Sunderland City Council

Item No. 9

CABINET MEETING – 3 FEBRUARY 2010

EXECUTIVE SUMMARY SHEET – PART I

Title of Report:
'Six Lives – The Provision Of Public Services To People With Learning Disabilities': A Report By The Parliamentary Health Service Ombudsman In Conjunction With The Ombudsman For Local Government

Author(s):
The Chief Executive and the Executive Director of Health, Housing and Adult Services

Purpose of Report:
'Six Lives: the provision of public services to people with learning disabilities' is a report by the Parliamentary Health Service Ombudsman in conjunction with the Ombudsman for Local Government published in March 2009. The publication contains investigation reports relating to six people with learning disabilities who Mencap believed died unnecessarily as a result of receiving worse healthcare than people without learning disabilities.

The purpose of the report is to report to Cabinet, Sunderland's response to the recommendations outlined in the Ombudsman's report.

Description of Decision:
Cabinet is asked to note the content of the report and agree to receive an annual report from the Learning Disabilities Partnership Board on learning disability issues.

**Is the decision consistent with the Budget/Policy Framework? ***Yes/~~No~~

If not, Council approval is required to change the Budget/Policy Framework

Suggested reason(s) for Decision:
Recommendation 1 of the Ombudsman's report is that all NHS and social care organisations in England should review urgently:

- The effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas, and

- The capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities, and

• Should report accordingly to those responsible for the governance of those organisations within 12 months of the publication of the report Therefore, Cabinet are requested to receive this report in line with this recommendation.	
Alternative options to be considered and recommended to be rejected: There are no alternative options	
Is this a "Key Decision" as defined in the Constitution? No **Is it included in the Forward Plan?** No	**Relevant Scrutiny Committee:** Health and Well-being Review Committee

CABINET **3 FEBRUARY 2010**

REPORT BY THE CHIEF EXECUTIVE AND THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING AND ADULT SERVICES

'SIX LIVES – THE PROVISION OF PUBLIC SERVICES TO PEOPLE WITH LEARNING DISABILITIES': A REPORT BY THE PARLIAMENTARY HEALTH SERVICE OMBUDSMAN IN CONJUNCTION WITH THE OMBUDSMAN FOR LOCAL GOVERNMENT

1. PURPOSE OF THE REPORT

1.1 'Six Lives: the provision of public services to people with learning disabilities' is a report by the Parliamentary Health Service Ombudsman in conjunction with the Ombudsman for Local Government published in March 2009. The publication contains investigation reports relating to six people with learning disabilities who Mencap believed died unnecessarily as a result of receiving worse healthcare than people without learning disabilities.

1.2 The purpose of the report is to report to Cabinet, Sunderland's response to the recommendations outlined in the Ombudsman's report.

2. DECSRIPTION OF DECISION

2.1 Cabinet is asked to note the content of the report and agree to receive an annual report from the Learning Disabilities Partnership Board on learning disability issues.

3. BACKGROUND

3.1 In March 2007, Mencap published the report 'Death by Indifference', which set out case studies relating to six people with learning disabilities who Mencap believed died unnecessarily as a result of receiving worse healthcare than people without learning disabilities.

3.2 Following this publication, an independent inquiry into access to healthcare for people with learning disabilities was carried out. The inquiry found convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment than those without learning disabilities. To address this, 'Healthcare for All' was published in 2008 which set out 10 principal recommendations to improve health service provision to people with learning disabilities.

3.3 Mencap, on behalf of the six families involved, then requested that the Health Service and Local Government Ombudsman investigate complaints about all six cases, three of which spanned health and social care.

3.4 *'Six Lives: the provision of public services to people with learning disabilities'* is a report by the Parliamentary Health Service Ombudsman in conjunction with the Ombudsman for Local Government and was published in March 2009. The publication contains investigation reports into each of the six cases and they illustrate some significant and distressing failures in services across both health and social care, leading to situations in which people with learning disabilities experienced prolonged suffering and inappropriate care.

3.5 The investigations found maladministration, service failure and unremedied injustice in a number, but not all, of the 20 bodies investigated (three Councils, 16 NHS bodies and the Healthcare Commission).

3.6 The report highlights the following complaints that were upheld against two Councils:

- Arrangements for the transition from residential school to adult care fell significantly below reasonable standards;
- Some of the maladministration was for disability related reasons;
- Failure to live up to human rights principles of dignity and equality;
- Poor complaint handling;
- Public service failure which resulted in an avoidable death;
- Failure to provide and/or secure an acceptable standard of care and consequently the care home resident's safety was put at risk;
- Less favourable treatment for reasons related to disability.

