Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust

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The Healthcare Commission

The Healthcare Commission’s full name is the Commission for Healthcare Audit and Inspection. It exists to promote improvements in the quality of healthcare and public health in England. We are committed to making a real difference to the provision of healthcare and to promoting continuous improvement for the benefit of patients and the public.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and has taken over some responsibilities from other Commissions. It:

- has replaced the Commission for Health Improvement (CHI), which ceased to exist on March 31st 2004
- has taken over responsibility for the independent healthcare sector from the National Care Standards Commission, which also ceased to exist on March 31st 2004
- carries out the elements of the Audit Commission’s work relating to the efficiency, effectiveness and economy of healthcare

We have a statutory duty to assess the performance of healthcare organisations, award annual ratings of performance for the NHS and coordinate reviews of healthcare with others.

We have created an entirely new approach to assessing and reporting on the performance of healthcare organisations. Our annual health check examines a much broader range of issues than in the past, enabling us to report on what really matters to those who receive and provide healthcare.

Investigating serious failings in healthcare

The Healthcare Commission is empowered by section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003 to conduct investigations into the provision of healthcare by or for an English NHS body.

We will usually investigate when allegations of serious failings are made, particularly if there are concerns about the safety of patients. Our criteria for deciding to conduct an investigation are available on our website at www.healthcarecommission.org.uk

In investigating allegations of serious failings in healthcare we aim to help organisations to improve the quality of care that they provide, to build or restore public confidence in healthcare services, and to seek to ensure that care provided to patients is safe throughout the NHS.

The Healthcare Commission is responsible for this report, and for ensuring that Sutton and Merton Primary Care Trust publish an action plan in response to this investigation. The action plan will be available on the Healthcare Commission’s website. The London Strategic Health Authority and the Healthcare Commission’s regional team for London will be jointly responsible for monitoring the implementation of the actions that have been agreed.
Executive summary

On February 8th 2006, the Healthcare Commission decided to investigate the service provided for people with a learning disability at Sutton and Merton Primary Care Trust (the PCT). The chief executive of the PCT had contacted the Healthcare Commission in January 2006 and requested that an independent investigation be carried out following a number of serious incidents in its learning disability service, including allegations of physical and sexual abuse. The request was supported by the South West London Strategic Health Authority. The aim of the investigation was to establish whether the ways of working at the PCT were adequate to ensure both the safety of people using the service and the quality of the service provided.

The Healthcare Commission examined the quality and safety of care at Orchard Hill Hospital, the community homes in Sutton and Merton, and at Osborne House in Hastings. Orchard Hill Hospital is one of the last hospitals to close where people with learning disabilities have lived for a long time; two judicial reviews delayed closure. The investigation also explored how the PCT worked with people with learning disabilities, their carers and their families, including how they were involved in decisions relating to care and treatment. Governance, management and leadership arrangements were also examined.

The investigation team comprised members of staff from the Healthcare Commission and external advisers, including a person with a learning disability and a representative from the Commission for Social Care Inspection (CSCI). The British Institute for Learning Disabilities (BILD) and the Department of Health’s Valuing People team also provided advice to the investigation team. In addition, the Healthcare Commission set up an external reference group to ensure a broad range of expert advice was received. Evidence was collected from interviews, analysis of documents, relatives and carers, visits and observations and a review by BILD.

Findings about the quality of care

The Healthcare Commission examined the houses that people lived in and the way in which care was delivered to 184 people with learning disabilities at the PCT. This included looking at the model of care provided, relevant national policies, best practice and whether care was based on the needs of individuals. We found that the model of care was largely based on the convenience of the service providers rather than the needs of individuals. For example, during meal times some people’s shoulders were wrapped in a large sheet of blue tissue paper, and they were then fed at a speed that would not allow for any enjoyment of the food.

The overall provision of activities was very low, with some people having only three to four hours of activity a week. The majority of activities were provided at Orchard Hill Hospital and many people came back to the hospital for GP, dental and chiropody services. They did not have the opportunity to gain access to the full range of healthcare in the community.

There were some examples of good practice regarding the quality of care, such as people living in smaller groups at Osborne House and people being taught how to make a cup of tea at the Woodlands Centre. However, most of the houses people lived in were unsuitable, with particular difficulties for people with mobility problems requiring wheelchairs and hoists. The

environmental constraints and the ways of working meant that the privacy and dignity of individuals were sometimes compromised.

Staff endeavoured to meet the healthcare needs of people for whom they were responsible but their efforts were compromised by lack of training and lack of specialist contribution from speech and language therapists, psychologists and physiotherapists.

Findings about services for people with behaviour that challenges

In the two houses for people with behaviour that challenges we found that there was a lack of regular staff and that staff had limited expertise. There was also evidence of rigid routines, a deprived environment with a lack of individualised care and insufficient meaningful occupation of time.

In these houses, staff did not report all incidents where the safety of people for whom they were responsible was compromised. There was no policy on the use of restrictive physical interventions and restraint. Although many staff believed that they were not using restraint, our observations and records demonstrated otherwise. Restraint was used inappropriately at times when it should have been used as a last resort. There was no system for monitoring the use of restraint. One woman had experienced a form of restraint for many years, where a splint on her arm was used to prevent movement in order to stop her putting her hand into her mouth. The psychology department did not believe that the continued use of this restrictive intervention was justified. Following a clinical review in February 2006 it was agreed to remove the splint for 30 minutes a day and for staff to observe behaviour. This plan of care has progressed to the splint being used for only three hours a day.

Findings about serious incidents

The investigation team examined 15 serious incidents that occurred in the learning disability service between December 2002 and November 2005. These were incidents of sexual and physical abuse including one incident when a woman with learning disabilities was raped. Many staff reported being shocked and saddened by the incidents. They said that morale had been adversely affected and some staff felt ashamed to say where they worked.

The local authorities of Sutton, Merton and East Sussex each had arrangements for the protection of adults less able to look after themselves and although they differed slightly they were based on the same principles and the policies met the national requirements. The majority of the reviews of serious incidents followed the correct procedures for the protection of adults less able to look after themselves. However, in some cases there were weaknesses in the implementation of the procedures such as poor communication, lack of staff awareness about adult protection, and poor follow-up of actions agreed at meetings.

Findings about short break care for children with learning disabilities

Short break care (also known as respite care) was provided to children and young people with a learning disability in a bungalow in Sutton. We considered this to be unsuitable because the rooms in it were too small. Although the Healthcare Commission had not been made aware of any specific concerns about the short break unit, it was considered important to find out whether the children had been appropriately cared for in what was predominantly an adult service. Prior to November 2005 there was little communication between the PCT’s learning disability service and the PCT’s children’s service about the short break unit. The Sutton team for adults with a learning disability was providing a service to some children in a local school that was not subject to proper contracts or properly funded. However, a comprehensive independent audit had been carried out at the short break unit during January and February 2006 at the request of the head of the children’s service.
and changes were being implemented in response to the findings.

There were inadequate arrangements in place to support staff working in the children’s short break unit until management responsibility was transferred from the learning disability service to the children’s service in November 2005. There were insufficient staff to ensure that children and young people could participate effectively in community activities, the roles of staff were unclear and staff were unable to give sufficient time to caring for and supporting children and young people.

Findings about how people influenced the provision of care

The investigation found that person-centred plans as described in Valuing People only existed for the minority of people. Most people did have some sort of plan for their care, although there was little evidence that these were reviewed regularly.

There was no provision of advocacy in the community houses with the exception of one house in Sutton. Relatives and carers were concerned about the future but said that they were generally satisfied with how the service was being delivered. Relatives wanted people to have more activities, especially in the evenings and at weekends. Few relatives had complained, yet there was little evidence that they were provided with information about how to complain.

Communication with people with learning disabilities was poor. Few staff had effective communication skills and the potential for people to communicate in different ways was not developed. A quote from the records of one person stated: “staff do not require communication training because the client does not speak”. This demonstrates an extremely poor level of understanding and does not acknowledge that those who do not use spoken language may have other ways of communicating.

Findings about arrangements for governance

To promote safe ways of working, the systems of governance of an organisation should ensure that there are sufficient staff in post to support the needs of the individuals to whom they are providing a service. Those staff must have the right training and opportunities for development and the right supervision and appraisals. There should also be good systems for the management of risk.

We found that, historically, staffing levels were low, with a reliance on temporary NHS and agency staff, and there were high rates of sickness and unfilled vacancies. There was poor attendance at mandatory training and insufficient investment in the development of staff. Supervision was not being carried out effectively and many staff had not had an appraisal, a situation which the PCT was not monitoring.

Insufficient action had been taken to address and manage risks that had already been identified. There had been an increase in reported incidents but the total number was still low. Policies and procedures were not systematically reviewed or effectively disseminated to staff.

A committee in the learning disability service provided staff with a forum to meet and share issues about the quality of the service, but its effectiveness was limited because issues identified did not always reach the governance committee, or the PCT’s board. Prior to 2006, reports to the board focused on the two judicial reviews previously referred to, and the hospital replacement programme, not the overall quality of the service.

Findings about management and leadership

Our investigation found that home managers did not have time to manage effectively due to historically low staffing levels. There were some examples of good practice by home
managers and modern matrons but neither group was seen to champion services for people with learning disabilities. The roles and responsibilities of modern matrons were not clear to staff.

Other PCTs that commissioned services at the hospital had concerns about the quality of care and the length of time taken to redesign the service. Partnerships were in place with Merton Local Authority and were also being developed with Sutton Local Authority. The strategic health authority’s monitoring of the quality of services provided to people with learning disabilities was not sufficiently robust. There remains a high level of concern about whether new services can be provided for people at Orchard Hill Hospital and at Osborne House by the target dates of 2009 and 2010 respectively, because of the limited management capacity and the insecure financial arrangements.

Conclusions

Institutional abuse occurs 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. This abuse was found to be prevalent in most parts of the learning disability service. Most people were unable to go out into the community most of the time. There was an extremely low level of activities on offer and even people who were based in the community did not participate in community life but returned to the hospital for healthcare or day activities. This type of institutional abuse was largely unintentional but it is abuse nevertheless. It was mainly due to lack of awareness, lack of specialist knowledge, lack of training and lack of insight. It was exacerbated by low morale among staff, shortages of staff, inadequate supervision and a lack of leadership. Most environments that people lived in were unsatisfactory with inadequate access for disabled people, poor decoration and furnishings, and insufficient space in bathrooms for hoists.

The way that short break care was provided was unacceptable as individuals requiring short breaks would be placed for a few days or weeks with other people who had lived together in a house for many years. This took up a lot of staff time and meant that the needs of people who had lived there for many years often took second place. For example, one person requiring short breaks had behaviour that challenged, and as a result of that behaviour other people living in that house stayed in their bedrooms for long periods because they were frightened.

There were serious deficiencies in record-keeping. In particular, the requirement for people to have a person-centred care plan based on the principles of Valuing People was not adequately met. The care plans that did exist were often not up to date and there was little evidence of regular reviews of these plans. Some people had plans called health action plans. However, the review by BILD found that, although some of these were comprehensive and detailed, they did not meet the requirements of Valuing People. Instead, the plans were focused on maintaining people’s health rather than focusing on improving people’s lives.

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, 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. Staff were also very apprehensive about trying new ways of working that might represent a risk to the individual. Generally, people with learning disabilities were not supported and encouraged to develop new skills, which can sometimes be achieved by taking therapeutic risks based on an agreed plan of care.

We found that there was inadequate specialist support for people with behaviour that challenges. For three years, the psychologist had repeatedly asked for more resources but had not been supported in this request. Due to
the absence of a policy about restraint and lack of training, staff were restraining people inappropriately without giving sufficient consideration to alternative approaches. Items such as straps on wheelchairs and splints on limbs were used to restrict movement, and their use was not regularly reviewed to determine whether they were still required.

An analysis of serious incidents showed that people were at risk from each other, and at times from staff. While no one could have anticipated some of the serious incidents that did occur, there were some weaknesses in the action that the learning disability service took after these serious incidents. If more robust action had been taken after each serious incident, this would have sent a clear signal about the PCT’s commitment to the safety of the people using its services. Staff appeared to be unaware of their duty to protect adults less able to look after themselves. Very few staff had attended training about the protection of adults less able to look after themselves and not all staff had access to the relevant policies.

The management of risk was not effective in the learning disability service. Although structures were in place, such as a risk register, this did not result in the necessary action being taken to address the risks that had been identified. Although most accidents were reported, there was evidence that not all incidents which put the safety of people at risk, or near misses, were reported. This meant that an opportunity to learn from incidents, accidents and near misses was limited, and as a result the PCT missed important opportunities to improve the service. At the same time there was a fear of taking therapeutic risks in the approach to care in the learning disability service that to some extent prevented the development of new skills in people with learning disabilities.

Our investigation found that the views of people with learning disabilities were seldom heard. They were not regularly sought and therefore could not be taken into consideration when decisions were made. Some staff believed incorrectly that if a person could not talk, he or she could not communicate. Very few staff had any specialist training in ways of communicating with people with learning disabilities and as a result interpersonal techniques became focused on observation and completion of tasks rather than on inclusion and development. Many relatives felt that the staff did the best they could and that they were kind and caring people. However, relatives, carers and advocates were not treated as partners in the process of planning care. In particular relatives were concerned about the future of the service and wanted the PCT to communicate more with them. This has improved in the last six months.

In November 2005, the 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. There have been many changes implemented and the move to a much larger bungalow with better access to play facilities will be completed early in 2007. Prior to that date, the unit was not known of by the head of children’s services in the PCT. Also its suitability had not been assessed in any way prior to an audit requested by the head of children’s services.

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. For example, people were cared for, rather than supported by staff to be as independent as possible. It was usually staff rather than people with learning disabilities who opened the front door to members of the investigation team and we were always introduced to staff but not always to people who lived in the houses. Some staff spoke about people as if they were not there and some staff spoke to each other at meal times and not to the person whom they were assisting to eat.

There were shortages of staff throughout the learning disability service, together with above average levels of sickness, unfilled vacancies...
and reliance on temporary NHS and agency staff, particularly at the hospital. The PCT increased the staffing budget for the learning disability service in April 2005 and again during our investigation but additional staffing alone will not necessarily make a difference to the lives of people with learning disabilities.

We found that insufficient staff had participated in relevant courses or attended mandatory training on what to do in the event of a fire, or how to move people safely. There was no robust system of supervision and very few staff had had an appraisal or a personal development plan.

There were failures in management and leadership, from home managers to the PCT’s board. Home managers did not have the time or the training to manage effectively. Instead they were working alongside healthcare assistants to support people with all aspects of daily living. The role of modern matrons was unclear and they were drawn into doing the work of the home managers rather than leading change. In addition, there were no clinical champions campaigning for or delivering improvements to the quality of care offered to people with learning disabilities.

The capacity and the effectiveness of the learning disability service management team was limited. There was no robust system for monitoring what was happening in the service and often managers thought something was happening or had been implemented when in fact it had not. Important messages about the learning disability service were not effectively communicated to the PCT’s board.

The PCT’s board received information about the proposed redesign of services from the hospital and Osborne House, and at an earlier time, about the two judicial reviews aimed at preventing the closure of the hospital. However, they did not get robust information that enabled them to monitor the quality of services for people with learning disabilities. These services had always been a small part of the overall responsibilities of the PCT and its predecessor organisations, which meant that it was difficult to compete for resources.

The fact that there had been seven chief executives in the last decade and four different organisations (with three different health authorities), created a lack of continuity and follow-up of management action. The unique combination of circumstances at this PCT, including the frequent changes in management and the two judicial reviews, meant that no one individual was responsible for the poor quality of services for people with learning disabilities. The current chief executive, with the full support of the PCT’s chair, requested this investigation and, although recognising it will be challenging, all are committed to acting on the findings and implementing the recommendations.

The closure of long-stay hospitals like Orchard Hill should have happened many years ago in line with the Government’s policy, as well as the closure of campus-type accommodation like Osborne House. The hospital is one of the last long-stay hospitals in the country to close and the PCT requires external support to ensure that this happens without unnecessary delay. In the light of our investigation the Healthcare Commission considers that the PCT is unlikely to be able to manage this process effectively without adequate transitional financial arrangements. Without these arrangements and effective change, the provision of services will continue to be provided in completely inadequate environments, making it extremely difficult for the PCT to implement new ways of working that are more in line with *Valuing People*. The redesign must be managed differently to ensure that new services are developed and provided to meet the needs of people with learning disabilities in these services.

**Key recommendations and progress**

A number of immediate changes were implemented while the investigation was underway. In particular there has been a
significant increase in the number of people with person-centred care plans and progress has been made in ensuring that people have comprehensive healthcare assessments. There has also been an increase in staffing levels and new staff have been appointed to clinical and managerial posts.

The following key recommendations by the Healthcare Commission aim to bring the PCT into line with best practice and national guidelines. (The complete list of recommendations, and further detail about the PCT’s progress to date, can be found at the end of this report.) The PCT is required to publish an action plan with timescales for action within nine weeks of the publication of this report.

- It is of fundamental importance that services for people with learning disabilities are based on individual person-centred care plans and health action plans that meet the requirements of Valuing People, to promote social inclusion and improve health. Such plans should be developed for all people using the learning disability services by the end of October 2007.

- Social, recreational and educational activities must be provided to enhance the quality of life of individuals. These should take place in people’s homes and in the community.

- The PCT must develop and implement a policy about working with restrictive physical interventions and staff should receive training where relevant in how to restrain a person. The use of restrictive physical interventions such as straps and splints should be reviewed and they should only be used as a last resort.

- The PCT must, after consultation with the Valuing People support team, engage the support of an external clinical team to provide mentoring and coaching for the home managers. They should help to develop skills in leadership and encourage staff in the homes to embrace new ways of working, based on an inclusive model of care.

- The PCT must take the necessary steps to assure itself that the workforce has the appropriate mix of skills, experience and training. Also that they attend mandatory training, that attendance is effectively monitored and if staff are found not to be attending, that action is taken.

- The provision of advocacy services should be reviewed to ensure that people with learning disabilities are able to articulate their own opinions and choices wherever this is possible.

- The board must satisfy itself that an effective mechanism for assuring quality is in place to monitor the quality of care, and the safety of people with learning disabilities. This must include information given to the board about the quality of care provided by the learning disability service.

- The strategic health authority must ensure that external support is provided to the PCT so that new services can be developed without further delay, and that the closure of Orchard Hill Hospital can be achieved by the agreed target date of April 2009 and Osborne House by the target date required by the White Paper Our Health, Our Care, Our Say of 2010.

- The strategic health authority must ensure that, from the board down, the PCT’s responsibility as a provider of services is clearly separated from its responsibility as a commissioner of services, and that the latter holds the former to account for delivery.

Wider lessons

This is the second investigation into services provided for people with learning disabilities that the Healthcare Commission has completed. In July 2006 we published the report of a joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust. There are some unique factors in this investigation which set it apart from the Cornwall investigation, such as the
two judicial reviews and the large number of people still living in a hospital setting. However, there are also some similarities in the findings, which may have relevance for other organisations providing services to people with learning disabilities:

- institutional abuse was occurring but staff were often unaware that what they were doing in fact constituted abuse
- people, their relatives and their advocates were not involved sufficiently in the planning of care and there were low levels of activities
- services for children with learning disabilities were provided in isolation from other children’s services
- the arrangements for governance did not allow for effective monitoring of the quality of the services
- the PCTs failed to commission safe services of good quality and the strategic health authorities failed to discharge their responsibilities to effectively manage the performance of the learning disabilities service

The Healthcare Commission intends to build on these wider lessons by carrying out a comprehensive audit of learning disability services both in the NHS and the independent sector throughout England. This will improve the understanding of the key issues affecting people who are using learning disability services, and also provide information about what improvements can be made by organisations which are providing learning disability services. It is anticipated that the results of this audit will be published in 2007.
Introduction

In February 2006 the Healthcare Commission decided to investigate the service provided for people with a learning disability at Sutton and Merton Primary Care Trust (the PCT), after the PCT contacted the Healthcare Commission about a number of serious incidents in its learning disability service, including allegations of physical and sexual abuse. The South West London Strategic Health Authority supported the need for an independent investigation. The aim of the investigation was to establish whether the ways of working at the PCT were adequate to ensure both the safety of people using the service and the quality of the service provided.

Prior to launching its investigation, the Healthcare Commission was already looking into concerns about standards of care at Osborne House in Hastings, part of the learning disability service provided by the PCT. We had been contacted in March 2005 by a member of staff from the Commission for Social Care Inspection with concerns about the response of the PCT to an allegation of abuse. These matters had been followed up and, although the findings of an investigation carried out by the PCT concluded that the staff at Osborne House were following the procedures for the protection of adults, the Healthcare Commission made recommendations to improve the quality of the service at Osborne House.

In December 2005, the strategic health authority wrote to the Healthcare Commission about a number of serious incidents in the learning disability service. These had taken place at Orchard Hill Hospital in Sutton and one of the PCT’s community houses in Sutton. The PCT confirmed that they were working closely with Sutton police and relevant local agencies as required by locally agreed procedures to ensure the protection of the public.

The chief executive of the PCT contacted the Healthcare Commission in January 2006 and requested that an independent investigation be carried out. Healthcare Commission staff visited the hospital in January 2006 to gather further information, which was later presented to the Healthcare Commission’s investigations committee. On February 8th 2006, the Healthcare Commission agreed that an investigation should be carried out looking at the learning disability service provided by the PCT.

Terms of reference

The Healthcare Commission agreed the terms of reference for the investigation in February 2006. They set out to examine:

- the quality and safety of the provision of care throughout the learning disability service
- the adequacy of the PCT’s model of service provision, and the extent to which it conformed to legal requirements, relevant national policies and best practice, particularly person-centred approaches
- the way the PCT worked with people with learning disabilities, their carers and their families, including how they were involved in decisions relating to the care and treatment of a person
- the governance of the learning disability service including arrangements at a strategic level to ensure the safety of users of the service and the quality of care
- management and leadership at all levels including joint working arrangements between the PCT and its local health community partners

A person-centred approach is one where the organisation and delivery of care is focused on the requirements and wishes of the individual. [See section 8 of this report for further details.]
any other matters which the Healthcare Commission considered arose out of or were connected with the above

About this investigation

The investigation team comprised of members of staff from the Healthcare Commission and external advisers, including a person with a learning disability and a representative from the Commission for Social Care Inspection. The British Institute for Learning Disabilities (BILD) and the Department of Health’s Valuing People team also provided advice to the investigation team. Full details of the investigation team are provided in appendix A.

In addition to the expert advice from external members of the investigation team, the Healthcare Commission set up an external reference group to ensure a broad range of expert advice was received. This group included representatives from professional organisations, a person with a learning disability and a carer. Details of the membership of the group are also listed in appendix A.

There were five main methods used to collect evidence for the investigation. These were interviews, analysis of documents, the views of relatives and carers, visits and observations and a review by BILD.

Interviews

The investigation team conducted nearly 200 face to face and telephone interviews and meetings from February 2006 to July 2006. Interviews and meetings were conducted with:

- staff from the PCT (past and present)
- staff from the wider health and social care community in Sutton, Merton and Hastings
- people who used the service provided by the PCT
- carers and relatives of people with learning disabilities
- staff or representatives from other relevant organisations, including advocates3 of people with learning disabilities

A summary of people interviewed is included in appendix B.

Analysis of documentary evidence

The investigation team analysed more than 1,200 documents provided by the PCT and other sources, including policies, minutes of meetings, correspondence, reports and records. The records of care given to a number of people with learning disabilities were examined in detail. A summary of documentary evidence is provided in appendix C.

The views of relatives and carers

We sent out questionnaires to 110 relatives and carers of people with learning disabilities and 44 replied giving their views on the service. We also interviewed 21 relatives and carers and met with the committee of parents and relatives of people at the hospital.

Visits and observations

The Healthcare Commission visited all the buildings in Sutton, Merton and Hastings where people with learning disabilities lived or attended a day centre. A total of 70 observation visits were carried out by the team, some of which were unannounced and some of which were notified to the PCT in advance. While the general purpose of the visits was to gather information about the physical environments that people lived in, they were also carried out to enable team members to assess the quality of care provided.

The British Institute for Learning Disabilities (BILD)

As part of the investigation, the Healthcare Commission asked BILD to review the quality of the service for people with learning disabilities

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3 Advocates are people who help other people express their views. The responsibilities of advocates are described further in section 8.
provided by the PCT. BILD visited the service in all locations and met with people with learning disabilities, their carers, relatives and staff. BILD also carried out an examination of healthcare records particularly looking at individual care plans. The findings of the review and other evidence, are included in the relevant chapters of this report. The executive summary of the findings from the BILD review can be found in appendix E.
The national context

Over the past 30 years, the approach to the provision of services for people with learning disabilities has changed significantly. Most of the large hospitals that were intended for people to live in for a long period of time (long stay hospitals) in the NHS in England have closed and the majority of people have been transferred to services in the community. Fewer than 3,000 people with learning disabilities continue to live as inpatients in campus accommodation, and 181 of these remain in a long stay hospital. Campus accommodation consists of a group of houses, clustered together, with some shared facilities. Many trusts have already moved away from this type of provision or are in the process of doing so. This shift in focus, from long term healthcare in hospitals and campus accommodation to social care in the community has been driven, particularly in recent years, by the Government’s policy of ending institutional care for people with learning disabilities. It is underpinned by several key pieces of legislation, national guidance and policies that include the following:

- guidance on assessing the medical needs of people with learning disabilities (HSG(92)42)
- guidance about multidisciplinary assessments of the needs of individuals (LAC(92)15) and Section 47 of the National Health Service and Community Care Act 1990
- guidance on funding continuing care
- the Care Standards Act 2000 which is a framework for the regulation of social care and independent healthcare services and was amended in 2003. Although the National Minimum Standards set out in this Act do not apply to current NHS provision for people with learning disabilities, they are generally regarded as quality standards that all healthcare organisations should aim to meet

No Secrets: The protection of vulnerable adults

In March 2000, the Department of Health published No Secrets: Guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse. Local authorities are required to follow this guidance.

No Secrets states that abuse takes place in many settings, including those environments previously assumed to be safe, or in public places. The guidance covers different forms of abuse, including physical, sexual, psychological, financial, material, institutional and discriminatory abuse, neglect and acts of omission. Under the guidance, local communities should have in place an inter-agency framework, which is formally agreed between all relevant agencies, to protect adults less able to look after themselves.

