

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk

A report for:

NHS England, South Region

Oxfordshire Safeguarding Adults Board

October 2015

Authors:

See investigation team appendix A

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1. Introduction

1.1 Connor Sparrowhawk was 18 when he was admitted to a learning disability short term assessment and treatment unit in Oxford¹ in March 2013. The unit is part of the learning disability services provided by Southern Health NHS Foundation Trust (Southern Health). Connor was found submerged in the bath on 4 July 2013. Staff tried to resuscitate him and an ambulance took him to John Radcliffe Hospital. He sadly died the same day.

1.2 An initial post-mortem examination concluded that Connor drowned as a result of an epileptic seizure. Southern Health carried out a serious incident requiring investigation [SIRI] 72-hour report (dated 5 July 2013). Southern Health also carried out an Initial Management Assessment. Southern Health commissioned Verita, an independent consultancy, to undertake Southern Health's internal investigation. This investigation concluded that Connor's death was preventable².

1.3 Following publication of Verita's first investigation report in February 2014, Oxfordshire Safeguarding Adults Board and NHS England, South Region had ongoing concerns about the quality and safety of learning disability services provided by Southern Health in Oxfordshire and the improvements that needed to be made. They therefore commissioned this further report in June 2014.

¹ Following consultation with his family, we refer to Connor by his first name in this report unless we are quoting from a document with uses his full name, or the initials, CS.

² The investigation report was published and can be found online at <http://www.SouthernHealthhealth.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=76277>

2. Chair's foreword

2.1 This investigation was commissioned by Oxfordshire Safeguarding Adults Board and NHS England, South Region, in light of Verita's first report into the care of Connor Sparrowhawk. That report had found that Connor's death on 4 July 2013 was preventable. The commissioners wanted to know whether there were wider commissioning, leadership or management issues that could have contributed to the inadequate care that Connor received.

2.2 This second report was compiled following a wide ranging enquiry and the involvement of many individuals, groups and organisations. It has been one of the largest investigations that Verita has carried out over the past decade. The report identifies a number of problems in commissioning, leadership and management of learning disability services, both locally and nationally.

2.3 Indeed, while our focus has properly been upon one tragic loss of life in one part of the country, I believe the report has implications not just for those who commissioned it, and for Southern Health NHS Foundation Trust, but across the country both for the NHS and for learning disability services. For example, there are lessons from what the report has to say about the challenges that arise when one service is merged with or taken over by another. There are lessons about the commissioning role, and the relationships between commissioners and service providers. There are insights that may prove useful for those considering the future of Deprivation of Liberty Safeguards (DoLS). And there are implications for those responsible for developing national guidance on learning disability services; amongst other things, we have found that there is little guidance on best practice specifically focused on short term assessment and treatment services of the kind where Connor lived and died.

2.4 In Verita's first report we identified a number of clinical practice issues that had led to poor team working and poor epilepsy risk management plans that, in turn, had resulted in Connor drowning in his bath. Despite the deficiencies we have identified during this second investigation, we have not concluded that they had a direct or indirect connection to the failures that led to Connor's death. However, it is also evident that the post-acquisition process followed by Southern Health made it less likely that poor practice would have been known about or checked.

2.5 On behalf of all those who worked on this investigation we would like to thank everyone who contributed to it. We know that our conclusions will prove challenging to many of those who have assisted us, but that is in the nature of independent investigations. I trust that the response to this report will be the redoubling of efforts locally, regionally and nationally to ensure a step-change in the quality of learning disability services, and the priority attached to them. Tragedies cannot be undone, but they do not have to be repeated.

Stephen Shaw
September 2015

3. Terms of reference

3.1 The terms of reference for the investigation (excluding the background information) are reproduced below.

“The purpose of this investigation will be:

- *To build on the learning from the existing Verita investigation*
- *To understand the wider issues around the organisation of Southern Health NHS Foundation Trust’s governance arrangements*
- *To examine the role of the local authority and clinical commissioning groups prior to and during Connor’s admission to the short term assessment and treatment team (STAT), including transition from children to adult services*
- *Examine underlying issues around the commissioning of the NHS elements (inpatient and community services) of the care pathways for people with a learning disability in Oxfordshire¹*
- *To review and understand how the wider system issues might have contributed to failures in Connor’s care and treatment and in respect of his death*
- *To examine in detail the application of the Mental Capacity Act (1983) in Connor’s case*

1 Overall Purpose

- *Identify whether there were any wider system aspects that contributed to the preventable death of Connor*
- *Identify areas where improvements to services, systems, commissioning and assurance could help prevent similar incidents occurring*
- *Identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning and*
- *Ensure that the investigation is conducted in an open and transparent manner*

¹ Learning disability services in Hampshire and Buckinghamshire were not part of this review, though some references are made to services in Buckinghamshire.

2 Main Objectives

- *To identify key issues, lessons learnt, recommendations and actions by all directly involved in commissioning, provision and assurance of the Oxfordshire Learning Disability Health Services*
- *To ensure Connor's family are involved in all aspects of the investigation*
- *To ensure Oxfordshire Safeguarding Adults Board are included in and participate in all aspects of the investigation*
- *To assess progress made on the delivery of action plans following the Verita investigation*
- *To undertake a review of the delivery of the action plans of this independent investigation, six months after it is published and share the report (to be published) with the family and stakeholders*
- *To assess progress made on the delivery of action plans following the Care Quality Commission inspection report published in November 2013*
- *To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies*
- *Identify care or service delivery issues relating to the use of Mental Capacity Act (2005) and the Mental Health Act (1983), identify learning and making system wide recommendations*

3 Terms of Reference

For context it is important to acknowledge that the inpatient services had originally been commissioned by Oxfordshire County Council as lead commissioner from Oxfordshire Learning Disability NHS Trust, in 2012 South Central Strategic Health Authority led an acquisition process, after a decision was made that OLDT were not able to proceed to Foundation Trust status. Southern Health NHS Foundation Trust successfully acquired OLDT services through this process. A DH Gateway review was undertaken to assurance the governance and quality of the transaction.

Although not necessary to review the acquisition process it is important to note the contractual changes that happened in December 2012 and their possible impact on both the provider and commissioners.

- *Review the events leading up to Connor’s admission, including transition management and planning from children to adult services, the alternative to admissions, contact with Connor’s family and school and preventative intervention offered before inpatient admission was sought*
- *Review and consider whether the purpose and aims of the Short Assessment and Treatment Unit were aligned to commissioners service specifications and the aims of Connor’s admission and expected outcomes*
- *To review the involvement and role of the local authority and Clinical Commissioning Group during Connor’s admission to the Short Term Assessment and Treatment Unit Team*
- *To consider if the management and leadership structure on the STATT unit was adequate*
- *To review the wider issues around the organisation of Southern Health NHS Foundation Trust’s governance, including examining recommendations from Deloitte’s report*
- *To understand the learning disability NHS elements of the commissioned pathway in Oxfordshire and to identify any potential gaps that may have contributed to Connor’s preventable death*
- *To fully review the use and application of the Mental Capacity Act (2005) and the Mental Health Act (1983) during Connor’s admission*
- *To understand and review the local contracting and quality assurance systems that were in place*
- *To review whether, prior to Connor’s death, the local authority, Clinical Commissioning Group and/or Southern Health NHS Foundation Trust were aware of any quality, safety or delivery concerns in respect of the Short Term Assessment and Treatment Unit, the broader learning disability provision and to consider whether appropriate action was taken to address any concerns*
- *To examine wider system assurance, regulation, national policy, national data, system monitoring of learning disability services and identify any contributing factors*
- *The investigation panel will have two independent lay people, one chosen by the family and another appointed jointly by NHS England and Oxfordshire Safeguarding Adults Board.”*

4. Evaluating evidence

4.1 Our challenge has been evaluating the weight of the evidence we have received (see appendix B) and its impact on the terms of reference. This extract from the terms of reference summarises the overall purpose of the investigation:

- *“Identify whether there were any wider system aspects [leadership, commissioning, acquisition] that contributed to the preventable death of Connor*
- *Identify areas where improvements to services, systems, commissioning and assurance could help prevent similar incidents occurring*
- *Identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning”*

4.2 The first bullet point is the primary purpose of our investigation. The next two bullet points have been examined in connection with what impact they may have had on Connor’s death and whether they indicate unsafe systems that may impact on other service users.

4.3 We said in our first report that Connor’s death was preventable:

“The failure of staff at the unit to respond to and appropriately profile and risk assess [Connor’s] epilepsy led to a series of poor decisions around his care - in particular the agreement to undertake 15-minute observations of his baths. The level of observations in place at bath time was unsafe and failed to safeguard [Connor].”

4.4 We said part of the reason for a lack of an effective risk assessment was that:

“Team working in the unit and with the community learning disability team was weak.”

“The unit lacked effective clinical leadership.”

4.5 We set out our draft initial findings in our stakeholder event in May 2015 and described our guiding test in evaluating evidence.

- Did the way in which learning disability services were commissioned by Oxford commissioners or managed or organised by Southern Health substantially contribute to the inadequate care and risk assessment received by Connor, which led to our finding that his death was preventable?

4.6 A number of participants were concerned about our use of the word ‘substantially’. They told us that this set too high a standard of evaluation: services could be managed in a substandard way but our test would make it almost impossible to connect these inadequacies with clinical decisions by staff providing care and/or treatment for individuals.

4.7 We reflected on these comments and altered our evaluation test and removed the word ‘substantially’. We felt we still needed evidence of a connection between the commissioning and management of services and the way the short term assessment and treatment team (STATT) performed their duties.

4.8 A quote from the executive summary of Sir Robert Francis’ report on Mid Stafford Hospital (which looked at the causes of the failings in care at the hospital between 2005-2009) gives guidance on one aspect of evaluating evidence relevant to this test:

“There is ... a difference between a judgement which is hindered by understandable ignorance of particular information and a judgement clouded or hindered by a failure to accord an appropriate weight to facts which were known.” (Paragraph 70)

4.9 This insight leads us to consider:

- whether commissioners and Southern Health failed to seek out information that they should have known or needed to know to provide a safe service; and
- whether commissioners and Southern Health had information that they failed to act on.

4.10 We have borne this in mind in this investigation.

Lessons from previous inquiries in the NHS

4.11 A research paper *Inquiries: learning from failure in the NHS?*¹ by Dr Kieran Walsh reviews inquiries in the NHS from 1969 to 2001. The paper makes many useful comments about the conduct of inquiries but for the purpose of this investigation it identifies a number of common themes which we set out below. We also kept these in mind as we evaluated the evidence. Dr Walsh says:

“Many inquiries produce similar findings about the causes or reasons for failure, even when they are focused on quite different clinical areas. Five common themes in reports are:

- *Organisational or geographic isolation which inhibits the transfer of innovation and inhibits peer review and constructive critical exchange*
- *Inadequate leadership, lacking vision and unwilling to tackle known problems*
- *System and process failure - in which organisational systems and processes are either not present at all or not working properly*
- *Poor communication both within the NHS organisation and between it and patients or clients, which means that problems are not picked up*
- *Disempowerment of staff and patients/clients which means that those who might have raised concerns were discouraged or prevented from doing so”*

Risks associated with acquisitions and organisational change

4.12 The terms of reference say *“Although not necessary to review the acquisition process it is important to note the contractual changes that happened in December 2012 and their possible impact on both the provider and commissioners.”* Sir Robert Francis provides a note of caution in his executive summary report on Stafford Hospital about the danger associated with organisational change:

“Where there are perceived deficiencies, it is tempting to change the system rather than to analyse what needs to change, whether it be leadership, personnel, a definition of standards or, most importantly, culture. System or structural change

¹ Dr Kieran Walsh, Reader in Public Management and Director of Research Manchester Centre for Healthcare Management, University of Manchester, published by the Nuffield Centre in 2003.

is not only destabilising but it can be counterproductive in giving the appearance of addressing concerns rapidly while in fact doing nothing about the really difficult issues which will require long-term consistent management.” (Our emphasis) (Para 1.104)

4.13 The acquisition of the services by Southern Health from a trust that had provided them for a number of years occurred nine months before Connor’s death, so we examined in detail the post-acquisition processes adopted by Southern Health and the commissioners and their possible impact on quality and safety¹.

Wider learning disability issues

4.14 Our investigation was not commissioned to review the current state of national learning disability services, but our terms of reference require us to look at commissioning, assurance and patient safety systems as they relate to Oxfordshire.

4.15 Many previous reviews of learning disability services have taken place, offering many views about how to improve them. The issue is whether - from national leadership down to local provision - these services are afforded sufficient priority against other competing demands.

4.16 We concentrate on whether any wider system issues, such as commissioning, management and leadership, impacted on the care received by Connor and his family and whether any of them may have prevented his death.

Key questions for evaluating the evidence

4.17 Our amended principal evaluation test to *“Identify whether there were any wider system aspects that contributed to the preventable death of Connor”* is.

- Did the way learning disability services were commissioned or managed contribute to the preventable death of Connor?

¹ In general in this report references to ‘quality’ of services are intended to encompass the safety of those services.

4.18 We formulated three key questions to address the evaluation test.

1. What did Southern Health and their commissioners know about the quality and safety of services in STATT before the acquisition?
2. What processes did Southern Health and the commissioners put in place to assess risk and to mitigate any potential reduction in quality of care?
3. Did Southern Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition (if any)?

4.19 We also reflect on the following questions.

- Did commissioners ensure that the transition to a different provider addressed known safety and quality concerns?
- Did the location of Southern Health's senior executives in Southampton and the trust's geographic distance from Oxfordshire have an impact on communication, support and oversight of the services provided there? In particular, did this impact on service users, families and staff in Oxfordshire?