4. THE OMBUDSMAN'S RECOMMENDATIONS

4.1 The specific areas of concern reported in the Ombudsman's Report are:

- Communication – specifically around the familiarity of legislation and guidance amongst non specialist professionals; how information is disseminated throughout organisations; the training and support available to staff to assist with the implementation and how accurately information is passed between professionals and the family.

- Partnership working and co-ordination – professionals not working together or making use of the skills and expertise of different disciplines, particularly across the boundaries of health and social care. There was evidence of poor transition and discharge co-ordination and planning and a lack of a designated professional to act as a co-ordinator to ensure effective planning and implementation.

- Relationships with families and carers – family members were not recognised for their knowledge of the person concerned and care workers were not treated as part of the team, leading to families and carers feeling excluded and ignored.

- Following routine procedures – in complex situations standards and guidance were not followed therefore significantly increasing the risk to vulnerable individuals.

- Quality of management – lack of personal accountability at management level and no senior support for staff trying to challenge poor practice and inadequate systems.

- Advocacy – there was no evidence of the availability or use of independent advocates in any of the six cases, which could have provided an additional safeguard for the rights of very vulnerable people.

- Complaint Handling – the investigation found evidence of poor complaint handling, including failure to understand complaints, little effort to clarify matters, fragmented systems, poor investigations with little rigorous testing of evidence, defensive explanations and a failure to address the complaint with a reluctance to offer apologies.

4.2 The Ombudsman's report therefore makes the following three recommendations:

1. All NHS and social care organisations in England should review urgently:

    - The effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas; and,

    - The capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities; and,

    - Should report accordingly to those responsible for the governance of those organisations within 12 months of the publication of the report.

2. Those responsible for the regulation of health and social care services (specifically the Care Quality Commission, Monitor and Equality and Human Rights Commission) should satisfy themselves, individually and jointly, that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory

requirements in relation to the provision of services to people with learning disabilities and that they should report accordingly to their respective Boards within 12 months of the publication of the Ombudsman's report.

3. That the Department of Health should promote and support the implementation of these recommendations, monitor progress against them and publish a progress report within 18 months of the publication of the Ombudsman's report.

5. SUNDERLAND'S FINDINGS

5.1 Led by the Learning Disability Partnership Board, Sunderland has reviewed the 7 areas of concern in line with Recommendation 1 and the findings relating to the local authority are detailed below:

5.1.1 **Communication**: within Health, Housing and Adult Services there are a number of mechanisms for disseminating information about policy, guidance and legislative developments, including:

- A fortnightly Document Alert system to inform the Directorate Management Team of all new policy, guidance, legislation, briefings and relevant reports;

- Policy briefings to the Senior Management Team as and when new policy is published;

- Workshops are held with frontline Managers to debate, discuss and understand emerging policy developments;

- Core Brief items are published to inform all staff across the Directorate of any new policy developments;

- The Learning Disability Partnership Board is made aware of any learning disability specific policy developments and these are reviewed in order to understand local implications and how the policy will be translated into practice;

- The Directorate has invested in workforce development including Learning and Development Co-ordinators who are attached to each service area, including learning disabilities. These Co-ordinators facilitate learning sessions with frontline staff around subjects including Personalisation and Individual Budgets;

- Sunderland's Learning Disability Partnership currently operates a single management structure, in which Social Workers and Community Nurses are managed by Health, Housing and Adult Services' General Manager for Disabilities Service. This enables effective communication amongst staff groups and across

organisations and the sharing of information and knowledge. This in turn supports better communication between professionals and families.

5.1.2 **Partnership working and co-ordination**:

- As previously mentioned, Sunderland's Learning Disability Partnership currently operates a single management structure. This structure ensures consistent leadership across staff groups with professionals working together for the best interests of individuals without the barrier of organisational boundaries.

- 'Futures', a person centred transition team has recently been established to support young people with disabilities and their families seamlessly and smoothly through the transition into adulthood.

- As part of the city's Resettlement Programme, a Learning Disability Resettlement Operational Team exists within Health, Housing and Adult Services to support people living in NHS accommodation to move into more appropriate individualised supported accommodation. The Council works extremely closely with Northumberland, Tyne and Wear NHS Trust to progress this "Campus Re-provision". The Team ensures that families, individuals and their carers, Providers and other stakeholders are involved in this activity.

- Both the Futures Team and the Learning Disability Resettlement Operational Team exist to ensure that there is effective co-ordination and planning of care around the needs of individuals, their families and carers and across organisations.

- The Learning Disability Partnership Board, Chaired by the Head of Adult Services has demonstrated successful partnership working since its inception in 2001. The Board includes stakeholders from a range of agencies and people with disabilities and family carers and it oversees all activity and developments in learning disabilities services. The Board reports to the Adult Social Care Partnership Board.