Valuing People

In March 2001, the Department of Health published the White Paper, Valuing People: A new strategy for learning disability for the 21st century. This paper set out four principles that underpin the approach to the provision of services for people with learning disabilities: rights, independence, choice and inclusion. The White Paper proposed a lifelong method, beginning with an integrated approach to services for disabled children and their families and then providing new opportunities for a full and purposeful adult life. It also outlined a
series of new policy initiatives, including the following:

• the replacement of old long-stay hospital accommodation with community-based housing and the aim that all people in long-stay hospitals should move to more appropriate accommodation by April 2004

• the development of ‘person-centred’ planning to support people with learning disabilities to exercise more choice and control over their lives. Person-centred planning is defined by the Department of Health as a “process for continual listening and learning, focused on what is important to someone now and for the future, and acting upon this in alliance with family and friends. This listening and learning is used to understand a person’s capacities and choices. Person-centred planning is a basis for problem-solving and gathering the resources necessary to pursue the person’s aspirations. These resources may be obtained from a person’s network, from service agencies or from a range of non-specialist and non-service sources”

• the establishment of learning disability partnership boards in each county, district or borough council (local authorities), which are responsible for implementing the elements of the White Paper relating to services for adults and the development of joint investment plans

**Mental Health Act**

The Mental Health Act 1983 governs the admission of a person to a psychiatric hospital against their will, their rights while detained, discharge from hospital and aftercare. The Act applies in England and Wales and in broad terms applies not only to people with mental illness, but also to people with mental impairment and severe mental impairment (which relates to people with learning disabilities), although only where this is associated with abnormally aggressive or seriously irresponsible conduct.

**Mental Capacity Act 2005**

The Mental Capacity Act provides a statutory framework to protect adults who may lack the capacity to make their own decisions. The Act is due to be implemented in April 2007 and is underpinned by five key principles which are:

• assume a person has capacity, unless proved otherwise

• do not treat people as incapable of making decisions unless all practicable steps have been taken to support them

• do not treat people as incapable of making a decision because their decision may seem unwise

• do things or make decisions for people without capacity in their best interests, not in the best interest of others such as relatives or carers

• before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way

**New safeguards for the most vulnerable people**

In June 2006 the Government published new proposals for closing what is known as the ‘Bournewood gap’, by introducing new safeguards for adults less able to look after themselves who need to be cared for in circumstances which amount to deprivation of liberty and who lack the capacity to consent. These safeguards will be introduced by amendment of the Mental Capacity Act 2005 as soon as parliamentary time allows. The Government’s proposals are in response to a judgement by the European Court of Human Rights in 2004 that the present arrangements surrounding deprivation of liberty involving someone lacking in capacity are not adequate.

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Our Health, Our Care, Our Say

The proposals in the White Paper *Our Health, Our Care, Our Say*, published in January 2006, are part of the Government’s wider reform programme to provide services designed around the patient, rather than the needs of the patient being forced to fit into the service already being provided. It has set a target for the end of campus accommodation for people with learning disabilities by 2010.
The local context

About Sutton and Merton Primary Care Trust

Sutton and Merton Primary Care Trust (the PCT) was established on April 1st 2002 by bringing together Nelson and West Merton PCT, Sutton Primary Care Group, part of East Merton and Furzedown Primary Care Group, South West London Community NHS Trust, therapy services from St Helier Hospital, and staff from the Merton, Sutton and Wandsworth Health Authority.

The PCT comprises of 56 GP practices, 16 clinics and health centres, two community hospitals (the Nelson and the Wilson), 77 community pharmacists, 35 optometrists and 74 dentists. It also provides services for people with learning disabilities from a number of properties, including Orchard Hill Hospital.

Prior to the PCT being established, the learning disability service was provided by South West London Community NHS Trust from April 1999 to March 2002 and before that by Merton and Sutton Community NHS Trust from November 1992 to March 1999.

The PCT serves a population of around 392,000 people living in Sutton and Merton. Figures from the Office of National Statistics (2004) about Sutton and Merton Local Authorities indicated that these were not deprived areas. The black and minority ethnic community make up 16.3% and 35.9% of the Sutton and Merton populations respectively. Black and minority ethnic people with a learning disability make up 24% of people living at the hospital, 13% of the people living at Osborne House and 37% of those living in the community houses.

In February 2006, there were 949 people registered with learning disabilities living within Sutton or receiving care funded by the PCT, 930 of whom were over 18 years of age. In Merton, there were 617 people with learning disabilities registered, 588 of whom were over 18 years of age.

As well as providing the learning disability services in Sutton, Merton and Hastings, which are described below, the PCT is also a commissioner of services for people with learning disabilities. This means that as well as working with the local population to improve health and wellbeing, the PCT has a duty to commission a comprehensive and equitable range of quality services within allocated resources. Key to this is the need to assess and review provision, decide on priorities, design services, manage demand and manage the performance of service providers.

The learning disability service

The PCT provides a service to 95 people living at Orchard Hill Hospital and to 59 people living in community houses in Sutton and Merton. There are day centres and community teams in both Sutton and in the Merton Local Authority area. The PCT also provides a service to 30 people living in five different types of accommodation at Osborne House in Hastings. Short break care for children with learning disabilities is provided in Sutton. Services for children are dealt with in more detail in a later chapter of this report. The majority of this report focuses on the lives of, and the care provided to, people living in the hospital, the community houses and Osborne House.

The Orchard Hill Hospital in Sutton

Orchard Hill Hospital (the hospital) stands in the grounds of the former Queen Mary’s Hospital for Sick Children in Carshalton.
Beeches. A total of 95 people with learning disabilities live in 11 buildings at the hospital; the majority of these were built around 1945. There have been very few admissions during the last ten years. Appendix D lists the number of people who live in each building together with the number of staff.

The people who live at the hospital are between 30 and 50 years old and most have severe learning disabilities and complex health needs. There are equal numbers of men and women who live there. Very few people are fully mobile and many use wheelchairs, some of which are specially adapted. Some people have sensory difficulties such as visual or hearing impairment. The majority of people need medication every day. Forty-seven people have epilepsy and eight of them are prone to a life threatening condition of protracted seizures. Forty six people have eating and swallowing difficulties or a serious weight problem and 14 people have been assessed as having behaviour that challenges services, such as self-harming behaviours (biting themselves or banging their head against a hard object).

The other services provided at the hospital are art, drama and music therapy, activities and therapies provided at the Woodlands Centre, a hydrotherapy pool, a health centre and a specialist dental service. The Sutton Local Authority education department operates a further education college at the hospital and at its new site, in Wallington.

The hospital is a long stay hospital and, in line with the Government’s policy initiatives during the 1990s, the then Regional Health Authority was responsible for closing the long-stay hospitals. The Merton and Sutton Community Trust considered the possibility of closing the hospital but no action was taken at that time.

In January 2000, when South West London Community NHS Trust provided the services at the hospital, Merton, Sutton and Wandsworth Health Authority made a decision to close the hospital. That decision was subject to a judicial review. The court decided that the health authority’s decision to close was flawed for two reasons:

- the health authority failed to take into account promises made to some people with learning disabilities or their families at the time of their admission, that the hospital would be a home for life
- the health authority had not made a detailed assessment of the needs of individuals which were required to be taken into account. Without this information the health authority could not properly determine how central Government policy impacted upon the group of NHS patients who then lived at the hospital

In view of this successful legal challenge to the closure of the hospital, five staff were recruited to plan and implement changes to the way services were delivered. In April 2002, with the demise of the Merton, Sutton and Wandsworth Health Authority, the PCT was charged with taking this work forward. Individual assessments of the needs of people living at the hospital were completed during 2003. A consultation exercise was then conducted and four options were put forward:

1. to keep the existing buildings
2. to develop a new village community on the hospital site
3. to develop a new service for all the people living at the hospital in the community
4. to build a small unit at the hospital and develop new community services

Since April 2002, the learning disability service at the hospital has been managed by the PCT. In November 2003, the PCT’s board agreed to consult for three months on option three. In May 2004, the PCT’s board was presented with, and approved, a proposal to transfer services from the hospital into the community. Following meetings with the Department of Health’s Valuing People team, a revised date for the closure of the hospital was set for March 2006.

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1 R v Sutton and Merton and Wandsworth Health Authority ex p Perry, Andrew and Harman [2001] Lloyds Rep 73.
In August 2004, two applications were made to the High Court on behalf of two people who lived at the hospital. The first was an application for a judicial review of the decision to close the hospital. The second application was to the family division of the High Court for a declaration that it would not be in the best interests of the same two applicants to move from the hospital. Both applications were withdrawn in June 2005 when the PCT and the official solicitor representing people with learning disabilities agreed a process whereby the needs of 38 people with learning disabilities were independently assessed. The assessments would then be taken into consideration in the planning process and ensure that the right model of care was developed. The assessments were due to be completed in August 2006 but were delayed because it took time to recruit the panel of experts to undertake them. There is now a third date for the closure of the hospital of April 2009.

The community houses in Sutton and Merton

The people that live in the community houses have a variety of abilities but all require 24-hour support and care. In addition to having a learning disability, some people have physical health needs and require support with eating and drinking, mobility, epilepsy and continence. Some people have a lack of awareness about danger or risk, and some have behaviour that challenges those providing services, including self-harming behaviour. People living in the houses required support with medication, personal care and daily activities. There are two houses in Merton and eight houses in Sutton, one of which is the children’s short break unit. Nearly all the community houses are campus style accommodation. Numbers of people who live in the community houses and numbers of staff are provided in appendix D.

Other services

At the Cheam Centre in Sutton and the Woodlands Centre at the hospital, people with learning disabilities are able to participate in different activities. The activities are designed to promote meaningful occupation of time and to improve the quality of life of people who attend the centres. A similar service is offered at the Freshfields Centre in Merton. The Merton Local Authority and the PCT jointly provide this service.

In Sutton, some staff are based in the community to support the health and social needs of people with learning disabilities living in the community. Services provided by the teams include assessment and care management, supporting people to access care at home, day and residential services and healthcare. The team works to keep people living in their own houses, or with their families, as independently as possible. The team comprises of different professionals such as doctors, nurses, social workers, psychologists, and speech and language therapists. Both the PCT and the Sutton Local Authority employ the staff that work together in this team and the local authority manage the team. Similar arrangements are in place in Merton.

Short break care

Short break care is when somebody is admitted to a home or hospital for a few days so that parents or relatives can take a break from their roles as full time carers. Some short breaks are provided to adults with learning disabilities at the hospital, and in a number of the community houses in Sutton and Merton. In Sutton there is a small bungalow providing short breaks to children with learning disabilities.
Osborne House in Hastings

The people who live at Osborne House have a range of abilities and needs. They require 24-hour support aimed at enabling them to make the most of their abilities and to have a healthy and fulfilling life. Following individual assessments of what people want and need, plans are being developed to provide new houses in the community for people who live at Osborne House.

The PCT inherited the running of Osborne House in Hastings. Originally Osborne House was used as holiday accommodation for people with learning disabilities from across south London, but from 1952 it was used as a permanent home. It is a large site in Hastings that provides services for 30 people with learning disabilities in five groups. Osborne House itself was built in 1868 and was split into two residences. There are three other accommodation units including a single storey building that was adapted in 1995. The day centre provides a range of activities as well as support to people who take part in activities in the community.
The quality of care provided

In order to assess the quality of care the Healthcare Commission examined the environment that people lived in and the way in which care was delivered. This included looking at the model of care provided, relevant national policies, best practice and whether care was based on the needs of individuals.

In consultation with people with a learning disability, BILD drew up a list of indicators of quality about things that were important to them. These were:

- I make everyday choices
- I make important decisions about my life
- I take part in everyday activities
- I have friendships and relationships
- people treat me with respect
- I am part of my local community
- I get the chance to do work or activities that are valued by others
- I am safe from bullying and abuse
- I get help to stay healthy
- people listen to the views of my family, friends and advocates

The evidence below demonstrates that very few of these quality indicators were met in the learning disability service.

The model of care

Several staff and some relatives repeatedly told the investigation team that the people at the hospital were unique and different from other people in England who had learning disabilities. This was not the experience of the investigation team. Other than the fact that there was a larger group of people still living together, they were no different from other people with severe learning disabilities who were being successfully supported to live in the community elsewhere.

The majority of staff interviewed said that care was institutionalised. By this they meant that care was based on the convenience of the institution and staffing rotas, and not the needs of the individuals living in the houses. Where it was focused on the needs of the individual, staff said that this was mainly on people’s health needs. Some care staff said that services were inadequate due to the shortage of staff and the large numbers of people living together. However, others said that a number of staff in care roles, particularly those at the hospital, were also institutionalised and were reluctant to change.

Staff described a typical day with roles ranging from cleaning to management. The general routine consisted of handover from the night staff, supporting people to take baths or showers, providing meals, escorting people to activities, appointments and visits and providing medication. Domestic staff worked in some of the houses and carried out cleaning duties.

Meal times were an example of the way the model of care worked in practice. Some staff said that they had developed expertise in feeding people with complex swallowing difficulties (dysphagia). However, few staff had any specialist training in swallowing difficulties, few had received advice or training from a speech and language therapist and mealtimes did not seem pleasurable. We observed some people having their shoulders wrapped in a large sheet of blue tissue paper from a roll, and then fed at a speed that would not allow for any enjoyment of the food. In one house, people
were lined up around a table waiting to be fed in what seemed like a queue.

There was little evidence of people having any choice in the food they ate, and drinks were limited in most of the houses to meal times, mid-morning, mid-afternoon and supper. In most houses at the hospital, meals were served at set times because they were cooked in central kitchens and then delivered to the houses. Staff were starting to do their own cooking in some of the houses. However, many kitchens were too small and lacked the necessary facilities for this to be introduced more widely.

Some people had specific dietary requirements relating to their health needs or religious requirements. We were informed that these requirements were not always met. One woman who had a kidney condition had guidelines on what she should eat, developed by a dietician. Not all staff were aware of her requirements and that resulted in her being given food that was not advisable for her to eat. That particular house had agreed to put these guidelines on display in the kitchen area to ensure that this did not happen again. This had not been done at the time of the investigation but has now been rectified.

In the community houses and at Osborne House, meal times were less rushed. Where possible people were involved in the preparation of the meal, and in some houses they were also involved in the choice of food they had and shopping for food.

At the hospital, some people attended a local church service, which was said to be non-denominational. Individual records showed that some people were of specific religious and cultural persuasion, which may have required them to attend a different form of religious worship. For example, there were a number of people who were recorded as being Roman Catholic and support to attend a Roman Catholic church on a regular basis may have been more appropriate in this instance. One set of records identified the need to find a mosque.

Staff said that this had not happened but that the person concerned seemed to enjoy the singing at the local church.

Following a serious incident in November 2005, the PCT introduced a policy preventing staff from working on their own with people in most of the houses. The policy was intended to benefit people and ensure their safety, but it meant that some people were no longer able to visit the homes of staff who had become friends. In a voluntary capacity staff took them out or to their own home, and in some cases people were considered to be part of the family. For example one elderly man with learning disabilities had, for many years, visited the home of a member of staff on a regular basis to watch football matches shown on television channels not available in the home where he lived. However, following a risk assessment being completed, a decision was made that this particular activity could continue. There was a mixture of views about whether people should be able to go home with members of staff. The view of the investigation team was that if there were sufficient opportunities for people to participate in activities, both in the houses they lived in and in the community, then it would not usually be necessary for people to go to the homes of staff.

We were told about the need for increased awareness at the hospital that intimate personal care should be delivered by staff of the same gender. On at least one occasion, a house where four men and four women lived had four male staff on duty and no female staff, which was contrary to good practice.

About half of the staff in the service had worked with people with learning disabilities for many years. While consistency, familiarity and security are important to people, these long term relationships made it difficult for staff to work in ways that promoted choice and independence. Members of the investigation team heard women over retirement age being referred to as “girls”. Several staff talked about “the children” and one senior member of staff told us how people with learning disabilities were seen as “babies”. Many staff talked about
the over protective role of some staff as “parental”. This was less so in some of the community houses and at Osborne House, where greater efforts were made to do things with people or to support people to do things themselves.

In some of the houses, people had to share bedrooms, which did not always provide people with sufficient privacy. As a result of a recent house closure, two people who did not previously know each other had to share a room. One of these women had to take medication to make her sleep at night so she would not disturb the other woman in the room by getting up during the night. Staff confirmed that once she got her own room, she would no longer have to take night time sedation. In one house, the administration of treatment such as an enema or rectal medicine was in the presence of the second occupant. Many of the bedrooms were small, making access with a hoist difficult if one was required for lifting purposes.

At Osborne House there had been some difficulties related to living arrangements with some people not getting on with each other, and others living in larger groups than was desirable. To address this people were invited to express their preferences, which were taken into account as much as possible before some building work took place and some people moved into different houses. The behaviour of one person in particular was significantly different as a result. Staff said, “He thrived on living in a small house where attention was readily available”. People were encouraged to make choices in their everyday life such as shopping for clothes, but did not actively take part in the running of the home. Some people helped with household tasks such as cleaning, washing and cooking. Staff said that people had limited choices about food because of pressure from managers to impose healthy eating and portion control. From discussions during visits there was evidence that staff still considered it their role to look after people, which in itself is an important role. However, there was little evidence that sufficient attention was given to developing each person’s individual potential.

In two of the community houses in Sutton, there was evidence of some people being frightened of others in the house. For example, one woman was scared to walk past someone who would kick out at her and as a result she spent a lot of time isolated in her bedroom to avoid that person. When the staff were asked about this they said that it was like any normal family environment, and that sometimes people did not get on.

Two houses in Merton had significant difficulties as a result of some people being offered short care breaks. Staff felt isolated and neglected by management and said that short breaks should be provided in separate establishments because it caused disruption for the people who lived there. We were told that some of the individuals remained in their rooms when certain people were there for short breaks. The commitment of staff to people with learning disabilities was what seemed to make the house function, despite limited contributions from qualified staff and the difficulties of providing short breaks. Similar challenges regarding the provision of short breaks were experienced in one of the houses in Sutton.

Living environments

Most of the houses at the hospital were old and in need of significant work to bring them up to an acceptable standard. The majority still had original sections of the hospital and gave the appearance of communal ward living. Some of the buildings where people lived did not provide the basic rights of privacy that most people would expect. A briefing to the PCT’s board dated May 2005 described a number of buildings as approaching a dangerous or unsafe condition. They had been kept going during the last two to three years through special allocations of funding. The PCT recognised that this would not be feasible in the longer term. The condition of the houses at the hospital was rated on a website developed by
NHS Estates, which lists the results of an annual inspection of environments in all trusts. The scores for the hospital in 2004 were in the acceptable category, but in 2005 the scores had dropped into the poor category.

It was difficult for people at the hospital to use their wheelchairs, as ramps were of a poor quality and the gradients were too steep. Also a small lip on the floor made manoeuvring wheelchairs difficult and obstructed access through some of the door frames of houses. Bathing facilities were also found to be inadequate and lacked privacy.

Although the hospital was in a residential area, it was not particularly close to, or within walking distance of, the town and other amenities. This made it difficult for people to be a part of their local community. Several relatives saw the hospital as a pleasant and safe environment for the people who lived there. However, staff complained that their cars were not safe at night and that they were sometimes broken into or vandalised, and things were stolen. Incident forms stated that young adults sometimes went onto the hospital site during the day, shouting offensive names to the people who lived there. Some incidents indicated a lack of security because occasionally these young adults entered the houses on the hospital site without permission and had to be asked to leave by staff.

Some of the staff in the houses at the hospital had put time and effort into making the accommodation as comfortable as possible and made attempts to personalise people’s bedrooms. Other staff appeared not to have given this much thought or in some instances said that it was not worth it because people would damage things, or they would not notice. In comparison, staff in most of the community houses and Osborne House had made a considerable effort in this area.

One house in Sutton had been modernised with good colour schemes and was designed for people with sensory needs and visual impairment. This house was spacious with good access and a well designed garden. Staff had developed their communication skills and used items to tell people what was going to happen. For example, they showed people a spoon to let them know that a meal was ready, or their coat to see if they wanted to go out.

Staff at this house spoke to the investigation team about the needs of people from a black and minority ethnic group which included specific meal choices and a special skincare routine that one person required. Staff in this house said that people seemed much happier than when they lived at the hospital. The staff also said that people with learning disabilities were achieving tasks that had previously been considered beyond their capability.

Many of the community houses did not have shower facilities and the bathrooms were in poor condition. Some bedrooms at Osborne House were very small but others that had been recently modernised were spacious and accessible. The bathrooms had been modernised and were well equipped, but space was quite limited in some of the lounge and dining areas that were in need of redecoration.

As people got older, it was becoming increasingly difficult for some of them to use the stairs. It was not possible to install lifts at Osborne House or in the community houses because of the design of and fabric of the houses, and the staircases could not be adapted to take chairlifts.

Some of the garden areas at the hospital were pleasant, but some of the houses only had tarmac or concrete courtyards for people to sit out in. One of the houses had a small garden and tomatoes in grow bags, to interest people to help grow flowers and vegetables. While the community houses had reasonably attractive gardens, many of the lawns were uneven with only small patio areas, making it difficult for people to go into the garden safely. The gardens at Osborne House were well maintained but they had steep paths without handrails that made it difficult for people to get around the site safely. Handrails have now been fitted, but disabled access requires further attention.
The health needs of people with learning disabilities

Statistically, people with learning disabilities die at an earlier age than people without learning disabilities. The highest causes of death for people with learning disabilities are respiratory disease, followed by cardiovascular disease. During the last 15 years, an average of three people a year died at the hospital. Most of the deaths were due to respiratory problems, such as aspiration pneumonia (which is often linked to difficulty with swallowing). Many people living at the hospital had difficulty with swallowing and were at risk of choking and suffering nutritional deficiency leading to weight loss.

At the time of the investigation, not all of the houses at the hospital had suction machines, which may be needed in an emergency if someone was choking. Those that did were not regularly checked and maintained. In one house the suction machine was broken for nearly a year before a replacement was purchased. When staff were asked about medical equipment they were not clear about when things were serviced, whether they had the right equipment or the right training to use the equipment.

A group of doctors, nurses and other professional staff carried out assessments during 2002 to determine the eligibility of people for continuing care. Continuing care is a general term that describes the continuing healthcare a person needs over an extended period of time as a result of a disability, accident or illness. The outcomes of these assessments were that ten people were assessed as needing a fully funded placement including nursing and personal care. Other outcomes included people being assessed as needing a variety of local authority placements with separate input provided directly by the NHS. The PCT said that these assessments would not determine who pays for the care because the PCT would continue to pay for that.

There was no specialist service to people from speech and language therapists who had expertise in the assessment and treatment of swallowing difficulties. There were three speech and language therapists who worked with the community teams for people with learning disabilities. None of the therapists had specialist expertise in working with swallowing difficulties and therefore were not able to respond to referrals from the hospital. One therapist said that she thought that there would be little effect even if they did provide a service at the hospital. She felt that, due to lack of training, staff would not be able to implement any recommendations they made.

The learning disability service had attempted to recruit a speech and language therapist with expertise in the management of swallowing difficulties but was unable to appoint to the post; this was partly due to a national shortage of speech and language therapists. A few people with particularly complex needs had been referred to a consultant physician and gastroenterologist, and had been assessed and received advice and treatment where required.

A dietician provided advice to care staff and attended meetings held every three months where care was reviewed. This was essential as people were at increased risk of obesity, and were less likely to have sufficient exercise. Despite the dietician’s advice, some people still continued to gain weight or did not lose weight when on a weight reducing programme. It was not clear whether all staff followed the nutritional advice given when supporting people with eating and drinking.

Epilepsy affects about 1% of the population but is more prevalent in people with learning disabilities, with nearly half of people with severe learning disabilities having epilepsy. Approximately 45 people living at the hospital have seizures, with eight people having more complex seizure patterns that sometimes included prolonged seizures. There were detailed recordings about seizures and regular charts were kept. Where necessary, expert advice was sought from a consultant.

1 Royal College of Nursing (2006) Meeting the health needs of people with learning disabilities – guidance for nursing staff
2 Royal College of Nursing (2006) Meeting the health needs of people with learning disabilities – guidance for nursing staff
neurologist or from the National Centre for People with Epilepsy. One clinician interviewed said that there was no nurse specialist in epilepsy working with people with a learning disability and that the PCT should consider appointing someone to such a post.

Staff said they tried to avoid taking risks and were anxious about going out with someone who might have a seizure. Some staff felt that this limited the opportunity for individuals to have new experiences and learn new things. In contrast, an example of good practice occurred when some people went out for a meal assisted by staff, and while they were out one person had a seizure. He was supported during this with as much care as possible to maintain his dignity, and when he recovered he was supported to continue with the outing. A few people have particularly complex seizures and need to go out with two people including a qualified member of staff.

Many people who lived at the hospital used wheelchairs and some of these were specially adapted. There were long waits for new chairs and for special adaptations to existing wheelchairs, but for specially adapted chairs this was a national problem. A relative said that one person had been waiting for six years for a new wheelchair. They were told that it was not necessary because adaptations had been made to the chair. However, the adaptations were not effective and the person was still awaiting a new chair. We were told that one person had to wait eight months to get a new chair. The investigation team was told of two people who had to share one wheelchair, which meant that they could not go out at the same time. When visiting one house, staff said that one man could bear his own weight but was unable to walk anymore. When speaking to his parents, they said he was able to walk at home from a chair to the living room and then to his bedroom. This suggests that some relatives and staff have different views of the capabilities of people.

A physiotherapy team provided a service to people at the hospital and also to people in the community houses. The manager of the team said they tried to promote and maintain the mobility needs of individuals. Staff said that although there was no waiting list for physiotherapy, people would benefit from increased provision of this service. There was no space for physiotherapy clinics in the day centres, which restricted developmental opportunities.

There was also little evidence that staff in the houses promoted people’s mobility. There was a lack of entries in the records confirming that people were regularly supported to spend time out of wheelchairs to move and promote flexibility. Until staffing levels were increased earlier in 2006, people were not supported on a regular basis to have time out of their wheelchairs on special floor mats and cushions. Very few staff had sufficient skills or knowledge of how to maximise mobility. The investigation team were told that staff used wheelchairs with people when going out because it was easier and quicker, not necessarily because it was warranted or in the person’s best interests.

