REPORT TO:	**ADULT SOCIAL SERVICES REVIEW PANEL** **17TH JULY 2012**
AGENDA ITEM NO:	**8**
SUBJECT:	**REPORT FOLLOWING CQC INSPECTION OF LEARNING DISABILITY HOSPITALS AND HOMES**
LEAD OFFICER:	**EXECUTIVE DIRECTOR FOR ADULT SERVICES, HEALTH & HOUSING**
CABINET MEMBER:	**COUNCILLOR MARGARET MEAD,** **CABINET MEMBER FOR ADULT SERVICES & HEALTH**
WARDS:	**All**
CORPORATE PRIORITY/POLICY CONTEXT: **A summary of the Care Quality Commission report on 150 themed inspections of learning disability services following the Winterbourne View abuse investigation.** •	
FINANCIAL IMPACT*: N/A*	
FORWARD PLAN KEY DECISION REFERENCE NO.: N/A	

1. RECOMMENDATIONS

The Adult Social Services Review Panel is recommended to

(1) Note of the work already being undertaken by the Joint Community Learning Disability Team and Commissioner to review all clients currently living in hospital provision.

(2) Note that the review is to determine who is to be discharged into community based provision whenever possible.

(3) Note that the review is to ensure that those requiring ongoing hospital treatment under a section of the Mental Health Act or via a Deprivation of Liberty safeguard are regularly reviewed and have access to advocacy.

2. EXECUTIVE SUMMARY

The report outlines the response by the learning disability service to the findings of the Care Quality Commission inspections of 150 NHS and private hospitals and care homes following the Winterbourne abuse scandal.

3. BACKGROUND

3.1 On 31 May 2011 Panorama broadcast a programme evidencing shocking abuse of patients with a learning disability at Winterbourne View private hospital in South Gloucestershire. The abuses uncovered are the subject of criminal investigations.

3.2 In June 2012 the department of health published an interim review of Winterbourne View Hospital and lessons to be learnt. The report does not focus on the actual events at Winterbourne View as these remain subject to criminal investigations. However it takes an overview of the health and social care system as it meets the needs of people with a learning disability and autism.

3.3 The report sits alongside the Care Quality Commission report following an inspection of 150 services for people with a learning disability across England and Wales. The services inspected included:

- 68 NHS trusts providing assessment and treatment and secure services
- 45 independent healthcare services providing assessment and treatment and secure services
- 32 adult social care services.

3.4 These establishments were inspected against two outcomes:

- The care and welfare of people who use services
- Safeguarding people who use services from abuse.

A service was deemed to be compliant if it met the two standards above or had only a minor concern uncovered for which there was an action plan to resolve it. Any service with a moderate or major concern was deemed to be non compliant.

3.5 **The inspections revealed that:**

- 48% of the 145 services that the report focuses on were non compliant across the two outcomes.
- NHS locations did better with both outcomes compared to private hospitals (63% and 33% respectively).
- Fewer than half (47%) of the residential care homes were compliant against both outcomes
- However 63% of people were living in residential homes that were compliant
- 51% of assessment and treatment units were compliant across both outcomes
- However a majority of people (58%) lived in the non compliant services.
- The length of stay for people living in an assessment and treatment unit ranged from 6 weeks to 17 years and in many cases was far too long to be consistent with the concept of assessment and treatment.

In none of the services inspected was the level of abuse found at Winterbourne View replicated.

3.6 **Key failings related to:**

- Failure to involve service users and families adequately in care planning leading to a lack of a person centred approach.
- Use of restraint and failure to record and monitor its usage in order to learn lessons from each incident and to reduce future occurrences.
- Advocacy services when in place were often of a poor quality.
- A lack of knowledge and clarity about deprivation of liberty safeguards.
- At 27 services, safeguarding adult incidents were identified that needed to be referred to the local authority for investigation. These referrals will be monitored by CQC until a satisfactory outcome is achieved.

3.7 The main conclusions of the CQC inspections are that:

- Too many people are being supported for too long in assessment and treatment units. The length of stay in private healthcare provision is greater than in NHS services.
- Restraint was not well understood, seclusion was often not recognised as being a form of restraint and there was insufficient recording and analysis to try to reduce the need for restraint.
- Greater awareness of and knowledge about deprivation of liberty safeguards is needed.

3.8 **The main recommendations are that:**

- Commissioners should urgently review the care plans for people in assessment and treatment units and ensure a plan for them to be moving on.
- Clinical commissioning groups and NHS commissioning board should work together to establish local person centred services.
- Commissioners should review the quality of advocacy services especially in services where quality of service is low.
- Providers must ensure that people in their service should be routinely involved in their care plan with accessible forms.
- Providers need to find ways to reduce the level of restraint and ensure staffs are well trained when restraint is unavoidable.
- Providers and commissioner must ensure there are quality assurance systems in place that include complaints procedures, access to advocacy, a welcoming approach to visitors and good support and supervision of staff.

4 IMPLICATIONS FOR CROYDON:

4.1 None of the services inspected by CQC as being non compliant with either major or moderate concerns were based in Croydon.

4.2 The work of the care support team in supporting Croydon providers and of the care forums which provide training to care providers on both safeguarding and mental capacity act issues are, we hope, at least in part a measure of this positive outcome.

4.3 The two Surrey and Borders Partnership Trust services inspected were both found to be compliant. This is encouraging as Croydon has 7 clients placed in Surrey and Borders homes which are currently designated active assessment and treatment units.