Critical and positive comments in the report

4.20 The executive summary of Sir Robert Francis' report on Mid Stafford Hospital provides guidance on what is included and excluded from a report. Reports of this nature can focus on the negative, but as Francis says:

“The fact that a critical comment is made about some action of an individual or an organisation does not necessarily mean that there are not many positive aspects to their work and contribution to healthcare.... What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report. In an inquiry required to focus on what went wrong and what needs to be changed it is simply inappropriate to qualify every critical comment with a

reference to unrelated positive points. It is the unhappy task of an inquiry to focus on what went wrong, and not on what went right.” (para 114)

Connor’s care

4.21 This investigation was commissioned principally to examine commissioning and management issues that may have contributed to Connor’s death. We were also asked specifically to look at the application of legal frameworks relevant to Connor’s inpatient admission and to examine his transition from child to adult services. Connor’s mother asked us to examine the progress of the implementation of updated epilepsy policies during Connor’s inpatient admission. We cover these aspects towards the end of the report. This is not to diminish their importance but we consider that these are best placed there.

5. Investigation approach

Interviews

5.1 We carried out interviews with staff from Southern Health, commissioners (including Oxfordshire County Council (the County Council), NHS Oxfordshire Clinical Commissioning Group (the CCG) and NHS West Hampshire Clinical Commissioning Group) and national bodies (including NHS England and the Care Quality Commission). Details of interviewees can be found in appendix C.

5.2 Most of our interviews were recorded and transcripts were sent to interviewees. We told individuals that unless transcripts were requested by an organisation that had legal authority to do so they would be kept confidential.

5.3 We also told interviewees that they could be accompanied at interview, though not by a legal representative.

5.4 The exception to the approach was interviews with senior executives/clinicians at Southern Health or who had previously worked there. The trust informed us by email that a number of their staff had requested that they be accompanied by a solicitor. The trust said:

“...a number of staff have asked to be supported by a solicitor appointed by the trust to provide advice and support about this matter. I wanted to make sure we were clear with you about the capacity in which the solicitor will act.”

“The solicitor is instructed by the trust and will be attending the interviews (where requested by staff) in her role as legal adviser to the trust. In this role, she will be supporting and advising the interviewees through the interview. If the interviewees so wish, she will be reviewing and commenting upon any transcripts produced and she will be taking notes of the interviews. Any notes that she makes may be shared with the trust. If she is sent any interview transcripts, by Verita or the interviewees, she will share these and any other comments upon them with the trust. The interviewees who have asked to be supported in this way are fully aware of the above points and are in agreement with them.”

5.5 We agreed to modify our usual approach in light of this demand and we told interviewees that Southern Health would see their transcripts. We considered that participation of Southern Health staff under revised conditions was in the public interest.

5.6 A number of Southern Health staff contacted us directly and asked to be interviewed. They were:

- Southern Health assessment and treatment services manager responsible for the STATT;
- band 6 charge nurse at STATT interviewed in the first Verita investigation; and
- former head of service for inpatient services for Oxfordshire, Buckinghamshire and Wiltshire.

5.7 Oxfordshire Family Support Network (FSN) and My Life My Choice helped us to gather the views of local families and service users. We are grateful to both organisations.

Stakeholder events

5.8 We held four stakeholder engagement events - three in October 2014 to explain the review and how we would carry it out and one in May 2015 to discuss our initial analysis and themes.

Interviews

5.9 We held 57 interviews and met with nine service users in individual or group interviews. We also held a focus group with the Oxfordshire community learning disability team.

Comment

Details of the interviewees can be found at appendix C.

Documents

5.10 We reviewed more than 250 documents (8,000 pages plus), including:

- internal and external reviews of services;
- acquisition plans for takeover of services at Ridgeway; and
- board papers from trust and commissioning organisations in relation to Ridgeway and Southern Health.

Anonymisation

5.11 We have considered what level of anonymisation should be included in this report. We have taken the view that clinicians (other than those with managerial responsibilities) should not be named. We have, where it is in our opinion helpful, named middle and senior managers and executives. In a number of places we have just included the role of an interviewee or someone who has provided evidence. No inference should be drawn from whether an individual has been named or not.

6. Executive summary

Background

6.1 Connor¹ was 18 when he was admitted to a learning disability short term assessment and treatment unit in Oxford in March 2013. The unit was part of the learning disability services provided by Southern Health NHS Foundation Trust (Southern Health). Connor was found submerged in the bath on 4 July 2013. Staff tried to resuscitate him and an ambulance took him to John Radcliffe Hospital. He died the same day.

6.2 An initial post-mortem report concluded that Connor died from drowning as a result of an epileptic seizure. Southern Health carried out a serious incident requiring investigation (SIRI) 72-hour report (dated 5 July 2013). Southern Health also carried out an initial management assessment. Southern Health commissioned Verita, an independent consultancy, to undertake its internal investigation. This investigation concluded that Connor's death was preventable.

6.3 The scope of this further investigation (as laid out in the terms of reference) is to:

*“Identify whether there were any wider system aspects [commissioning, leadership, management arrangements] that **contributed to the preventable death of Connor** [our emphasis].”*

“Review whether, prior to Connor's death, the local authority, Clinical Commissioning Group and/or Southern Health NHS Foundation Trust were aware of:

- any quality, safety or delivery concerns in respect of the Short Term Assessment and Treatment Unit*
- the broader learning disability provision and*
- to consider whether appropriate action was taken to address any concerns.”*

¹ Following consultation with his family, we refer to Connor by his first name in this report unless we are quoting from a document which uses his full name, or the initials, CS.

6.4 As part of this investigation we did the following.

- Held 57 interviews and two focus groups.
- Reviewed more than 250 documents (8,000 plus pages), including:
 - internal and external reviews of services;
 - acquisition plans for takeover of services at Ridgeway; and
 - board papers from trust and commissioning organisations in relation to Ridgeway and Southern Health.
- Held four stakeholder engagement events:
 - three meetings in October 2014 to explain the review and how we would carry it out; and
 - a meeting in May 2015 to discuss our initial analysis and themes.

6.5 The following is a timeline of the main events relating to this investigation.

2011

- 1 January -County Council enters into a contract with Ridgeway for the provision of learning disability services.
- March - Ridgeway decides not to proceed with its foundation trust application.
- 31 May - Winterbourne exposé documentary shown on BBC¹.
- December - First Care Quality Commission (CQC) visit to Slade House (this was the site that included John Sharich house and the short term assessment and treatment unit known as STATT in which Connor died on 4 July 2013.)

2012

- March - CQC report on Slade House (which said that it was meeting all essential standards of quality and safety).
- September - CQC Mental Health Act review of detained patients at John Sharich House.
- 1 November - Ridgeway taken over by Southern Health.
- 7 November to 31 December -County Council review of STATT.

¹ In 2011 a BBC Panorama programme identified serious abuse of people with learning disabilities at a privately run hospital in Gloucestershire. This led to a number of reviews and the conviction of 11 former members of staff.

2013

- 4 February - County Council and NHS England project team visit STATT as part of post-Winterbourne project.
- 19 March - Connor admitted to STATT.
- 1 April - PCT abolished/CCG created.
- 4 July - Connor died.
- 16, 17 and 23 September - Second CQC visit to STATT and third to John Sharich House.
- 24 September - STATT closed to new admissions.

2014

- 24 February - Verita report published.
- 17 April - Monitor enforcement notice on Southern Health.

Overall evaluation of the evidence

6.6 Our investigation was not commissioned to review the current state of national learning disability services, but our terms of reference require us to look at commissioning, assurance and patient safety systems as they relate to Oxfordshire. Where we can we have made observations and sought to identify lessons about national learning disability issues in the body of the report.

6.7 We looked for links between wider system issues and the care received by Connor and his family and whether any such issues might have prevented his death.

6.8 In our first investigation into Connor's care we found his death preventable:

“The failure of staff at the unit to respond to and appropriately profile and risk assess CS’ epilepsy led to a series of poor decisions around his care - in particular the agreement to undertake 15-minute observations of his baths. The level of observations in place at bath time was unsafe and failed to safeguard CS.”

6.9 We said that part of the reason for the lack of an effective risk assessment was that:

“Team working in the unit and with the community learning disability team was weak.”

“The unit lacked effective clinical leadership.”

6.10 We set out our evaluating test for assessing the evidence as:

- Did the way learning disability services were commissioned or managed contribute to the preventable death of Connor?

6.11 We formulated three key questions to address the evaluation test.

1. What did Southern Health and their commissioners know about the quality and safety of services in STATT before the acquisition?
2. What processes did Southern Health and the commissioners put in place to assess risk and to mitigate any potential reduction in quality of care?
3. Did Southern Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition (if any)?

6.12 We also reflected on the following questions.

- Did commissioners ensure that the transition to a different provider addressed known safety and quality concerns?
- Did the location of Southern Health’s senior executives in Southampton and the trust’s geographic distance from Oxfordshire have an impact on communication, support and oversight of the services provided there? In particular, did this impact on service users, families and staff in Oxfordshire?

Families and service users

6.13 We interviewed families and service users because their experience is an important measure to assess whether the outcomes claimed by professionals and service providers are experienced by those service users and families. These interviews were not carried out using a social science research methodology and we acknowledge that this is a small self-selecting sample. Despite this the stories that were shared with us provide valuable insight into the struggles that many service users and families have to cope with. The individual stories were not shared with Southern Health or the County Council to get their response and they are therefore unmediated accounts. Despite this they remain an important context when considering policies, procedures and the effectiveness of organisations supporting service users and families.

Service users

6.14 On the whole, people with learning disabilities involved in this investigation shared positive experiences about the community learning disability team. In particular, the provision of an acute liaison nursing post in Oxfordshire provided individuals with valuable support when they were admitted to general hospital.

6.15 However, service delivery could be improved in some areas. In particular, people wanted shorter waiting times for assessments, to be involved in important decisions, to have greater independence in money management and for members of the community learning disability team to attend their review meetings more often.

6.16 We were privileged to meet and interview 12 families who were using or had used Oxford learning disability services. Some key messages emerged from the interviews. The main one was that family input or involvement was not valued. Service engagement with families both in transition, assessment, and care planning meetings about their son or daughter was minimal. These families were all keen to help services improve and they had useful knowledge and experience to offer.

6.17 The struggles some of these families had endured were evident throughout the interviews. The interviewees reported that they found recounting their story often painful

but they were keen to contribute to this independent investigation because they wanted services to improve.

6.18 The narratives of this group of families provide serious lessons that need to be heard by service providers. Listening to families, as we have learnt from Winterbourne View and Mid Staffordshire NHS Foundation Trust inquiries, is vital.

6.19 The significant message from these interviews was that families felt that engagement and partnership working with them is not always at the heart of Oxfordshire learning disability services (Health and Social Care). Although there were some examples of good practice these were largely reported within the context of services that were constrained by poor information, inadequate budgets, poor leadership and coordination and at times an unwillingness to listen or involve families.

6.20 The important element of our interviews is that some people do not feel that learning disability services are providing the level of quality that they should. It is the responsibility of all parts of the service to listen to these stories and learn from them.

What did Southern Health and their commissioners know about the quality and safety of services in STATT before the acquisition?

National and commissioning context

6.21 No national service level agreements are in place between NHS England and learning disability service providers, unlike for mental health services. This means that service models for learning disability provision are open to wide variation throughout the country and there are no national standards against which learning disability services can be assessed.

6.22 We identified only a small amount of best practice guidance specifically in relation to short term assessment and treatment units.

6.23 The background created by the Winterbourne View exposé was felt particularly strongly in Oxfordshire where some service users were directly affected because they had

been Winterbourne residents. For clarity Connor was not an ex-Winterbourne resident and none of the service users in STATT were either.

6.24 The Winterbourne View exposé focused attention on the abuse that had happened there and on restraint in particular. From Oxfordshire’s point of view, commissioners had concerns about services in Wiltshire and Buckinghamshire, some of which related to restraint. Their attention was naturally focused there. By contrast, Oxfordshire services had experienced fewer incidents so they received less attention.

6.25 The general view of those we spoke to was that while people did not see the services provided by Ridgeway as outstanding, neither did they see them as particularly bad at that time. Commissioners and staff at the strategic health authority (SHA) had a perception that the services had once been ground-breaking but were now declining. These views were supported both by the CQC visit to STATT in 2011 and by the Contact Consulting report (see below).

6.26 Concerns about the quality of Ridgeway services tended to relate to those outside Oxfordshire. Commissioners thought that services in Oxfordshire needed less attention, although they were acknowledged as being old-fashioned and reliant on a bed-based model of assessment and treatment.

Preparation for the acquisition

6.27 As will be seen in the main body of the report Southern Health had a well thought out strategy for preparing for the acquisition which from our review of the available evidence was carried out effectively. This included a wide range of communication processes and quality and safety reviews.

Quality and safety reviews prior to acquisition

6.28 A number of reviews were carried out before or around the time of acquisition. We list below those that focus on quality and safety.

CQC inspection - reported in March 2012

6.29 The inspection report concluded that John Sharich house and STATT both met the two essential standards that were assessed.

- Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights¹.
- Outcome 7: People should be protected from abuse and staff should respect their human rights².

County Council review - November to December 2012

6.30 Twelve visits took place at varying times of the day, during the week and a weekend over four weeks. The review found ten standards being met and two partially met. The two that were partially met were the standard for care plans and the standard for working in partnership.

Contact Consulting review - reported September 2012

6.31 This was commissioned by the SHA because it had concerns about safeguarding, patient safety and organisational culture. The report highlighted *“a disconnect between senior leaders within OLDT and the staff delivering or managing the services in terms of the understanding of quality issues and the assurance that actions needed have been taken and are fully implemented.”*

Comment

This finding was crucial because it alerted Southern Health to the need to have systems in place to provide it with accurate assessments of quality and whether actions to

¹ (Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010)

² (Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010)

improve services were actually carried out effectively. Consideration of the trust's systems and processes is dealt with in detail below.