The hospital’s hydrotherapy pool, built in the late 1960s, had some improvements completed in 2004. When the investigation team visited this pool they felt it was not fit for purpose. Besides the external walls of the building being in poor condition, sometimes sessions had to be cancelled because the temperature of the water was either too cold or too hot. Advocates complained that people who needed to use the hydrotherapy pool were not able to do so on a regular basis. An examination of the use of the pool for a period of three weeks showed that it was significantly under-utilised and that very few sessions were with people who lived at the hospital. The pool itself was unattractive with evidence of mould growing in some areas. Staff said that sometimes the water was dirty because at times people who used it were incontinent. We were told that staff were reluctant to support individuals to use the pool, which was an essential therapy for some people and not just a leisure activity. An
advocate said that they had agreed with staff in one house to share the support for an individual to use the pool because this was identified as a clinical need and the person obviously got a lot of pleasure from this activity. After a number of weeks the advocate found they were carrying out all the sessions and the staff were unable to fulfil their side of the agreement.

Until July 2006, a consultant psychiatrist was employed by the PCT for three sessions (1.5 days) a week at the hospital and in the community houses in Sutton. Individual reviews of care provided were carried out every three months by a team including nurses and therapists, and these were chaired by the consultant psychiatrist. People, their relatives and advocates did not participate in these reviews. It was acknowledged that because of the severity of the disability of some people, they would not be able to participate in their reviews. We were told that due to time constraints, GPs were unable to contribute to the clinical reviews.

Two clinical psychologists worked with the community team for people with learning disabilities, one in Sutton and one in Merton. There was very little capacity for either of these psychologists to work with people at the hospital. Several staff said they would value more psychology contribution, especially when working with people with behaviour that challenges. An entry in one person’s records highlighted this, stating that the “client requires much more psychological and behavioural support than he currently receives”.

Two aromatherapists regularly visited people in the hospital and in some of the community houses. They provided hand and foot massage, which people appeared to enjoy. However, some staff felt that there could be more interaction between the therapist and the person rather than just the task. One observer thought this process could be improved if the therapist explained to the person what she was doing and why. However, a different observer noted good interaction between the therapist and an individual having a foot massage.

The individuals receiving aromatherapy massages paid £4 for each treatment out of their personal monies. In previous years this had been paid for out of charitable funds.

Four GPs from a local practice held daily clinics at the hospital and those GPs plus two others from the same practice provided 24-hour cover for emergencies. Sometimes people were too ill to attend the clinic and in those cases home visits were facilitated. There was also a specialist dental service provided at the hospital and a chiropody service. The majority of staff were satisfied with the GP service although a few staff, who were used to weekly visits from a GP, felt that the GPs should see people more frequently to review medication.

There were concerns from some staff about how the health needs of people would be met when the hospital closed. A health improvement group met regularly to plan and develop ways of working to meet the future healthcare needs of individuals, including commissioning a higher level of healthcare services where required. The learning disability service commissioned a national organisation, the Foundation for People with Learning Disabilities, to develop ways of working with people with particular needs, such as epilepsy. This was seen as useful piece of work by all involved although there was a recognition that more needed to be done because about a third of the people living at the hospital have complex needs.

Despite the limited contribution from some professions, there were examples of the skill and care that some staff at the hospital had demonstrated when working with individuals. For example, one man had become acutely underweight and staff were uncertain whether he would survive. Dedicated staff spent a great deal of time supporting this man and he has now put on weight, which has significantly reduced the risk to him.

In a few of the community houses, people were able to participate in a full range of community facilities to promote health in the same way

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8 The consultant psychiatrist was also qualified as a physician and a psychotherapist
that any member of the public would access health services. In most of the community houses, people occasionally went to cafes and shops in the community but then returned to the hospital for day care, GP services and dental services. The White Paper *Valuing People* (2001) advises that the majority of people should get their healthcare needs met in the community.

People who lived at Osborne House were all registered with local GPs, and accessed community services for dental care, chiropody, physiotherapy and so on.

**Health action plans**

*Valuing People* stated that by June 2005, everyone with a learning disability should have a care plan detailing the action required to maintain and improve the health of the individual.

Very few staff had completed training about how to develop health action plans. Most people had a plan of care about their health needs that were regularly reviewed, but these did not meet the requirements set out in *Valuing People*. In particular there was a lack of action to improve the health of the individual. Staff said that not enough time was spent discussing the needs of individuals at the three-monthly reviews. There were usually only two or three hours to go through the health needs of all the people living in a house or group of houses. In one group of houses in Sutton, the health needs of 20 people living in four houses were reviewed in two hours. No records of these meetings were seen, as they were not kept in each person’s records. Health action planning meetings were attended by a variety of people but not the individual who the meeting was about, his or her relatives or an advocate, which would have been good practice.

In one community home in Sutton, people had numerous care plans with a page of information on specific care areas such as continence, brushing teeth, shaving, dressing, eye care, toilet use, and eating preferences. In a community home in Merton, staff said they had to ring the hospital before they could contact a GP if someone was ill. Investigation team members were reassured that in an emergency staff would dial 999.

The investigation team found that good progress had been made in implementing health action plans at Osborne House using a format based on supporting the individual. A learning disability service audit found that 29 out of 59 people in the community houses had health action plans. When members of the investigation team visited one of the houses there, one woman had her care plan in her bedroom and brought it to show them. This plan met the principles set out in *Valuing People* and had pictures, maps and charts that the person had clearly been involved in developing, and she told them about each part of the plan.

**Essence of Care**

In February 2001, the NHS Modernisation Agency published a toolkit called the *Essence of Care*, which reinforced the importance of getting the basics of the model of care right to improve the experience of patients. It focused on areas such as food and nutrition, privacy and dignity, personal care, oral hygiene and continence care. In 2003, one further topic on communication was published. This toolkit was aimed at helping organisations identify best practice, against which they could then assess themselves, in order to produce and implement an action plan to improve the quality of care.

The minutes of meetings show that between August 2004 and October 2005, eight meetings were held to progress work on the *Essence of Care*. The learning disability service chose to progress work in one area, that of nutrition. There was a poor attendance at meetings, with membership only of people from the hospital. The minutes identified a need to do more work on *Essence of Care*. At the time of the investigation, training for staff on *Essence of Care* had not yet started although two managers had attended a study day. All houses
were sent some information about a national nutrition tool, although during the investigation we found staff had no awareness of this tool. The PCT has provided their best practice guidance for good nutrition dated January 2006.

The learning disability service carried out an assessment at Osborne House in January 2006, which indicated that staff were unaware of *Essence of Care*. The operational management meeting minutes of July 2005 stated that the *Essence of Care* nutrition standards had progressed well compared with other organisations. The investigation team found no evidence to support this statement.

The operational management meeting minutes of October 2005 stated that the strategy for quality was to include *Essence of Care*. The nursing and allied health professions strategy dated April 2005 stated that actions for 2005/2006 included *Essence of Care* being developed throughout the organisation. The PCT provided minutes of the learning disability quality committee for 2005, which showed that while *Essence of Care* was on the agenda, discussions kept being deferred to the next meeting due to problems with timing and availability.

**Meaningful occupation of time**

One study of what people did at the hospital showed that the majority spent less than five hours per week outside their houses. When people did get the opportunity to do activities outside their houses, very few did anything outside the hospital. Staff throughout the PCT said that while they would like to provide more activities for people both in and out of their houses, they were unable to do this because of staffing shortages and low staffing levels. Most staff recognised that people did not have the opportunity for sufficient stimulation or activity. Many staff said that people were very different when they were on holiday or when they went on an outing. Other staff said that people were disabled by the model of care offered to them and the limited amount of activities available.

At the hospital a range of therapeutic activities was provided by staff at the Woodlands Centre. Staff and relatives described the staff and the managers at Woodlands as enthusiastic and motivated. There were therapy rooms nearby for drama and music therapy. Different staff worked in these services including occupational therapists, drama and music therapists, technicians and helpers. The majority of staff and relatives held the activities and therapies delivered by this team in high regard. We observed some people learning how to turn equipment on and off by pressing a large switch, some people enjoying music and dancing, others were being taught how to make a cup of tea and others were making some masks for a totem pole. There was a garden specifically designed for people with sensory impairment. Some staff worked in a voluntary capacity to support people in accessing activities in the evening and at the weekend.

Staff at the centre felt that a lot more could be achieved if the activities were continued in some way when people returned to the houses they lived in. For example, staff could support people to use their newly acquired skills in making cups of tea. There had been attempts to do this and to encourage care staff to work in a different way but this had not been successful and no longer took place. The staff at the Woodlands Centre made efforts to keep members of staff in the houses up to date with things that happened when people attended the centre. However, these efforts were not seen to be reciprocated by staff in the houses. Staff at the centre were not kept up to date about changes in a person’s care, or if a person had been unwell.

Some people from the hospital and the community homes attended courses at the local education college at Orchard Hill. They took courses in community living, music appreciation, personal and social development and physical education. Some staff interviewed seemed unclear about how people were able to access these courses.

The Cheam Centre in Sutton was attended daily.
by about 25 people. It provided activities and therapy for individuals and small groups of people. No one from the hospital or the community houses in Sutton attended this centre. The Freshfields Centre in Merton was larger than the Cheam Centre and had a range of staff specialising in drama, music, art, physiotherapy and massage. Freshfields Centre staff worked some weekends and some evenings in order to support people participating in activities in the community such as horse riding and swimming. There was a committee at this centre called the ‘Speak Out’ group, which had links to the local authority partnership board.

At Osborne House, a questionnaire conducted by staff at the local day centre highlighted that most people enjoyed going there. They wanted to go out more to pubs, cafes, shops and the cinema. People also wanted to be involved as much as possible in planning things and felt that staff needed to be more aware of people’s likes and dislikes. People were free to participate in the activities at Osborne House for as little or as long as they wanted. When the day centre was visited during the investigation, it was lively, with different activities ranging from karaoke to writing, computer work and games. People attended the local college to learn new skills. When possible, staff supported people to go into the local town, to other locations and on holidays.

In a few of the community houses, there were examples of motivated staff giving up their own time to ensure that planned outings took place. For example, staff took one man out for a birthday dinner with his relatives on their day off work. We also met two people who had paid employment opportunities. One person from a community home in Sutton worked part time in one of the houses at the hospital, and one person from Osborne House worked part time as a gardener at the local park.

Staff said they tried to take people on regular holidays, the frequency of which varied from annually to every three years. We were told that this was not always possible because it was difficult to find places with good enough facilities for people with disabilities, and also because of inadequate staffing levels. Information gathered by the advocacy service at the hospital showed that only half of the people living there had the opportunity to go on holiday during 2005. Twelve people went on holiday for five to seven nights and 31 people went away for three nights. In total, six people travelled outside the UK. The remainder did not go on holiday. Staying away from home is clearly not appropriate for all people, and it may not have been their preference to go on holiday. However, we were told this was only likely to represent a small number of people living at the hospital. It was not clear who paid for what on the holidays, and there was little evidence to suggest that the holidays chosen on behalf of people represented their preferences. There was a holiday policy, but this was undated and it was not clear when it was developed or whether it had been recently reviewed.

At both the hospital and in the community houses, staff said that some of the reasons that people did not participate in more activities included:

- transport difficulties, including inadequate access to transport and lack of staff who were able to drive
- insufficient availability of staff, particularly since January 2006 when staff were advised not to go out with people on their own
- activities being cancelled
- people unable to participate in activities due to health problems

**Assessing the quality of care**

In January 2004, the South West London Strategic Health Authority wrote to the PCT asking it to consider each of the risk factors of a possible serious service failure. These risk factors had been identified in an investigation into events on Rowan Ward at Manchester
Mental Health and Social Care Trust by the Commission for Health Improvement. The risk factors were:

- a poor and institutionalised environment
- low levels of staffing
- high use of bank and agency staff
- little staff development
- poor supervision
- lack of knowledge of incident reporting
- closed and inward-looking culture
- weak management at ward and locality level
- geographical isolation

The initial audits for these assessments were carried out using a form provided by the strategic health authority that was amended to include other areas identified by the learning disability management team. In January 2005, it was agreed that a subgroup to progress this work would be accountable to the learning disability service director through the work of the committee that looked at quality. Also, a task force was set up for one of the houses at the hospital to take action to manage risk, to oversee the recruitment of staff and to make environmental changes identified in the audits.

In May 2006, a report to the PCT’s board reported that a pilot audit had been carried out in January 2005 on three of the houses at the hospital. The audit stated that incident reporting was too low, staff were not sufficiently trained in some areas of care, there was an unclear accountability structure, staffing levels were not adequate to meet the needs of the individuals residing in the houses and there was a need to improve the physical environment. There was no evidence that these issues were formally transferred into action plans. In October 2005 it was agreed to roll out the programme to all the houses in the service. Although the PCT was asked by the strategic health authority in January 2004 to complete these risk assessments by May 2006, only 10 out of a possible 25 audits had been completed.

The Healthcare Commission examined the audits that had been completed and found inconsistency in the way they were carried out and that not all the areas of risk were examined in each audit.

Findings about the quality of care

In summary, the findings about the quality of care provided are:

- there was little evidence that the BILD quality indicators for people with learning disabilities were achieved in the service
- the model of care was based on the convenience of the service providers rather than the needs of individuals
- overall provision of activities was very low, in some cases people living in the service got only three to four hours of activity a week
- many people living in the community houses came back to the hospital to access GP, dental and chiropody services and did not have the opportunity to gain access to the full range of healthcare in the community
- there were some examples of good practice regarding the quality of care
- the environments people lived in were mainly unfit for purpose with particular problems for people with mobility problems requiring wheelchairs and hoists
- the privacy and dignity of individuals was sometimes compromised
- staff endeavoured to meet the healthcare needs of people for whom they were responsible but their efforts were compromised by lack of training and lack of specialist contribution from speech and language therapists, psychologists, and physiotherapists
- the hydrotherapy pool was environmentally unsatisfactory and was only used by a few people who lived at the hospital
• the majority of people with learning disabilities had a plan of care about their health but did not have a health action plan

• relatives, carers and advocates were not invited to attend the three monthly reviews of people who lived in the houses

• work using *Essence of Care* benchmarks was limited and was not carried out in a timely manner

• there was a good practice guideline for nutrition but there was little awareness of this guideline among staff

• environmental and staffing constraints at the day centres limited the delivery of day services focused on the needs of the individual

• the majority of activities were provided at the hospital, with people who live in the community coming back to the hospital to attend the day centre, rather than accessing facilities in the community

• the learning disability service had no robust method of assessing the quality of care provided at the hospital, in the community homes or at Osborne House
The provision of care for people with behaviour that challenges

This chapter examines the provision of services to people with learning disabilities who sometimes have behaviour that challenges, and where restrictive physical interventions were used.

Difficult behaviours shown by people with learning disabilities are often the result of an interaction between the individual and the environment in which they live. Behaviour that challenges, sometimes called challenging behaviour, is described as ‘culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to, ordinary community facilities’

In 1993 the Department of Health published Services for people with learning disabilities and challenging behaviour or mental health needs, known as the Mansell report. The report identified five key themes:

• the importance of the social context of the behaviour
• the importance of management commitment
• the service development process
• issues related to exemplary services balanced against cost constraints
• comprehensiveness in joint commissioning between trusts and local authorities

The service to people with behaviour that challenges

People with behaviour that challenges live in different houses at the hospital, and in the community. There are two houses in particular for people with behaviour that challenges at the hospital. Eight men live in one home and four men and four women in the other home. When visiting these houses we found environments that were not homely. They were not specifically designed for the purpose they now serve and, as a result, staff found it difficult to observe people adequately. In one house, the fabric of the building was in a poor state of repair and a chair was chained to the table in the dining area. An activity board showed some people did not do any activities for four days and one person was scheduled for only three hours’ activity a week. Efforts were being made to address this and an empty house at the hospital was used as a base for activities.

There were rigid routines in both houses with everyone having their meals at set times. There was little evidence of choice of food, although in one house investigation team members did observe people being offered a choice of tea or coffee at drinks time and these were made individually. In the other house, drinks were all made in one large pot and everyone appeared to have the same amount of milk and sugar in their drinks. At breakfast time in one house, the majority of people were served a bowl of porridge with two large dessert spoons of sugar put on it. There seemed to be no awareness of the fact that sugar was already put in the porridge in the hospital kitchens during cooking, neither did there seem to be consideration for individuals’ taste preferences or dietary needs. In one house everyone had to change into their nightclothes before the night staff came on duty although there was some flexibility as to what time people went to bed. The investigation team observed that some people could not go into their bedrooms when they wanted because the doors were kept locked to keep other people out of them.

The front door to one of these houses had a handle that was so high up that many people could not reach it and this ensured that people did not leave without a member of staff to accompany them. The front door to another house had a small button type handle that had to be twisted, which was difficult for some people to use. There was also an alarm, alerting staff when a person was trying to leave without a member of staff. There was a view that some people were detained inappropriately as they lacked the capacity to consent to their own treatment. Some staff and advocates believed that people should have been assessed to see whether their rights would be best met if the Mental Health Act 1983 was considered and applied if necessary.

Staffing these two houses adequately had been very difficult for the learning disability service. There was a high turnover of staff and it was difficult to recruit people with expertise in working with people who have behaviour that challenges. Both houses had a high reliance on temporary NHS staff and agency staff. Of those staff that had worked there a long time, some were described as being resistant to changing from a custodial model of care to one that offered more choice and taking therapeutic risks with people. Members of the investigation team visited both these houses on several occasions and found there was little interaction with people living in the houses. However, this was more noticeable in one house than in the other.

One manager said that lack of regular staffing contributed to incidents occurring, and that high use of temporary staff created problems because of lack of knowledge about people with learning disabilities and the ways of working with them. There were concerns from advocates about the number of incidents in these houses that were not reported. Several staff confirmed this during our interviews with them. From April 2005 to March 2006, in one home there were 70 documented incidents and in another home there were 44 documented incidents. The Healthcare Commission makes no assumption about the numbers of incidents themselves, as incident reporting should be encouraged to allow an organisation to learn and improve.

Some plans of care and guidelines examined in the houses were drawn up for specific behaviours. Not all of these were dated, making it difficult to know whether they were current. Authors of guidelines were not identified and there was no evidence as to whether the guidelines were being followed. Some charts of behaviour were made, which indicated that staff did have a method for identifying what happens before and after an incident in order to manage the behaviour appropriately.

There was a high incidence of physical assault by people in these two houses both on staff and on other people who lived there. In response, the learning disability service commissioned training for staff about behaviour that challenges and conflict management. Between January and May 2006 a total of 44 staff attended this training. In 2004 and 2005, 46 and 52 staff respectively, attended this training.

When people are restrained on a regular basis in a hospital setting they should be assessed to see if their rights and treatment needs could best be met through the use of the Mental Health Act 1983. None of the people who lived in these houses had participated in such an assessment and no one was actually detained under the Act. The consultant psychiatrist had considered this and taken advice from the PCT’s legal advisers. The consultant psychiatrist informed us that the PCT’s legal advisers had advised that detention of a person under the Mental Health Act could not be implemented for people at the hospital. The view of the investigation team was that, in a hospital setting, if a person met the requirements of the Act, it should be possible to apply the Act providing a second opinion was obtained from another professional.

Sometimes when people were disturbed, medication was given, although staff said they
only used this as a last resort. There had been no audit of the use of medication given when required if people were disturbed or unwell. A pharmacy manager said that she was confident that there was no misuse of medication. She said that if she had any concerns she would raise them with the GPs or at the clinical review. When visiting one house we were told that no medication was ever put into food. During later visits to the same house, investigation team members observed two separate occasions when tablets were put into yoghurt and then fed to people on a spoon.

The PCT’s medicines policy was dated 2004 and was being reviewed at the time of the investigation. A union representative confirmed that the PCT did encourage drug errors to be reported. A member of staff told the investigation team about a prescribing error a GP had made and when this was checked against the list of incidents, it appeared that this error had not been reported.

**Restrictive physical intervention**

Restrictive physical intervention, sometimes referred to as restraint, is also described as “any method of responding to challenging behaviour, which involves some degree of direct physical force to limit or restrict movement”\(^\text{10}\). BILD describes four categories of restrictive physical intervention that are sometimes used, these are:

- manual restraint, where the person is physically controlled by another person taking hold of them
- mechanical restraint, where an object is used to restrain (such as a splint on an arm)
- removal to another place, which covers any required change of environment including time alone in a specific place
- straps on wheelchairs, which were safety measures to restrain a person from falling out and were provided in every wheelchair. For a person without the ability to undo the straps they can also be used as a restraint to prevent challenging behaviour.

In 2003, the Department of Health issued guidance about the use of restrictive physical interventions (LEA/0242/2002). The guidance stated that any use of restrictive physical interventions must be regulated by a specific policy. There was no policy in use in the learning disability service, neither was the use of restrictive physical interventions being monitored within the learning disability service in a systematic way.

Good practice requires that “any organisation or service that supports people whose behaviour may be challenging, acts within a framework of support that includes a risk management procedure which includes a service policy and the care plans of individuals”\(^\text{11}\). A key component of that framework of support is supervision and training. “Staff must be supervised and people should be provided with the relevant information, training and support necessary to fulfil their role”.

Some staff had attended training to increase their skills in preventing and defusing conflict. During interviews, several staff said that they needed to be trained in restraint and that not enough people had been trained. One home manager said “we try to use de-escalation skills, but when a client is assaulting another client or a member of staff there is little you can do without jumping on the client to restrain him or her”.

Some staff said that they did not use restraint. One member of staff who worked in a house for people with behaviour that challenges explained that “sometimes we just have to hold a person’s wrists for a while”. During visits to the hospital, investigation team members observed people being restrained physically when their behaviour was disturbed. This included holding a person’s legs when they were kicking out from their wheelchair, pushing a person back down into a seat when they were trying to get out, and we also observed a type of

\(^\text{10}\) BILD (2000) *Physical Interventions – A Policy Framework*  
\(^\text{11}\) BILD (2000) *Good Practice in Physical Interventions – a guide for staff and managers*
chair that a person was restrained in (a Kirton chair). We were told that sometimes this chair was used for extended periods of time when it was not supposed to be. An advocate said they saw the individual being restrained in the chair while staff put Christmas decorations up. A review of records indicated that the man had been restrained in this chair on 33 occasions during a ten month period usually for 10 to 15 minutes and sometimes for up to 30 minutes. The records of these episodes do not report any efforts to de-escalate the incidents. A note on the care plan guidance said that these incidents should still be noted even though they were not considered to be episodes of restraint. The care plan was reviewed in March 2006 and discontinued as the individual no longer needed to be restrained.

One woman had experienced a form of restraint for many years. A splint prevented movement in her arm in order to stop her putting her hand into her mouth. The psychology department did not feel that the continued use of this restrictive intervention was justified. Following a clinical review in February 2006, it was agreed to remove this for 30 minutes a day and for staff to observe behaviour. In October 2006 the splint was only being used for an average of three hours a day. A senior member of staff told us that they had seen restraint used inappropriately and that they had challenged staff on these occasions. For example one man was strapped into a wheelchair when he went out because he picked things up off the floor.

Findings about services for people with behaviour that challenges

In summary, the findings about services for people with behaviour that challenges are:

- there was a lack of regular staff working in the two houses for people with behaviour that challenges
- staff had limited expertise in dealing with behaviour that challenges
- there was evidence of rigid routines, a deprived environment with lack of individualised care and insufficient meaningful occupation of time
- there had been no audit of the use of medication when people were distressed
- there was evidence that staff did not report all incidents
- there was no policy on the use of restrictive physical interventions
- many staff believed that they were not restraining people, but observations and records demonstrated that people were being restrained
- restraint was used inappropriately at times and there was no system for monitoring the use of restraint
Serious incidents

There is no nationally agreed definition of a serious incident. The PCT’s serious incident policy (revised January 2006) describes a serious incident as any incident, either on PCT premises or involving PCT business, which:

- caused unexpected death, or serious injury, or was life threatening where foul play is suspected
- involved a hazard to the public health such as an outbreak of infection
- involved the vulnerable adults policy
- involved a child protection incident
- may have given rise to other serious criminal charges
- involved a serious attack on a patient, a staff member or a visitor
- caused serious damage to NHS assets
- involved the allegation of serious misconduct
- involved suspicion of large scale theft or fraud or impending litigation

The Healthcare Commission investigated the handling of serious incidents by interviewing current staff at the PCT, examining PCT documents of internal investigations and reviews and meetings, attending two of the multi-agency meetings that were organised by Sutton Police and by visits to houses where incidents either took place or were alleged to have taken place. A summary of information from that work is detailed below. We have focused on what action the PCT did or did not take once they were aware of the serious incidents, and we have considered whether or not the PCT complied with the policy for the protection of vulnerable adults.

The PCT had a policy for adult protection (undated), which stated that the PCT would follow the adult protection procedures of the London Boroughs of Sutton, Merton and East Sussex County Council (the local authorities). It then stated that the policy should be read in conjunction with the East Sussex County Council’s multi-agency policy, and the guidelines for the protection of vulnerable adults in the London Borough of Sutton (2002). It did not refer to the Merton Local Authority’s protection of vulnerable adults policy and procedure (2002), nor had it been updated to reflect that the Sutton procedures were revised in June 2005. At this time, a committee looking at quality issues in the learning disability service identified that the serious incident policy and the vulnerable adults policy needed to be complementary. The serious incident policy was revised to take this into account (January 2006), and the vulnerable adult policy for the PCT was in the process of being revised (drafted December 2005).

The revised procedures for Sutton addressed the requirements of the Department of Health guidance, No Secrets, for the protection of vulnerable adults and identified abuse as having many forms, which could be physical, sexual, psychological, financial or material, neglect or acts of omission or discriminatory. The policy lists indicators of signs of abuse and includes indicators of institutional abuse in this list, which are:

- no flexibility of bedtimes or waking times
- shared commodes or being left on commodes for long periods
- dirty clothing or bed linen
- lack of personal possessions or clothing
• deprived environment or lack of stimulation
• misuse of medical procedures
• lack of individualised care
• inappropriate confinement or restrictions
• sensory deprivation

Serious incident A

In December 2004, an employee of the PCT was arrested and charged with committing a sexual act with a woman with learning disabilities who lived in one of the community homes in Sutton. The member of staff pleaded guilty and was given a suspended sentence, a supervision order and was placed on the sex offenders’ register.