- From 1 April 2009, the Local Authority is now responsible for commissioning community services for people with learning disabilities in Sunderland and this will strengthen the already very successful partnership working and co-ordination that exists.

5.1.3 **Relationships with families and carers**:

- As referred to in the developments above, families and carers are central to the process of assessing, planning and co-ordinating the care of individuals, as it is recognised that carers have an immense contribution to make in terms of the knowledge they have about the person with a learning disability they care for as they know them best.

- One of the principal aims of Sunderland's multi-agency Carers Strategy is to ensure that carers are recognised and listened to as an expert care partner and the strategy identifies staff training around the role of carers and their contribution as the key to making this a reality.

- At a strategic level, Sunderland has a good history of involving carers in service planning and developments, through working groups and Boards such as the Learning Disability Partnership Board and its sub groups, Older Family Carers Group and General Managers and Carers Representative Groups. This involvement ensures that families and carers are involved in service developments, which results in improved involvement at an individual level.

5.1.4 **Following routine procedures**:

- There are a range of different types of small group living schemes for people with learning disabilities. Some are registered and need to comply with standards and regulations; these are monitored by the regulator CQC (Care Quality Commission). Supporting People schemes also have a national framework that sets out standards and quality monitoring. Locally, the Directorate has a Social Care Governance Team which monitors quality standards and advises whether these are being met or not. This includes looking at the quality of the policies and procedures the organisation has in place and monitoring how organisations implement their policies.

5.1.5 **Quality of Management**:

- As previously described the single management structure operating within the Learning Disability Partnership aims to provide consistent quality management and leadership across learning disability services.

- The Council has invested hugely in supporting and developing managers through offering the Sunderland Leadership Programme. This is a core management development programme designed to support the vision of a one council approach.

5.1.6 **Advocacy**:

- Health, Housing and Adult Services has for a number of years commissioned SAFE (Sunderland Advocacy for Empowerment) to provide independent advocacy for people with learning disabilities and more recently expanded to include people with physical disabilities. The support provided by SAFE is independent of statutory services, is a free confidential service, and is based on empowering people to have a voice and recognises the right of each individual to take control of his/her own life.

5.1.7 **Complaint Handling**:

- The issue of the accessibility of the Directorate's complaints procedures was considered some years ago by the Council as part of promoting good practice. In respect of social care complaints, a range of information is available informing people about the procedure and how to make a complaint. This includes a leaflet and a procedure arranged in an accessible format. The Complaints Team have worked with Sunderland People First (a self advocacy group), to ensure that the information is suitable for people with a learning disability. Further work is being carried out to make this information accessible to people using self directed support.

- Work has commenced to review complaints information and PALS procedures across the NHS to make sure that it is made much more straightforward. The council is engaged in discussion with Health to support a co-ordinated approach to this area.

- Although not for individual complaints, the Local Involvement Network commissioned by the local authority exists to ensure that users of care services and carers have a voice in influencing and scrutinising services, particularly where there are areas of concern in service delivery. On a wider level, this can provide a mechanism for highlighting and addressing areas of poor practice or concern.

- Sunderland's Safeguarding Adults Partnership Board comprises of agencies and organisations who work closely together to safeguard adults who, because of their dependency on others, are more vulnerable and therefore at greater risk of abuse. This includes people with learning disabilities. This multi-agency forum has the strategic lead for safeguarding and all agencies are required to work in line with the Sunderland Safeguarding Adults Procedural Framework. These ensure that any concern or allegation of abuse is taken seriously and dealt with sensitively and professionally and in a way that is appropriate to the needs of the individuals.

6. NEXT STEPS

6.1 Reporting to the Adult Social Care Partnership Board, the Learning Disability Partnership Board has tasked the multi-agency Learning Disability Health Sub Group to oversee progress against the recommendations in detail.

6.2 The three NHS trusts are progressing much of this work through their 'Healthcare for All' action plans which are reported to NHS North East (Strategic Health Authority) on an annual basis.

6.3 It is proposed that Cabinet receive an annual report on learning disability issues in Sunderland.

7. REASONS FOR DECISION

7.1 Cabinet are requested to receive this report in line with Recommendation 1 of the Ombudsman's report.

8. ALTERNATIVE OPTIONS

8.1 There are no alternative options

9. RELEVANT CONSIDERATIONS/CONSULTATIONS

People with learning disabilities
Family carers
Learning Disability Partnership Board
Learning Disability Health Sub Group
South of Tyne and Wear NHS Trust Board
Northumberland, Tyne and Wear NHS Trust Board
City Hospitals Sunderland NHS Foundation Trust Board
Adult Social Care Partnership Board

10. BACKGROUND PAPERS

'Healthcare for All: Independent inquiry into access to healthcare for people with learning disabilities', Sir Jonathon Michaels, 2008

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