6.32 The Contact Consulting report did not identify any concern specifically about STATT.

Quality and safety review - July to November 2012

6.33 This was carried out/overseen by John Stagg, interim divisional lead nurse at Southern Health, and involved reviewing previous assessments and carrying out:

- mock CQC assessments;
- client journey/high risk patient reviews; and
- a matron walk-round.

6.34 The report of the different strands of this review said:

“Although there is evidence of good practice within OLDT services, there is a need to:

- *ensure consistent practice and monitoring across services;*
- *engage staff at the patient level in monitoring and improvement; and*
- *increase the evidence of multidisciplinary working including the approach to address clinical assessment and treatment and clinical risk assessment and risk management.”*

6.35 Southern Health presented the quality and safety report to a meeting with commissioners and the SHA on 27 November 2012. They accepted it and asked for an action plan to be prepared. This was done.

Summary

6.36 A number of reviews of the services took place before the acquisition. They were commissioned by various organisations and identified a number of improvements to be made.

6.37 The various reviews of the Ridgeway services did not give them a clean bill of health. The reviews raised concerns about governance at Ridgeway and whether local managers were fully aware of the quality of local services. Managers needed to improve multidisciplinary team working and risk assessments and care planning. Even so no acute concerns about the safety of services in STATT were raised by the reviews. The more acute concerns were focused on the non-Oxfordshire services of the former Ridgeway Trust.

6.38 Commissioners and other external partners expected that Southern Health would have a strategy to address the issues raised in the County Council, Contact Consulting and the Southern Health quality review, if not in late 2012 then as soon as possible in 2013.

6.39 The next section of our report looks at how Southern Health responded to the issues in the reports.

What processes did Southern Health and the commissioners put in place to assess risk and to mitigate any potential reduction in quality of care¹?

In particular, did Southern Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition (if any)?

Changes to senior leadership

6.40 Kevin O'Shea, clinical director for learning disabilities made it known a few months before acquisition of the Ridgeway services that he did not want to continue in this post after acquisition. Amy Hobson, operational director also made it known either before or

¹ Based on previous research it is widely understood that care can deteriorate during significant organisational change.

close to the point of acquisition that she also did not want to continue in this role (the actual time when this was made known is a matter of dispute). Both were experienced learning disability professionals and a number of interviewees told us that they were widely seen as key to the successful leadership of the future service.

6.41 Some aspects of the post-acquisition actions stalled as a result of these senior leadership changes. The County Council wrote to Southern Health in February 2013 asking why they had had very little contact from Southern Health divisional managers since taking over.

6.42 Difficulties arose soon after the acquisition in ensuring the availability of sufficient senior and experienced divisional managers to take forward vital post-acquisition actions. In particular to progress actions arising from the various quality assessments that had taken place before the acquisition.

6.43 The trust had in place a 100 day plan for the post-acquisition period designed to ensure a smooth transition of Ridgeway services into Southern Health normal performance and governance processes. In the first months of 2013 a handover took place between Amy Hobson and Lesley Munro. This was combined with Dr O'Shea also having indicated prior to the acquisition that he did not want to continue in post as he was carrying out his role as clinical director on top of a full-time consultant role.

6.44 The trust board executive directors were slow to respond to the wish of these senior leaders not to be part of the future leadership of the learning disability directorate. Kevin O'Shea was not replaced until September 2013 and did not play a major part in post-acquisition activities. He said that he adopted a caretaking role during this period. The new learning disability divisional director, Lesley Munro, (an experienced director but not experienced in learning disability services) took over in March/April 2013.

'Business as usual'

6.45 Various people described the approach taken by the trust board directors to manage the new services after acquisition as 'business as usual'.

6.46 Katrina Percy, chief executive of Southern Health, told us that the newly acquired service was run as part of the Southern Health learning disability division, not as a separate division. This meant implementing actions through normal divisional business plans and monitoring them through the executive performance review process.

6.47 This approach meant that quality and safety were to be monitored through the learning disability division's ordinary assurance processes and no extra measures were put in place to monitor the quality and safety of the former Ridgeway services.

6.48 The Contact Consulting report had warned of disconnect between senior leaders in Ridgeway and their staff delivering or managing the services and their understanding of what their services were doing.

Comment

It was appropriate for Southern Health to put in place, post-acquisition, its quality assurance and governance processes. These relied on sound information feeding into the processes. But for Southern Health to only rely on its normal reporting mechanisms without addressing the Contact Consulting warning and ensuring that information from local managers was accurate was a serious failure.

6.49 An example of this was that John Stagg produced an update of his quality and safety review for Southern Health in May 2013. He did this by receiving information/assurance from various local managers. He told us he and senior divisional staff realised when STATT failed the CQC inspection in September 2013 that the assurances he had received were not accurate or lacked sufficient evidence.

6.50 A 'business as usual' methodology for a newly acquired service may appear appropriate if the service being acquired is mature and relatively problem-free. This was not the case in the Ridgeway services. Contact Consulting had warned of issues in local leadership; governance of serious incidents, along with particular difficulties about care issues in non-Oxfordshire services. There was also a need to begin dealing with the cultural change required of an established learning disability service joining a large mental health and community trust with a small learning disability service.

Engagement and communication

6.51 We saw evidence that Southern Health had put considerable effort into communication before the acquisition. This was a combination of newsletters, focus groups, joint working with Ridgeway staff and some away days.

6.52 Communication after acquisition appears to have been mostly carried out as if it was ‘business as usual’. In responding to our draft report the trust told us:

“Rather than communications being managed by the central communications team specifically for former Ridgeway Staff, the plan was for former Ridgeway Staff to receive the same centrally issued communications as the rest of the organisation did, with communications that were specific to them being managed by Amy Hobson and her senior management team in line with the trust’s existing operational management. ‘Business as usual’ did not therefore mean ‘no specific communications’ for former Ridgeway staff...”

Comment

We are not saying that no communication occurred after acquisition. Our concern is that over-reliance on systems that were well known to Southern Health staff was unwise. There should have been as much effort put in to the post-acquisition communication and engagement as prior to it, in particular for new divisional managers and executives to get to understand the service that had just been acquired.

6.53 Sue Harriman, Southern Health’s former chief operating officer, told us she believed that Southern Health underestimated the engagement needed to understand the organisation and its history, the culture of the Oxfordshire services and the commissioning culture.

Post-acquisition impact on local services

6.54 In September 2013 (after Connor’s death), the CQC undertook an unannounced inspection of Slade House. Both John Sharich House and STATT were inspected.

6.55 The inspection report criticised both units but found failings at STATT to be of more significant concern. In contrast to the themed inspection in late 2011, CQC inspectors reported of STATT “... *there were several areas of concern that required urgent action*”.

6.56 The unannounced inspection covered 10 regulations including those reviewed as part of the themed inspection in 2011. Of the 10, four were assessed ‘action needed’ and six ‘enforcement action’.

6.57 After the poor report from the CQC inspection in September 2013 and the concerns of commissioners, Southern Health commissioned an independent management consultant to investigate the leadership and management of the Slade House services. She said:

“...there was a lack of higher level coordinated support to deliver the service safely through the operational consequences of the merger coupled with a culture of helplessness.”

“There were very few, if any formal processes for review and sign off of action plans over the past 12 months. This is symptomatic of a service in crisis.”

6.58 Southern Health commissioned another report after the CQC visit. It was carried out by an area manager for a service in Hampshire.

“The governance arrangements which prevailed post-transaction did not readily enable communication and a change culture due to a top down approach, and apparent lack of empowerment for front line staff.”

Mental health legislation

6.59 We commissioned Professor Peter Bartlett, professor of mental health law at Nottingham University, to review the approach and practice of the Mental Health Act (MHA),

Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) assessments as they related to Connor's care in STATT.

6.60 He concluded that the use of the MCA in this case raised issues for the trust. In particular, the need to improve the relevant policies. His review of the notes raised questions as to whether the MCA was implemented properly in STATT. He said that these shortcomings did not appear to have been significant factors in Connor's death, but they do appear to be matters where care could have been improved.

6.61 He also concluded that the use of both the DoLS and the MHA was consistent with professional practice at the time.

Staff morale

6.62 In our first investigation into Connor's care we found that morale of the staff in STATT as a result of the acquisition was not a factor in the decisions and actions taken by the clinical team.

6.63 We re-interviewed the charge nurse of STATT at his request. We re-interviewed at our request the unit manager of STATT and John Sharich house. Both were in post during Connor's time in STATT.

6.64 Both had concerns about the state of services at that time, although these interviews did not suggest to us that the impact of the acquisition was a factor in the way that clinical decisions were made about Connor's care.

6.65 The range of reviews carried out before the acquisition gave Southern Health and commissioners no acute concerns over the way STATT was being managed.

6.66 None of the reviews that were carried out into Ridgeway services before Connor's death identified weaknesses in clinical team work within STATT.

6.67 We found weaknesses in the way Southern Health carried out its post-acquisition management of the Ridgeway services. Extra safeguards and assurance approaches would

have enabled them to identify much sooner deterioration in the quality of the services at STATT.

6.68 We found important gaps in the leadership of learning disability services by Southern Health after acquisition. The departure of the two learning disability leaders left this newly acquired service in a vulnerable position and caused delays in implementing the new Learning Disability Service Strategy.

6.69 The CQC inspection, the three subsequent reviews and our first investigation identified deterioration in the quality of services in STATT. If the post-acquisition arrangements had been better this deterioration could have been picked up sooner.

Findings

F1 Legislation and guidance was in place during the period of Connor's care in relation to:

- admission and discharge;
- transition from children's services to adult services;
- care planning; including, risk assessment and involvement of families;
- multi-professional and multi-agency working;
- adult safeguarding; and
- commissioning, including contracting and commissioner quality reviews.

F2 NHS England and learning disability service providers do not have any learning disability national service level agreements, unlike those for mental health services. This means that service models for learning disability provision are open to wide variation throughout the country and consequently there are limited national standards against which learning disability services can be assessed.

F3 We found only a small amount of best practice guidance specific to short-term assessment and treatment units. The main exceptions were the guidance issued by the Royal College of Psychiatrists in 2010 and that produced in 2013 in relation to commissioning services - which the college part-authored.

F4 We endorse the work of Sir Stephen Bubb (appointed by NHS England to report on learning disability services in the light of the Winterbourne scandal) in seeking to ensure that the commitments made by NHS England to people with learning disabilities and their families and carers are met. NHS England must give the priority required to ensure the targets set out in *Time for change* are delivered and real and substantial change in learning disabilities services takes place.

F5 The trust undertook appropriate, adequate and reasonable due diligence into the quality and safety of the services prior to acquisition. The due diligence reviews did not identify any acute concerns about the safety of services in STATT. The more acute concerns were focused on the non-Oxfordshire services.

F6 The County Council quality and contracts review carried out in November and December 2012 was thorough. It was conducted over a number of days and the range of interviews was comprehensive and appropriate. As matter of good practice, it would have been beneficial to include NHS professionals in the team.

F7 The communication and engagement strategies Southern Health put in place for the period up to the acquisition were of a high quality and comprehensive. The approach taken to communication and engagement with Ridgeway staff after acquisition was inadequate and failed to ensure that the natural concerns of a staff group taken over by a large and distant trust were properly addressed.

F8 The post-acquisition model of 'business as usual' was flawed because concerns had been raised about the quality of management in Ridgeway. Southern Health divisional managers needed to fully engage with managers and clinicians in Ridgeway to ensure that the board level executives could rely on the reports they were receiving.

F9 Southern Health was taking over a long-standing service and the approach to the post-acquisition period lacked a viable strategy to mitigate the negative effects of significant organisational change. In particular they lacked:

- a communication strategy that was as effective after the acquisition as before it, so that as far as possible staff concerns during the immediate months after the acquisition were listened to and acted on; and

- an enhanced presence of Southern Health senior executive leaders meeting with staff, families and commissioners in the former Ridgeway area in the year after acquisition.

F10 The decision of the best-interest assessor that Connor was not deprived of liberty was consistent with the law and the practice of best-interest assessors at the time.

F11 The approach to the MHA by the staff of STATT appears to have been consistent with law and practice at the time.

F12 The use of both DoLS and the MHA were consistent with professional practice at the time.

F13 Southern Health's strategy for introducing a number of clinical pathways and maps was appropriate.

F14 The clinical decisions of the qualified and registered health professionals at STATT around the care of Connor's epilepsy and risk management as set out in our first report were inappropriate and unsafe. They were not caused by a failure to have in place appropriate epilepsy policies or trust guidance.

F15 The learning disability divisional action plans developed in 2014 are of a good quality, comprehensive in their scope and linked directly to the issues CQC and Verita identified, post-Connor's death. Southern Health recognised a potential shortfall in capacity for the oversight of the plans and responded by commissioning external experts (MBI Health Group). They combined this with the commissioning of an external review of quality. This demonstrates that they recognised the problems and acted to address them.

Conclusions

Conclusion 1

6.70 The County Council, commissioners of the STATT, carried out a quality monitoring review of STATT in November/December 2012. An action plan was produced by Southern Health and this was reviewed by the commissioners in July 2013. The commissioners also

reviewed the update of the Southern Health quality and safety review in May 2013. The commissioners chased up Southern Health senior managers in the first few months of the contract to get them to be more engaged with the regular contract review meetings.

6.71 There is no evidence that acts or omissions of commissioners contributed to the inadequate care received by Connor that led to his preventable death. We set out our rationale for this in our overall conclusion.

Conclusion 2

6.72 Quality reviews carried out before the acquisition or at the point of acquisition did not find that STATT had acute clinical, managerial or systems failures. In contrast, concerns were focused on the non-Oxfordshire part of the former Ridgeway services where patient safety risks had been identified.

Conclusion 3

6.73 An over reliance on a 'business as usual' approach to this acquisition was not appropriate. Southern Health should have ensured that any deterioration in the quality of services could be identified quickly and by processes that Southern Health had confidence in.

