20 Governance and Strategic arrangements
- Recommendations 21 –23 redesigning services

3.2 The PCT Board through quarterly service reviews of the Learning Disability Service is monitoring the majority of the recommendations. These reports will also be shared with the Sutton LDPB.

3.3 A Steering Group chaired by the Executive Head of Learning Disabilities is currently designing the Action Plan with support from 2 consultants, 2 carers, and a person with a learning disability from Sutton, Unions, staff, managers, and commissioners. This will lead to a series of workshops and recommendations for action.

4. **Issues for the Council**

4.1 This report has received national scrutiny with significant media and professional interest focusing on meeting core health care standards and the implementation of the ‘Valuing People’ Objectives within Sutton. There are implications for Council Services. There are some criticisms of past relationships between Sutton Council and Sutton and Merton PCT, including weaknesses in partnership frameworks. Although the HCC notes progress made over the last year.

4.2 **Council Governance, Policies and Practice**

4.2.1 Because Orchard Hill Hospital is within its boundaries the London Borough of Sutton, the Council has specific duties and responsibilities for ensuring that people are safe and that new services, commissioned by the Council for people being re-provided for in Sutton, meet best practice.

4.2.2 This requires people moving out of Orchard Hill and into the Sutton Community to be seen as having the same rights as any other Sutton citizen. This also requires the Council social work Learning Disabilities service to be informed by evidence-based practice and to be commissioning social care services that promote people’s independence. An ongoing review of existing contract specifications within the changing commissioning culture will help the council to achieve this outcome and this work has been accelerated since the summer of 2006. The pace of change and modernisation pressures require ‘fit for purpose’ commissioning and procurement processes that deliver in a timely manner otherwise there will be a risk of future delays.

4.3 In order to further progress work, it is requested that Strategy Committee note the following areas for development:

a. Adult Protection  
b. Political Scrutiny  
c. Contracting and Procurement  
d. Future re-provision of Orchard Hill  
e. Social Work Practice

4.4 **Council Progress**

The HCC has highlighted:

a. Significant progress made by the Council in strengthening the Safeguarding Vulnerable Adult Procedures (which will have a benefit for all vulnerable adults in Sutton). The February Annual Conference for Safeguarding Vulnerable Adults will see a series of new policies and procedures being introduced that
will significantly strengthen local Protection of Vulnerable Adults (POVA) processes – including a proposal to establish a Serious Cases Review Panel. There is also acknowledgement that POVA training is now in place for staff at the PCT.

b. The strengthening of the Learning Disabilities Partnership Board which will have a role in overseeing and scrutinising the work of the Action Plan in partnership with the PCT Board and respective Scrutiny committees of Sutton and Merton (for Merton’s 12 residents). Carers will also be encouraged to voice their concerns through the carers support network that supports the work of the Sutton LDPB.

c. The HCC also acknowledged how Sutton has championed the right of people with learning disabilities to be citizens of their own communities via the innovative annual conference of the Sutton Partnership.

d. The report also acknowledges the joint work being undertaken by Sutton and Merton Councils with the PCT to strengthen commissioning through the development of Partnership Agreements under the 1999 Health Act and work that has been started around the Green Light Mental Health Toolkit.

5. Financial Implications

5.1 The NHS is funding the revenue and capital streams of the Orchard Hill re-provision.

5.2 As a result of the CSCI inspection, at such short notice, the service requires resources to meet the preparation needs and the smooth running of an inspection process which is critical to the Council’s performance ratings. Initial estimate for project management, administrative support, and project work come to £60k. Most of this expenditure will fall in the current financial year and will be funded from current year underspends. Any expenditure in 2007/08 will be contained within agreed budgets for that year.

6. Influence of the Council’s Core Values

6.1 The Council’s 5 Core Values of Partnership, Respect, Innovation, Diversity and Empowerment will inform future council commissioning and can already been seen in the Annual Sutton Partnership and launch of the new Learning Disabilities Partnership Board

7. Contribution to the Achievement of the Council’s Priorities for Change

7.1 This work can contribute to priority 8 – Progressing the Development of mechanisms and services to improve the health and well being of Sutton residents.

8. Background Papers

“Valuing People – A New Strategy for Learning Disability for the 21st Century” – DOH

“Consultation: Orchard Hill – Services for people with a learning disability living at Orchard Hill” – Health Scrutiny and Social Care Services Performance Committee, March 2004

“Modernisation of Day Services” – Strategy Committee, September 2006

Application for Tender Waiver – Learning Disabilities, Strategy Committee, November 2006