As soon as the police notified the PCT of the incident, the member of staff was suspended. His employment was terminated on the basis that the charge was incompatible with his role. The former chief executive of the PCT asked for the incident to be investigated, which involved meetings with the police, interviews with staff and managers, and a review of records.

The vulnerable adults policy was followed but the first meeting held under the terms of the policy was held after two weeks had elapsed. Such a serious incident would have warranted calling a meeting within three days as stated in the 2002 policy. The meeting did not result in clear outcomes, failed to establish the facts and did not focus sufficiently on the needs of the other people who lived in the community homes where the member of staff worked.

All staff employed by the PCT since March 2002 have been subject to an enhanced check of whether they have a criminal record. Prior to this, the previous system of police checking was used. However, neither check would have shown a reason not to employ the member of staff until his recent conviction.

Arising from this, the PCT reviewed the policy and the way it was implemented. This review was carried out and a new policy introduced in June 2005. It was identified that the PCT policy to manage serious incidents should be revised to clarify the identification of a person to lead work following an incident. Greater clarity was also required about what could and what could not be done while the police investigation was underway. This work has been completed and the PCT has a revised policy (January 2006). Although employers were not required to undertake enhanced criminal record checks on people employed before March 2002, the PCT was proactive and had conducted checks on all staff working with adults less able to look after themselves. No concerns were identified arising from this exercise that were incompatible with the jobs that staff were doing.

There were 18 recommendations arising from the investigation; most of them have been completed and acted on but a few had not been achieved. For example there was a recommendation that serious incidents should be investigated by someone independent from the service the incident had occurred in. This had not been put into action for some of the subsequent serious incidents in the learning disability service.

Serious incident B

On November 2nd 2005, a serious incident was reported of a possible sexual assault carried out by a member of staff with the same victim of serious incident A. Due to the nature of the incident the police were contacted immediately. The Sexual Offences Act 2003 describes sexual assault as a person intentionally touching another person in a sexual manner when the person being touched does not consent to the touching. The member of staff was arrested by the police and charged with rape. He was subsequently dismissed from the employment of the PCT. In July 2006 he pleaded guilty to sexual activity with a woman unable to give consent and was later sentenced to six years’ imprisonment.

The wellbeing of the individual concerned and other people living at the same house was considered paramount. Specialised support
was secured from an organisation that supports people who may have been abused. The relatives of the individual concerned and of other people living in the house were informed. Locks were changed on the door to the house and additional staff were allocated to work there.

Regular meetings were held in response to this incident, the first of these being on November 4th 2005, with representatives from the police, Sutton Local Authority and from the PCT (including the director of human resources). There was no advocate present to represent the victim as the PCT did not provide advocacy services to people who lived in the community houses.

Staffing arrangements were reviewed in the relevant community houses and staff were no longer able to work alone. This had an adverse effect because it reduced the level of activities which could be offered to people throughout the service. Staff in the community houses worked extended shifts at times in order to facilitate outings for people. Increased staffing arrangements were agreed in February 2006.

Most of the recommendations listed in an action plan following the serious incident had been progressed and, at the time of the investigation, some were still in progress. Training in awareness of vulnerable adult procedures was provided for some staff in the community houses during February and March 2006. Also policies for staff supervision and for intimate and non-intimate care had been drafted.

When members of the Healthcare Commission’s investigation team visited this house and nearby houses in February, April, May and June 2006, they found that staff were still in a state of shock. Some staff said they found it hard to believe that such a thing could have happened. Others said they were disappointed by the response from management. Until then they had felt quite neglected and unsupported by managers. After the incident there were several visits from different managers and requests for information. Initially, staff said that they had insufficient information, not only for themselves, but in order to be able to adequately answer the questions of relatives and carers.

During interviews with the home manager of the house where the rape took place, he described how he had raised concerns with occupational health and with his managers about whether the member of staff should work at the house. He raised his concerns in writing with the occupational health manager, community homes manager and human resources manager.

The home manager said that he was told he risked disciplinary action being taken against him if he persisted in writing letters objecting to the member of staff coming to work at the house. He also reported being told by the human resources manager that his actions would be seen as harassment of the member of staff. This was confirmed by his immediate manager, who also raised concerns on behalf of the staff at this house about the member of staff coming to work at the house. Arising from the comments of the human resources manager, the home manager accepted that the member of staff must restart work, which he did in September 2005. Although concerns were raised, it must be said that at no time did anyone ever suspect that a such a serious incident would occur.

At her interview, the human resources manager denied saying that the actions of the home manager would be seen as harassment, or that he risked disciplinary action being taken against him. She did acknowledge she had said that “any acts of isolation or non-cooperation with the member of staff’s right to return to work could be deemed as victimisation”. She added that both human resources and occupational health services were there to advise and support management and staff of the PCT, and that any decision about staff at work was ultimately the manager’s responsibility.
When interviewed by the Healthcare Commission’s investigation team, the community homes manager stated that he was unaware of the full concerns of the home manager until after the serious incident. He believed that the main concern of the home manager was about the lack of reliability of the member of staff with regard to the possibility of further periods of non-attendance at work.

Serious incident C

On November 17th 2005, a person living in one of the houses at the hospital attacked two other people with learning disabilities. The incident was reported by the advocate as an adult protection alert to the Sutton Local Authority. A meeting was held on November 25th 2005, attended by staff from Sutton and Merton Local Authorities, from the PCT and an advocate. The incident was reported because of continuing concerns about the safety of people in this house and knowledge that this was not an isolated incident. The notes of the meeting report that although one person had a bruise on their face, it was from an earlier incident that same month. An incident report had not been completed but the person had been seen and assessed by the GP. Twelve actions were agreed arising from that meeting including a requirement to notify relevant authorities about any future incidents, and the appointment of a modern matron as a temporary home manager. At the time of our investigation, most of the actions had been completed and some were in progress.

Serious incident D

Following a reconfiguration of services at the hospital, two people were required to live in the same house, despite staff and advocates expressing concerns to managers about the compatibility of these two individuals before the moves took place. One person was known to like hugging people, and the other person was likely to find this behaviour unacceptable, and might communicate this through behaviour which was challenging. On November 21st 2005 a serious incident occurred, where one man bit the other man. The injury was severe, requiring treatment at the local A & E department. The incident was not immediately reported to the modern matron, nor were guidelines for supporting the two individuals promptly reviewed. The incident was reported as an adult protection alert to the Sutton Local Authority and a meeting was held on December 1st 2005. The meeting was attended by staff from Sutton Local Authority, the PCT and by an advocate. Nine recommendations arose from the meeting including a new member of staff being identified to coordinate care and ensure a choice of activities.

An independent review was requested by an advocate and the PCT informed the Healthcare Commission complaints investigator that a number of factors contributed to this incident, which included:

- not all staff were aware of the risk assessments for the two individuals
- information relating to risk assessments and guidelines were difficult for staff to access
- staff did not have adequate training prior to the individuals moving into a house together
- there were no structured programmes of activities for the individuals concerned

A meeting was held in December 2005 to review action taken. One member of staff was spending time with the victim of the incident to keep him safe. Progress had been made where possible on some recommendations. Some work had taken place in identifying activities for each person and writing programmes but this had not resulted in any changes in practice at the time of the review.

Serious incident E

On November 22nd 2005 a person living at the hospital was bitten on the arm causing bruising. This was immediately reported to the Sutton Local Authority but was not considered
to be an adult protection issue. The individual’s advocate took up the issue with the Sutton Local Authority who then informed the PCT on December 9th 2005 that the matter should be dealt with through the adult protection process. A meeting to consider these issues was held on January 4th 2006.

PCT staff attended the meeting together with staff from the Sutton Local Authority and advocates. A few weeks before the incident, a decision had been made to reduce the medication of the man who bit someone and staff said that his hallucinations had increased as a result. Medication reviews were usually held every three months but staff could access GPs at the hospital to change medication. It was identified in those minutes that staff were trying to find an environment for the man to live with fewer people. A review meeting was held in March 2006 and at that time no alternative placement had been secured for the individual concerned.

**Serious incident F**

On November 30th 2005, a man living in one of the houses at the hospital entered a woman’s room and masturbated. Then, on December 2nd 2005, staff heard an alarm go off and observed the same man lying on top of the woman while she was in her bed. They were fully clothed and there was no evidence of sexual assault by penetration.

Both these incidents were reported as adult protection alerts to the Sutton Local Authority and a meeting was held on December 7th 2005. The meeting was attended by staff from Sutton Local Authority, the PCT and two advocates representing both people involved. Minutes of the meeting confirm that this was not the first time such an incident had happened in this house and that the doors were alarmed at night. Earlier in the year it had been decided that because one individual was constantly in and out of his bedroom and his alarm was disturbing others, it would be deactivated. Advocates were neither involved in nor alerted to this change. Recommendations made at the meeting included reviewing the use of the alarms, ensuring that training in vulnerable adult procedures should be a priority and that an extra member of staff should be available, at all times, to provide support and observation.

In February 2006, when two members of the investigation team visited the house where the incident occurred, they observed a man masturbating in the corner of a lounge where men and women were sitting. Staff either did not see this behaviour or chose not to respond at that time. This incident was reported to the manager of the learning disability service and investigated. On a subsequent visit we were shown a copy of a specific care plan that had been developed in order to support the individual to learn what behaviour was acceptable in public and what was not. At interview an advocate said that they remained concerned about the vulnerability of a woman living in this house.

The Healthcare Commission’s complaints team carried out an independent review of the concerns raised by advocates about the safety of the woman living in this house. During this review the PCT said that although the risks were managed effectively for a significant period, they acknowledged that the arrangements made for her protection were not sufficiently robust in the longer term. The PCT also acknowledged that the guidelines for staff were not adequate to enable them to manage the risks appropriately. The review made three recommendations relating to the numbers of staff, the skills of staff and the provision of training to staff.

In January 2006, a potential new placement was identified for the man involved in these incidents but in June 2006 he was still living in the same house. The PCT now believe that measures have been taken to reduce the risk of a further incident to an absolute minimum.
Serious incident G

In January 2006, allegations were made that a member of staff committed a sexual assault, some 16 years ago, on a man with learning disabilities. The member of staff was suspended by the PCT until his employment was terminated February 2006. He was charged by the police with indecent assault on January 26th and was held in custody until February 20th 2006 when he was granted bail. The criminal case was discontinued by the Crown Prosecution Service on March 4th 2006 due to lack of evidence to secure a conviction. The member of staff lodged an appeal against dismissal to the PCT and submitted a claim to the Employment Tribunal for unfair dismissal. Following the intervention of the Advisory, Conciliation and Arbitration Service, the matter was resolved.

Serious incident H

Early in 2006, a member of staff was suspended from duty as a result of an alleged physical assault on a person with learning disabilities. This case was reported to the police and investigated but no charges were made. This incident was reported in accordance with the vulnerable adults procedure and a meeting was held on February 24th 2006. Since that allegation was made, two further allegations of physical abuse have been reported involving the same member of staff. The incidents were said to have taken place in 2005. The disciplinary process was initiated and the member of staff has been dismissed. An appeal has been lodged against this decision and the outcome awaited.

Records indicate this member of staff had previously assaulted a person with learning disabilities four years ago. It was alleged that he slapped, kicked and punched the person. The incident was witnessed by two other staff, one of whom said they had seen this member of staff assault other people with learning disabilities. This case did go to court but the member of staff was found not guilty. However, the PCT disciplinary panel believed that the assault did happen and he received a final written warning.

Other serious incidents and related matters

The investigation team examined several serious incidents that occurred between December 2002 and November 2005. These included:

- a female member of staff slapping a man with learning disabilities on the back of the head
- an allegation of inappropriate sexual behaviour between two men with learning disabilities
- a man with learning disabilities slapping a man he lived with on the head, shouting and swearing at other people and entering a woman’s bedroom without her consent
- a member of staff allegedly shouting and raising a fist to a woman with learning disabilities
- a man with learning disabilities throwing a chair that hit another man he lived with

A letter from the former chief executive of the PCT to the Healthcare Commission stated that there were no serious incidents between January and September 2005. Our investigation found one serious incident to have taken place in June 2005. The risk manager said that all serious incidents were reported to the strategic health authority. A list of serious incidents received from the strategic health authority dated June 2006 only listed seven of the fifteen serious incidents examined.

Many staff at the PCT reported having been shocked and saddened by the incidents during the last two years and said that morale has been adversely affected. Some staff said they felt ashamed to say where they worked because some of the incidents had been reported in the local papers.
Findings about serious incidents

In summary, the findings about serious incidents are:

• arrangements for the protection of vulnerable adult between the local authorities of Sutton, Merton and East Sussex differed slightly but the principles they were based on were the same and the policies met the requirements of *No Secrets*

• the majority of the reviews of serious incidents correctly followed the procedures for protection of vulnerable adults

• in some cases there were weaknesses in the implementation of the procedures such as poor communication, lack of staff awareness about adult protection, and lack of robust follow-up of actions agreed at meetings

• there was a poor response to the concerns of a home manager about a member of staff in serious incident B

• not all staff had undergone adult protection awareness training

• the majority of serious incidents were at the hospital

• there was an equal number of serious incidents between staff and people with learning disabilities and between people with learning disabilities who lived together

• out of date policies about serious untoward incidents have been revised during the last 12 months
Short break care for children with a learning disability

Short break care was provided to children and young people with a learning disability in a four bedded bungalow in Sutton. Although the Healthcare Commission had not been made aware of any specific concerns about the service provided, it was considered important to find out whether the children with learning disabilities had been appropriately cared for in what was predominantly an adult service.

Prior to November 2005, the service providing short breaks for children and young people with learning disabilities was managed by the PCT’s learning disability service. Sutton Local Authority had not been involved in the management of this particular service. Because this service was part of an NHS trust, it was not registered either as a home or hospital under the Care Standards Act 2000. It had not been inspected by the Healthcare Commission, the Commission for Social Care Inspection (CSCI), or by their predecessor bodies. None of these inspectorates were aware of the existence of the service. Croydon CSCI advised us that it would not normally register a children’s short break facility in accommodation that was classed as hospital premises.

Joint area reviews are multi-inspectorate reports on children’s services in a local authority. All 150 authorities in England will have been reviewed between September 2005 and December 2008. During the spring and summer of 2005, the PCT piloted the methodology for the joint area reviews. The first joint area review and performance assessment was undertaken with Sutton Local Authority between February and April 2005. The Healthcare Commission was concerned that specific information had not been received about the PCT’s short break unit for children with a learning disability, either prior to or during its conduct of the pilot joint area review in Sutton between February and April 2005. At no time during visits to Sutton in 2005 was the children’s short break unit mentioned by name although PCT staff with responsibilities for disabled children and young people were interviewed. Evidence was provided that referred to a residential unit which opened 364 nights a year but it was not clear that this was the short break unit for children with a learning disability.

Neither the head of children’s services, the designated nurse for child protection nor the school nurse with responsibility for disabled children knew of the existence of the children’s short break unit prior to November 2005. The manager of the children’s trust in Sutton stated that communication between senior officers at Sutton Local Authority and the children’s short break unit was sporadic before November 2005. Since that time, staff had worked together much more effectively on a joint action plan to improve the service.

The environment of the short break unit

During our visits to the children’s short break unit we made a number of observations. It was a small bungalow that had two single rooms and one double bedroom but only one bathroom and toilet. Some modernisation work had recently been completed to improve the environment, but the main difficulty was insurmountable in that the bungalow was too small for children and young people who required the use of a wheelchair to get around. A move to a larger bungalow had been agreed and was scheduled to take place early in 2007.
The model of care at the short break unit

There were 33 children and young people aged eight to 18 years registered with the short break unit. Each month, referrals were considered by a panel including staff from social services. The unit accommodated both boys and girls and up to four children at any one time. Children of the same sex shared the double room and either a boy or girl occupied the other two single rooms. We were advised that the unit tried to avoid having one boy or one girl in isolation. During term time the children attended a local specialist school.

Three children appeared content and well cared for and the investigation team observed good interaction between staff and the children and young people who were living in the unit. We were told there was a system of person-centred planning but until the audit initiated by the head of children’s services, there had been no systematic monitoring or external audit of the services. The care plans, although comprehensive, did not meet the requirements of Valuing People. They were not written in a person-centred way and they were not in an easy to read format.

The staff cleaned the house, as well as doing the shopping, cooking and looking after the children, but there was little evidence of the children being involved in these activities other than occasionally helping with the shopping. The domestic duties took a lot of time, which limited the time available for supporting and playing with the children. This was a concern identified in the audit, and it was advocated that roles be differentiated between childcare and domestic duties.

Parents and carers were advised of the investigation in advance of our visit and were invited to attend a number of briefings and discussions. Those who attended provided positive feedback about the unit. Staff appeared to provide valuable support for the children and young people, their families and carers.

A minibus was used by people who lived in the adjacent houses for adults with a learning disability, and by children in the short break unit, although outings were conducted separately. No evidence was received about whether any staff had obtained advanced driver’s qualifications, which would have been desirable. Staff reported that regular outings were difficult to arrange when there were staff shortages as such events required additional staff.

Staffing at the short break unit

The unit manager had previously worked in both the adult and children’s services in the learning disability service, but this had changed and she was now specifically managing the children’s short break unit. Three new staff joined the unit in December 2005. The unit manager was a qualified children’s nurse with training in learning disabilities. There were six registered nurses working in the unit, most of the other staff were support workers with national vocational qualifications.

Since November 2005 two staff had worked during the day and for the most part at night, which had not been possible before. Staff told us that they were concerned that a number of outings had to be curtailed as they were not able to go out on their own with children and young people, and insufficient numbers of staff were available. The unit manager said that due to staff shortages, staff often worked in excess of contracted hours, worked split shifts and some had to curtail holidays or days off to cover shifts. Sometimes staff could not be freed up from duties to attend training. The manager reported that staff had felt isolated until the head of children’s services from the PCT took over in November 2005. Before that, there was limited support from senior management or the children’s services. Staff were receiving considerable support from the head of children’s services and mandatory training, including training about child protection, had been made a priority. There were meetings with
local social workers who undertook the joint assessments and reviews of children who used the service.

All staff providing care to adults less able to look after themselves and to children should have an enhanced criminal record check. We were advised that all staff had received enhanced criminal record checks after November 2005. The human resources director said at interview that relevant checks had been carried out on all staff and documentary evidence demonstrated this.

Child protection

Although there were named and designated individuals within the PCT who were responsible for safeguarding children in Sutton, access to their services had been limited until November 2005. Neither the specialist nurse for disabled children nor the designated nurse for child protection knew about the children’s short break unit until 2005, although both reported to us that they had worked in the PCT for a number of years.

The short break unit had a copy of local procedures about safeguarding children. Since 2005, the named nurse for child protection has provided some safeguarding training. The head of children’s services confirmed that that staff were now invited to attend the relevant training programmes, although there was limited engagement with the local authority’s area child protection committee training initiatives prior to this time.

Health records and care plans for people at the short break unit

Records were all hard copy and there was limited access to IT systems within the PCT. Records were stored inappropriately in an unlocked cupboard in the kitchen. Not all records had a care plan and some nursing notes were separated from the young person’s file. The entries themselves were legible, dated and signed although we observed that some notes had spaces between entries, which could permit retrospective additions.

Policies and procedures at the short break unit

We were concerned that until the head of children’s services took over management responsibility in November 2005, the unit was using policies and guidance drafted by predecessor trusts. We were told that these were in the process of being updated but the task was not complete at the time of the investigation. In the absence of the internet and access to the PCT’s network, the IT capabilities were limited.

The consent to treatment procedure was being revised at the time of our visit. However, there was no consent policy in place for community outings, nor an outline of how many staff were required to support children and young people on external visits.

Transferring from children’s to adult services

There was a specialist disability school nurse who focused on supporting people to move from children’s to adult services, but she did not have any contact with the children’s short break unit prior to November 2005. Her role was being revised to encompass a greater focus on transition arrangements. It was unclear whether nurses at the nearby specialist school knew about the children’s short break facility.

Community services for children with a learning disability

During the investigation, the Healthcare Commission was informed that the Sutton Community Learning Disability Team for Adults was delivering a service to children with learning disabilities. A community nurse was attending a local children’s school twice a week to provide healthcare support. This service was
not commissioned and was not part of the contracted work of the PCT’s children’s service. The Healthcare Commission advised the head of the children’s service and the interim director of the learning disability service to address this issue.

**Audit of care at the short break unit**

When the PCT’s head of children’s services took over the management of the learning disability services short break unit for children in November 2005, she immediately requested an independent, external audit of the short break unit services. A former CSCI inspector carried out the audit, and the unit was measured against Standards for Better Health which included an environmental assessment. The investigation team commends the head of children’s services for organising the audit of the services provided in the children’s short break unit. The audit report was 111 pages in length and a comprehensive action plan had been developed in response to the audit findings and was in the process of being implemented.

**Findings about the short break service to children with learning disabilities**

In summary, the findings about the short break unit to children with learning disabilities are:

- prior to November 2005, there was a lack of communication between the PCT’s learning disability service and the PCT’s children’s service about the short break unit
- the Sutton Disability Partnership for Children and Young People were not aware that the short break unit was managed by the PCT’s learning disability service until November 2005
- there were insufficient staff to ensure that children and young people could participate effectively in community activities
- the PCT had collaborated in the updating of the local safeguarding children’s board procedures, but some local children’s procedures still required updating, particularly about consent
- there was a lack of robust 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
- the roles of staff were unclear and staff were unable to give sufficient time to caring and supporting children and young people
- the bungalow was small and unfit for purpose, although a move was planned to a larger bungalow during summer 2006
- children’s and young people’s notes were stored in an unlocked cupboard
- the Sutton team for adults with a learning disability were providing a service to some children in a local school that was not properly contracted and funded
- an external independent audit had been carried out at the short break unit and an action plan developed which was being implemented
How people influenced the provision of care

There are many ways that the views of people with learning disabilities, and those of their carers and relatives can influence the provision of care. The most important way is through the development and implementation of a person-centred plan. Other ways are through the work of advocates, through efforts to consult with and hear the views of carers and relatives, and through the PCT complaints systems. Integral to every way of involving people in the provision of care is effective communication, which is also considered in this chapter.

Person-centred plans

People with learning disabilities and their families should expect everyone involved in providing or commissioning services to accept *Valuing People’s* key principles of rights, independence, choice and inclusion. They should also expect all professionals to work from a person-centred approach. Person-centred planning involves continual listening and learning, focussing on what is important to someone now and in the future, and acting upon this to solve problems in alliance with their family and friends. There are five key principles to a person-centred plan:

- the person is at the centre
- family members and friends are full partners
- the plan reflects the person’s capacities, what is important to the person (now and in the future) and specifies the support they require to make a valued contribution to the community
- it builds a shared commitment to action that will uphold the person’s rights
- it leads to continual listening, learning and action and supports the person to get what they want out of life

The learning disability service conducted an audit in March 2006 and found that 40% of the people at the hospital had a type of person-centred plan. The learning disability service had a draft protocol dated May 2005, which stated that individual plans should be reviewed annually but there was little evidence of this. Only 43 staff of a workforce of approximately 442 had completed training in person-centred planning between April 2002 and May 2006.

Managers in the learning disability service acknowledged that there had been little progress in terms of person-centred planning. Some staff said that everyone had a person-centred plan, but when asked about this, they showed a lack of understanding about person-centred planning. One manager said that everyone living in the house he managed had a person-centred plan. The investigation team found no evidence to support this. In looking at 46 care plans we observed:

- little evidence of the involvement of people, their relatives or advocates in their care plans, choices and decisions
- some care plans contained insufficient information
- some care plans were comprehensive and included information about likes and dislikes, but were not in an easy read format
- few individuals and relatives had copies of care plans
- some care plans were not personalised
- there were many different types of plans
- plans tended to focus on physical care needs
• inconsistency of content
• lack of clarity of purpose
• plans were rarely dated with little evidence of updating to meet changing needs
• risk assessment forms were in place
• there were some guidelines for different areas of care

Good practice in care planning included one very comprehensive care plan at the hospital, which was seen as particularly useful for new staff. However, it did not appear to be developed using a person-centred approach. Another plan contained positive information about the person as opposed to negative details seen in other files. The majority of files contained a record of ‘a day in the life of...’. These varied in content from a few lines to four pages giving details of what happened from the time of getting up in the morning to going back to bed at night, but focused mainly on physical care needs. Dates were not recorded, making it difficult to identify when they were written or when changes were made.

In the community houses, no one who lived there had up to date plans. The plans that people had were those used before person-centred plans were introduced. The learning disability service audit showed that only seven out of 59 people had person-centred plans in place. There did appear to be numerous sets of records and staff said that much of their record-keeping was duplicated. The daily nursing notes and daily report book were seen by some staff as unnecessary and a legacy of hospital working.

At Osborne House in January 2006 some progress had been made in implementing person-centred planning. Dates had been set to meet with those people who did not have person-centred plans to begin developing them. One person showed the investigation team her person-centred plan and confirmed that she kept it in a box in her bedroom. Another person had a very detailed plan about getting up in the morning and, during a visit to the house, two members of staff were observed taking two hours to work through the requirements of the plan. This meant that other people were left on their own, although they seemed content. There was evidence that the home manager regularly reviewed the records of how care was delivered. For example, one comment asked that the staff refer to people with learning disabilities in a more positive way.

Since the appointment of an interim director of the learning disability service in November 2005, stronger efforts have been made to progress person-centred planning. However, at the time of the investigation, progress still appeared to be very slow. We were told that there was a conflict in trying to get the person-centred plan right for a person’s immediate needs, as well as for the future.

Advocacy services

Advocacy services are crucial for people with a learning disability and this model is supported by Government policies such as Valuing People. The White Paper states that “effective advocacy can transform the lives of people with learning disabilities by enabling them to express their wishes and aspirations and make real choices. Advocacy helps people put forward their views and play an active part in planning and designing services that are responsive to their needs. This applies to people with severe and profound learning disabilities and to the less severely disabled”.