Conclusion 4

6.74 The post-acquisition process by Southern Health was not effective because:

- the two key managers with an experienced learning disability background, prior to or close to the date of the acquisition, made it known that they did not want to be part of managing the new services;
- the trust had not put in place sufficient and timely actions needed to begin to address the cultural change required of an established learning disability service joining a large mental health and community trust with a small learning disability service;

- the trust did not evaluate or address the known concerns about the quality of local leadership; and
- local managers were also dealing with a number of significant issues existing in the non-Oxford part of the former Ridgeway services.

Overall conclusion

6.75 In our first report we took the view that the key issue in Connor's care was poor practice by clinical staff. We have not seen anything during our work on this second investigation to change that. While we have identified deficiencies in the way Southern Health carried out its post-acquisition actions and that these had an impact on staff (as the independent reports commissioned by Southern Health in late 2013 show in relation to the Oxford services) there is no evidence that these affected the clinical decisions or team working in STATT, as they related to the care of Connor.

6.76 If Southern Health had carried out their post-acquisition actions more effectively this may have identified weaknesses in the way staff in STATT were working. We have not seen evidence which would allow us to conclude that this would have prevented the poor decisions around Connor's care.

6.77 The failures in care during Connor's inpatient admission were not caused by Southern Health managers or commissioners. The clinical staff failed to carry out procedures and processes that were their responsibility and within the competence and knowledge expected of registered health professionals. Principally clinical staff did not effectively work together and follow NICE guidelines regarding the care of individuals with epilepsy.

Recommendations

R1 Commissioners should continue to ensure that service user views are (and are seen to be) taken into account in commissioning decisions.

R2 In light of the comments from Professor Bartlett and the new Code of Practice, Southern Health should update their Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policies to provide clearer guidance about:

- overall responsibility for implementation;
- MCA provisions concerning best interests in the context of restraint;
- the determination of deprivation of liberty;
- the eligibility requirement; and
- the provision of independent mental capacity advocates.

7. Background

7.1 Oxfordshire Learning Disabilities Trust, also known as ‘the Ridgeway Partnership’, or simply ‘Ridgeway’ was established in 1992¹. Its headquarters were at Slade House in Oxford. It ran services predominantly in Oxfordshire and Buckinghamshire, but also in Berkshire, Wiltshire, Dorset and Bath, and North East Somerset. Services that we make reference to in this report are:

- Postern House (Wiltshire);
- Slade House: comprising the short term and assessment team unit (STATT) and John Sharich House (Oxfordshire);
- The Ridgeway Centre² (High Wycombe, Buckinghamshire); and
- The Chilterns (Amersham, Buckinghamshire).

7.2 A long-standing government policy has been for all NHS trusts to become foundation trusts. By 2011, Ridgeway was one of only two specialist learning disability trusts in the country. In line with the national policy that all NHS trusts should become foundation trusts by 2014, Ridgeway had hoped to do so. However, it concluded in March 2011 that it was not possible. Its turnover of £40m was too low for it to be viable and it decided not to proceed. The alternatives of becoming a social enterprise or becoming a partner with other local trusts were considered and rejected. In the summer of 2011 the services Ridgeway provided were included in the NHS merger/acquisition process.

7.3 A number of factors contributed to the decision to include Ridgeway in the merger/acquisition process. The drive for all trust services to be part of a foundation trust created a momentum for change, but the concerns about Ridgeway services discussed above were also important. Events at Winterbourne View of poor care and abuse (exposed by the BBC) gave many people concerns about learning disabilities services particularly small specialist providers. Ridgeway services were not implicated in the BBC programme but would have been considered as a small specialist provider. More generally, there were concerns about the quality of services provided by Ridgeway and many believed that the integration of these services into a larger trust would be the best way of ensuring consistent quality. A commissioner at the County Council told us:

¹ Source - Ridgeway Partnership: Quality Accounts 2011/2012

² The name of this unit has changed in the past, but this is how it is currently referred to.

“I think Ridgeway was an organisation that was struggling for life, in organisational terms, because they were a small trust, they made various attempts to be a foundation trust, they’ve looked at other opportunities before deciding to go into their merger and acquisition process... my impression at that time was that Ridgeway saw itself as merging with an organisation, not being acquired by an organisation, would be my view. I think that’s probably symptomatic that they didn’t necessarily realise how small a fish they were.”

7.4 Another County Council commissioner said:

“I suppose personally I got to a point where, by the time we were starting in 2011 on looking at the merger and acquisition, I felt that maybe Ridgeway were never going to quite deliver that and we need a bigger, more resourced organisation to actually move that forward. The big hope - well, belief as well - was that Southern Health were going to be able to help us deliver that, and that’s very much what we were looking for through the acquisition process.”

7.5 The acquisition was led by the strategic health authority through a project board comprising the strategic health authority, directors of Ridgeway and the lead commissioner for learning disability services from the County Council¹. The project board sought expressions of interest from NHS foundation trusts. Bidders were invited to submit a pre-qualifying questionnaire. Thirteen bids were submitted, of which 12 passed the threshold.

7.6 Southern Health was selected as the preferred bidder in January 2012. Its bid included offering a new model of care based less on the use of beds and more on promoting independent living. Julie Kerry of NHS England, said:

“They were miles ahead of the other organisations. The other organisations, both Calderstones and the Hertfordshire Partnership Trust, felt quite institutional models. Calderstones was basically a bed-based service. Southern Health’s model was not like that and throughout the interviewing processes Amy Hobson and Katrina [Percy] in particular were impressive in terms of being able to describe what the pathway would look like, what outcomes they would be able to deliver and how they would be able to deliver them. In my head they were miles above the other organisations”.

¹ The process was set out in a paper to the Oxfordshire County Council cabinet on 17 January 2012.

7.7 A County Council commissioner told us:

“...there was no doubt that Southern Health did a good bid and the bits that I was part of the assessment for, they presented really good stuff. They tended to score well across the board. They backed it up and they were able to provide a good account of it in the interviews and board-to-board as well.”

7.8 Jan Fowler, chief nursing director for clinical standards at NHS South Central Strategic Health Authority at the time, said:

“I think people had confidence that Southern Health was the right provider to support these services, they had a good track record, they had very impressive individuals and that meant that actually, they were the solution to quite a difficult problem”.

7.9 The following is a timeline of the main events relating to this investigation:

2011

- 1 January - County Council enters into contract with Ridgeway for learning disability services.
- March - Ridgeway decides not to proceed with foundation trust application.
- 31 May - Winterbourne exposé documentary shown on BBC.
- December - First Care Quality Commission (CQC) visit to Slade House.

2012

- March - CQC report on Slade House (meeting all essential standards of quality and safety).
- September - CQC Mental Health Act review of detained patients on John Sharich House.
- 1 November - Ridgeway taken over by Southern Health.
- 7 November to 31 December - County Council review of STATT.

2013

- February - County Council and NHS England project team visit STATT as part of post-Winterbourne project.
- 19 March - Connor Sparrowhawk admitted to STATT.
- 1 April - PCT abolished/CCG created.
- July - Connor died.
- 16, 17, and 23 September - Second CQC visit to STATT and third to John Sharich House.
- 24 September - STATT closed to new admissions.

2014

- 24 February - Verita report published.
- 17 April - Monitor enforcement notice on Southern Health.

7.10 In this chapter we set out the national backdrop against which Southern Health and commissioners were operating at the time of Connor’s admission and since his death. This is drawn from the following part of our terms of reference¹:

“To examine wider system assurance, regulation, national policy, national data, system monitoring of learning disability services and identify any contributing factors.”

7.11 We take into account not only best practice and guidance, but also the legislative environment within which practitioners, managers and commissioners were working. We include in this section a summary of the evidence we collected. More details of legislation and guidance is available in appendices G and H.

Best practice and guidance

7.12 This section deals with the best practice and guidance available to commissioners, managers and practitioners regarding:

- learning disability services; and

¹ We pick up additional aspects of this chapter throughout the report, particularly in relation to the inspection and regulatory environment.

- commissioning services.

7.13 We sought to identify generally agreed standards against which to judge performance in order to establish if the structures, processes and practices across the region, and specifically within Southern Health and STATT, were ‘fit for purpose’ and correctly functioning.

7.14 We undertook a review¹ of statutory requirements, guidance and best practice in relation to both these areas. We identified 10 policies and statutory requirements; and nearly 20 examples of best practice guidance that we deemed to be the most relevant to learning disabilities. We identified a similar number of guidance documents in relation to commissioning services generally, although none specific to learning disability services.

7.15 Hazel Watson, mental health and learning disabilities lead for NHS England, told us:

“What learning disability has never had is a national service framework, so the discussion that we are having internally at the moment is how we can do that, whether politically we can do that, whether the system would receive that, how the system would receive it, what levers we might use in order to make that stick. Certainly colleagues in the system are telling us actually something like a national standard framework would be really helpful.”

7.16 She also told us that there was considerable inconsistency in the way learning disability services are organised and commissioned.

Health and Social Care Act and the Care Quality Commission

7.17 The Health and Social Care Act (HSCA) 2008 (regulated activities) Regulations 2010 are underpinned by the ‘essential standards of quality and safety’ and were used by the Care Quality Commission (CQC) to assess providers. The essential standards were replaced in 2015 with the ‘fundamental standards’ that reflect the introduction of the Care Act 2014².

¹ The review preceded the introduction of the Care Act (2014) and the Children and Families Act (2014).

² On 1 April 2015 the Care Act 2014 will become legislation. This shall replace the bulk of legislation that precedes it. The Health and Social Care Act will still be used however the 2010 regulations will be replaced with the 2014 regulations.

7.18 However, for the purpose of this investigation we primarily consider legislation and guidance in place at the time of Connor's admission (e.g. the HSCA), though we comment on how the Care Act may make a difference. See appendix D for details about the fundamental standards.¹

7.19 CQC guidance grouped the essential standards into six areas:

- involvement and information;
- personalised care;
- treatment and support;
- safeguarding and safety;
- suitability of staffing; quality and management; and
- suitability of management.

7.20 The guidance set the criteria against which health and social care organisations were first registered, and later assessed.

Comment

We were struck by the volume of documentation available in relation to learning disability services and commissioning services. Though a great deal of guidance is available to those working in - and commissioning - learning disability services, very little statute is in place. This means that there is information about what should be done, but little in the way of requirements.

There is little in statute in terms of legislation pertaining to learning disability services (e.g. Autism Act 2009, Carers and Disabled Children Act 2000).

Guidance from the Department of Health is available to learning disability services which focuses on specific aspects of care such as transition, safeguarding, epilepsy care and shared decision-making with people with learning disabilities.

¹ In the interest of brevity we have excluded regulations that though applicable to the service are not immediately relevant in the context of this review e.g. Regulation 13, management of medicines.

The issue, however, is the consistency of how this guidance is implemented locally. Without greater statutory force no requirement exists for local services to ensure that the services they provide comply with such guidance.

Finding

F1 Legislation and guidance was in place during the period of Connor's care in relation to:

- admission and discharge;
- transition from children's services to adult services;
- care planning; including, risk assessment and involvement of families;
- multi-professional and multi-agency working;
- adult safeguarding; and
- commissioning, including contracting and commissioner quality reviews.

Commissioning services

7.21 The NHS underwent significant reorganisation in 2013. The Health and Social Care Act 2012 abolished primary care trusts (PCTs) and strategic health authorities (SHAs) on 31 March 2013. The Act received Royal Assent on 27 March 2012 and the majority of changes were brought into effect on 1 April 2013. CCGs and NHS England took on their statutory responsibilities on 1 April 2013.

7.22 These changes provide an important backdrop to the period immediately following Southern Health's takeover of Ridgeway.

7.23 The reforms made major changes to commissioning arrangements. Under the old system commissioning was carried out by PCTs, overseen by strategic health authorities and the Department of Health. This was replaced by a system of clinical commissioning groups (CCGs), led by local GPs. A single national body, NHS England (formally known as the NHS Commissioning Board) was made responsible for authorising the CCGs and commissioning 'specialist services'.

7.24 It is not possible to compare the old and new bodies directly because they have different responsibilities. For example, commissioning primary care had been the responsibility of PCTs but now falls to NHS England. Many learning disability services fall within the definition of ‘specialist health services’ and are therefore now commissioned directly by NHS England. However, continuing health care is commissioned by clinical commissioning groups. The changes were a major pre-occupation for many NHS staff in the months up to 1 April 2013 and immediately afterwards.

Comment

The scale of the NHS reorganisation and the impact it had on staff and services should not be underestimated. These changes directed focus on implementing changes and operating under the new working model.

7.25 CCGs¹ are subject to oversight from NHS England. The CCGs statutory duties² are based on a wide range of legislation. The duties do not make specific reference to commissioning learning disability services.

Comment

CCGs have no specific statutory requirements in relation to the commissioning of learning disability services. However, CCGs still have an obligation to NHS England to demonstrate that they have made reasonable adjustments to ensure services are fit for people with learning disabilities.

7.26 Hazel Watson, mental health and learning disabilities lead for NHS England, told us:

“...we are going to have to produce something consistent to support learning disability commissioners to commission consistently... in fairness to our

¹ CCGs are responsible for commissioning the majority of health care services in England.

² <http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf>

commissioning colleagues, even those who are very clear on what needs to be commissioned and how services could change and look, as you say, without some national levers and national imperatives, it makes their jobs harder.”

7.27 CCGs, like NHS England and social care providers, are subject to the NHS five domains. The five domains¹ are:

1. *“Preventing people from dying prematurely*
2. *Enhancing quality of life for people with long-term conditions*
3. *Helping people to recover from episodes of ill health or following injury*
4. *Ensuring that people have a positive experience of care*
5. *Treating and caring for people in a safe environment and protecting them from avoidable harm”*

7.28 There is guidance specific to learning disability services. *Health Inequalities and people with learning disabilities in the UK: 2011, implications and actions for commissioners*² outlines ways in which commissioners can reduce health inequalities.

