REPORT TO: Healthy Halton Policy & Performance Board

DATE: 12 January 2010

REPORTING OFFICER: Strategic Director – Health & Community

SUBJECT: Progress in responding to the Ombudsman report "Six Lives: the provision of public services to people with learning disabilities"

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report is presented to Healthy Halton Policy & Performance Board in response to the recommendation made in the joint Health Service and Local Government Ombudsman report regarding complaints made by Mencap on behalf of families of six people with learning disabilities who died between 2003-5 whilst in NHS or local authority care.

1.2 The Ombudsman concluded that the findings from their investigations pose serious questions about how well equipped NHS and Councils are to plan for and provide services tailored to the needs of people with Learning disabilities. They went on to make three recommendations, the first of these is targeted at all NHS and Social care organisations who:

"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 disability in their area.
- 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 Ombudsman's report."

2.0 RECOMMENDATION:

That the Healthy Halton Policy & Performance Board:

i) Note the contents of this report;
ii) Considers what, if any, further action is needed.

3.0 **SUPPORTING INFORMATION**

3.1 **Overview of the report**

In March this year the Health Service Ombudsman and Local Government Ombudsman published a joint report Six Lives: the provision of public services to people with learning disabilities, based on findings from their investigations in response to complaints brought by Mencap following publication of their report Death by Indifference (2007). This report outlined case studies of six people with learning disabilities who Mencap believed died unnecessarily as a result of receiving a lower standard of healthcare than afforded to the general public and prompted the independent inquiry, chaired by Sir Jonathon Michael, into access to healthcare for people with learning disabilities. These findings were reported in Healthcare for All (DH 2008).

3.2 In total the Ombudsman investigated 20 complaints against public bodies including PCT's, NHS acute sector providers, GP's and local authorities. These investigations found maladministration, service failure across the whole system of health and social care and unremedied injustice. In some cases these failures were attributed to disability related reasons stemming from poor leadership and understanding of disability legislation and guidance and the need to make reasonable adjustments. The Ombudsman also found some failures to observe the principles of human rights in particular dignity and equality.

3.3 The investigation found that during the lives of the people concerned basic policy, practice guidance and procedures were not followed, adjustments not made and the co-ordination of services was found to be absent.

3.4 There were a number of complex factors that led to failure to offer good care to individuals in vulnerable situations. The following areas of concern were highlighted not just for people with learning disabilities but also for other vulnerable groups who may be similarly affected and would also benefit from a change in culture:

- Communication
- Partnership Working and co-ordination
- Relationships with families and carers
- Failure to follow routine procedures
- Quality of management
- Advocacy

3.5 Appendix 1 sets out the complaints upheld by the Ombudsman and the systems/practices in place or being progressed by the Council and its partners to guard against such occurrences. Appendix 2 gives similar consideration to the further issues highlighted in the

report, which impacted upon the care given to individuals.

3.6 **Healthcare for All**

The Ombudsman supported the detailed findings of the independent inquiry into access to healthcare for people with learning disabilities, Healthcare for All, and action to improve access to and quality of healthcare has been embedded into the Valuing People Now Delivery Plan (DH 2009).

3.7 Across the Halton and St Helens PCT footprint responsibility for implementing these elements of the delivery plan rests with a multi-agency steering group with representation from Health and Social Care commissioners, acute sector and specialist health providers, GP's, Mencap and care coordinators/managers. Healthcare for All is a standing item on the agenda of the Halton Adult Learning Disability Partnership Board and the People's Cabinet.

3.8 **PCT Governance**

Earlier this year PCT Management Executive Team (MET) considered a report on responses to Government policy and strategy relating to adults with learning disabilities including Healthcare for All. A further report will be taken to MET and also the Clinical Excellence Committee in response to the Ombudsman report.

3.9 **Complaints procedures from 1st April 2009**

Poor complaint handling was also highlighted within the report as compounding the distress experienced by families. From April this year changes in the complaint system established the Ombudsman as the second and final tier across the health and social care system.