Two advocacy organisations were contracted by the PCT to support people at the hospital. One organisation provided advocacy for the majority of people who lived at the hospital as well as for five individuals who had moved to a house in Sutton. Other than for these five individuals, there were no advocacy services provided to people in the community houses. An advocate from a different organisation was contracted by the PCT to support people at Osborne House for 22.5 hours a week. She saw people individually as well as in a weekly talking group. The investigation team were concerned about
whether the advocacy services, at the levels currently funded, were able to meet the needs of people with learning disabilities effectively.

During our interviews, a few staff raised concerns about the independent status of advocates, as they were based on the hospital site and at Osborne House and were funded by the PCT. We found no evidence to suggest that the independence of the advocacy services was compromised by the contractual arrangements. A few families and care staff felt that advocates were taking control of people’s lives. However, this perception is not unique to this learning disability service. One family told us that they had opted to use an alternative advocacy service and were happy with this arrangement. Another family found it difficult to stop an advocate being involved and wrote to their MP to get the service stopped. There were also examples of when advocates had been helpful and supportive of family members. They had achieved positive changes for people in areas such as:

- a review of and changes made to a pain management care plan
- increased social opportunities for some individuals to use community facilities
- increased staffing levels to reduce certain risks to people

Advocates felt that there was an initial resistance to their work by care staff, but following a review and the introduction of new ways of working in 2004, relationships had generally improved. Some advocates reported that they had not been informed either by care staff or learning disability service management about important things that affected the life of a person on whose behalf they were an advocate.

The views of relatives and carers

Some people had varying levels of contact with their relatives. One person had daily visits, some people had weekly visits and others had letters and cards at special times of the year, while many people had no contact. During the investigation, relatives and carers expressed concern about the closure of the hospital and future services, the management of the PCT, the level of activities for people and the allegations of abuse.

The Healthcare Commission sent 110 questionnaires to relatives and carers in March 2006 and 48 replies were received. The majority were from relatives and carers of people who lived at the hospital. Of the replies received, 34 were from people who had been in contact with the learning disability service for over 15 years. The majority of people were generally satisfied with the level of activities and the care offered. Ten respondents had complained, five respondents had seen things that they did not like such as staff complaining about work, lack of staff and poor care. Thirty-three relatives and carers confirmed that the person had a plan for their care and the majority stated that they were able to contribute to that plan. Most of the respondents said that they felt staff valued their personal opinions, had adequate knowledge of their relative and that staff kept them well informed about issues concerning their relative. Many felt that the PCT did not keep them informed about changes to the learning disability service. Eight people were aware of an accident or incident involving their relative.

Most relatives acknowledged that they had been consulted about the future of the services. The PCT said that it had made communication with relatives an explicit feature of its consultation plans, and that this included individual meetings with the chief executive if required. Consultation documents and minutes of meetings about plans to provide different services showed that people were able to influence decisions taken by the PCT. However, some relatives were concerned about proposed changes because they had been told that at least a third of the people who lived at the hospital did not respond well to change. They were aware that a psychological assessment indicated that some individuals would experience some level of trauma from moving.
A few individuals had previously had increased levels of behaviour that challenges after moving into a community house, and had returned to the hospital when their community placement had not been a success. There was a concern that this option would not be available when the hospital closed. One relative told us that, although she would be sad to see the hospital close, she would accept it, as long as the medical needs of individuals were met. The view of some relatives, supported by the consultant psychiatrist, was that some people should remain at the hospital. A few relatives and some staff believed that Valuing People was only applicable to a very small percentage of people living there.

Key points raised by relatives and carers were:

- the majority of staff were caring and hard working
- money should be used to upgrade facilities at the hospital
- decisions about new services would be influenced by financial constraints
- there were too few opportunities for people to go out and not enough activities for people to do in the houses
- staff did not have enough training about how to support people with severe learning disabilities
- there was a shortage of certain types of staff like psychologists, speech and language therapists and physiotherapists
- there was a lack of access to hydrotherapy for some people
- they were not involved enough in planning care and some care plans were not followed properly, particularly by temporary staff
- communication about changes was poor but this was improving
- there was a lack of faith in the managers of the PCT
- there were concerns that people might be relocated to other areas and that ageing relatives and carers would be unable to visit
- relatives were worried that the proposed new community houses would be less secure and create new risks (such as busy roads, lack of understanding from the public, criminals etc.) compared with the perceived freedom to roam at the hospital
- there were concerns about access to health services once people left the hospital

Relatives and carers said that they were surprised when the sexual abuse allegations were reported in the press, as they had no previous concerns regarding this. They were concerned that the good level of care they felt the majority of staff provided had been tainted by the abuse allegations. Families said that they were adequately informed by the PCT about the recent criminal investigations.

Commenting on the environment that people lived in, relatives said that the atmosphere at a home in Merton had become less ‘homely’ as a result of restrictions by management (such as care workers being told not to use affectionate terms such as ‘darling’). One relative praised the quality of the facilities and amenities at the hospital; however they felt that the PCT had allowed things to become run down recently due to plans for closure. One person’s parents reported that their son’s bedroom had been used as a storeroom for six years and that occasionally they had found staff using it as a ‘rest room’.

Some staff at the hospital said they did not think that everyone benefited from contact with their relatives. This was particularly the case when relatives managed people’s finances and were appointees for their benefits, which staff saw as restrictive. There was concern from one set of relatives regarding the management of people’s money. For example one relative thought that aromatherapy was unnecessary and expensive as it cost a quarter of a person’s basic weekly allowance of £16. There was an indication from some staff that they felt they
knew people better than a person’s relatives did. However, there were instances when it was seen as a real benefit to the individual to see their relatives regularly, such as when they were able to go on trips with relatives.

Complaints

The PCT had a complaints policy and procedure that was approved in November 2002, revised in July 2004 and was to be reviewed in July 2005. There was no evidence that the policy had been reviewed as at May 2006. The PCT’s board received quarterly complaint activity reports detailing complaints it received. The appendix of the PCT annual report 2004/2005 detailed changes made as a result of complaints received that financial year, but no changes were reported for the learning disability service.

In the learning disability service in 2003, there were four complaints. Three of these were about clinical issues and one about the environment. In 2004, there were two complaints; one about staff attitude and one about general standards of care. In 2005, there were five complaints but the reports to the PCT board did not provide details of the complaints. The small increase in the number of complaints in 2005 was attributed to the work of the advocacy services.

The PCT said that considering the inherent difficulties and sensitivities facing the learning disability service, the number of complaints reported was surprisingly low. Given the size of the learning disability service, the investigation team would have expected a higher number of complaints. The PCT does not have an easy to read version of the guidance about how to complain and although there is a poster, this poster was not seen in any of the houses. There was no evidence that the complaints process was promoted in the learning disability service. Some relatives told us that they did not like to complain about the care staff because they had to maintain a relationship with them. The investigation team felt that these factors contributed to the low volume of complaints.

The complaints department and the patient advice and liaison service presented joint sessions at monthly induction training for new staff. The training highlighted the links and differences between the two services and encouraged staff to assist people who may have concerns, to use the complaints process. One modern matron and four home managers in the learning disability service had completed training about the complaints procedure. Dealing with or learning from complaints was not mentioned in the learning disability service operational plan.

The chair of the complaints panel confirmed that there were complaints leaflets in Makaton (a system of sign language), but said that he personally had not seen the leaflet. Although a poster was supplied on request to the investigation team, the PCT did not supply the complaints leaflet they had referred to. The chair of the panel also said that when he asked, he was reassured that the complaints procedure had been promoted throughout the learning disability service.

The minutes of the learning disability quality committee discussed progress with formal complaints in May and July 2005. From September 2005, details of complaints were included in the quality report for the integrated governance committee. There was some evidence of learning from complaints such as training for specific groups of staff. There was no evidence that lessons learnt were communicated effectively throughout the service.

Since July 2004 the Healthcare Commission has been responsible for reviewing this second stage of complaints that have not been resolved at a local level by the NHS organisation about which the complaint was made. Up to May 2006, 24 cases had been referred to the Healthcare Commission about the PCT’s services, seven of these related to the learning disability service. Advocates had referred six, and a relative referred one. The main concerns were:

- lack of adequate arrangements for feeding
an individual and lack of involvement of a
speech and language therapist

• lack of access to an identified clinical service
for an individual (use of hydrotherapy pool)
• risk of sexual abuse between people living in
the same house
• risk of being injured and concerns about
inappropriate use of restraint
• failure to give priority to an agreed move due
to lack of agreement about funding
• requirement for more individual activities for
those unable to participate in group
activities due to behavioural challenges.
• lack of availability of specialist seating
resulting in a person spending a long time
in bed

Communication

Staff and advocates reported that insufficient
consideration had been given to support people
living at the hospital to communicate. This
included lack of training in deaf awareness,
sign language and Makaton, lack of
understanding of communication with people
who do not use formal communication, and the
specific requirements of people with dual
sensory loss. Communication profiles were
drawn up in 1998, and some people had a
communication passport drawn up in
2000/2001, but very few of these had been
systematically reviewed. Rarely did members of
the investigation team observe staff having
conversations with people at the hospital. Only
in one bungalow was there evidence of staff
telling a person that they were about to be
moved and why, or what they were being served
for dinner. Where communication strategies
had been developed these were not used
consistently.

One person communicated using British Sign
Language but was not supported by staff skilled
in this area. Some staff were observed
speaking to this person when his back was
turned and, given that he was profoundly deaf,
this was not effective, nor did it reflect an
understanding of his sensory loss. Another
person communicated by Makaton and some
British Sign Language. Her key worker and her
advocate were the only two people who
consistently communicated with her in this way.
A third person had a communication aid, which
had been broken for two years and had not
been replaced or repaired. There were no
electronic communication aids available to help
people express themselves. A quote from the
records of one person stated: “staff do not
require communication training because the
client does not speak”. This demonstrates an
extremely poor level of understanding and
does not acknowledge that those who do not
use spoken language may have other ways
of communicating.

There were some good examples of
communication, for example a group at the
Woodlands Centre did some effective work on
communication using signs, objects, smells
and sounds to support individuals to prepare
for and understand moving to a different home.
At Osborne House, staff spoke to people in a
respectful manner and no one was talked about
in their presence or in the presence of anyone
else. People who lived there were included
in conversations.

There were a few examples of information
being developed in an accessible format for
people, such as an easy read version of
proposals to replace services at the hospital
with care in the community, leaflets from the
day centres, information from the local
authority partnership boards and a poster to
tell people about the investigation.

Findings about how people
influenced the provision of care

In summary, the findings about how people
influenced and were involved in the provision of
care are:

• person-centred plans as described in
  Valuing People only existed for a minority of
  people. Most people did have a plan of care,
but these were not based on the principles of person-centred planning and there was little evidence of regular reviews of care plans

- there was no provision of advocacy in the community houses with the exception of one house in Sutton. There had been some difficulties about ways of working with advocates but following a review of advocacy services this had improved

- relatives and carers were concerned about the future but were generally satisfied with how the services were being delivered. They wanted more activities, especially in the evenings and at weekends

- complaints about care in the learning disability service were few in number given the size of the service and there was little evidence that people were informed about how to complain

- communication with people with learning disabilities was poor, insufficient staff had effective communication skills and the potential for people to communicate in different ways was not developed

- there was little provision of information in easy to read formats. Integrated arrangements for governance representing best practice should be in place in all healthcare organisations
The PCT’s systems of governance

Integrated systems of governance are processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives and ensure safe and quality services.

To promote safe ways of working, the systems of governance of an organisation should ensure that there are the right numbers of staff in post to support the needs of the individuals to whom they are providing a service. Those staff must have the right training and opportunities for development and they must also have the right supervision and appraisal systems. There should also be good systems for the management of risk and health and safety.

Numbers of staff

In interviews and during our visits, nearly everyone we spoke to expressed concerns about the staffing levels throughout the learning disability service. When asked what difference they would like to see, the most frequent response was “more staff”. Many staff at the hospital said that they were unable to guarantee the safety of people with learning disabilities given the staffing levels at the time when the investigation began. Staff reported that there were usually one or two staff working at night and three or four covering the day shifts. There had previously been one member of staff at night and two or three during the day. We were told that rosters should provide one qualified member of staff per shift but due to shortages and sickness this was not always possible. Some of the staff nurses worked on a roster to cover the hospital site for emergencies and certain types of drug administration because healthcare assistants regularly took charge of houses. However, we were assured that healthcare assistants that took charge of houses had completed additional training required in the administration of medication. We were told that there were at least two occasions between January and March 2006 when as few as two qualified staff were on duty to cover 11 houses with 95 people living in them.

Managers at the PCT, including one senior manager and one member of the PCT’s board, said that staffing levels were low and that this had detrimental effects, such as people not being able to participate in activities as a result. Another manager said that the PCT was unable to guarantee the safety of people in its learning disability service because of low staffing levels and lack of supervision and support for staff. Staff said that during 2005/2006 there was a freeze on recruitment and one manager said they felt pressured not to appoint to a vacancy. The investigation team looked at the duty rosters of staff for January to March 2006. They showed that NHS temporary staff or agency staff were often used. Permanent staff worked on their days off or during periods of annual leave, in order to ensure the houses were adequately staffed. This indicated that the number of staff was insufficient to meet the needs of the service, rostering was poor, and sickness was not being managed effectively. In 2003, a PCT audit of rosters in the learning disability service provided “satisfactory assurance” that managers had established sound systems for setting staff rosters and ensuring that staffing levels were adhered to. The audit was extremely limited in that it only looked at duty rosters for the week ending November 16th 2003 and the associate director of nursing was the only person interviewed.

When asked how decisions were made about the numbers of staff employed, the learning
disability service provided a document stating that the numbers of staff were based on meeting individual needs. They said that decisions were informed by best practice frameworks, for example *Valuing People*, Department of Health standards and Royal College of Nursing guidance. A manager in the learning disability service said that priorities were defined within their business plan to ensure that needs could be met within the staffing resources available. Staffing establishments had also been based on a combination of other factors including historical patterns of service, staffing arrangements and service affordability.

The numbers of staff at the hospital had increased from 150 in 2003/2004 to 153 in 2004/2005 and 167 in 2005/2006. Staffing levels in the community houses in Sutton and Merton were fairly constant during the three years with establishments of around 137 staff. This was similar to Osborne House in Hastings which had 41 staff employed.

To measure staff turnover, the total number of staff leaving an organisation each year is expressed as a percentage of the total number of staff employed. The PCT quoted the following staff turnover rates for the learning disability service:

<table>
<thead>
<tr>
<th></th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
</tr>
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<tbody>
<tr>
<td>Orchard Hill Hospital</td>
<td>12%</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>Community Houses</td>
<td>11%</td>
<td>4.4%</td>
<td>6%</td>
</tr>
<tr>
<td>Osborne House</td>
<td>7%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>10%</td>
<td>10%</td>
<td>11%</td>
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The average turnover rate for public services is 11.5% although in health services this is higher at 14.1%. By comparison the total turnover rates for the learning disability service indicate a below average turnover rate. However, these figures should be considered alongside the fact that the PCT induction course was completed by 141 new members of staff in the learning disability service between April 2004 to December 2005. While some of the 141 were temporary staff, this does suggest that with a workforce of 442, more than 25% of staff were new to the service in a two-year period.

The learning disability service supplied information confirming that 32 staff had been dismissed since 2002. The reasons for dismissal varied from ill health to gross misconduct and included dismissals for sexual abuse, neglect, and physical abuse of people with learning disabilities. Seven of these dismissals were related to the serious incidents examined earlier in this report.

The average sickness absence rate for the learning disability service was 6.6%, varying from 5.1% to 7.2% between April 2002 and February 2006. The 2005 NHS sickness absence survey showed that an average sickness rate for PCTs in England was 4.2% and for mental health and community trusts, which included learning disability services, it was 5.3%.

**Training and development**

The learning disability awards framework (LDAF) is a set of national qualifications designed for people working in a learning disability service. This training had not been provided and none of the staff interviewed said that they had completed it. Although not mandatory for NHS trusts, *Valuing People* states that from April 2002, all new entrants to learning disability care services should be registered for qualification on LDAF. There is a target requiring 50% of care staff to have achieved level two in a relevant National Vocational Qualification (NVQ) by 2005 for people working in social care settings. If this target applied to the learning disability service, about 200 care staff would need to complete an NVQ. Records for March 2006 showed that only 46 staff had completed NVQ level two or three and that 13 staff were in the process of completing an NVQ. A manager in the learning disability service said that more than 50% of care staff had achieved an NVQ. It is not clear as to which set of figures is correct.
The PCT stated that three areas of training were mandatory for all learning disability staff, which should be completed within certain timescales. All staff should attend a fire lecture, annual training in manual handling and training in diversity. There are other types of mandatory training that staff with specific duties should do every so often: for instance staff involved in food preparation and serving should complete food hygiene training.

Figures supplied by the PCT show that in 2005 only 229 staff (from a workforce for the learning disability service of 442) attended a fire lecture, 164 attended manual handling training and 29 attended diversity training, although 75 had attended this training in 2004. The Healthcare Commission has found that, overall, nearly 20% of trusts said that they did not meet the standard, or had insufficient assurance that they met the standard of all healthcare workers participating in mandatory training (of those 20%, over half were PCTs).

Although a senior manager of the PCT said that risk management awareness was a mandatory course for all staff, only 101 clinical and non-clinical learning disability staff and 35 managers and team leaders had completed this training since April 2002. The course syllabus contained up to date and comprehensive information about risk management and health and safety issues. Only one member of staff had completed training developed by the National Patient Safety Agency to effectively investigate serious incidents.

Staff working with people with learning disabilities should have completed training in the protection of adults less able to look after themselves. During January to May 2006, 73 staff completed this, 35 during 2005, and 18 during 2004. Many NHS organisations known to the investigation team had made this training mandatory for care staff and had begun a programme of staff training in 2002 or 2003.

Between April 2002 and May 2006, of approximately 442 staff in the learning disability service the following numbers of staff had attended key training courses (some staff attended more than one course):

- 49 attended training in child protection awareness, which some organisations have made mandatory
- 12 attended training about autism
- 60 attended training in communication skills, including a type of sign system called Makaton
- five attended training about nutrition and dietary needs
- 115 attended training on the subject of epilepsy
- 172 completed first aid training
- 166 completed infection control courses
- 131 attended various learning disability courses such as understanding mental health needs for people with a learning disability, but only 11 of the 131 attended values training
- 41 completed administration of medicines course
- 44 completed some form of training in person-centred planning
- seven completed training on supervision
- 29 completed leadership training

The investigation team expected higher numbers of staff to have attended training on the topics in this list, but particularly in child protection awareness and in adult protection awareness.

Most staff interviewed said that mandatory training was taking place but that sometimes it was difficult to attend due to staffing constraints. When we asked staff what differences they would like to see, the second most frequent answer was about the need to increase the provision of training. The majority of staff spoke about a freeze on training during 2005/2006, when due to the financial problems of the PCT there was no training other than
mandatory courses. When this was raised with a senior manager, he said that this was not true and that where training was essential an application would be considered.

**Supervision**

There are two types of supervision provided by and to NHS employees; these are clinical and managerial supervision. Managerial supervision is between a line manager and an employee and is focused on the performance of employees and the monitoring of their workload. It should involve regular reviews of their performance to ensure that an employee is competent and focused on meeting agreed objectives. Clinical supervision, although not statutory (except for midwives), is between clinical staff and is seen as good practice. Clinical supervision is a formal process of professional support and learning which helps individual practitioners to develop knowledge and competence for their own practice.

The PCT’s clinical supervision policy (dated May 2005) stated that a system of clinical supervision was being established in most areas. There were draft guidelines for staff supervision in the learning disability service (undated), which stated that all full-time staff should receive formal supervision from their line manager at least once every eight weeks. Some staff from the learning disability service did attend PCT meetings about clinical supervision, and supervision was a regular item at the learning disability quality committee meetings. However, this did not result in supervision consistently taking place for staff in the learning disability service.

In a statement dated April 2006, the learning disability service said that there was no information available about the compliance or uptake of either managerial or clinical supervision of staff in the service. There has not been an audit to assess supervision of staff in the service. Some said that supervision did not happen and that it was not relevant to their grade. Others said that they were supervised externally but that they funded this themselves. The latter point tended to be made by therapists rather than nurses or healthcare assistants. Where people were supervised, rarely was this free from interruptions as recommended in the policy. Interviews with managers confirmed that supervision was not happening in all locations, did not happen as frequently as it should and was not consistent.

**Appraisal**

An effective system of appraisal is a vital tool both for managers and staff in the NHS. In an appraisal, targets are agreed that are relevant both to the individual and to organisational objectives. The extent to which these targets are met can then be assessed with a view to staff having feedback on their performance.

The PCT had a policy on appraisal (dated November 2005), which stated that all staff should have an annual appraisal. The learning disability service stated that there was no information about the uptake of appraisals for staff. During our interviews many staff said they had not had an appraisal for a long time. Some staff confused appraisal with supervision, and some staff said that they did have annual appraisals. From 2003 to 2005, 80 staff in the learning disability service attended training about the appraisal process.

Only 101 staff out of a workforce of approximately 442 staff in the learning disability service participated in the 2005 Healthcare Commission NHS staff survey. Of those 101, just over half said that they had received an appraisal in the last twelve months. Interviews with senior staff confirmed that appraisals were not happening in all locations for all staff, and that some staff were not clear about the role of appraisal.

**Improving Working Lives**

*Improving Working Lives* is a Department of Health standard by which NHS employers and staff can measure the management of human
resources. Organisations are judged against their ability to demonstrate a commitment to improving the working lives of their employees. The PCT had achieved stage three (the final stage) of the Improving Working Lives initiative. In order to achieve this it submitted a self-assessment report in 2005 and a sample of staff were interviewed. The self-assessment covered recruitment and retention of staff, supervision, training and development, the working environment, sickness absence and other areas. The PCT scored itself a total of 33 (minimum pass mark 32, maximum score 36). The evidence included in the self-assessment report, which had been externally validated in October 2005, differed from the evidence found in this investigation about the learning disability service.

The management of risk

The PCT’s risk management department led the implementation of risk management. There was a risk management strategy and a risk assessment policy. The head of risk management and the health and safety manager had worked with the learning disability service to try to ensure that risk management worked effectively. Evidence reviewed as part of this investigation including risk audits, risk assessments and risk registers, showed that the structures and processes were in place to collect information on risk, such as the development of a register of risks, assessments of risk, the reporting of incidents and accidents, and policies and procedures. However, issues arising from reports generated by these processes had not been properly acted upon in the learning disability service. An example of this was when the health and safety manager had to write to the learning disability management team in March 2006 expressing his concern with the lack of progress on work to be done at Osborne House.

The PCT had demonstrated to the NHS Litigation Authority that it met the standards for level one of the Clinical Negligence Scheme for trusts as it had achieved a score higher than 75% in all of the relevant criteria. The report dated February 7th 2005 recorded an overall percentage score of 89%. An area of improvement identified in that assessment was that the board should receive a quarterly report showing incident trends in the PCT.

The learning disability management team were responsible for identifying risks for the service and then entered them onto the register. Staff and managers at all levels then completed assessments of risks that should be reviewed by managers and by members of the risk management team. Many of the risks on the register were related to individuals who lived in the service and, during 2005, it was agreed to remove all the risks that were about specific people. The intention was that these risks should then be addressed by risk assessments and placed on a person’s file. The PCT had not done a review of records to be able to assess whether this had happened.

As at March 2005, there were 57 risks identified on the risk register for the learning disability service. Eleven of these were of particular concern, such as the decline in staffing levels, the assault or abuse of people with learning disabilities by staff or other people living in the houses, and lack of access to people with the right skills like speech and language therapists, psychologists etc.

The learning disability service supplied copies of 24 general risk assessments. Eleven of these were undated and 13 were dated March 2005. These covered a variety of topics including assisting a person to eat and drink. There were also 13 general risk assessments of some of the products used in the learning disability service, such as disinfectant. There was no evidence of these assessments being adapted to meet the needs of people in different houses and no evidence that they were systematically reviewed and updated.
Incidents and accidents

The minutes of the learning disability committee dated April 2005 detail concerns that staff in the day services were not reporting incidents of bites and scratches where the skin was broken. Many staff we interviewed confirmed this was correct. However, they also felt that the reporting of incidents had improved, which was supported by an increase of 360 reported incidents in 2003/2004 to 678 reported incidents in 2005/2006.

Nationally, trusts estimate that an average of 22% of incidents and 39% of near misses go unreported, and that medication errors and incidents leading to serious harm are the least likely to be reported. A learning disability service in a different trust with a smaller residential service than the PCT had 913 reported incidents in 2005/2006.

When an incident form was completed, it was sent to the modern matron for additional comments and then was sent to the risk department. Sometimes these forms took several weeks to get to the risk manager, delaying any urgent recommendations that the risk department may have made following an incident.

When we examined the information from the forms for 2005/2006, some reports were not clear and sometimes one incident generated two or three incident forms. Of 678 reported incidents, 87 were about self-injury by the person with learning disability, 94 were about staff being injured by a person with learning disability, and 66 were about injuries between people living in the houses. Both staff and people with learning disabilities incurred some injuries during episodes of restraint.

Some staff and advocates were concerned that risk assessments and risk plans were not always being followed and that this led to incidents that could have been avoided. Staff said that they wanted more feedback about the outcome of investigations into incidents or accidents that they reported. The risk department produced a quarterly publication called *Risky Business* to disseminate learning from incidents and also sent information to the modern matrons that should have been passed on to staff in the houses.

Health and safety

The learning disability health and safety committee monitored accident and incident forms and developed relevant policies. Reports from this committee went to the learning disability quality committee and to the PCT’s health and safety committee.

Annual audits were undertaken in each house, to assess whether risk management standards were achieved, maintained and improved. The audits were carried out by a manager from the risk department, with a modern matron or a home manager. They consisted of a physical inspection of the house to identify existing or potential hazards; and covered training, policies and procedures, and risk assessments. The health and safety team were part of the risk management service and had a vacancy for a manual handling risk manager for 12 months. This meant that some training courses for staff were cancelled, progress reports were limited, attendance at training events was not always monitored and an external company was contracted to carry out training courses, at additional cost to the PCT.