7.29 These included:

“To improve life outcomes, it is important to commission specialist learning disability health services that work in partnership with social work professionals and others who are concerned with wider life outcomes”

7.30 The guidance draws attention to the role of families, highlighting the finding of the Department of Health *Six Lives progress report*³ (2010) that:

“Effective engagement of people with learning disabilities and their families is essential to delivering personalised, effective services and equal outcomes”.

7.31 Further examples of guidance include *Improving the health and wellbeing of people with learning disabilities: An evidence-based commissioning guide for clinical commission*

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213789/dh_123_138.pdf

²https://www.improvinghealthandlives.org.uk/securefiles/150109_1537//IHAL%202011%20healthin%20equalityguidance.pdf

³https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216180/dh_120_494.pdf

groups¹ (2012, revised in 2013). This guidance covers a number of areas including primary care services, acute hospitals, specialist adult learning disability services, and cross cutting commissioning considerations. It says:

“CCGs have responsibility for commissioning services for people with learning disabilities detained under the Mental Health Act, and those deemed to be a health responsibility under NHS Continuing Health Care (CHC) criteria. They need to work jointly with Local Authority colleagues, providers and others to ensure that good local services are available to support people who challenge services and those with complex needs to prevent the need for expensive and potentially risky out of area placements.”

7.32 The Joint Commissioning Panel for Mental Health produced *Guidance for commissioners of mental health services for people with learning disabilities*² (2013). The guidance contains 10 key messages which include:

“Commissioners should work in partnership with provider services in primary and acute care, and with local authorities including public health...”

And:

“Commissioning of mental health services should support the development of local, person-centred services, leading to the development of skilled local providers.”

7.33 The guidance highlights the role of NHS England to:

“... ensure that clinical commissioning groups (CCGs) work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities, and that a substantial reduction should occur in the reliance on inpatient care for these groups of people.”

¹http://www.rcgp.org.uk/learningdisabilities/~/_media/Files/CIRC/LD%20Commissioning/RCGP%20LD%20Commissioning%20Guide%20v1%200%202012%2009%2024%20FINAL%20pdf.ashx

² <http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf>

And:

“It is important to remember that NHS England should be promoting and facilitating joint and collaborative commissioning by local authorities and CCGs to support the development of better services.”

7.34 The guidance also notes the role of commissioners in monitoring performance:

“Commissioners should evaluate the outcomes of the service models they are providing, checking for evidence of effectiveness, safety and user satisfaction.”

7.35 The Oxfordshire *Joint Strategic Needs Assessment Annual Report 2014* reports that *“in September 2013, 1,923 adults with learning disabilities were known to social services in Oxfordshire.”* For context, the total population of the county in the 2011 census (adult and child) was 655,000. The known learning disabled community accounted for a very small percentage of the total population.

7.36 Although outside of the core scope of this report, we would simply note the inevitable tension within commissioning bodies of having the requisite internal expertise to commission highly complex services (obviously not just those for learning disabilities, but all high-complexity/low prevalence services) and then to effectively monitor and assess these within a finite workforce with many competing demands. This line of thought inevitably leads to consideration of wider scale commissioning and oversight concentrated in fewer, specialist bodies.

Comment

Some commissioning guidance for learning disabilities services was available to commissioners in 2013. The application of this guidance was - and is - challenging given the highly complex, specialist nature of the service requirement.

National service level agreements

7.37 A service level agreement (SLA) is a contract between commissioners and service providers. It sets out the expectations of both parties and any penalties in the event of failing to deliver services. An SLA can also be used to ensure that the provider knows specifically what it is supplying. It is likely to include what standards will be in place and any methods of monitoring performance. CCGs have SLAs with health services providers and commissioning support units, although no national standards exist for what they should include.

7.38 We are aware that further work on national standards for learning disability services is currently being carried out. Some of this, at the date of this report, is out for consultation.

Finding

F2 NHS England and learning disability service providers do not hold any learning disability national service level agreements, unlike those held for mental health services. This means that service models for learning disability provision are open to wide variation throughout the country and consequently there are limited national standards against which learning disability services can be assessed.

Assessment and treatment units

7.39 In this section we consider what national guidance is available in relation to the remit of assessment and treatment units in the NHS. This section partly deals with the relevant section of the terms of reference set out below. It is further discussed in other parts of the report.

“Review and consider whether the purpose and aims of the short term assessment and treatment unit were aligned to commissioners’ service specifications and the aims of Connor’s admission and expected outcomes.”

7.40 In May 2011 *Panorama* broadcast an investigation into Winterbourne View hospital, South Gloucestershire - a private hospital owned by Castlebeck¹. It was an independent sector assessment and treatment facility for people with learning disabilities and challenging behaviour. The programme showed staff physically and psychologically abusing residents. The CQC and South Gloucestershire Council had received warnings about the hospital but took no action.

7.41 The programme led to concerns about learning disability short term assessment and treatment units being discussed more publicly and to the Department of Health and CQC launching investigations.

7.42 The Department of Health estimated in 2012² as part of its review into Winterbourne View Hospital that there were “3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are in assessment and treatment units”.

7.43 The Department of Health interim report³ (2012) noted:

“Too many people are placed in in-patient services for assessment and treatment (A&T) and are staying there for too long... This model of care goes against government policy and has no place in the 21st century. People should have access to the support and services they need locally - near to family and friends - so they can live fulfilling lives within the community... Many people with behaviour challenges - especially those living in assessment and treatment units - have little independence or choice and control.”

7.44 *Improving the health and wellbeing of people with learning disabilities: An evidence-based commissioning guide for clinical commissioning groups* (2012) advises that in relation to assessment and treatment inpatient services:

“CCGs should check that people with learning disabilities in assessment and treatment services are reviewed on a regular basis. People with learning disabilities and their families should be given the support they need to ensure they can take an active part in these reviews... discharge planning should commence on admission,

¹ Castlebeck went into administration in March 2013.

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

³ *Department of Health review: Winterbourne View Hospital, Interim report (2012)*

and the length of stay should be carefully monitored. Commissioners should be clear about the respective roles of organisations in relation to commissioning and care co-ordination arrangements, and there should be a formally agreed communication schedule, which includes... on-going communication with families, carers and advocates.”

7.45 The government set a mandate to the NHS Commissioning Board¹ (2013) as part of its response to Winterbourne View, which included the objective:

“... ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people.”

7.46 Southern Health describes on its website the purpose of its assessment and treatment units:

“...provide a range of therapeutic interventions for people who have a learning disability, and also have complex and difficult to manage behaviours which can't be assessed or treated safely in community based settings. The length of stay for service users ranges from one month to 18 months; the average being five months.”²

7.47 The CQC inspection report published in November 2013 said:

“We asked the nursing staff what benefit they thought the STATT gave people who were being treated there. One person said that behaviour modification therapy was used. Another told us that medication regimes were started.”

7.48 During our investigation (2014) into the death of Connor, we found that staff had differing interpretations of the purpose of STATT. One senior clinical member of staff described the unit as akin to a “generic psychiatric acute admissions ward”.

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256497/13-15_mandate.pdf

² <http://www.SouthernHealthhealth.nhs.uk/services/learning-disability/assessment-treatment/>

7.49 The Royal College of Psychiatrists¹ 2010 guidance sets out standards for short term assessment and treatment units that cover general standards, timely and purposeful admission, safety, environment and facilities. The College noted that some of the standards were aspirational and it was unlikely a facility would have them all in place. However, it added that the standards were based on key documents and were designed to demonstrate compliance with the Healthcare Commission standards in place at the time.

Finding

F3 We found only a small amount of best practice guidance specific to short term assessment and treatment units. The main exceptions were the guidance issued by the Royal College of Psychiatrists in 2010 and that produced in 2013 in relation to commissioning services - which the college part-authored.

Winterbourne View joint improvement programme

7.50 The Department of Health published its final report into Winterbourne View Hospital in 2012 - *Transforming Care: A national response to Winterbourne View*². The report set out a programme and timetable of action for commissioners and providers. The report also included this commitment:

“Starting now and by June 2014, we must - and we will - transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with challenging behaviour.”

¹ *Accreditation for inpatient mental health services - learning disabilities (AIMS-LD). Standards for adult inpatient learning disability units - assessment and treatment units (2010) Royal College of Psychiatrists.*

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

7.51 The report outlined a timetable of actions from June 2012 until summer 2016 as part of this process. Actions included:

“By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area...”

And:

“We expect directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.”

7.52 A joint NHS and local government improvement team (Winterbourne View Joint Improvement Programme - WVJIP) was put in place to support and take forward the changes proposed in the report.

7.53 We spoke to Zandrea Stuart, an improvement adviser for the WVJIP. She explained that the team came into post in September 2013. The team is hosted by the Local Government Association, partly funded by NHS England and reports to some degree to the Department of Health. The Winterbourne View board provided governance.

7.54 The role of the team was primarily to support local area partnerships, identify key issues and start exploring these with providers, people who used services and their families. Zandrea Stuart added that the expectations of the role of the team were not initially clear (beyond job descriptions). Equally she was not sure if the team was necessarily clear enough about what systemic elements of transformation needed to take place nationally.

7.55 The WVJIP published a stocktake¹ of progress in October 2013. The report outlined a number of concerns that required local development. These included cross-boundary working relationships, whole-life course planning, use and understanding of the Mental Capacity Act (MCA), community investment and personalisation of care.

¹ <http://www.local.gov.uk/documents/10180/12137/Winterbourne+View+Joint+Improvement+Programme+-+stocktake+of+progress+-+executive+summary/279d340e-dcb1-4880-b352-cf67a45604e3>

7.56 Zandrea Stuart explained that as the work of the WVJIP progressed, it identified a number of fundamental issues at local level in relation to pathways and outcomes for people with learning disabilities. She also added that WVJIP realised that the right services were not necessarily in place locally to ensure that the aims of the programme could be achieved.

7.57 NHS England reported in June 2014 that a key target in the Winterbourne programme of action had not been met. This was:

“... all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014.”

7.58 As a result, NHS England asked Sir Stephen Bubb to review this area and provide recommendations; *Winterbourne View - time for change*¹ was published in November 2014. The report set out 11 recommendations in relation to *“strengthening rights, forcing the pace of commissioning, closure of inpatient institutions, building capacity in the community and holding people to account”*.

7.59 Sir Stephen Bubb told us:

“As I said in my [report] foreword, it’s top down/bottom up, so it’s pressure from both that you need. Pressure from the top in terms of reform of commissioning and closing institutions, and pressure from the bottom in terms of people’s right... Commissioning focus based on [a] charter of rights is quite an important aspect of the issue, but I also take a very strong view that this institutional care is not appropriate and therefore these institutions should be closed, but we did not put a timeline on that because we didn’t think it would be terribly helpful to put another timeline that they failed to deliver.”

¹ <http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf>

7.60 He went on to say he held NHS England responsible for leading the changes in partnership with other agencies and local bodies. We asked him if he thought that there was sufficient ‘angst’ to drive and implement real change. He told us:

“I think there is now, probably in a way that there wasn’t before.”

7.61 Zandrea Stuart said that services needed to be transformed to get people out of assessment and treatment units. She said that in implementing change in learning disability services, guidance and policy were plentiful and levers are available. She said such a programme of change would take a number of years and a clear process.

“I think the levers are right, in the degree of we know what we need to do... what we have not done is said ‘It is going to take five years and this is the way that it is going to happen, bit-by-bit’. I think that is part of the problem with all policies, with all guidance, you are not advising how you implement.”

7.62 The WVJIP completed work at the end of March 2015.

7.63 In January 2015 NHS England responded to Sir Stephen Bubb’s report with *Transforming Care for People with Learning Disabilities*¹. It sets out a work programme with focus on:

- *“Empowering individuals - giving people with learning disabilities and/or autism, and their families, more choice and say in their care.*
- *Right care in the right place - ensuring we deliver the best care now, whilst re-designing services for the future; care should be in the community and closer to home.*
- *Regulation and inspection - tightening regulation and the inspection of providers to drive up the quality of care.*
- *Workforce - developing the skills and capability of the workforce to ensure we provide high quality care.*

¹ <http://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf>

- *Data and information - making sure the right information is available at the right time for the people that need it, and continuing to track and report progress.”*

7.64 Sir Stephen Bubb produced an update of his November 2014 report in July 2015. The title provides an insight into the content of his report: *Winterbourne View - time is running out*. The following quotes from the executive summary outline the challenges ahead:

“The transforming care programme has not yet delivered anything tangible in terms of new community facilities or closures.” (paragraph 6)

“There are two areas where it is clear that not enough progress has been made. The first is a question of leadership. In the first six months that have passed since Time for change, very little has been communicated to key stakeholders about how the transformation will be achieved.” (paragraph 7)

“It is also clear that while we have the promise of a closure programme, little attention has been given to the need for gearing up capacity and response of providers. It will be impossible to deliver a closure programme without ensuring robust community provision.”(Paragraph 8)

Comment

The final Department of Health Winterbourne Review report in 2012 outlined an extensive programme of action due for completion in the summer of 2016. A key target for delivery was not met in 2014 and this in turn generated further review and more actions. A variety of reports produced over the last 10 years offer good practice guidance on learning disability services. Unfortunately, this has not resulted in the transformation of services it might have done.

Learning disability services have a similar history to mental health services rooted in large hospital-type institutions. Most have now been closed. The need for an alternative to hospital for mental health services has resulted in the development of community services brought about by considerable top-down change and development. Learning disability services have not seen the same commitment by the legislators, the

NHS, and local authorities. The voice of people with learning disabilities and their families is still muted.

It is still uncertain whether the introduction of the Care Act and the Children and Families Act - and their relevant mandates - will provide the mechanism that has been missing to implement long-term substantial change in learning disability services.