3.10 These national changes have given us the opportunity to review procedures and build on processes to further improve people's experience of the complaints system in Halton. Initiatives developed include:

- The introduction of a triage system to assess timely and proportionate action in response to complaints
- Early personal contact to clarify the complaint, desired outcomes and to agree timescales for the investigation
- Cross organisational cooperation to provide a coordinated response where appropriate
- Development of best practice for investigations and resulting reports
- Scrutiny of responses to complaints to assure quality

- Monitoring of any resulting actions, to ensure compliance with recommended actions
- Feedback system to measure satisfaction with how complaint was handled
- Reporting mechanisms to ensure learning from complaints is shared and used to develop improvements in services

Halton is also involved in developing ongoing improvements in complaints handling, including:

- The Development of National Complaint Standards by the National Complaints Managers Group, commissioned by the Association of Adult Directors of Social Services (ADSS)
- Exploration, within the North West Complaints Managers Group, of alternative methods of complaint resolution (eg mediation).
- Training programmes through these groups to improve the skills of those handling and investigating complaints.

4.0 POLICY IMPLICATIONS

4.1 As the Ombudsman suggested there is a plethora of Council policies and procedures that social care staff and service providers must comply with. The challenge is to ensure that these policies are relevant and effective and being consistently applied. This will be achieved through continued engagement with people who access services and their carers to monitor implementation and develop policy, alongside strong leadership from the Council and its partners, to build organisational cultures that value the human rights of individuals.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

Halton's Multi-agency Transition Strategy and Protocol ensures that information, guidance and support is available to young people with complex needs and their families. This helps to disperse any anxiety and uncertainty about what happens next and offers reassurance that Children's and Adults services are working together to make this a positive experience.

5.2 Employment, Learning & Skills in Halton

A successful Transition process for young people with complex needs supports improved outcomes in relation to their future employment and ability to access training opportunities.

5.3 A Healthy Halton

The actions outlined in the appendices to this report, many of which will be progressed through working in Partnership with NHS Halton and St Helens, will improve access for people with learning disabilities to generic health services offering an appropriate level of care to aid recovery and return to their home and precent admission to residential care.

5.4 **A Safer Halton**

None identified.

5.5 **Halton's Urban Renewal**

None identified.

6.0 RISK ANALYSIS

6.1 There is potential for legal challenge under the Disability Discrimination Act or Disability Equality Duty around inequitable access to services provided or commissioned by the Council.

6.2 There is a risk of an adverse report by CQC if inspectors are not satisfied with local authority progress on the recommendation in Six Lives for local authorities to review systems and services provided or commissioned (see 1.2).

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The Ombudsman view equality as finding alternative methods to make services available to people with disabilities in order to achieve equality in outcomes rather than treating everybody in the same way. The focus for services needs to be on the outcomes for the individual and this requires flexibility within working practices and procedures to enable reasonable adjustments to be made whilst adhering to policy.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Six Lives: the provision of public services to people with learning disabilities 2009 Local Government Ombudsman and Health Service Ombudsman	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Investigation into the service for people with Learning Disabilities provided by Sutton and Merton Primary Care Trust 2007 Healthcare Commission	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age

Joint investigation into services fro people with Learning Disability at Cornwall Partnership NHS Trust 2006 CSCI/Healthcare commission	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Death by Indifference 2007 MENCAP	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Valuing People Now Delivery Plan 2009 DH	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age
Healthcare For All 2008 DH	Runcorn Town Hall Heath Road Runcorn WA7 5TD	Audrey Williamson Operational Director Adults of Working Age

APPENDIX 1

Halton's progress

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
Arrangements for transition from residential school to adult care fell significantly below a reasonable standard.	Halton Borough Council – Adult Social Care	• Dedicated Transition Co-coordinator post jointly employed by Children & Young People and Health & Community. • Multi-agency Transition Protocol in place supported by Operational Managers Group meeting regularly to track individual cases/needs. Protocol under review to extend age range to 14-25 • Health Action Plans for age <18 and health professionals linking in to Transition reviews being explored. • "Change It" project exploring what support is needed locally to avoid placements in residential schools/colleges. • Development of Challenging Behaviour Service underway to prevent people being sent to distant specialist placements • Self-assessment questionnaire by 1/12/2009
Maladministration/less favourable treatment for reasons related to disability	All Health and Social care agencies need to take responsibility for this and	• Action plan agreed by multi agency

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
	Healthcare for All group will progress this across agencies. These areas of progress relate to Halton Borough Council.	HealthCare for All steering Group • Equality impact assessments undertaken on new policies • All procured social care services are subject to providers complying with policies to ensure equal access to and conduct within services. • Adult Safeguarding Board raises awareness of institutional abuse. • No Secrets re-launch will follow publication of DH Guidance on Safeguarding, which will include concerns raised by learning disabled people.
Council failed to live up to human rights principles of dignity, equality and autonomy	Halton Borough Council	• Halton Dignity Champions Network established. Champions from Adult Social Care, Elected members, 5BP, local hospitals, voluntary sector and independent sector providers. • Dignity Charter developed and all providers are expected to work to this. • Dignity in care co-ordinator post (2 years) to working across Health and Social Care. Liverpool John Moores University evaluating post – baseline,