Between March and April 2005, 16 audits of health and safety were conducted. Key areas where improvements were identified included the working environment, fire safety and maintenance. A senior manager said that although areas for improvement were identified, often within the home managers’ or the service’s control, sometimes insufficient actions had been completed when checked six months later.

A number of projects to improve the health and safety of staff and people with learning disabilities were completed during 2005/2006 out of a budget of £20,000. The improvements included ramps to improve access to a day centre, replacement flooring in two of the...
community houses and hand washbasins in two other community houses.

Some staff and managers at the hospital were concerned that they would not be able to respond effectively if there was a fire, because so few staff had attended their mandatory training. At certain times, especially during the night, staffing levels were insufficient to ensure that wheelchair users could be evacuated promptly. In January 2006, a meeting led by the health and safety manager considered the issue of evacuation and agreed eight action points to be put into place to ensure evacuation procedures were robust. These included checks on fire safety equipment and plans for a mock evacuation during the day, but at the time of the investigation, both the actions and the mock evacuation had yet to be completed.

There were health and safety concerns in some of the community houses, such as a fire detector not being fitted in one area where the laundry was done and automatic closers not being fitted on some doors. At Osborne House there were concerns about a fire door being propped open; however this was because there was no automatic closer fitted to the door even though a request to fix it had been submitted. We brought this to the attention of the managers of the learning disability service and it was rectified.

The PCT was aware that some of the buildings at the hospital contained asbestos. A full survey was carried out in 2005, which found a significant amount of asbestos in the underground utility ducts and some in the roof spaces of houses, and this was judged to be a high or medium risk to people if it was disturbed. It was recommended that some asbestos be removed, while some areas were recommended for sealing off as they were of low risk. The PCT said that minor works could be carried out, but that they decided to wait until the houses were unoccupied before removing all the asbestos.

An important part of effectively managing risk in any trust is ensuring that there are up to date and relevant policies and procedures for staff to follow. The PCT supplied copies of 109 documents in response to our request for current strategies and policies relating to the learning disability service. Upon receipt of these we created an itemised list and noted that some were not dated or had dates from 2002 or earlier. We found policies in one house dating back to 1992, which had not been reviewed or withdrawn from use. Many houses had old policy and procedure files from organisations that had previously managed the learning disability service. We sent the list of policies and procedures back to the PCT, who explained that 30 of the policies and procedures were being reviewed or awaiting management changes before updating. The PCT said that other policies would be reviewed following an organisational restructure.

Reviewing clinical and non-clinical policies for the learning disability service was an essential element of the 2006/2007 business plan. It was acknowledged by the PCT that many were out of date. The PCT assured the investigation team that the policies would be addressed in turn according to a prioritised list drawn up with the service. In the meantime the human resources department continued to update policies in discussion with staff representatives and agreed to a revised policy to manage sickness and absence.

When interviewed by the investigation team, staff reported difficulties in obtaining the most recent policies and procedures. This was largely because many of the community houses and the houses at the hospital did not have access to email or to the PCT’s internal website. When we visited houses, we observed many files with out of date policies and procedures in offices. When asked about this, one manager said there was a culture of not throwing anything away and that he was thinking of compiling a new file with all the relevant policies and redistributing it to all the houses. The investigation team would support this approach and would add that out of date policies should be removed.
Financial matters

The *Residents Financial Affairs Policy* (undated) provided a framework for staff to support a person to use their funds. Home managers were responsible for ensuring that staff understood the policy and implemented it effectively. The policy covered requesting cash, ordering goods, managing a person’s weekly allowance, and money for outings and holidays. An undated addendum to the policy stated that if the resident had capacity, he or she would be a signatory on the account with two other authorised signatures.

Internal audits from 2003/2004 and 2002/2003 reported satisfactory assurances of the system for administration and safe custody of money at the PCT and the procedures for controlling the financial affairs of people. The most recent audit report entitled *Residents’ Monies*, dated July 2004, concluded by giving assurance that new accounting systems for residents’ monies were sound and generally operating satisfactorily. We observed that there was a policy and procedure in place, and receipts were obtained and stapled to forms that were completed for expenditure. We observed different recording methods in some houses, for example one person signed for expenditures in some houses and two people signed for expenditures in other houses.

Evidence gathered from our interviews provided different perspectives about financial management matters including:

- conflicting evidence about whether people had their own bank account, or whether things were run through a hospital bank account
- some people had a personal allowance of £5 per week which was used if they needed personal items
- home managers did not have financial training but more responsibility was being devolved to staff in the houses for the management of money
- some people got higher rates of benefits than others when their entitlement to the higher rate was thought to be the same
- for people at the hospital and in the community houses, money was collected each week from the finance office at the hospital

The PCT confirmed that people do not have their own bank accounts and that they had two accounts dedicated to managing people’s funds. A current account receives funds from the Benefits Agency and elsewhere. A deposit account holds people’s savings. The sums are posted to individual ‘accounts’ set up on the PCT’s patients’ monies system. Sums in excess of £400 held on behalf of a person in the current account are transferred to the deposit account at the end of each month. Work was underway at the time of the investigation to have regular benefits paid to the deposit rather than the current account, and to establish individual bank accounts for people with a high street bank.

Although separate from residents’ finances, the PCT’s finances do impact on the learning disability service and the management of finances is an important part of the governance of an organisation. At the end of March 2006, the PCT was £6.7 million overspent. A statement from the PCT stated that some of this was attributable to the costs of the two judicial reviews of 2000 and 2004 about the closure of the hospital. A total of £716,000 had been spent on the two judicial reviews (£189,000 in 2004/2005 and £527,000 in 2005/2006). The costs of management time were not included in these figures. The total costs of both judicial reviews were met from the PCT’s budget allocation and which affected the PCT’s decisions about funding all the services for which it was responsible. During the last three years the PCT had spent almost £1,000,000 on improving the environment at the hospital. The learning disability service received 5.4% increase on its budget for 2005/2006. In the two years to March 2006 approximately £100,000 of charitable funds were spent at the
hospital and in the community homes. This included £35,000 on a sensory garden at the hospital and £35,000 on aromatherapy sessions for people living at the hospital.

The learning disability quality committee and the PCT’s governance committee

The governance work of the learning disability service was carried out through the quality committee. The quality committee reported to the PCT’s governance committee, which then reported to the PCT’s board.

The governance committee had questioned the size of the quality committee’s membership but, as this was the only forum bringing together staff from across the learning disability service where professional and clinical issues were aired, the membership was not changed.

In January 2006, the interim director for the learning disability service said that previous agendas of the quality committee appeared overloaded and she therefore intended to shorten agenda items, review membership and rethink the committee’s workload. Four sub-groups were then established:

- health and safety
- education and training
- standards for better health (including risk and clinical negligence)
- improving the health of people with learning disabilities

The quality committee produced a report dated June 13th 2005 for the governance committee, which detailed 14 issues to take forward, including:

- not all areas had developed local medicines protocols
- as a result of risk assessments a taskforce was set up for one of the houses for people with behaviour that challenges, to take action on risk management, recruitment, the environment, monitoring incidents and reviewing staffing
- further training was required for all staff on risk management incident reporting and complaints
- the vulnerable adults policy and the serious incidents policy needed to be complementary
- training was required to improve record keeping
- training was needed for staff working with behaviour that challenges
- a steering group to review and improve the individual planning process
- the requirement to recruit a training consultant and implement a new training strategy by August 2005
- the need to develop further guidance for staff about roles, responsibilities and the appropriate application of robust risk management processes that prevent unnecessary restrictions in the daily lives of individuals
- to develop a policy about taking risks by October 2005

Minutes from the PCT’s governance committee meeting on June 15th 2005 recorded that the associate director of nursing in learning disabilities gave the background to the quality committee’s report and advised that a draft business plan and action plan had been written. The minutes stated that the report was noted but there was no other record in the governance committee’s minutes of the report nor was there a record of any feedback on the report.

A further report produced by the quality committee was noted in the minutes of the PCT’s governance committee meeting on October 19th 2005, but again there was no other mention or detail in these minutes relating to the content of the report. The next meeting of the quality committee on November 25th 2005
notes that the associate director of nursing in learning disabilities presented the report to the governance committee and that “no comments had been made”. This implied to the investigation team a possible lack of support for the work that the associate director of nursing was promoting.

The former director of the learning disability service attended five of the eight meetings of the PCT’s governance committee. One meeting in November 2005 was cancelled due to the absence of key personnel. At the previous meeting the chair of the PCT, who was a member of that committee, expressed concern about the number of apologies and stressed that this was an important sub-committee of the PCT’s board, which should take priority. The poor attendance impacted on the effectiveness of the committee.

The PCT’s governance report for 2004/2005 had nine objectives specific to the learning disability service. These are listed below together with the director accountable for the objectives:

- to implement the risk assessment in relevant service areas – director of nursing
- to increase the use of the PCT’s intranet – director of facilities and information technology
- to maintain and develop services for people with learning disabilities – director of learning disability service
- to ensure all staff have an appraisal and a personal development plan – director of human resources
- 75% of staff to attend mandatory training – director of nursing and joint chairs of professional executive committee
- to implement Essence of Care benchmarking – director of nursing
- to improve care to people with epilepsy – director of learning disability service
- to manage the hospital closure project – director of learning disability service
- to develop the sensory garden – director of learning disability service

Very few of the above objectives for the learning disability service were completed and this was reflected in the 2005/2006 governance report dated April 2006.

The PCT’s board

The PCT’s board received copies of the minutes of the governance committee, but minutes of the board’s meeting did not record any discussion about them. The board meeting agenda listed the governance committee minutes for acceptance and the minutes stated that they were noted and accepted.

During 2002 and 2003 the PCT’s board discussed reports about the care provided to people at the hospital and in the community homes. It endorsed action designed to improve the quality of care as well as agreeing that services should be provided away from the hospital. From the beginning of 2004, minutes of the PCT’s board detail the following agenda items about the learning disability service:

- the judicial review
- [lack of] funding for the transitional phase of the change project regarding the hospital
- the new arrangements for governance for the change project and subsequently receiving the minutes of the hospital change board

From January 2006, minutes noted more detail and discussion regarding the learning disability service. This included the appointment of new key staff and the presentation to the board of the 2006/2007 learning disability operational plan (March 2006), when the board gave approval to recruit more staff. Performance reports to the PCT’s board did not include any mention of the learning disability service and focused on A&E and acute services. Issues identified in the minutes of the learning disability quality committee were not reaching the PCT’s governance committee and were not
therefore reaching the PCT’s board. Evidence reviewed by the investigation team found a discrepancy between what the PCT’s board was told and what was actually happening or not happening in the learning disability service. During interviews, it was clear that the non-executive directors on the PCT’s board relied on verbal assurances from the executive directors that effective action had been taken, when that was not always the case.

**Findings about the PCT’s systems of governance**

In summary, the findings about the PCT’s systems of governance are:

- historically staffing levels were low, with a reliance on temporary NHS and agency staff
- there were high rates of sickness and vacancies that were difficult to fill
- there was poor attendance at mandatory training and insufficient investment in the development of staff
- neither clinical nor management supervision was being carried out effectively
- many staff had not had an appraisal and there was no monitoring of this
- risk management was not effectively implemented in the learning disability service and insufficient action had been taken to address and manage risks identified on the register of risks
- there had been an increase in incident reporting but it was still low
- policies and procedures were not systematically reviewed, they were not effectively issued and there was a lack of version control
- there was an inconsistent approach to the management of people’s money and managers had little training in financial management
- the learning disability quality committee was useful in that it was the only forum for staff to meet and share issues, but its effectiveness was limited because issues identified did not effectively reach the governance committee, or the PCT’s board
- the PCT had a governance committee but there was no record of this committee discussing or debating issues brought to it by the learning disability quality committee
- the learning disability service had not always been represented at the PCT’s governance committee and attendance was poor
- the interim director of the learning disability service reviewed the quality committee’s role and function
- prior to 2006, minutes of the PCT’s board focused on the judicial review and the hospital replacement programme, not the overall quality of the learning disability service
- the PCT’s board did not receive accurate, regular information about the learning disability service
Management and leadership

During our investigation, concerns were expressed by staff, relatives and advocates about the capacity and capability of managers to manage and lead staff to work in new ways with people with learning disabilities. These concerns particularly related to home managers, modern matrons and some members of the learning disability management team. Some staff questioned whether the PCT’s board was fully committed to the provision of services to people with learning disabilities, and concerns were expressed about the effectiveness of other organisations, such as the Sutton and Merton Local Authorities partnership boards and the South West London Strategic Health Authority.

Home managers

Until recently, home managers worked as part of the staffing numbers for each shift undertaking tasks that should have been done by care staff. This meant that they did not have dedicated time to undertake management duties. Effective leadership has many aspects including role modelling appropriate behaviours and working alongside staff. Some managers told us that they did not have time to ensure that staff were appropriately supervised, attended mandatory training and appraisals were carried out. They were unable to ensure that all the actions from adult protection meetings, or from health and safety audits were carried out. Some managers were able to audit records and develop plans of care for people, but others told us that they did not have time to do this.

Managers said that they were dealing with crises and had no flexibility. They rarely had time to meet with other home managers and met with modern matrons every four weeks to discuss issues such as staffing. Like the staff they managed, managers themselves reported difficulty in attending training and had not had specific training in how to manage. They also felt that they received insufficient supervision and support from their managers, and when they did have supervision it was often interrupted and was not held in a confidential space for them to reflect and learn.

Modern matrons

All trusts with inpatient beds were required to develop plans to establish modern matron posts by April 2002, in order to provide leadership, which would drive up standards of care. A risk report for the learning disability service completed in November 2002 identified that the existing management structure was inadequate. To support home managers in fulfilling their roles, four matrons were appointed at the hospital between November 2003 and January 2004. Each had overall responsibility for three houses at the hospital and also had key areas of clinical responsibility.

A review carried out in July 2005 found that there was a lack of clarity around the roles and responsibilities of the matrons. The review report stated that improvements had been made in communication between staff and they had helped to develop staff at the hospital. Some staff felt that the matrons were not committed to change and that it was not apparent what they had achieved. Some staff said that the matrons had not worked as a team and that they had not been assertively campaigning for people’s needs to be met.

The review of the role of matrons also stated that they received inadequate support from senior managers, they felt under-resourced, and they had too much paperwork to do. As at
June 2006 not all the matrons had received feedback on the findings of the review. Twenty-three recommendations arose from that review, which were in the process of being implemented. Two of the matrons recently retired from the roles and the PCT was considering options for the way forward.

Our evidence indicated that matrons fulfilled duties that home managers did not have time to do. One matron said that when appointed they did not anticipate the enormous role and duty required of them. Another matron reported that they were “fire fighting all the time”.

The learning disability management team

The management team of the learning disability service consisted of:

- the director of the learning disability service
- the manager of operations
- the associate director of nursing in learning disabilities
- the business manager
- the project manager
- the commissioning manager
- the modern matrons
- the community services manager

The community services manager and the modern matrons were accountable to the manager of operations although, as qualified nurses, the matrons were professionally accountable to the associate director of nursing in learning disabilities. The investigation team had concerns about the capacity of the management team to deliver what was seen as a huge agenda.

At one time the consultant psychiatrist, who worked one and a half days a week, was able to influence and contribute to the management team by contributing to monthly meetings. During 2005, the remit of some of the meetings changed from being meetings where decisions were made to meetings that were more consultative in nature. The consultant psychiatrist said she felt excluded from important meetings and that the clinical voice was not heard and acted upon sufficiently by the learning disability management team or the PCT’s board. However, she did meet with the chief executive of the PCT several times a year and had the opportunity to raise concerns there.

The consultant psychiatrist said that she had a good understanding of the possible advantages of the Mental Health Act 1983 and the Mental Capacity Act 2005 for people with learning disabilities and acknowledged that more needed to be done, particularly in relation to restraint and locked doors at the hospital. The consultant psychiatrist also had a good understanding of the physical health needs of people with learning disabilities and was keen to ensure that these were met. One of the PCT’s joint chairs of the professional executive committee had led a project to develop enhanced healthcare packages for people with learning disabilities and at interview also conveyed a good understanding of the physical health needs of people.

Overall, clinical leadership in the learning disability service was perceived as limited and senior managers developed concerns about it. This was partly because of the model of care that was being delivered, and partly because of the lack of availability of staff from other professions, for example psychologists and speech and language therapists.

The former director of learning disabilities was appointed in September 2002 and left the PCT in October 2005. Prior to that he had worked as the project manager for the redesign of services. The former chief executive said that, when the post of director of the learning disability service was advertised, to which the project manager had applied, none of the candidates were considered suitable. It was thought that the project manager could develop the capacity for the post, and he was offered a temporary contract, initially for six months, to
allow time for that to be achieved. This was then extended for two further periods of six months before being made permanent. The former director of the learning disability service said that the temporary nature of the post, the limited resources in the learning disability service and the demands of the judicial review made it difficult, if not impossible, for him to achieve change. However, some staff interviewed said that this was more about the capability of the former director; and some relatives as well as staff from other organisations said that they found it very difficult to get answers to letters that they wrote to him. The former director was a also member of the PCT’s board in a non-voting capacity. Staff in the PCT said that there was a lack of leadership for people with learning disabilities at board level while the former director was in post.

An interim director of the learning disability service was appointed in December 2005 who had previously worked for the Merton Local Authority. In May 2006 the post was then jointly appointed to by the PCT and Sutton Local Authority. The interim director’s contract has been extended in recognition of the volume and complexity of work that the management team has to address.

The associate director of nursing in learning disabilities had the lead responsibility for quality. She was also responsible for ensuring that clinical supervision was taking place. Evidence presented earlier in this report shows that there was no robust system for monitoring quality, and that clinical supervision was not happening regularly throughout the service.

Managers interviewed said that a lot of their time had been taken up by the two judicial reviews that took place in 2000 and 2004. This included providing support and advice to directors and other senior managers in the PCT, meeting with relatives and carers, meetings with staff, preparing information and responding to correspondence. Some managers interviewed seemed almost traumatised by the experience of the two judicial reviews and said that they found it a very stressful time.

The PCT’s board

In the last decade, the learning disability service has had seven chief executives [two of which were joint chief executives]. It has been part of four NHS organisations that have been overseen by three different health authorities. The current organisation is one of the largest PCTs in England, spanning two London boroughs.

The leadership of a PCT is based on a complex relationship between the chair, the chief executive and the chair of the professional executive committee, in this case joint chairs. It is influenced by the work of the PCT’s board and the professional executive committee. We were told that at times there were conflicting priorities for the PCT between what the local population wanted, what the strategic health authority required and what local professionals wanted. The former chief executive was seconded from the PCT to a post at the strategic health authority at the end of October 2005, and an interim chief executive was immediately appointed to lead the PCT (in addition to continuing to lead her own PCT).

The PCT’s director of nursing is responsible for the standard of nursing care throughout the PCT. Although not directly responsible for what was happening in the learning disability service, she was accountable for implementing supervision throughout the PCT and ensuring that certain risk assessments were carried out where necessary. Earlier evidence detailed in this report confirms that neither of these tasks were carried out effectively in the learning disability service. Evidence from interviews also identified a lack of responsibility on the part of some directors for taking action and a lethargy about following things up with any consistency. Letters and action plans show that some managers would take an interest for a short time but action was not effectively monitored to check what was actually happening and whether...
it was making a difference to the lives of people with a learning disability.

**Commissioning**

All NHS organisations are required to produce a business plan called a local delivery plan. The local delivery plan is the main vehicle for NHS planning and commissioning and, as such, it forms the basis on which strategic health authorities hold PCTs to account. The PCT’s local delivery plan for 2003 to 2006 only contained two bullet points relating specifically to learning disabilities in the section relating to issues impacting on the achievement of objectives. These were:

- business case for redevelopment
- major premises and staffing risks

The PCT also provided a copy of their local delivery plan initiatives (undated). This did not include any specific references to the learning disability service, however the PCT’s business plan demonstrated objectives to:

- progress the agreed transfer of services from the hospital
- improve the quality of services for people with learning disabilities
- continue to deliver services through aligned locality structures, taking into account the requirements of the new White Paper *Our Health, our Care, our Say*
- progress work on the requirements of *Valuing People* including partnership agreements with local authorities, developing person-centred plans and securing agreement for the majority of people at the hospital to move out to the community
- develop a business plan integrating both community and hospital services, ensure resources to support a safe service, ensure provision for young people in transition to adult services and establish performance management and quality frameworks to measure the service

In June 2006, the PCT said it was committed to ensuring best practice for all the work for which it had a responsibility, including both commissioning and the delivery of services. Although there were separate resources dedicated to commissioning and to service delivery, there was little evidence that joint commissioning influenced service delivery. For example, systems were not in place to enable the work of the public health director to influence commissioning of learning disability services. There were no joint commissioning strategies in place for people in either Sutton or Merton between the PCT and the local authorities.

All PCTs in England have participated in independent *Fitness for Purpose* reviews commissioned by the Department of Health. The review of the PCT included an organisational assessment and the use of a commissioning diagnostic tool, which would allow the organisation to measure itself against other PCTs. The PCT had volunteered to be in the first wave of these reviews, and the results of the review will be of interest to this investigation in order to determine whether the management structures for commissioning and providing the learning disability service are satisfactory.

Although there were 184 people living in the PCT’s learning disability service, some of these people were funded by other PCTs. This was because when people first required care they lived in an area other than Sutton or Merton, where there was no suitable service available. There were eight other PCTs that commissioned a total of 65 places for people in the PCT’s learning disability service. Of these, 40 were at the hospital, six at Osborne House and 19 in the community houses in Sutton and in Merton.

In February 2006 the Healthcare Commission wrote to all eight PCTs to find out how they monitored the quality of commissioned services for people in learning disability placements. All eight PCTs replied and confirmed that they monitored quality through a variety of methods.
including the involvement of care managers, participation in reviews and meetings, joint working with the local authority, visits to the hospital at least twice a year and by reviewing documents. Some PCTs expressed a concern to the Healthcare Commission regarding the quality of care being offered at the hospital, and others expressed a concern about the length of time it had taken to find suitable placements for people. A few of the PCTs have stated that they intend to cease to commission services at the hospital. The PCT reported that prior to the Healthcare Commission investigation there was no record or recollection of concerns raised by the commissioning PCTs about the quality of care provided.

Partnership working with the local authorities

Effective partnerships are key to achieving social inclusion for people with learning disabilities. Sutton Local Authority, Merton Local Authority and East Sussex Local Authority are important partners in the development of the learning disability service because services are delivered to people in those areas. Each local authority has a learning disability partnership board that was established in 2001 as a requirement of Valuing People. Although not statutory bodies, learning disability partnership boards are responsible for:

- developing and implementing joint investment plans
- overseeing the ways agencies work with each other and the planning and commissioning of services for people with learning disabilities
- ensuring that arrangements are in place to achieve a smooth transition to adult life for learning disabled young people

Both Sutton and Merton partnership boards appeared to function according to the requirements set out in Valuing People. Evidence received from the Merton partnership board indicated that there were detailed discussions, frequent meetings and good progress. There was scope for the Sutton partnership board in particular to become more influential in its ways of working. Evidence from the Sutton partnership board meeting minutes reflected a huge agenda but lack of progress, although a business group had been set up to push forward the work. At our interview, the director for the learning disability services stated that he was keen to support the development of the partnership board and saw it as one of his priorities to take this forward. A recommendation has been made for a further service inspection of learning disabilities to be undertaken in Sutton.

The PCT had no formal arrangements for working in partnership with East Sussex Local Authority and no one from the PCT attended the meetings of the learning disability partnership board. The members of the partnership board were aware of Osborne House but in the last two years there had been no specific item about Osborne House.

There were good working relationships between the PCT and Merton Local Authority, and the joint management of the Freshfields Centre was a good example of this. There had been a formal partnership agreement in place between the PCT and the Merton Local Authority since December 2003. A service inspection for people with learning disabilities was undertaken by the Commission for Social Care Inspection (CSCI) in March 2004 and the overall judgement was that “some people were being served well and the capacity for improvement was excellent”. During visits to Merton and in meetings and interviews with staff from the Merton Local Authority, we heard concerns about the quality of care provided at the hospital and the lack of progress in redesigning this service.

Recent progress had been made between the PCT and with Sutton Local Authority although historically there had been a poor relationship and problems in working jointly. Some managers said this was due to the personalities of people in senior positions.
director of learning disability services appointed in May 2006 is responsible for all aspects of the learning disability service including the transfer of services from the hospital. There was no formal partnership agreement in place at the time of the investigation although the Sutton Local Authority and the PCT had agreed to develop two formal partnership agreements. One agreement was to be for assessment and care management and the other for initial arrangements to lead to joint commissioning. The Social Services Inspectorate undertook a service inspection for people with learning disabilities in October 2001. The overall judgement was that some people were being served well and the capacity for improvement was promising.

The strategic health authority

The South West London Strategic Health Authority was created on April 1st 2002 and was superseded on July 1st 2006 by the London Strategic Health Authority. The strategic health authority is responsible for ensuring that national priorities are integrated into local plans and strategies, and ensuring high quality performance throughout London. It provides a key link between the Department of Health and the NHS.

When effective management of performance is in place and operating well, it should ensure that services delivered are safe, that the needs of the people using services are being met and that they are of high quality and good value for money. The former chief executive of the strategic health authority visited the hospital on several occasions and had communicated to the Department of Health her concern that people who lived there needed a different model of service to be provided. The strategic health authority was keen to support the PCT’s plan to transfer services from the hospital but was criticised by a senior manager at the PCT for rejecting the first business plan designed to achieve this. The strategic health authority explained that they was unable to support this as it did not have a financial plan for managing the transition. Some managers at the PCT felt that the strategic health authority could have done more to support them to achieve change. The strategic health authority was said to take a ‘hands off’ approach to performance management unless there was a serious incident.

Strategic health authoritys are responsible for signing off the local delivery plans of PCTs. As the South West London Strategic Health Authority signed off this PCT’s local delivery plan, which did not contain an objective about the care of people with learning disabilities, it did not fulfil its responsibility to adequately manage the performance of this PCT. The strategic health authority collected some information about the learning disability service for serious incidents and annual progress reports of the PCT’s governance plans. The governance plans did have some objectives in them about the learning disability service but many of these were not achieved. The director of nursing at the strategic health authority did meet with the PCT’s director of nursing and the associate director of nursing for the learning disability service to provide guidance and discuss progress.