Finding

F4 We endorse the work of Sir Stephen Bubb (appointed by NHS England to report on learning disability services in the light of the Winterbourne scandal) in seeking to ensure that the commitments made by NHS England to people with learning disabilities and their families and carers are met. NHS England must give the priority required to ensure the targets set out in *Time for change* are delivered and real and substantial change in learning disabilities services takes place.

8. Service users

Introduction

8.1 We interviewed families and service users because their experience is an important measure to assess whether the evidence of professionals and service providers achieves the outcomes they claim. These interviews were not carried out using a social science research methodology and we acknowledge that this is a small self-selecting sample. Despite this the stories shared with us provide valuable insight into the struggles that many service users and families have to cope with. The individual stories were not shared with Southern Health or the County Council to get their response and they are therefore unmediated accounts. Despite this they remain an important context when considering policies, procedures and the effectiveness of organisations supporting services users and families.

Background

8.2 This chapter presents some of the personal insights shared with us by a number of people with learning disabilities who live in and receive services in Oxfordshire.

8.3 Some participants at the May 2015 stakeholder event suggested that we specifically contact families and individuals who had direct experience of STATT from 1 November 2012 to 31 July 2013 and invite them to meet us. We interviewed one family who had a son in STATT in July 2013. We wrote to them through Southern Health. No additional families or individuals came forward, though a number of our interviewees have been in STATT at other times.

8.4 The interviews were either conducted face to face on an individual basis or as part of a broader focus group. The individual interviews were recorded, transcribed and reviewed and grouped by key themes and messages by a minimum of two members of the Verita team. The focus group discussion was captured on flip charts that were transcribed using an easy-read format and were then reviewed for accuracy by members of My Life My Choice (MLMC) a local advocacy group.

8.5 All the individuals had direct experience of using services provided by Southern Health or Ridgeway (including TQ21¹), although only two had direct experiences of the STATT.

8.6 This chapter brings together individual views about health and social care services in Oxfordshire. They are supported by quotes and views expressed by the focus group.

The contributions of individuals

8.7 As was the case with families, identifying people to take part in this investigation would have been difficult without the support of local organisations. Verita contacted MLMC and they agreed to act as a conduit both for contacting individuals and for supporting the interview process. Invitations to take part were sent to individuals who were in contact with MLMC together with related information. Using a third party to distribute the invitations enabled people to ask questions and discuss the investigation before making an initial decision about taking part.

8.8 An associate of Verita and a facilitator of MLMC discussed the interview schedule, questions and timeframes before the interviews. They agreed that the interviews would take place over two consecutive days, day one being a focus group discussion and day two for hourly individual interviews. A synopsis of the individuals who participated in the interviews is included. Eight participants attended the focus group discussion. All names are pseudonyms.

Individual	Accommodation	Services for people with learning disabilities that are or have been used
Mr A	Lives in Oxford in an independent living arrangement Self-advocate	STATT Community learning disability team General practitioner

¹ TQ21 is a social care service provided by Southern Health. This service was not part of our investigation. However, because this is a service to people with learning disabilities provided by Southern Health we did not distinguish the comments we received from people with learning disability, their families and carers from other services.

		Hospitals Learning disability service consultation
Ms B	Lives in Oxford in an independent living arrangement Self-advocate	Community learning disability team Money management General practitioner Hospitals Learning disability service consultation
Mr C	Lives in Oxford Independent living Self-advocate	Money management Community learning disability team Hospitals
Ms D	Supported living Self-advocate	Money management Care management community Learning disability team General practitioner

8.9 The next section captures some of the key issues that emerged from the individual interviews and focus group discussion. They focus on some key areas, the community learning disability service and STATT. There is also a section on how individuals felt about their involvement in the planning and commissioning of learning disability services.

Community learning disabilities team (CLDT)¹

- ‘I’d give them a 9’
- ‘Alarm system is good press button and they come out’
- ‘Got me involved with lots of different activities’
- ‘Helped me to learn how to cook’
- ‘Helped me to find college courses’
- ‘Hard to fill in the referral form and helped me’
- ‘Helped me to get involved with cooking’

¹ Under this series of headings we present two forms of evidence. The bullet point lists are comments that arose as part of our group discussions. As we did not record the focus groups we present these as indirect quotes. The direct quotes are taken from the record made during individual interviews.

- ‘Quick response when you call’
- ‘Quick to arrange meetings if you need them’
- ‘Make meetings accessible’
- ‘They find the information you need quickly’
- ‘Helped me with money management’
- ‘Hospital liaison nurse works well good partnership with members of the MLMC and local hospitals.’

“I’m glad I have [...], she’s my community nurse, yes, I have known her for 15 or 16 years’

[Mr C - CLDT]

“One certain young lady (nurse) there was very good. I couldn’t sleep at times because my sleeping was affected at nights, and she would let me use the staff room computer and play games on the computer, and my nurse looked after me when she was on duty. The other staff didn’t help that much.”

[Mr A - STATT]

“Well, [...] gave me like a CD with the relaxing - the relax - That helped me a lot.”

[Mr C - Psychology, CLDT]

“The only person I have help from is from the OT [occupational therapist]. I did have help from [...]. She helped me out because I wanted to do some cooking. I had no cooking skills or anything like that. I contacted OT, and I asked them for some help, and I met up with [...] and another lady, who has left now, and she came along and did some cooking and gave me some easy read menus.”

[Mr A - CLDT]

“The OT and the nurse like from the learning difficulty team were really good.”

[Ms B - CLDT].

“I get help from [XX], she’s one of the - what do you call them? [Acute Liaison Nurse], she keeps an eye on the patients.”

[Ms D - CLDT]

“The nurse and the OT were very good, they teached [sic] me to cope.”

[Ms C - CLDT]

“He pays all the bills for me, because I’m not very good at paying bills. He don’t come to see me. Every time, when we’ve got letters and it’s to me, I send them off to [...] so he can have a look at them to see if I’m in the red, or what.”

[Ms C - Money Management]

Things that could be better

- ‘Assessment process can take a long time’
- ‘Long waiting list’
- ‘Alarm system takes a long time’

“When I was in STATT there, I know a couple of the lads who were in STATT before CS was there, and they didn’t like it they said, ‘Some staff don’t help me, we’re bored here’.”

[Mr A - STATT]

“Because they think I am not capable of looking after money and they want me to go to Money Management, but I don’t want to go to Money Management. They are going through and not consulting me or anything, they did it all behind my back.”

[Mr C - Money Management]

“Some help and some not.”

[Ms C - CLDT]

“The first care manager I had was not very nice, but the one I have now is better.”

[Ms C - CLDT]

“I don’t want to go on supported living, I would like to buy my own care in, I would like to be able to afford it.”

[Ms C - CLDT]

Comment

Community learning disability teams in Oxfordshire are made up of a range of health and social care professionals such as therapists, psychologists, nurses, psychiatrists and social workers and administrative positions. CLDTs have employed other people such as the acute liaison nurse to tackle some of the difficulties that some people with a learning disability have when accessing mainstream health services¹².

On the whole, people with learning disabilities shared positive experiences about the community learning disability team. In particular, the acute liaison nurse in Oxfordshire was valued for the support she provided to individuals who had been admitted to general hospital.

However, there were some areas where improvements could be made by service providers. In particular, people wanted shorter waiting times for assessments, to be involved in important decisions, have greater independence in money management and for members of the CTLD to attend their review meeting more often.

GPs and hospitals - What is working well?

- 'Very understanding of learning disabilities'
- 'New doctors are inducted into who I am'
- 'He explains to me what is wrong'
- 'Gave me good information'
- 'Finds different ways to help'
- 'They made the prescription bigger so I could read it'
- 'Was careful with me after an accident'
- 'Explained everything'
- 'Hospital passport's more understood by doctors and nurses'

¹ Mencap (2007) *Death by Indifference*, London, Mencap.

² Michael (2008) *Healthcare for All: Report of the independent inquiry into access to healthcare for people with learning disabilities*. London.

GPs and hospitals - Things that could be better

- ‘Hospital transport not arriving as agreed’
- ‘Lots of jargon, no easy read and people talking over me’ (example given as the 111 service¹)
- ‘Told to use the walk in clinic - but can’t as the service is closed’
- ‘No communication about what was happening’ (ambulance service)
- ‘Difficult to complain as not in easy read’
- ‘If you don’t know who to call it’s hard’
- ‘Lots of information on the internet but not everyone can use it.’

“They don’t understand me sometimes, they don’t listen properly. When I said ‘you need to check me properly’ she got moody.”

[Ms C - GP]

“I feel like the bloke who I saw yesterday was rushing I think he was rushing to get us in and out and see somebody else before his dinner.”

[Mr C - hospital doctor]

Comment

The people we spoke to had variable experiences of mainstream health services in Oxfordshire. The areas they said could be better were in line with national experience about the inequalities people with learning disabilities face when using mainstream health services. The inequalities and poor care that people with learning disabilities experience when they use mainstream health services have been the subject of many reports.²³⁴

¹ 111 is the NHS non-emergency number

² Disability Rights Commission (2006) *Equal Treatment Closing the Gap*. Leeds, DRC.

³ Emerson & Baines (2010) *Health inequalities and people with learning disabilities in the UK: 2010*. Learning Disability Observatory, London.

⁴ Mencap (2007). *Death by Indifference. Following up the Treat me right report*. London, Mencap.

8.10 Good practice guidance and resources are readily available. For example, the guidance produced by a range of learning disability agencies to support clinical commissioning groups¹. The areas this guidance highlights are supported by a range of studies and reports that also identified similar failings across mainstream health services:

- poor communication;
- delays in diagnosis and treatment;
- failure to recognise pain;
- failure to fully implement the Mental Capacity Act (MCA) 2005;
- poor handling of complaints;
- capacity and consent and making sure the law is followed; and
- advocacy supporting people to make choices and speak up when they are not happy.

8.11 Learning disability agencies acknowledged that some improvements had been made, but also that people must receive a good health experience at all times.

Having a say about local services now and in the future

- ‘I work with the learning disability team nurses on the Big Plan² - meet up at the social care building as part of a group’
- ‘Big Plan - we are experts by experience on a panel with others. Had seven meetings and they asked for our ideas, asked for our feedback. We will also be part of a wider consultation after the draft was written’
- ‘I visited people with Bill Love from the National Development Team to ask people on STATT and Stepdown what services were like’
- ‘MLMC helped with the consultation - supporting service users to give their feedback on Southern Health Plans’
- ‘I was on a panel to help people decide what services we needed to buy’

¹ Public Health England (2012) *Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Guide for Clinical Commissioning Groups*. Improving Health and Lives website.

² This is a new plan for learning disabilities services prepared by Oxfordshire County Council

“I have been involved with the Big Plan. It went really well. We got across to the offices of the County Council. We had a meeting with them.”

[Mr A - Big Plan]

“Yes, because we had more to say. It was about ten of us in there, and we couldn’t all have our say, but in a great big room - yes. You can’t hear what you are saying.”

[Mr C - consultation meeting]

“Yes they listened to me at the Big Plan meeting.”

[Ms B - Big Plan]

“The woman who was taking the minutes, she tried to write it all down and she said she would take it all back to the Big Plan people, and to see what they think.”

[Mr C - Big Plan]

Having a say in local services - what could be improved

- ‘Some of what we said was listened to, some wasn’t’
- ‘It was a big document and hard to get involved’
- ‘Some decisions were already made’
- ‘Transition (Ridgeway to Southern Health) was hard’
- ‘What was said has not happened (they said services would get better in Oxfordshire)’
- ‘Ridgeway used to put on fetes for us to ‘chew the fat’
- ‘The service (Southern Health) that was chosen was not what we had picked and I felt blamed by other ‘service users’ for the end decision’

“But it was in a great big room - yes. You can’t hear what you are saying.”

[Mr C - Big Plan Meeting]

Comment

Some of the people we interviewed had been involved in local planning and the development of services for people with learning disabilities. Two individuals

mentioned the 'Big Plan', a recent Oxfordshire plan for learning disabilities that the County Council had been consulting on. Some people had also been involved in the bidding process that resulted in Ridgeway becoming part of Southern Health.

Conclusion

8.12 People in England with learning disabilities have experienced major change over the past 15 years. Many of the people we spoke to felt that local services for those with a learning disability had improved. The feedback about the CLDT was generally positive with some staff such as the acute liaison nurse singled out as especially helpful. However, the experiences of services were inconsistent and some people had waited a long time for assessments by the CLDT. This meant that the aspirations of individuals about their independence, choices and rights were not always addressed. We were told by some service users that they received little feedback about admission and assessment services.

8.13 Some of the people we spoke to had been involved in the bidding process that resulted in services moving from the Ridgeway to Southern Health, and more recently had taken part in a consultation exercise about the 'Big Plan'. The people we interviewed were members of My Life My Choice.

Southern Health patient experience survey - learning disability division

Context

8.14 Southern Health told us after our May 2015 stakeholder event that our findings were contrary to their own understanding of the views of services users and families as shown by the results of their patient experience survey over the year to April 2015. They supplied us with the results of their survey.

Patient experience survey results¹

8.15 Southern Health uses a simple three-point scale on its learning disability patient experience surveys - 'Good', 'OK' and 'Bad'. It consists of eight questions concerning a particular aspect of the service, and a final question to rate their overall experience - *"How would you score the health care you were given?"*

8.16 For the learning disability service as a whole, 432 responses were received. The overall experience question was answered positively - 82.9 per cent of respondents rated Southern Health as 'Good' and a further 15.2 per cent as 'OK'. No respondents rated the service as 'Bad'. The picture was similar in Oxfordshire, with Oxfordshire Community learning disability scoring 86.6 per cent 'Good' and a further 11.7 per cent as 'OK', again with no negative responses (out of 119 respondents).

8.17 Some dissatisfaction was evident - most notably in response to the statement *"Staff were friendly and I could ask questions"*. 2.3 per cent of respondents rated this as 'Bad', and 5.5 per cent of respondents rated as 'Bad' the statement *"I know how to contact the Learning Disability Team"*.