4.4 Over the past few years Croydon LD services have been taking a very proactive role with regard to people placed in both long stay NHS and private hospital provision.

4.5 The White Paper, 'Our Health Our Care Our Say (2006)' made a commitment to close NHS Campuses by 2010. Campus provision refers to people who have been living in long stay hospitals for more than 12 months and who are not detained under the Mental Health Act. NHS residential campuses do not offer the best possible support and opportunities for independence and choice for people with learning disabilities.

4.6 The policy aim is for people not to *live* in NHS facilities, but to receive the best possible support and treatment from NHS services. Where appropriate, this should include specialist services which are as close to home as possible.

4.7 Because of this clear policy direction as well as our own professional view that people should be enabled to live independently in the community wherever possible, Croydon LD service has ensured that the needs of all clients living in a hospital setting, including those detained under section, or in active assessment and treatment units, have been closely reviewed and care managed. All clients who were previously subject of the 'Campus' definition have been reassessed and re-provided for. Croydon now has no Campus clients.

4.8 Croydon LD team has also acted to ensure that any client living in a hospital setting and who is unable to give consent, is there either under section of the mental health act or in one case, a deprivation of liberty safeguard has been set in place to authorise the placement via the mental capacity act. This is subject to regular review.

The current position in detail:

4.9 Croydon has 7 clients currently living in private hospital provision. All these clients have been actively case managed by a care manager who specialises in mental health work. The plans for these people have been ongoing for some time and are not in response to the CQC report but they are consistent with the CQC findings.

4.10 Of these seven people:

- 1 client lives in a hospital listed as having moderate concerns. He has been there for 6 months detained under section and is planned to move on from there within the next 6 weeks to a supported living tenancy. His care has been actively monitored throughout and he has made good progress there.
- 1 client, detained under s3, lives in another private low secure unit also found to have moderate concerns. He is now being referred to an NHS specialist LD hospital, managed by South London and Maudsley Trust which is closer to home.

- 1 client, detained under s3 of the MHA, is living in a step down unit – not part of the CQC report. There are no current concerns about his care and he has active involvement from an advocate and ex foster family.
- 1 client detained under s3 had already moved in March 2012 from a unit that was identified by CQC as causing concerns. He is now living in a setting that is not listed as having concerns. He is subject to a deprivation of liberty safeguard authorisation which means that his placement in the hospital has been assessed by a best interest assessor under the mental Capacity Act. He has contact from a family member who is a strong advocate for him.
- 1 client, detained under s3, is living in a hospital where there are no concerns. There are plans to move her to a local unit if she will agree to move or under best interest. This would improve access to her parents who are actively involved and who advocate for her and would like her to be closer to them.
- 1 client, detained under s3, is living in a private hospital found to have minor or no concerns. He has active family involvement and an advocate. There are no plans to move him as he seems well suited to the setting and previous attempts to place him in a community setting failed.
- 1 client has recently moved from high security to medium security NHS hospitals. Neither establishment featured in the CQC report. He is under s3 of the MHA. He has close family involvement and a solicitor acting for him.

4.11 All clients placed under detention on a section 3 of the mental Health Act are subject to regular review by a tribunal and have legal representation. This is in addition to the usual care management reviews. The care manager has to provide social enquiry updates to each tribunal hearing.

4.12 In addition to these 7 clients, there are a further 7 clients who are all living in provision run by Surrey and Borders partnership NHS Trust. Again these clients have been actively case managed for the past two years plus to look at options for moving them into a more local community based, supported living or residential care provision. Like the first 7 clients, they have very complex needs and were formally part of Campus, long stay hospital, provision. We have actively worked with the NHS Trust to review all their needs and for their existing setting to change from active assessment and treatment to residential care homes registered by the CQC.

4.13 These seven clients have a mixture of either close family involvement or advocacy and sometimes both, to protect their interests and this aspect is being continuously reviewed. Work is ongoing for each of these seven people to assess whether they can move back to Croydon and into supported living accommodation. Any changes have to be carefully assessed taking account of the impact on people, many of whom are autistic, of major life changes and the views of their families. The assessments for all these clients mentioned are holistic and include care management and psychiatric review and in many cases also learning disability nursing and psychology input.

4.14 At any one time there may be a small number of clients with learning disability placed on a voluntary basis or under a section of the mental health act in commissioned beds at the Bethlam Hospital. This is in response to mental health breakdown and need for acute assessment and treatment. These patients will all receive a team approach including psychiatry, nursing, psychology and case management with the aim of discharging them back into

the community as soon as possible.

4.15 Over the past few years, the learning disability service has been actively seeking to keep people close to home wherever possible, as advocated by the CQC report, and has regularly established supported living services in Croydon, using support providers from a framework agreement, so that people can have tenancies and enjoy normal community life. This approach has been successful in keeping a number of people with very challenging behaviour out of more restrictive settings and enabling the full support of the joint community learning disability team to be mobilised for them.

5 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 There are no financial implications or risks.

6. LEGAL CONSIDERATIONS

6.1 These are set out in the body of the report.

7. HUMAN RESOURCES IMPACT

7.1 There is no human resource impact arising from this report.

8. EQUALITIES IMPACT ASSESSMENT (EIA)

8.1 There is no equalities impact.

9. CRIME AND DISORDER REDUCTION IMPACT

9.1 Part of the Dignity agenda is to ensure that vulnerable people are not subjected to criminal activity by their professional or voluntary carers.

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BACKGROUND : N/A