Redesign of services

In June 2001, a project board was set up with a project manager to redesign services provided at Osborne House. The terms of reference stated that plans had been discussed since 1984 but no agreement had been reached because of changes in personnel, organisational changes and competing priorities. As part of this project work a risk assessment was completed. Although it was not dated, it was attached to a letter from the director of learning disability service dated October 17th 2001. This document stated that the PCT had accepted that there was likely to be no long term future for the current buildings and that services had to be transferred. This report assumed that the buildings would be in use for a maximum of two years.
A project plan for the redesign of services was prepared in October 2005 and terms of reference agreed in January 2006. In May 2006 the business case for the redesign of services at the hospital had been submitted to the PCT’s board. This was agreed subject to the details of the model of procurement being finalised and ongoing negotiations about finances to underpin the redesign. Assessments and service and financial modelling work were undertaken with an expectation that a final business case would be presented to the PCT’s board in March 2007.

There were concerns from staff, relatives and advocates about whether the right model of redesign was being developed. We were told that in order to save on the amount of land the PCT required, it had been suggested that two houses could be developed in a two-storey building. Advocacy services were concerned that this would undermine moves to provide more individualised support and would restrict the activities of those people living upstairs such as access to the garden. However, plans have not yet been completed as the reports from the external assessors will be taken into account before they are finalised.

PCT board members had made an effort to be informed about best practice in learning disability services and, from April 2002 to April 2004, they visited other services for people with learning disabilities across London and in the South of England to gain an understanding and knowledge of services. At our interview, the chair of the PCT’s board confirmed that she and the board were committed to the redesign of services at the hospital and at Osborne House; however this depended on securing transitional funding from the Department of Health. Both the strategic health authority and the PCT had made strong representations to the Department for support with this issue.

The investigations team remain concerned about the redesign process and whether limited management capacity and insecure financial arrangements can be addressed to ensure that new target dates of April 2009 for Orchard Hill Hospital and 2010 for Osborne House are met.

**Findings about management and leadership**

In summary, the findings about management and leadership are:

- home managers did not have time to effectively manage staff due to historically low staffing levels
- there were some examples of good practice by home managers and modern matrons but managers and matrons were not seen to be champions for people with learning disabilities
- the roles and responsibilities of modern matrons were not clear
- home managers and modern matrons required more support and training opportunities
- clinical leadership of the learning disability service was limited
- other PCTs that commissioned services at the hospital had concerns about the quality of care and the length of time taken to redesign the service
- there was a lack of priority given by the PCT to the learning disability service
- there was a formal partnership agreement in place with Merton Local Authority but not with Sutton Local Authority
- the strategic health authority did not ensure the high quality performance of the PCT with regard to the provision of care to people with learning disabilities
- there was a high level of concern about the redesign process, particularly whether limited management capacity and insecure financial arrangements could be addressed to ensure that new target dates for the redesign were met
Conclusion and recommendations

In January 2006, after several serious incidents had occurred including allegations of physical and sexual abuse, the interim chief executive of Sutton and Merton PCT contacted the Healthcare Commission. The Healthcare Commission agreed to conduct an independent investigation into the learning disability service provided by the PCT. The investigation focused on the hospital in Sutton, 10 community houses in Sutton and Merton, and Osborne House in Hastings. It also looked at four of the day centres and the way the PCT worked with the local authorities.

The investigation team examined the quality of the service and whether it was working to the standards set by national policies. The team looked at whether the ways of working ensured that people who lived in the services were safe. The views of relatives and advocates were sought and the PCT's arrangements for governance were examined. The investigation team also considered the management and leadership of the learning disability service.

The team found poor quality services in which the safety of people with learning disabilities was not given sufficient priority. The views of people with learning disabilities, their relatives, carers and advocates were not regularly sought or acted upon. There were weaknesses in the governance system, which meant that action was not always taken in the way it should have been.

While under the responsibility of the PCT, the children’s short break unit was in a building which was not suitable and there was a lack of robust management of the service. There were failings at all levels in the management and leadership of the learning disability service, although for some of these failings there were mitigating factors.

The quality of care

Institutional abuse occurs when the lifestyles of individuals are sacrificed in favour of the rituals and routines of the institution. This abuse was prevalent in most parts of the learning disability service as the model of care was not centred on the needs of the individual. Most people were unable to go out into the community sufficiently often. There was an extremely low level of activities on offer and many people based in the community did not participate in community life but returned to the hospital for healthcare or day activities. Meal times at the hospital were arranged to suit the staff rosters and the work of the main kitchens. Meal times were viewed by many staff as a task that had to be completed as quickly as possible. This type of institutional abuse was largely unintentional, but it was still abuse. It was mainly due to lack of awareness, lack of specialist knowledge, lack of training and lack of insight. It was exacerbated by low staff morale, shortages of staff, inadequate supervision and a lack of leadership.

There was some progress away from institutional living in the community houses and at Osborne House. Staff had taken the time to try to make these environments more like normal houses. Food and meal times were given more consideration but there was still a lack of planning for the future in order to identify changing needs or the improvements required in people’s lives. When people were known to be unhappy living with certain other people, there was no plan or intention to consider moving people to somewhere more appropriate where they might be happier.

With the exception of two buildings at Osborne House and one house in Sutton, the
environments that people lived in were impoverished and completely unsatisfactory. The decoration was poor throughout the houses, with insufficient personalisation of areas, although there was evidence that staff had tried to personalise bedroom areas in the community houses and at Osborne House. Some people had to share bedrooms and this resulted in privacy and dignity being compromised. Throughout the service, many of the bathrooms and bedrooms were small and not everyone had shower facilities. There appeared to have been little investment in the buildings or the gardens. Many gardens were not suitable for people who required the use of a wheelchair, lawns were uneven and some had paths that sloped or steps that were difficult to walk on. Some houses had a concrete courtyard that people were able to sit out in for fresh air surrounded with a large wire fence that gave the impression of people’s freedom of movement being restricted.

Despite the fact that the hospital and the community houses were in the London boroughs of Sutton and Merton, the services were isolated because of lack of integration with the local communities, lack of learning from other learning disability services and lack of expertise. Staff had had very little exposure to different ways of working.

The model of short break care was unacceptable in that individuals would be placed for a few days or weeks with other people who had lived together in a house for many years. This took up a lot of staff time and meant that the needs of long term occupants often took second place. In one example, the person requiring short break care had behaviour that challenged the service and many of the long term occupants of the house stayed in their bedrooms because they were frightened of that person.

There were serious deficiencies in the learning disability service with record-keeping practices, particularly with the requirement for people to have a person-centred care plan based on the principles of Valuing People. Very few people had a care plan that met these requirements. The care plans that did exist were often not up to date and there was little evidence of regular reviews of the plans. Some people had plans called health action plans. However, the review by BILD found that, although some of these were comprehensive and detailed, they did not meet the requirements of Valuing People. Instead, they were focused on maintaining people’s health as it was, and not sufficiently focused on improving their health.

The health requirements of people were generally met although this should have been to a higher standard in some areas. There was insufficient contribution from speech and language therapists and physiotherapists. This was particularly important at the hospital because a significant number of people who lived there had eating, drinking and swallowing difficulties and required support with mobility.

The overall model of care was one that promoted dependency. It was not dynamic and there was little evidence of clinical effectiveness or practice 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 could do and staff were very apprehensive about trying new ways of working that might represent a risk to the individual. Generally, people with learning disabilities have not been supported and encouraged to develop new skills. This can sometimes be achieved by taking therapeutic risks based on an agreed plan of care.

The safety of people with learning disabilities

At the time of the investigation there were concerns about the safety of people in the learning disability service. An analysis of serious incidents showed that people were at risk from each other and at times from staff. While no one could have anticipated some of the serious incidents that did occur, there were some weaknesses in the action that the learning disability service took after these
serious incidents, which, if addressed differently, would have sent out a clear signal about the organisation’s commitment to the safety of people. Staff were largely unaware of their duties with regard to the protection of adults less able to look after themselves. Very few staff had attended any training about this, and not all staff had access to the relevant policy.

There was inadequate specialist support for people with behaviour that challenges. The psychologist had asked for additional resources for three years but not been supported in this request. Due to the absence of a policy about restraint and lack of training, staff were restraining people inappropriately without sufficient consideration of alternative approaches. Items such as straps and splints were used to restrict movement and their use was not regularly reviewed to determine whether they were still required.

The management of risk was not effective in the learning disability service. Although structures were in place, such as a risk register, this did not result in the necessary action being taken to address the risks that had been identified. Where risks had been identified in the houses that people lived in, insufficient action was taken to address these risks. Although most accidents were reported, there was evidence that not all incidents or near misses were reported. This meant that the opportunity to learn from incidents, accidents and near misses was limited, and as a result the PCT missed important opportunities to improve the service. The PCT needs to develop a culture where staff feel safe to report all incidents, accidents and near misses. At the same time and in stark contrast to the above, there was a fear of taking risks in the learning disability service that to some extent prevented the development of new skills in people with learning disabilities.

The views of people, their relatives, carers and advocates

The views of people with learning disabilities were seldom heard. Their views were not regularly sought by the PCT and therefore could not be taken into consideration when decisions were made. Some staff believed, incorrectly, that if a person could not talk they could not communicate. Very few staff had any specialist training in ways of communicating with people with learning disabilities and, as a result, interpersonal techniques became focused on observation and completion of tasks rather than on inclusion and development.

Many relatives felt that the staff did the best they could and that they were kind and caring people. However, relatives and carers felt they were not treated as partners in the process of planning care. In particular, relatives were concerned about the future of the service and wanted the PCT to communicate more with them, although this had improved in the last six months.

Not all people with a learning disability had access to advocacy services. Where there was access to an advocate, the advocate was not able to contribute to the clinical reviews.

The children’s short break unit

Since November 2005, when the children’s trust took over the management of this unit, it has been well managed with many changes implemented including the planned move to a much larger bungalow with better access to play facilities. Prior to November 2005, the unit was not known about by those responsible for the children’s services in the PCT nor had it been inspected in any way prior to the audit requested by the head of children’s services.

Staff in the learning disability service

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. For example, people were cared for, rather than assisted to be as independent as possible. It was usually staff, rather than people with learning disabilities, who opened the front door to members of the investigation team and we were always introduced to staff but not always to people who lived in the houses. Some staff spoke about people as if they were not there, and some staff would speak to other staff members at meal times and not to the person whom they were assisting to eat.

There were shortages of staff throughout the learning disability service, usually as a result of incorrectly matching staffing levels to the individual needs of people. The service had above average levels of sickness among staff. Some vacancies were hard to fill and there was a reliance on temporary NHS and agency staff, particularly at the hospital. The PCT increased the staffing budget for the learning disability service during our investigation but additional staffing alone will not necessarily make a difference to the lives of people with learning disabilities.

There were insufficient numbers of staff participating in relevant training courses or attending mandatory training, such as what to do if there was a fire or how to move people safely. There was no robust system of supervision and very few staff had had an appraisal or a personal development plan.

Management and leadership

There were failures in management and leadership at all levels, from home managers to the PCT’s board. Home managers did not have the time or the training to manage staff effectively and they were working alongside health care assistants to support people with all aspects of daily living. The role of modern matrons was unclear and they were drawn into doing the work of the home managers rather than being able to lead change in the group of houses for which they were responsible. There was a notable absence of any clinical champions campaigning for and delivering improvements to the quality of care offered to people with learning disabilities.

The capacity and the effectiveness of the learning disability service management team were limited. There was no robust system for monitoring what was happening in the service and often managers thought something was happening or had been implemented when in fact it had not. Important messages from the learning disability service were diluted at the PCT’s governance committee so that by the time messages got to the PCT’s board, the information members received was minimal.

The PCT’s board received information about the proposed redesign of services at the hospital, at Osborne House and about the judicial review. However, they did not get comprehensive and up to date information that enabled them to monitor the quality of services in learning disabilities. The leadership of the PCT was based on a complex relationship between the chair, the chief executive and the joint chairs of the professional executive committee, influenced by the work of the PCT’s board and the professional executive committee. At times there were conflicting priorities for the PCT between what the local population wanted, what the health authority required and what local professionals wanted. Services for people with a learning disability had always been a small part of the overall services provided by the PCT and its predecessor organisations, which meant that it was difficult for it to compete for a share of resources with other healthcare services.

The PCT, as both commissioners and providers of the services for people with learning disabilities and behaviour that challenges, has not ensured implementation of the good practice identified in the Mansell report. Also the PCT’s local delivery plan had no objectives in it specifically relating to the learning disability service.

Dealing with the two judicial reviews absorbed
a significant amount of managers’ time as well as money. The efforts of some relatives, to challenge the PCT through a second judicial review about the change of plans for some people with high support needs were well intentioned, but it meant that the redesign to improve the quality of service for many people was delayed. Most people continued to receive an out of date model of care, in poor environments with systems that did not guarantee their safety or promote their health and development satisfactorily. The work for the two judicial reviews and the delays to changes being implemented continue to have an adverse impact on some people, including staff, managers, relatives and carers, but most of all on the lives of the majority of people using the service.

The poor quality of care in the learning disability service has not occurred overnight and the frequent changes of management and leadership played their part in this. The fact that there were seven chief executives in the last decade and four different organisations (under three different health authorities) created a lack of continuity and follow-up of management action. Although members of the PCT’s board had visited different learning disability services, there was limited expertise, and a lack of the right information at board level about the needs of people with learning disabilities. The unique combination of circumstances that have occurred in this PCT means that no one individual was responsible for the poor quality of services for people with learning disabilities. The current chief executive, with the full support of the PCT’s chair, requested this investigation and, although recognising it will be challenging, all are committed to acting on the findings and implementing the recommendations.

The closure of long stay hospitals like Orchard Hill should have happened many years ago and better services provided, in line with the Government’s policy, as should the closure of campus-type accommodation like Osborne House. The hospital is one of the last long stay hospitals in the country to close, and the PCT requires external support to ensure that this happens without unnecessary delay. The PCT is unlikely to be able to manage this process effectively without adequate funding arrangements as it will need to invest in new facilities while continuing to run the old ones. The Healthcare Commission remains concerned that without robust funding arrangements and effective change, services will continue to be provided in completely inadequate environments, making it extremely difficult for the PCT to implement new ways of working that are more in line with Valuing People. The work now taking place to develop new services must ensure they are developed and provided to meet the needs of people with learning disabilities in these services.

Progress since the investigation began

Although an action plan has yet to be developed in response to the recommendations made in this investigation, the PCT has already made some progress as described below.

The PCT reported that in October 2006 person-centred plans had been completed in respect of 97 people. It is intended that work on the person-centred plans will be complete by April 2007 for people living at the hospital and by October 2007 for those people in the community homes. People and their relatives are now involved in care planning meetings and in service improvement groups.

The learning disability service has introduced a template designed to help staff ensure that people have comprehensive healthcare assessments and healthcare plans, which are consistent in approach and quality. It has been accompanied by guidance from senior staff about the way each component of the template should be completed. The associate director of nursing is leading the work to review and renew healthcare assessments and plans for all people living at the hospital. This work was due to be completed in October 2006.
The PCT plans to combine information from community care assessments, healthcare plans and person-centred plans for each person into a single plan, which drives day-to-day practice and encourages a planned and cooperative approach among all staff to delivering care. The single plan defines outcomes for delivery and home managers will be held accountable for securing those outcomes. The approach is being piloted in four houses at the hospital.

In July 2006, the template used to audit risk was revised to ensure it incorporated the requirements of new standards published as part of National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 to 2007/08, published by the Department of Health in 2004.

The learning disability quality committee has been redesigned both in terms of structure and the conduct of business. The committee meets quarterly, receiving reports from its sub-groups. The sub-groups are: health and safety, governance, staff development and human resources, two groups concerned with health improvement and an equality and diversity group. Discussion at the first two committee meetings under the new arrangements points to their success in focusing on the full range of quality issues and action on some important matters, including training on manual handling and accident and incident reporting, clinical supervision arrangements, risk reporting and professional qualifications.

The PCT has taken advantage of senior staff retirements to bring in operational managers to the PCT from organisations that will provide services in the future to people at present cared for at the hospital. Among the benefits of this will be an early transition from a service-based model of care to a community-based approach that encompasses the whole range of people’s needs.

From August 2006, the PCT appointed a consultant psychiatrist to the service for people with learning disabilities. The consultant will work full time for six months, and future requirements will be reassessed during that time. The PCT acknowledges that more than the three consultant sessions available to date will be needed. A permanent appointment has been made to the vacant post in the community team for a consultant psychiatrist. The PCT and the mental health trust have renewed their commitment to work together on improving services.

Support provided by the psychology service has been increased. Also the PCT is recruiting a speech and language therapist to provide dedicated support to people who have difficulties with swallowing (dysphagia). This, together with the newly appointed consultant psychiatrist, will assure that there is a more robust clinical team for the service, and enhanced clinical leadership.

The provision of care to people with behaviour that challenges has been the focus for close attention. Service improvement groups, which involve service managers and staff, people, relatives and advocates, have been established in three houses at the hospital and one community home. These groups bring together staff, relatives and advocates to identify action that will improve the quality of care provided. Staff from one of the new providers of care have been seconded to work alongside staff and people in the two houses for people with behaviour that challenges. Some successful problem solving and innovative thinking are already evident in the early work of the service improvement groups. For example, changing the use of rooms to provide more quiet space and room for group activities, and joint work with a local GP practice to improve the service they provide together.

The PCT is recruiting a nurse with expertise in working with people with behaviour that challenges to support all staff in their work. The policy on restraint, drafted in April 2006, is now viewed as a working policy. Its use is regularly reviewed by the service’s quality committee and the policy is amended in light of that.
The first part of training for staff at the hospital on the treatment of serious incidents has been completed. It covers the need to be alert to incidents, the appropriate initial response and reporting, investigation and the systems designed to protect adults less able to look after themselves. The PCT is committed to the rolling training programme described in the training strategy for the service.

Serious incidents are now investigated by a person independent of the service. The newly appointed director for the service, who is responsible for adult protection throughout Sutton, has made it clear that high standards must be achieved for investigation and subsequent action on recommendations. The interim director has taken on the role of interim deputy director to assure continuity and that the momentum for improvement is not lost. The change of leadership for the service has introduced a change in style that now involves people with learning disabilities and their relatives in decisions about healthcare. There are closer, yet appropriate, working relationships with advocates. There are regular meetings between advocates and the deputy director, and advocates can also approach the director of the service when required.

The local strategic partnership for Sutton includes political and business leaders and chief officers among its membership. They hosted a conference in October 2006, which was part of its programme to challenge assumptions about people with learning disabilities and promote the role that people with learning disabilities have as citizens. This conference was run by people with learning disabilities.

During the same month, the Sutton learning disability partnership board was relaunched. The board is now chaired by the local authority cabinet lead for Social Services and contributes to the scrutiny of all local learning disability services. This includes the scrutiny of Orchard Hill Hospital, the development of new services and ensuring that the principles of Valuing People are being implemented.

The Sutton Local Authority introduced a performance management framework for the service, which forms part of its delivery and improvement statement.

The question of increased management capacity at the PCT is being addressed, in the first instance, by seconding staff from future care providers to work at the hospital, and drawing those providers into the service’s operational management team and its work.

One of the joint chairs of the professional executive committee led the work to reform the primary care service to people at the hospital, working closely with the general practice based there.

Staffing establishments have increased at all levels of the service. The number of posts at the hospital has increased from 153 to 239 posts and from 137 to 188 posts for the community houses. In most houses this means that there are four people on each daytime shift and two people at night. Not all posts are filled, but recruitment efforts continue. Staffing at Osborne House has also increased from 41 to 52 posts.

The PCT has established a part time management development programme that will begin in September 2006 for 12 months for home managers. The programme comprises sessions for home managers to reflect on their practice that are also supported by contributions from the PCT’s learning disability training consultant. Monthly workshops for home managers provide protected time for professional and operational management development. The workshops focus on leadership skills and behaviour and have
included, for example, a visit to an independent sector provider to observe how other managers manage.

As part of its training strategy, the PCT has established an annual programme of training for up to 60 people each year for the next two years, which leads to the award of an NVQ level 2 or 3 in health and social care and an in-house competence programme for pre-NVQ candidates. In addition to the qualification programmes, the PCT is focusing its attention on training that is mandatory, training related to the protection of adults less able to look after themselves and training where specific practice needs are identified. A programme of education for managers will ensure that they achieve a registered manager’s award and so qualify them to manage services as they move into a community setting.

PCT managers will be joining Sutton Local Authority managers in training and development as a prelude to the creation of a Sutton-wide development programme for all learning disability service managers.

The PCT introduced line management sessions at eight-weekly intervals for the service’s staff in February 2006. Clinical supervision for qualified nurses began in October 2006. Full compliance has not yet been achieved but the PCT is committed to full implementation by March 2007.

The PCT has introduced a process for regular review of all its policies and procedures. The quality committee considers risk management explicitly at each meeting and considers whether there are any additions or amendments to the risk register as a result.

The operation of the PCT’s governance committee and the PCT’s board have been reviewed as part of a national assessment commissioned by the Department of Health. Revised arrangements are due to be in place by April 2007. The trust has acted on themes emerging from the assessment and has initiated plans to ensure a clear distinction between the leadership for its commissioning and responsibilities for its service provider functions. It has also reviewed the way that the board is assured about the quality of the services provided by the PCT. Having received and considered a monthly report on operational issues for people with learning disabilities in the course of the Healthcare Commission’s investigation, the board will now receive a routine quarterly report about the service. The report will detail action against objectives in the learning disability service business plan, including progress on recruitment to key posts and information about staff supervision and training. The board will also continue to receive regular reports about the work on plans to move services from Orchard Hill Hospital and Osborne House.

As part of the review of the service’s management structure, the role of the modern matron has been reviewed. From September 2006 two posts will remain: one will focus on supporting the learning disability services associate director of nursing to deliver healthcare and the other on managing a number of community homes. This new structure, which includes two staff from the independent sector, aims to improve the skills and experience available to meet current objectives and to prepare the service for transition.

The Sutton and Merton Local Authorities, the PCT and the mental health trust from which services are commissioned, are also working together on a strengthened model for commissioning mental health services, based on a mental health toolkit called the Green Light Toolkit.

Reflected in current plans is the intention to move services from the hospital during 2008/2009. Recent consideration of the service model and the resources available has led to further work on the proposed service model and associated estates strategy. The outcome of that work was due to be considered by the PCT’s board in November 2006.
**Recommendations**

The Healthcare Commission expects the PCT to consider all aspects of this report. Here, we highlight areas where action is particularly important.

**Quality of care**

1. It is of fundamental importance that services for people with learning disabilities are based upon individual person-centred care plans and health action plans that meet the requirements of *Valuing People*, to promote social inclusion and improve health. Such plans should be developed for all people living in the learning disabilities services by the end of October 2007.

2. The PCT must ensure that medical, nursing and therapeutic care is provided in accordance with best practice throughout its learning disability service.

3. Social, recreational and educational activities must be provided to enhance the quality of life of individuals. These should take place both in people’s homes and in the community and should include developing links with relevant groups on work, training and education. Many of these should be in place and be provided by March 2007.

4. The PCT must immediately implement the new policy about working with restrictive physical interventions. Staff should receive training where relevant in how to restrain a person. The use of restrictive physical interventions such as straps and splints should be reviewed and should only be used as a last resort.

5. The PCT should make sure it has firm links to the adult protection coordinator in the local authority. The PCT should also ensure that training is provided about the protection of adults less able to look after themselves so that staff recognise abuse and know how to report it.

6. The model for the provision of short break care must be reviewed to ensure that it does not disrupt the lives of people already living in community homes.

7. The PCT must ensure that services provided for children with a learning disability are fully integrated with other children’s services.

8. Improved working arrangements are needed between children’s and adult services, to ensure that there is a smooth and effective transition for people with learning disabilities.

9. The PCT must implement all the objectives identified in the learning disability service business plan by March 2007 (the full 2006/2007 business plan can be found at appendix F). This includes progressing work on appraisals and supervision of staff as well as ensuring access to specialist healthcare such as that provided by psychologists and speech and language therapists.

**Staff development and training**

10. The PCT must, after consultation with the *Valuing People* support team, engage the support of an external clinical team to provide mentoring and coaching for the home managers, and to help develop skills in leadership to encourage staff in the homes to embrace new ways of working, based on an inclusive model of care.

11. The PCT must take the necessary steps to ensure that the workforce has the appropriate mix of skills, experience and training, that they attend mandatory training, and that this is effectively monitored and action taken if staff are not attending.

12. Training that embraces the principles of *Valuing People* must be provided to all staff. Staff should be encouraged to visit other services and learn from best practice in other parts of the country.

13. A dedicated programme of education and development is needed to improve the communication skills of staff.

14. The PCT must ensure that there is a robust system for reviewing and updating all policies and procedures, that these are made available to staff and that their implementation is monitored.
Empowering people who use services

15. The PCT should develop policies and procedures that encourage and enable people who use its services to exercise choice and control over their own care.

16. The provision of advocacy services should be reviewed to ensure that people with learning disabilities are supported to articulate their own opinions and choices wherever this is possible.

17. The PCT must develop an easy read version of the process for raising concerns or making complaints, and ensure that people with learning disabilities, their relatives, carers and advocates are informed about the process for making complaints.

Governance and strategic arrangements

18. The board must ensure that services for people with learning disabilities are included in the local delivery plan.

19. The board must satisfy itself that an effective mechanism for assuring quality is in place to monitor and provide assurance on the quality of care and the safety of people with learning disabilities. This must include information to the board about the quality of care provided by the learning disability service.

20. The strategic health authority should work with the PCT to ensure that learning from the independent review of the Cornwall Partnership NHS Trust’s board, arising from the Healthcare Commission’s investigation, is considered and acted upon, where relevant.

Redesigning services

21. The PCT must work with the local authority to ensure that the redesign of services is based on assessments of the needs of individuals, is sufficiently resourced, incorporates quality standards which are based on best practice, is understood by staff and is effectively monitored.