Oxfordshire Family Support Network (OXFSN) research study

8.18 OXFSN carried out a research study *A local experience of national concern* whose aim was to identify:

- 1. "Potential gaps to assist in developing an action plan to shape the training and support OXFSN delivers as an organisation"*
- 2. The information, advice and support that would help to make both access to services and treatment easier to understand and use*
- 3. External factors that affected the experiences of the families e.g. transition from children's services to adult services."*

¹ Further details of the survey can be found at:
<http://www.southernhealth.nhs.uk/workday/patient-experience-survey/>

8.19 Details of the research methodology and details of the findings can be found in the report. The report was completed in May 2014. It was sent to Oxfordshire CCG on 16 May 2014.

8.20 The OXFSN report agrees with many of the issues that we cover in our chapter on families and service users. It provides many more examples of the quality of provision and services that families experienced than we could include in this report.

8.21 In addition to the production of the report, OXFSN produced and presented an impact statement to NHS England on 4 July 2014, the first anniversary of Connor's death. The impact statement is available from OXFSN¹. We set out here some of the headings covered in this statement:

- loss of trust;
- fears about location;
- staff quality and training;
- poor communication increases anxiety;
- worries about key information not getting to the right people;
- concerns about record keeping;
- concerns regarding the level of therapeutic activities;
- lack of available options;
- concerns about other deaths attributed to natural causes or unexplained deaths;
- concerns about a knee-jerk reaction;
- concerns over physical restraint; and
- safe practice for people with epilepsy and other health needs.

Comment

It is understandable that Southern Health should wish to highlight that the outcome of its patient experience survey suggests that most learning disability service users were happy with the service. An essentially positive response in such a survey does not invalidate the views or experiences of the people who came forward to speak to us or those who took part in the OXFSN study.

¹ Oxfordshire Family Support Network, Level 2, The Charter, Abingdon, OX14 3LZ.
Info@OxFSN.org.uk

In social science research it is not possible to compare information supplied by face-to-face interview with information gathered through a patient experience questionnaire. Each is valid in its own way. The experiences conveyed to us and to OXFSN by families are a valid expression of their experience. They took the time to come and meet us and to meet OXFSN to share their experiences.

We are aware of the 'sample bias' that the context of our investigation introduces, but we believe that Southern Health would do well to reflect on the views expressed above and continue to give them due weight.

9. Family stories

Introduction

9.1 The experience of service users and their families must be central to any evaluation of services. We have sought to include that experience as much as possible. In this chapter we describe some of the family stories we were told and in the following chapter we summarise comments we heard from service users themselves.

9.2 Many changes have taken place over the past 20 years in the provision of health and social care services for people with learning disabilities. The changes have resulted mainly from policy and societal changes. The strategies in *Valuing People* and *Valuing People Now*¹² were key drivers at the beginning of the 21st Century. These reports took a human rights perspective and outlined four basic principles of independence, choice, inclusion and rights for individuals with learning disabilities. The strategies were set in the context of person-centred care and have influenced service provision. These documents are no longer in force but continue to influence local service delivery through structures such as learning disability partnership boards.

9.3 Other more recent key national reports that have influenced the current commissioning and delivery of services for people with learning disabilities are: *Transforming care* programme as a result of the abuse at Winterbourne View³, and the *Confidential inquiry into the premature deaths of people with learning disabilities*⁴. We set out in appendix E a number of other documents and articles relevant to this and the next chapter.

9.4 Families who support a child, young person or an adult with learning disabilities have a lived experience that can help and inform professionals and services, providing them with a different and often unique perspective. Their knowledge and skills in parenting and in some instances as siblings are often a 24-hour experience of commitment, challenge, care and love.

1 Department of Health (2001) *Valuing People: A strategy for people with learning disabilities in the 21st Century*. HMSO, London.

2 Department of Health (2009) *Valuing People Now*. HMSO, London.

3 Department of Health (2012) *Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report*, London, DHSS.

4 Confidential Inquiry Team (2013) *The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)* Bristol, Norah Fry Research Centre.

“As a parent you never stop worrying about your children. No matter how old they are and what they’re up to or how successful they are or whatever else, you still think about them. But in the case of a child with a learning disability it’s a permanent concern.”

[Father of daughter with LD - TQ21]

Background

9.5 This chapter presents some of the personal stories a group of families from Oxfordshire shared with us. Each of these families is unique but they have in common that they all have a family member who has a learning disability or autism. As a result, they all have valuable insight into learning disability services that are commissioned and delivered in Oxfordshire.

9.6 The quotes we have included in this report are short extracts from interviews of at least an hour in length. We did not share the transcripts of the interviews with Southern Health or the County Council. Both organisations have responded to us when reviewing our draft report with explanations and commentary on the extracts. We have not included their comments as to do so would leave any differences between families and them unresolved. The extracts are here as illustrative of the views and experiences as expressed by these families. It is for the organisations to consider the general issues raised and with their staff review their own contacts with families.

Comment

Capturing the experiences of families of people with learning disabilities has never been easy since lives are not readily compartmentalised, neither should they be. However, by listening to the narratives of local families we gained insight into their day-to-day experiences of learning disability service provision.

9.7 Most of the interviews with these families were held face to face in Oxfordshire. Two were carried out over the phone. All were recorded, transcribed and were reviewed in terms of key themes and messages by a minimum of two members of the Verita team.

9.8 This chapter should not be regarded as empirical research but this does not lessen the impact of common themes that emerged from our conversations with these families. This chapter has valuable messages for commissioners and health and social care service providers in Oxfordshire. These are supported by quotes and vignettes.

Family contributions

9.9 Finding families to take part in this investigation would have been difficult without the support of local organisations. Therefore, Verita contacted the Oxfordshire Family Support Network (OXFSN) and the local community learning disability teams (CLDT) to ask for help. The OXFSN agreed to act as a conduit for contacting a number of families. The CLDT provided a list of families they were in contact with and we contacted them directly. We received two positive responses via this route. Using a third party organisation to distribute the invitations enabled families to ask questions and discuss the work before making an initial decision about taking part in it.

9.10 Verita then contacted the families who expressed an interest in taking part and arranged interview dates. Families were interviewed over three days about their experiences of Oxfordshire learning disability services. All names used here are pseudonyms in order to respect the confidentiality of these families.

Parent/next of kin	Family member with learning disabilities	Learning disability services
Mrs A	Andrew, 25, profound and multiple disabilities	24-hour supported living (Southern Health - TQ21)
Mrs B	Ben, 20's, learning disabilities	Community team (North)
Mr and Mrs C	Carol, 43, moderate learning disabilities	24-hour supported living (Southern Health - TQ 21)

Mrs D	David, 45, moderate learning disabilities and some mental health problems	John Sharich House (2004) STATT (2010) Oxfordshire learning disability community team
Mrs E	Evan, 19, still in education, provisional diagnosis of bipolar disorder with mainly symptoms of mania	Admission services (out of county) Community specialist learning disability team Oxfordshire (CPA process)
Mr F	Freya, 30, moderate to mild learning disabilities	TQ 21 supported living (Southern Health)
Mrs G	Glen, 56, moderate learning disabilities and mental health problems	2002/2003 - STATT Ridgeway 2012/13 - STATT Southern Health
Mrs H	Harry, 16, moderate learning disabilities and a diagnosis of autism, epilepsy and behaviour that challenges	Learning disability CAMHS services Out of county learning disability services
Mr I	Ivan, 25, mild learning disabilities and mental health problems	STATT July 2013 - Southern Health
Ms J and Mr J	John, severe learning disabilities, epilepsy and autism	Supported living - Southern Health
Mrs K	Kevin, 20, profound learning disabilities and associated physical health problems	Supported living and community team - Southern Health
Mr L	Larry, 50s, severe learning disabilities and Pica ¹	Southern Health supported living

¹ Pica is the consumption of substances with no significant nutritional value

Key themes

Transition

9.11 The difficulties of achieving positive outcomes in transition from child to adult services and to ‘coming of age’ have been acknowledged in many government policies and associated guidance documents. The importance of getting the transition right was acknowledged in *Learning Disability Strategies*.

9.12 Transition from adolescence to young adulthood for people with a learning disability has often been characterised by discontinuity of service provision rather than continuity. This is an unsurprising finding and one confirmed by many research studies¹.

9.13 Transition should be a way to enable and support a young person to move to a new life stage. Planning for transition must be person-centred, with the young person's preferences, goals and aspirations centre stage.

Comment

This investigation focuses on the role of public agencies but it is in the privacy of family households and relationships that continuity of care is experienced and the price of discontinuity is paid. Parents were often not engaged in the process and their views about the life-long needs of their son or daughter were often dismissed and ignored by professionals.

Despite widespread knowledge of the importance of young people and their families having a good transition a number of the families we interviewed described the transition as rushed, uncoordinated and financially driven.

¹ May, 2000, Grove, 2001, Heslop et al 2001, Heslop, 2002, Beresford, 2004, Smart, 2004

9.14 Nationally the transition process is multidisciplinary and multiagency but it is most often led by social services. A care manager is appointed to work with the individual and their family. Some stories of transition in Oxfordshire follow:

“When he was 21 we got a letter from Social Services saying his place was too expensive, we’re going to take him out, and they actually sent us a letter saying they were going to remove him by force and take him to a place of safety where we would not have access to him, unless we found him somewhere else. We had two weeks to find him somewhere.”

[Mrs A]

“They put huge pressure on to move my son, because the house he was living in, the funding was cut by the local authority he was living out of the county. I had no more than two months to arrange a change of placement for him; she wasn’t prepared to give us more time to allow him to transition more gradually.”

[Mrs B]

“My son was sectioned as an ‘out of county’ because there are no placements in Oxford - probably a year before he transferred to adult services I asked for a meeting to make sure everything was put in place for the transition, and of course, it never happened.”

[Mrs E]

“There were many agencies involved with supporting him out of school. I think it was about five different agencies, all excellent and willing but there wasn’t a cohesive plan pulled together soon enough, we asked for help and he was taken and sectioned (out of county).”

[Mrs H]

“The whole thing in all of this is the complete nightmare, which maybe isn’t this remit, of the flexibility of budgets, trying to manage than. But there’s nobody that I can really think ‘you really get this’ that’s in Southern Health.”

[Mrs K]

“I have always raised this; families should be informed at 17 about everything that’s around. What I discover each day is that parents don’t know about their benefits, or any of those things.”

[Mrs E]

“The transition review has fallen a bit by the wayside, but I have been going to Oxfordshire Family Support Network for the transition reviews every year.”

[Mrs H]

“There was a lack of help initially, although it must have been happening, but the feeling of helplessness. Actually, the lack of let’s get something done. It’s just allowed to worsen, which, to be honest, doesn’t help the individual, themselves. We finish up involving more and more people, but not having any outcomes, so we are wasting resources.”

[Mr I]

Comment

Transition from children’s to adult services is already a period of great uncertainty for individuals and their families and the uncertainty experienced and expressed in these stories have added to the families’ burden.

These family experiences share a number of themes: poor coordination, lack of or little information-sharing, lack of involvement, budgetary decisions that appear to influence service options and a sense of poor leadership during a significant transition in the life of their daughter or son.

Transition need not be problematic because most individuals who need to transition from school to adult care are known. They are normally in local schools and even if out of county have a professional assigned to them. Plans developed with the individual and their family can be put in place over a number of years.

Transition policy and protocol

9.15 The families shared with us their experiences of trying to understand what should happen during the transition pathway. Some had asked Southern Health if they could receive a copy of its transition policy/protocol to increase their awareness.

“I still have not received a transition protocol; eventually he did send me this basic, very basic, little guideline thing that you could have written in ten minutes. I was really alarmed - Oxfordshire didn’t transition him over properly but you can see why as Southern Health has no transition policy for coming in.”

[Mrs E].

Making a complaint

9.16 The complaints shared with us during the interviews related on the whole to Southern Health. They suggested to us that when things went wrong and a complaint was made, it was not always responded to with empathy or transparency. Some families described responses from Southern Health that had a dismissive tone.

“I eventually got a response from Southern Health, I never got an apology.”

[Mrs A]

“I wrote my first complaint letter to Southern. It was addressed to Ms K Percy CEO of Southern Health. It outlined areas where care and support to us as a family had fallen far short of acceptable.”

[Mrs A]

9.17 Katrina Percy, chief executive of Southern Health, responded in a four-page letter the family received some eight weeks later: Mrs A said:

“She told us that our issues had been investigated on her behalf. [...] had interviewed all the staff I had specifically mentioned in my letter, and found them to be without foundation - what it does basically, it’s a nah nah nah nah letter - the first thing you said, no, blah, blah second thing no, you’re wrong, third thing no

your wrong. It is just like that, you don't want to hear it - I can send it to you, but it's just right back at you, you're wrong."

Concerns

9.18 Some of the experiences that the families shared were not described as formal complaints but were concerns about how services were being managed after Southern Health acquired learning disability health services in Oxfordshire. The concerns raised relate to both the County Council and Southern Health.

9.19 Families shared with us a number of changes to services that had been introduced after the acquisition. These changes were not always discussed with the family and the outcomes had an impact on the individual in receipt of services and their family.

"At the point at which Southern Health took over there was a team of people working there. I would say five out of the ten staff originally there when Southern took over have gone, including the supervisor and four of the key staff. That's a 50 per cent change."

[Mr and Mrs C]

"If somebody doesn't turn up tonight, they'll bring in what they call bank worker to provide support. I put it simply like this, if you went home tonight and somebody knocked on your door and said I'm coming to sleep over in your house tonight, how would you feel? I would feel horrified."

[Mr and Mrs C]

"Reviews take place but no social services care manager attends, not for the last three years. Social services are stretched."

[Mr and Mrs C]

"They would all sit around and watch Jeremy Kyle. Yes, that was on the television while you know there is nobody sitting in there. Oh, God that seems to be the favourite of people who are looking after people like my son."