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		progress review and future options for post.
Poor complaint handling	Halton Borough Council	• See section 3.9 of report
Local authority contributed to 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 residents safety was put at risk.	Halton Borough Council	• All residential and domiciliary care providers within Halton supporting learning disabled adults are rated Excellent or Good by CQC. • Independent sector contracts are subject to robust monitoring by Contracts and Supporting People team. • In house supported living services funded by supporting people are also subject to monitoring. • Quality of in house day services is monitored through independent inspection by a group of self-advocates and family carers.
Short comings in fulfilling of responsibilities with regard to planning for the health needs of people with profound and multiple learning disabilities (PMLD)	Halton Borough Council/Halton & St Helens PCT	• Joint Commissioning Strategy has identified number of younger people with profound and multiple learning disabilities and Transition Operational Group will plan for move into adult services • Proposed extension of Health Action Plans for under 18's will highlight specific individual health need for

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		people with profound and multiple learning disabilities and wider learning disabilities population. • In 2009/10 all adults with a moderate or severe learning disability who are known to social care will be offered an annual health check through their GP • The Warrington and Halton Hospitals NHS Foundation Trust has re-launched its hospital passport, which captures an individual's salient information that will help nursing staff provide appropriate care and support.
Service failure in care and treatment including nursing care and arrangements for discharge to an adult care home	Halton & St Helens PCT	• Dedicated Community Matron for people with learning disabilities in Halton tracks admissions to and discharge from hospital and liaises with community support services/social care as appropriate. • Link between Community Matron/LD Nurses within Adult Social Care and Hospital Discharge Team will be reviewed to streamline discharge process. • Within the Acute Sector, Warrington and Whiston Hospitals have each

Ombudsman's decision on upheld complaints	Lead organisation/Directorate	Progress to date
		appointed a Community Matron to advise staff and improve the hospital experience for patients with learning disabilities.

APPENDIX 2

Halton Progress – Other areas of concern highlighted by the Ombudsman

Note many of the actions in Appendix 1 will also address these concerns but have not been repeated below.

Concern	Progress to date
Communication	• Partnership Board developing a Communication Strategy to promote its work and ensure people have access to appropriate information • Successful communication pilot project recently completed with people with PMLD in day services leading to improved working practices and support. This work is now being extended to independent sector providers. • Information sharing protocols in place between Social Care, PCT and Specialist health service provider (5BP) • Health passports being launched at Warrington Hospital detailing persons needs and preferred method of communication
Partnership Working and co-ordination	• Integrated health and social care Community Learning Disability Team offering a single point of access and referral into intensive support services • People's Cabinet acts as a conduit between professionals and learning disabled adults in Halton to influence strategy and decisions making and ensure improved outcomes for people. Chair of cabinet is co-chair of Partnership Board. • CQ requires local NHS bodies to refer their "annual health check" to Partnership Board for comment providing an opportunity to ensure that people with learning disabilities are getting good, fair and safe treatment and support from Health services.
Relationships with families and carers	• Regional family forum event held in July and three priorities identified for Partnership Board to work on. • Follow up event planned for 2010 to consider annual report on Partnership Board progress. • Person centred reviews and support planning include family members as

	they know an individual best and are part of a person's circle of support.
Advocacy	• Support in Halton is available through Council funded generic advocacy service – Advocates. People with learning disabilities or their families are main users of this service. Capacity is monitored to ensure waiting times are minimised. • Learning Disability Development Fund has been invested for a number of years in developing support for self-advocates. Halton now has a pro-active self-advocacy support group which hosts the People's Cabinet. To provide a period of stability for the group funding has been agreed to March 2011.
Quality of management	• In response to previous reports into support for people with learning disabilities (Sutton & Merton and Cornwall) an action plan was developed. This is now overseen by the Quality sub-group of the Adult Safeguarding Board. The Safeguarding Board reports into the Safer Halton Partnership and annual reports are taken to Healthy Halton and Safer Halton Policy and Performance Boards.
Failure to follow routine procedures	See Section 4.1 Policy implications • The Halton Multi-Agency Adult Safeguarding Board supports the development of and keeps under review local policies relating to Vulnerable Adults sharing learning from national and local experience and research with relevant Teams/Agencies.