22. The strategic health authority must ensure that the PCT develops new services without further delay, and that the closure of Orchard Hill Hospital can be achieved by the agreed target date of April 2009 and Osborne House by the target date in Our Health, Our Care, Our Say of 2010.

23. In line with the target in Our Health, Our Care, Our Say, the PCT must review its current model of community home provision and improve its community services to enable it to move away from the model of campus accommodation by 2010.

National recommendations

24. In light of the learning from this investigation and the Healthcare Commission’s previous investigation into Cornwall Partnership NHS Trust, clarification from the Department of Health on what a modern learning disability service should look like would help PCTs to commission services for people with learning disabilities. The results of the Healthcare Commission audit of learning disability services should feed into this guidance.

25. The strategic health authority must ensure that, from the board down, the PCT’s responsibility as a provider of services is clearly separated from its responsibility as a commissioner of services, and that those responsible for the latter, hold the former to account for delivery.

What happens next?

The PCT is required to prepare an action plan within nine weeks of publication of this report, to address the recommendations of this investigation. It is expected that this will be prepared in partnership with people who live in the service, their relatives, carers and advocates, as well as representatives from relevant local organisations such as the local authorities. The London Strategic Health Authority and the Healthcare Commission will monitor the implementation of the action plan.
and the outcomes on a regular basis and there will be a review of progress after 12 months.

Wider lessons
This is the second investigation into services provided for people with learning disabilities that the Healthcare Commission has concluded. There are some unique differences between this investigation and that of the Cornwall Partnership Trust such as the two judicial reviews and the large number of people still living in a hospital setting. However, there are also some similarities in the findings, which may have relevance for other organisations providing services to people with learning disabilities. Key similarities are that:

- the services were isolated and the models of care were outdated
- institutional abuse was occurring but staff were often unaware that what they were doing in fact constituted abuse
- there was a lack of awareness about the protection of adults less able to look after themselves
- the quality of services for people with behaviour that challenges were poor
- people were denied opportunities that should be available to them and insufficient activities were provided
- services for children with learning disabilities were provided in isolation from other children’s services
- there was a lack of awareness about restraint and its appropriate use
- supervision arrangements and training for staff providing care were poor
- there were deficiencies in record-keeping and in the planning of care
- changes were not implemented effectively to improve the quality of the services
- the arrangements for governance did not allow for effective monitoring of the quality of the services
- historically, learning disability services had not been well resourced
- people, their relatives and their advocates were not involved sufficiently in the planning of care
- the PCT’s commissioning functions failed to commission safe services of good quality
- the strategic health authorities failed to discharge their responsibilities to manage effectively the performance of the learning disabilities services
- in the Cornwall Partnership Trust and in the Sutton and Merton PCT, the combination of factors detailed above conspired to make people with learning disabilities largely powerless to control their environments or their lives, and made the poor care and abuse that we have described possible.

The Healthcare Commission intends to build on these wider lessons by carrying out a comprehensive audit of learning disability services both in the NHS and the independent sector throughout England. This will improve the understanding of the key issues affecting people who are using learning disability services, and also provide information about what improvements can be made by organisations which are providing learning disabilities services. It is anticipated that the results of this audit will be published later in 2007.

Acknowledgements
The Healthcare Commission would like to thank the following people for their help and cooperation with the production of this report:

- all the people with a learning disability who live in the services provided by Sutton and Merton Primary Care Trust
• the relatives and carers of people with a learning disability who contributed either in person, over the phone, or in writing

• the agencies and organisations who gave their views and submitted relevant documents to the investigation, including the advocacy services, BILD and the *Valuing People* support team

• past and present staff interviewed during the investigation and those who assisted with the organisation of the investigation, particularly Hilary Scott
Appendix A: The investigation team and expert reference group

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Royal College of Psychiatrists

Sue Picton
National Family Carer Network

Dr Tom Tait
Royal College of Nursing
Appendix B: Summary of people interviewed

The investigation team conducted a total of 191 interviews from February to July 2006. Of these, 159 were interviews of PCT and former PCT staff and other bodies, including some interviewees who were seen or interviewed more than once. Thirty-four relatives, carers and advocates contacted the investigation team, and 33 interviews were carried out either face-to-face or by telephone. One person was interviewed twice. The following list shows a breakdown of those interviewed:

Interviews of PCT and former PCT staff
- Chief executives and executive/deputy directors
- Chairman and non-executive directors
- Managers
- Modern matrons
- Consultants/GPs
- Home managers/assistant home managers
- Healthcare assistants
- Therapists
- Union representatives
- Others

Other interviews
- South West London Strategic Health Authority
- Sutton and Merton Local Authorities
- Other NHS trusts
- Relatives and carers
- Staff from the PCT
- Advocates
- Others
Appendix C: Evidence and sources of information

Evidence from interviews with:
- past and present members of staff in the PCT
- people with learning disabilities and their relatives and carers
- people from other relevant organisations such as advocacy organisations, other PCTs, the strategic health authority and the local authorities

(Some people interviewed also provided documentary information.)

Evidence from observations at:
- Orchard Hill Hospital
- the community houses in Sutton and Merton
- Osborne House
- Freshfields, Cheam, Woodlands and Osbourne House Day Centres

Evidence from documents obtained from the PCT:
- relevant policies and procedures, such as the reporting of incidents
- agendas and minutes of meetings, including meetings of the PCT’s board, the integrated governance committee, the learning disability quality committee and meetings in the learning disability service
- business plans and other strategic planning documents
- information on incidents in the learning disability service
- governance documentation, such as risk registers
- self-assessments, audits and position statements written by the PCT
- assessments for the clinical negligence scheme for PCTs
- routine and custom made information provided by the PCT
- documents relating to staff numbers, use of bank and agency staff, appraisal, supervision, induction and training
- information for people with learning disabilities, for example leaflets
- documents relating to Essence of Care
- reports of complaints
- minutes of meetings involving the PCT and other members of the health community and meetings with London boroughs
- information relating to ways of working with other organisations

Evidence from documents from the South West London Strategic Health Authority:
- clinical governance reports
- information relating to incidents

Evidence from documents obtained from the Sutton and Merton Local Authorities:
- local delivery and joint investment plans
- quality assurance documentation
- other strategic planning documentation
- delivery and improvement statements
Evidence from national documents and Healthcare Commission information:

- **Valuing People**

- **No Secrets – Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse 2002**

- Findings from the Healthcare Commission’s national surveys of staff in the NHS

Where appropriate, we also took account of the absence of relevant information and the PCT’s inability to provide us with information or evidence in particular areas.
Appendix D: Comparison of staff each shift by place of work

### Orchard Hill Hospital

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### Community houses

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### Osborne House

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<tr>
<td>Y</td>
<td>5</td>
<td>1.5</td>
<td>Sleep in at night</td>
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* Four service users will have moved out by 30 September.

** New staffing levels were introduced at Osborne House in May 2005 and have remained at the level given above. The increased staffing level was not funded in 2005/2006, but is funded in the current year.
Appendix E: BILD’s summary of their review

This report informed the Healthcare Commission about the services received by people with a learning disability from Sutton and Merton Primary Care Trust. It was approached from the perspective of looking at life though the eyes of those who were recipients of the services.

The majority of people were unable to offer information themselves because of limited communication skills, and one-to-one interviews were not possible. A different approach was therefore adopted and three main methods of study were used: participant observation, unstructured interviews with staff, advocates and people where possible and document analysis. A total of 46 people were visited and their care plan records examined. Every house was visited at Orchard Hill Hospital, the community houses in Sutton and in Merton and Osborne House in Hastings. An average of four hours was spent at each dwelling. Two of the day services were also visited.

The initial impression of the hospital was one of being taken back more than 20 years. At one time, long stay institutions were seen as normal places to live for people who were considered to be different and who required significant support to maintain life. The service offered was regimented and operated on routine practice. There was no evidence of spontaneity, excitement or fun.

Meal times were systematic and in the majority of cases, people had blue tissue paper wrapped around their shoulders and were fed at a speed that would not allow for any enjoyment of the food. The meals came from the hospital kitchen and always looked the same. In one house a trolley with a bowl of water was wheeled in and everyone had his or her face washed in a routine manner with little communication throughout the procedure. Drinks were distributed at set times and it did not appear that any thought was given to whether a person might be thirsty or hungry.

BILD saw no evidence to show that any staff were unkind or meant any harm to the people; it was more a continuation of long standing practice and lack of initiative to change tradition. On the whole, staff were caring but perhaps misguided. A few staff appeared uninterested and were just there to do a job. Only at the Woodlands Centre did BILD see any evidence of changes in practice.

There was evidence at Osborne House that significant changes from institutionalised living had been put in place. People were treated with respect and a lot of consideration given to their individual needs. Changes had been made to modernise accommodation and staff were more interactive with the people. Issues were raised about the appropriateness of sexual relationships between people. There was a risk that any relationship may be regarded as abusive in situations where it was difficult to assess whether there was informed consent. The PCT could go some way to resolving this dilemma if appropriate sexual awareness and sexual health training was offered to people and staff.

There was some progress from institutional living in the community houses and staff had taken time to make them more like normal houses. Food and meal times were given more consideration but there was still a lack of planning for the future in order to identify any changing needs or the improvements required in people’s lives. When people were known to be unhappy living with certain other people, there was a lack of planning or intention to
consider moving people to somewhere more appropriate where they might be happier.

Some of the houses at the hospital had put time and effort into making the accommodation as comfortable as possible and had made attempts to personalise bedrooms. Others had not given this any thought, or in some instances said it was not worth it because people would damage things or they would not notice. In comparison, all but one of the community houses had made considerable effort in this area. When houses were cared for, it gave the impression that people would be too.

There was a noticeable inconsistency in the way that care was provided across the PCT. There were no common standards of practice that staff adhered to, and what happened in each home was dependent on the home managers. This was equally so for the hospital and the community houses. At Osborne House, there was more consistency across the site but it was unique to them and did not appear to come from any PCT management initiative.

There was evidence of good practice both in care and record keeping by staff in one house at the hospital. Records on this house appeared to be reviewed and signed and dated when this happened. There was also an activity board in the office, which clearly indicated how many times people were going out and what activity they were taking part in. There was noticeable respect for people in this bungalow and on arrival the researcher was introduced to all of them.

In the majority of the other houses this was not the case and dating of any records and care plans was poor. It was difficult to identify when information on file had been drawn up and there was no evidence to show that any plans or assessments were reviewed or updated. Only in one house was there evidence of a set of plans that were very up to date and recently drawn up, and these should be recommended for use across the whole service. The care plan was comprehensive with a detailed action plan and the manager of the house said this would be regularly reviewed. At Osborne House they had also started to draw up person-centred plans and those that were seen were well put together and showed client participation.

Any planning system is a tool to be used to enhance a person’s life. It is only of value if it has an effective action plan that is regularly monitored to ensure that identified outcomes are being met. The plans are not an end in themselves and staff should be encouraged to put the plan into action and ensure it is an up to date document that is regularly used. Records and files were neatly kept and easy to use, with most sets of records having a contents page. However, this is of little importance if the content of information within the files gives minimum up to date information.

There were isolated cases of notes being more up to date but this was always when there were imminent or recent changes in living accommodation. When local authorities or health authorities purchased the placement of people, there was some evidence of a different type of care plan. The local authority initiated these and on occasion annual reviews were held when social workers were involved. For some people who had recently moved, there was no evidence of new guidelines or plans put in place to take account of changing needs. Often staff said that paperwork took up too much time and that much of it was duplicated. It did not appear that the use of computers was encouraged for keeping records. If this were done efficiently it would save time and records could be updated regularly with recorded dates and times.

The PCT did not have a current policy or protocol on managing behaviour that challenges or physical intervention. In some circumstances medication was prescribed to be given when staff thought it necessary for behaviour management, although all staff said they only used this as a last resort. There were only one or two instances of charts and recordings being made to support the management of behaviours that were deemed
to be challenging. This indicated that very few staff had a method for identifying what happened before and after an incident so that they could learn to manage behaviour in the most appropriate way. There were occasional guidelines on file for behaviour management but no evidence of when these had been drawn up. As all incidents were not recorded, there was no way of identifying if the guidelines were always followed. Often, it was not clear who drew up or monitored the behaviour guidelines. The three or four staff that appeared to use some initiative in dealing with behavioural issues had worked previously for a different NHS trust and had received some training.

Many of the people and staff would have benefited from psychology advice but the majority of staff said that this was not available. There was a contradiction here and some staff did seem to think they could access psychology through the clinical reviews. However, only one client from those selected for interview was recorded as receiving any recent psychology advice, and this was for the management and use of arm splints.

Only at Osborne House did staff recognise that people were choosing to communicate through their behaviour; others appeared to think that people were just difficult to manage. At other houses, staff lacked insight and knowledge into behaviour management and there was no evidence that they attempted to understand what people were communicating to them. It would appear that the majority of staff would benefit from communication training.

There was evidence of good recordings about epilepsy and regular charts were kept of seizure activity. This was monitored and reviewed in the clinical review meetings. People underwent regular health screening and were referred for specialist medical consultations at general hospitals when necessary. Overall the medical care of people was seen to be good and was high on the agenda. This was not reflected in their mental wellbeing and people would benefit if staff adopted a more person-centred, holistic approach to their care.

Across the PCT’s services, staff recognised that people did not have the opportunity for sufficient stimulation or activity. All staff interviewed said that people were very different when they were on holiday or went on an outing. Staff said “people think and feel the same as we do but I don’t think that managers understand this”, “they get so bored”, “they are very different people when we take them out”. Staff did not, however, see it as their responsibility to bring about any change in this area. Whether through lack of training or individual initiative, they saw it as the responsibility of others because they were already too busy.

There were opportunities for activities within the houses if these had been recognised by staff. All people would benefit from being involved in taking part in the everyday tasks required to run a home. If they had been included, they would not have been left sitting on their own while staff carried out the work. There are many ways of involving people in sensory activities, for instance in the kitchen or taking part when their bedrooms are being attended to. For the houses that did undertake their own shopping for food and other items, there was again an opportunity for people to take part in this. It may take some additional planning and more frequent shopping trips but that could easily be included as a regular planned activity.

Some houses did have the support of domestic staff either for cleaning duties or for cooking meals but again there was no consistency to this and no one was able to tell the researcher why this was the case.

People at the hospital, Osborne House and one of the community houses in Sutton all had access to independent advocacy provision. People in the remaining community houses did not. The advocacy services were commissioned by the PCT and, while it was good to see the PCT were committed to providing advocacy for the people, they often appeared to disregard any recommendations that advocates made.
There was also a limit to how effective the current number of advocates could be for the 130 or so people they supported. They were not consistently involved in the regular review meetings where they could offer an independent viewpoint on behalf of people, although they had been asked to contribute to one-off reviews convened to discuss future provision. People also appeared to be excluded from the regular review meetings.

It would be unreasonable to suggest that people living in the PCT services are safe from harm. There was evidence that a number of people were at risk of abuse or injury from other people. Sometimes the offending client’s behaviour was aggressive, and staff were not skilled at managing this. There were also proven occasions of sexual abuse by a member of staff towards people. Further allegations of abuse are still under investigation. Staff also said that abuse of a sexual nature had occurred by one client on another. BILD does not believe that all client-to-client abuse incidents have been reported to, or investigated by, the police. The authenticity of the claim is unclear although locks have been put on bedroom doors in one house to avoid any further risk.

Overall, people at Osborne House appeared to be much happier than other people seen at the hospital. Although people at Osborne House may be seen to be more able and perhaps easier to understand, it is usual to see some form of emotion from people with more complex needs. At the hospital this did not appear to be the case and the majority of people were withdrawn and unresponsive. Where people did exhibit some form of emotion it was often negative and aggressive.

People living in the community houses were regarded by staff as being much happier and capable of achieving tasks that had previously been considered beyond their capability. There was no way the researcher could make this comparison but in one bungalow people did appear to be more actively involved in the home and enjoyed the opportunity to eat their lunch in the garden with the staff.

All the accommodation, apart from one community house in Sutton, would fail to meet today’s standards for providing care services under the Care Standards Act 2000. All services fell short of the quality of life outcomes that research has shown that people with a learning disability consider important if they are to experience a reasonable standard of living. The only outcome that was met with a degree of certainty was that of receiving support to stay healthy.
## Appendix F: The PCT’s learning disability service business plan 2006/2007

### The vision for the learning disability service

The Sutton and Merton PCT vision for people who have severe/complex learning disability is that they will:

- live as independently as possible with appropriate levels of support
- access healthcare through primary and secondary care services in line with the general population
- be assisted to achieve their own goals and aspirations (‘person-centred’ planning)

In order to achieve this vision, the priorities for 2006/2007 are:

- individual care planning
- improving health
- workforce development
- community learning disability teams (CLDTs)
- redesign of residential services
- governance and quality assurance

### Individual care planning - current position

There is a range of care planning in place, which needs to be streamlined and better coordinated.

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Timescale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review health action plan tools across CLDTs and residential services and agree a common tool. Implement.</td>
<td>AD</td>
<td></td>
<td>Performance indicator baseline March 2006 target 2006</td>
</tr>
<tr>
<td>Increase ‘person-centred’ plans for people served by the CLDTs.</td>
<td>HC/KDP</td>
<td>By March 2007</td>
<td>Performance indicator baseline March 2006 target 2006/2007</td>
</tr>
<tr>
<td>Within the PCT residential services review and streamline care planning for residents, ensuring that health and social care needs are fully addressed and outcomes identified.</td>
<td>AD</td>
<td>May 2006</td>
<td>Need to ensure that care plans are in place in each home for each individual which reflect the day to day work required to translate ‘person-centred’ plans and health action plans into action.</td>
</tr>
<tr>
<td>Develop home managers’ skills to enable them to lead the care planning process.</td>
<td>AG</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Increase the number of personal plans.</td>
<td>Home managers/SD</td>
<td>By June 2006</td>
<td>Performance indicator baseline March 2006 target 2006/2007</td>
</tr>
</tbody>
</table>
**Improving health - current position**
- healthcare is provided across the directorate in different ways. People in residential services receive their healthcare support from a combination of the in-patient clinical team and primary healthcare.
- all learning disabled people who live in the community are registered with a GP; some people also receive direct health intervention from the CDLTs.
- health promotion and facilitation are operating within the CDLTs but there is no clear service specification defining health outcomes.

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<thead>
<tr>
<th>Action Required</th>
<th>Lead</th>
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<tbody>
<tr>
<td>All residents at the hospital and in the community houses to be registered with a GP.</td>
<td>MW/JB/AG</td>
<td>Begin during 2006/2007</td>
<td>Action plan to be devised in health improvement sub-group.</td>
</tr>
<tr>
<td>Identify health needs, which should be met within mainstream services and increase health facilitation to achieve this.</td>
<td>HC/KDP</td>
<td>Ongoing</td>
<td>Process to be led by health improvement sub-group.</td>
</tr>
<tr>
<td>Define health promotion priorities (to include smoking cessation, reducing obesity, reducing drug/alcohol usage, access to screening). Draw up action plan to implement.</td>
<td>Health Improvement Group CLDTs</td>
<td>Ongoing</td>
<td>Group reports to directorate management team and the quality committee.</td>
</tr>
<tr>
<td>Set up a new psychology service for residential services.</td>
<td>AD/AG</td>
<td>July 2006</td>
<td>Bid for new resources 2006/2007.</td>
</tr>
<tr>
<td>Establish a service to provide advice and support for people who have difficulties with eating and swallowing.</td>
<td>AD</td>
<td>July 2006</td>
<td>Bid for new resources 2006/2007.</td>
</tr>
<tr>
<td>Support the inclusion of people with learning disability and mental health needs to access mainstream services; define the need and access points for specialist support both inpatient and outpatient.</td>
<td>NB/HC/KDP</td>
<td>Sept 2006</td>
<td></td>
</tr>
</tbody>
</table>
Workforce development – current position

Given that the service is moving towards community-based provision with a focus on meeting a range of health and social care needs, both the structure of the service and the staff skills within the service will need to change. For staff in residential services, the focus needs to be on moving into the community with opportunities to develop and improve skills. For health staff within CLDTs, there is a lack of clarity about their development needs within the PCT. These needs should be considered as part of the increasing role of the CLDTs in supporting people with learning disabilities in the community.

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<tr>
<th>Action Required</th>
<th>Lead</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>Review and in turn reorganise existing residential staff teams and hierarchy to reflect the social care model.</td>
<td>AD/AG</td>
<td>Review by May 2006</td>
<td>Work will be undertaken with the Orchard Hill Hospital Project HR sub-group overseeing the process.</td>
</tr>
<tr>
<td>Implement training strategy to address key areas of:</td>
<td>AD</td>
<td>From April 2006 onwards</td>
<td>Staff development sub group of the quality committee to oversee developments.</td>
</tr>
<tr>
<td>• management development (modern matrons, home managers)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• team development</td>
<td></td>
<td></td>
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<tr>
<td>• core skills</td>
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<tr>
<td>Ensure staff supervision is carried out in line with procedures.</td>
<td>AG</td>
<td>Ongoing</td>
<td>Performance indicator baseline March 2006 target March 2007 100%</td>
</tr>
<tr>
<td>Review the provision of clinical supervision.</td>
<td>AG/JK</td>
<td>By May 2006</td>
<td></td>
</tr>
<tr>
<td>Ensure all staff have an annual appraisal.</td>
<td></td>
<td>Ongoing</td>
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</table>

Community learning disability teams – current position

The Sutton and Merton CDLTs are providing integrated health and social care support to people living in the community. Services provided by the teams include needs assessment and care management, facilitating access to home based care, day and residential services and ensuring healthcare needs are addressed. These teams aim to keep people living in their own houses or with their families as independently as possible.

Currently the PCT is not closely specifying the health outcomes required of CLDTs.
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<tr>
<th>Action Required</th>
<th>Lead</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Review CLDT work programmes and specify outcomes required.</td>
<td>AD</td>
<td>July 2006</td>
<td>To tie in with Section 31 specifications.</td>
</tr>
<tr>
<td>Develop a Section 31 agreement with Sutton Council to take forward lead commissioning, integrated services and a pooled budget.</td>
<td>NB/AD</td>
<td>First phase July 2006</td>
<td>Section 31 is part of the Health Act 1999.</td>
</tr>
<tr>
<td>Review Section 31 agreement with Merton Council to:</td>
<td>NB/AD</td>
<td>October 2006</td>
<td></td>
</tr>
<tr>
<td>• further develop lead commissioning and the appointment of a joint commissioning manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increase the pooled budget by including section 28a funds</td>
<td></td>
<td></td>
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<tr>
<td>• establish a new accountability framework following the appointment of the joint executive director in Sutton</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• establish a performance management framework</td>
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</table>

**Governance and quality assurance – current position**

The PCT’s governance framework clearly identifies the areas that require action. These are included in the directorate’s strategy for quality.
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<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Timescale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance</strong></td>
<td>AD</td>
<td>Ongoing</td>
<td>Monthly monitoring by the directorate management team.</td>
</tr>
<tr>
<td>To work within the allocated budget for 2006/2007. To delegate budgets to residential home managers. To review commissioning arrangements for Section 28a and placement budgets.</td>
<td>AG/JG AD/KA NB</td>
<td>June 2006 July 2006</td>
<td></td>
</tr>
<tr>
<td>Review the service level agreement with the mental health trust; set monitoring requirements in line with the Green Light Toolkit.</td>
<td>AD</td>
<td>May 2006 and ongoing</td>
<td></td>
</tr>
<tr>
<td>Bed down the new quality committee structure and review effectiveness.</td>
<td>AD</td>
<td>Review October 2006</td>
<td>Quality committee framework to be signed off March 24\textsuperscript{th} 2006. Sub-groups to focus on clinical governance, health and safety, staff development, health improvement and equality.</td>
</tr>
<tr>
<td>Establish a performance management framework which will ensure regular monitoring of the business plan objectives and performance indicators.</td>
<td>AD</td>
<td>May 2006</td>
<td>Reports to be quarterly to directorate management team.</td>
</tr>
<tr>
<td>Increase user and stakeholder involvement in residential provision via the home-based task/development groups.</td>
<td>AG</td>
<td>April 2006 onwards</td>
<td></td>
</tr>
<tr>
<td>Introduce monthly monitoring visits for all residential houses.</td>
<td>AG</td>
<td>Checklist to be drawn up by May 2006</td>
<td>Spot checks on areas such as regularity of supervision, availability of up-to-date care plans, quality of case recording etc.</td>
</tr>
<tr>
<td>Complete all actions arising from: • serious incident action plans • Healthcare Commission visit to Osborne House • Healthcare Commission investigation of residential services</td>
<td>AD</td>
<td>May 2006 Sept 2006</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>Review the equality strategy; implement action plan.</td>
<td>AD</td>
<td>May 2006 and ongoing</td>
<td></td>
</tr>
</tbody>
</table>
Re-provision of NHS residential services - current position

The latest date for the replacement of services currently at Orchard Hill Hospital is December 2008. Ashcombe House is being brought into this programme. Osborne House has its own development plan. A programme needs to be set in place for the remaining community houses. There are 96 people who remain living at the hospital and 89 people who are living in community houses.

<table>
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<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Timescale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orchard Hill Hospital</td>
<td>JB/AG/HC/KDP</td>
<td></td>
<td>While residents remain at Orchard Hill Hospital, staff will go there to provide services.</td>
</tr>
<tr>
<td>Align Woodlands therapy services with community teams.</td>
<td></td>
<td>2006/2007</td>
<td></td>
</tr>
<tr>
<td>Pursue individual placements for the 13 people identified in the re-provision programme.</td>
<td>JB</td>
<td>2006/2007</td>
<td></td>
</tr>
<tr>
<td>Support the move of mental health services from Orchard Hill Hospital site.</td>
<td>AD/NB</td>
<td>2006/2007</td>
<td></td>
</tr>
<tr>
<td>Community houses</td>
<td>RC/AG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draw up and agree a strategy for the replacement of community houses.</td>
<td></td>
<td>2006/2007</td>
<td></td>
</tr>
<tr>
<td>Short break care</td>
<td>NB/HC/KDP</td>
<td>July 2006</td>
<td></td>
</tr>
<tr>
<td>Review NHS and local authority short break care and agree a new plan for provision.</td>
<td></td>
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</tbody>
</table>
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