[Mrs G, STATT]

“That’s how it’s been and I can understand that boy getting out of his room, going into a bath and nobody knowing. Unless there was some real big crisis going on, [...] used to spend his life in his bedroom on his own.” [for accuracy staff were aware that Connor was in the bath]

[Mrs G, STATT]

“Once they give the money to us they are actually shot of us, they don’t want to deal with us and they don’t want to know our problems. She [care manager] really is there to help if there is something untoward, we don’t know; we really don’t know her role either.”

[Father E]

Comment

These complaints and concerns suggest that families seldom make formal complaints about services, and when they do, the complaints are serious. All concerns or formal complaints families make require a rapid response that is empathetic and clear; this was not generally the experience of these families.

In response to our draft report the trust told us that the statutory regulations governing complaints:

“...do not require a rapid ‘response’. They require the NHS provider to acknowledge receipt of the complaint within three working days and to set down in writing the ‘response time’ for investigating and responding to the complaint. They set a longstop date of six months. The trust endeavours to respond to complaints as quickly as possible.”

The trust then states:

“It is inappropriate for Verita’s comments to impose an obligation/duty that is more stringent than is required by the statutory regulations governing this process.”

We fully recognise that there are regulations governing responding to complaints and our comments were not designed to impose a new duty or obligation on the trust. However, it often takes a lot of courage for families with disabilities to complain and whatever the formal regulations say they are expecting and hoping for a prompt response.

Family support

9.20 Families we interviewed described individual staff that had been kind and they named support staff, nurses, doctors and administrators who had made a positive difference.

9.21 Despite these individual acts of kindness, families told us of a lack of consistent proactive support offered or provided by the range of learning disability services, community teams, TQ21, admission and assessment services. When the family experienced additional stress, they often gathered strength and support through their connections with other families or through the family network, rather than through professional or service organisations.

“I have support from my friends who have learning disabled children.”

[Mrs G]

“I am very fortunate I’ve got a very strong family network and friends, so I don’t need people seeing me.”

[Mrs E]

“I think we have been supportive of each other. I don’t know how we would have got on without each other’s support. We haven’t really had any support as a couple.”

[Mrs H]

“Walking the journey with me, I suspect it’s supposed to be the care manager.”

[Mrs K]

Comment

Medical, nursing and social care regulators emphasise the importance of professional workers maintaining empathetic and trusting relationships with families. They also emphasise the value of active and reflective listening skills in understanding a family and individual needs. Access to a named individual is vital. However, many of the families we met could not name their key worker or care manager.

Involvement and engagement of families

9.22 A positive experience for the individual and families is often achieved by building a partnership through early involvement in service planning, delivery and evaluation as well as the provision of timely and seamless advice and support, especially during periods of transition. Involving people with learning disabilities, their families and advocates in service planning, enables the provision of individualised services.

9.23 Successful services provide individualised pathways of care based on a thorough understanding of the individual and their experience. Care should be person-centred and consist of a coordinated assessment of need, agreement of expected outcomes, provision of care and treatment, followed by a joint review of achieved outcomes with the people receiving services and their carers¹².

9.24 These are some stories families shared with us about their involvement in the care of their son, daughter or sibling:

“There was a certain amount of controversy about that because I used to go to the meetings. I discovered you can go to the meetings, I think it was weekly on STATT, so I turned up at every meeting. I don’t think I was a welcome guest.”

[Mrs G, STATT]

“I thought that he would immediately receive direct support there, and obviously, he would be safe, not only for himself but I was worried about him shouting at people in the streets, which is not right. However, their initial reaction was

¹ Two of the 10 recommendations of Commissioning Guidance 2013

² <http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf>

actually, we let people settle down, which surprised me. I wouldn't want to leave an impression that we didn't come across kind and caring people, because we did, but they seemed to just want him to settle in as if you are settling into a hotel when you are on holiday. He was not in the mental state to do that."

[Mr I, STATT]

"How did they communicate changes with us? We didn't get any communication from Southern Health."

[Mrs D]

"I have stated from the very beginning any meetings about [...], any discussions, we need to be informed if possible and it is right to be invited even if we are there for part of the meeting and then go when others are discussed, none of that has ever happened."

[Mr and Ms J, TQ 21]

"There is the fear of things happening like with Connor again, it has prevented guys from having a life, it has put on such restrictions and they are too scared to do anything. If it is not tried and tested a dozen times they don't want to do it, because if anything goes wrong they are not supported, and the staff are scared."

[Mr and Ms J]

"Partners, no, not in that sort of formal way, although we made a point, Whenever we visited STATT they would give us an update of what was happening, what they were trying to do with him, how they were trying to interact with him etc. The staff and various representative from various bodies would get together weekly, and they said that we could attend those if we wanted, but there were more internal things."

[Mr I]

"They didn't involve families in developing the Big Plan, it's out for consultation at the moment, I read in the Big Plan¹ or the letter that came with it that the Big Plan would start in coincidence with the renewal of Southern Health contract bid"

[Mr and Mrs C]

¹ Oxfordshire's Learning Disability Strategy 2015-2018 (draft)

“Since Southern Health took over things gradually went down, down and we were stopped there were four of us that used to attend trust meetings (Ridgeway), we were just ignored and we weren’t invited to any more board meetings, we just weren’t invited to anything.”

[Mrs G]

“We went to this terrifying meeting with Mr J Jackson, [from the County Council] we are anxious about the Big Plan.”

[Mrs C]

“Sometimes we didn’t see him because he would be asleep, and sometimes he wasn’t in a fit state to be seen so I don’t know what was happening during the day. However, he was refusing food; he didn’t eat anything for about three and a half weeks.”

[Mr I, STATT]

“The one thing I will say about Southern Health is they didn’t improve it (STATT). I can say that they didn’t improve things compared to Ridgeway, eight years before.”

[Mrs G, STATT]

9.25 These are examples of positive comments from the families:

“They were very supportive in terms of the social worker and learning disability CAMHS [Oxfordshire], the lady from continuing care was also very supportive, but they do not have the facility.”

[Mrs H]

“There were some excellent people in Ridgeway. I don’t really know Southern Health very well, but some of the people we’ve worked with over the time, have their heart in absolutely the right place.”

[Mr C]

“My GP has always been very good.”

[Mrs H]

“Some of the people in STATT were brilliant, there are a few people there that were really kind to [...] and they did an awful lot for him”.

[Mr I]

“I am invited across to the LA review every three months, and that’s good. Everybody is there that has an interest in how he’s doing, and we become genuinely involved and asked for our views and opinions”.

[Mr I]

Comment

The families we spoke to gave some examples of good practice but these were often outweighed by the difficult experiences they had endured. Based on what they told us, these families had low expectations so they appreciated even small gestures of openness, engagement and support by staff.

Getting the right services

9.26 Most of the families thought they were consulted on large-scale change but not actively engaged or involved in decisions about a member of their family or local service change.

“We probably ended up having a meeting with them about the quality of care, and our concerns, about every six weeks, and email after email - we really fought, because we thought, they just need to understand what they’re doing wrong, and do it right, it just never occurred to us at that point that they didn’t actually care.”

[Mrs A]

9.27 Another mother explained how she would contact the learning disability services asking for help and stay on the line until they found someone for her to talk to. This mother was desperate to speak to someone and found that this was the only way to get a response. The result was being kept waiting on the phone for 20 minutes or longer.

“Do you still want to hold? Absolutely! Just find someone for me to speak to, please’. That’s one of the techniques that have been discussed between Mums, and I keep passing that on now, just block the line, and just stay on there until you get someone to speak to!”

[Mrs K]

9.28 The lack of high-quality and timely support from services was a theme that emerged from the interviews.

“Support? They don’t, you grit your teeth and you get on with it, don’t you. I have some very good friends that I turn up and just break down, many a time.”

[Mrs K]

“They say, this is another problem mother, we’re doing our best you’re just causing problems, and you’re one of the worst ones we’ve ever come across. I’m knackered now, I’m knackered and I can’t do it.”

[Mrs K]

“We spent from August 2012 to May 2014 totally ignorant of how our son died.”

[Mrs A]

“They view me as a pain in the arse; they absolutely hate me. The last manager would literally run out of the door if he heard ‘Hi [...]’.”

[Ms J]

“It’s not because they were bad people but because somehow along the way they weren’t taught to care about their people.”

[Mrs G]

Comment

Rather than parents and families feeling listened to and supported by services, the families we spoke to said they felt as if they were treated like the enemy. They found themselves battling to get help from managers whose job was to provide a public service.

These families felt that the learning disability services in Oxfordshire had been better in the past but that services had deteriorated over the past two to three years.

Vignette: Mrs K

Mrs K - Experience of community learning disability team and TQ21. This is a social care service commissioned by the County Council and delivered by Southern Health. The assessment of need for each family is determined by the County Council.

What would be your story of learning disability services in Oxfordshire?

"It's a very poor one but I think that's across the board from transitioning to not having doctors, or anybody to rely on, to being told that there are things out there, you go and investigate it. In Southern Health I talked through with them the care package that I wanted at home and from the start they could not fulfil what they said they were going to fulfil. Then I think, over the last couple of years, with all the difficulties that they've been having, my personal opinion was the managers didn't care anyway, because it was just another problem, they weren't that bothered about sorting the problems out, because there were so many..."

Conclusions

9.29 We were privileged to meet and interview 12 families who were using or had used Oxfordshire learning disability services. Some key messages emerged from the interviews. The main one was that family input or involvement was not valued. Service engagement with families both in transition, assessment, and care planning meetings about their son or daughter was minimal. These families were all keen to help services improve and they had useful knowledge and experience to offer.

9.30 The struggles of some of these families was evident throughout the interviews. Their stories were often painful for them to recount but they were keen to contribute to this independent investigation because they wanted services to improve.

9.31 The narratives of this group of families provide serious lessons that need to be heard by service providers. Listening to families, as we have learnt from Winterbourne View and Mid Staffordshire NHS Foundation Trust inquiries, is vital.

9.32 The significant message that emerged from our interviews was that families felt that engagement and partnership working with them was not always at the heart of Oxfordshire learning disability services (health and social care). There were some examples of good practice but the prevailing opinion of the families was that services were constrained by poor information, inadequate budgets, poor leadership and coordination and at times an unwillingness to listen or involve families.

9.33 The important lesson from our interviews is that some people do not feel that learning disability services are providing the level of quality that they should. It is the responsibility of all parts of the service to listen to these stories and learn from them.

Recommendation

R1 Commissioners should continue to ensure that service user views are (and are seen to be) taken into account in commissioning decisions.

10. The Ridgeway Trust era

10.1 Ridgeway were given a five-year contract to provide learning disability services in January 2011. Oxfordshire County Council and Oxfordshire Primary Care Trust (PCT) established a pooled budget for learning disability services as early as 2006. This arrangement continued and now the County Council takes the lead on commissioning for most learning disability services in Oxfordshire on behalf of itself and the clinical commissioning group (CCG). This includes commissioning NHS specialist learning disability services. This places on the County Council the responsibility to ensure that the services commissioned fulfil their contractual obligations and are safe and appropriate. The County Council are also responsible for evaluating the quality of the services. The PCT (and now the CCG) was responsible for assuring quality in NHS services and reviewing serious incidents for all health services across Oxfordshire, giving them some additional direct insight into the learning disability services provided.

Background - Winterbourne View

10.2 Many people told us that the BBC Panorama documentary on Winterbourne View in May 2011 changed the landscape of learning disability services. The consensus until then was that learning disability services were not given the attention they deserved, either nationally or locally. The broadcast triggered a scramble for commissioners to assure themselves that the sorts of abuses identified in the documentary were not occurring with their providers. A senior manager in the CCG told us:

“I do think Winterbourne was a watershed moment because suddenly, I guess everyone was alert to having come from this position where we thought [learning disability was fine]... we’ve been through this whole process of moving back into the community and it’s the hospitals that don’t look after people with learning disability. The learning disability services are good and suddenly I think- there was also a lot of discussion following Winterbourne about out-of-area treatments and there was all this focus of ‘oh it’s out-of-area, that’s dangerous’.”

10.3 We were told by various interviewees that Winterbourne View was not seen as being remote from Oxfordshire. The County Council had three people at Winterbourne View, which the council used when Slade House was full.

Comment

The Winterbourne View scandal had an impact across the country, but it was felt particularly strongly in Oxfordshire, where some service users were directly affected. This issue was on the minds of many involved in providing services in Oxfordshire. It has led to services being evaluated, with Winterbourne View used as a comparator.

Background - non-Oxfordshire services

10.4 Ridgeway ran services in a number of locations in addition to those in Oxfordshire. At this time (2012) there were specific concerns about Postern House in Wiltshire and services in High Wycombe and Amersham in Buckinghamshire, known as “*the non-Oxfordshire units*”.

10.5 At Postern House in August 2012 a CQC inspection found “*...inconsistencies in people’s personal records which could potentially increase the risks of inappropriate care or treatment*” leading them to conclude that the service was not compliant with the outcome relating to records, although they said this had only a minor impact on people who use the service). Also in 2012, the County Council decided not to admit any patients to Postern House, where an incident had taken place and a serious incident (SIRI) report had not been disclosed.

10.6 Concerns had also arisen at the units in Amersham and High Wycombe. Some related to the frequency and rationale for the use of restraint. A quality-assurance review of services in the Amersham unit (the Chilterns) was carried out by the Buckinghamshire commissioners. It reported in September 2011, raising questions about quality and governance. A contract default notice was issued in respect of poor SIRI reporting.

10.7 In a letter to Dr Sara Ryan (Connor’s mother) (4 April 2014), Ian Wilson, then chief executive of the CCG, said:

“From May 2011 to May 2013 there were 10 SIRIs reported by the Ridgeway Partnership/Southern Health about former Ridgeway Partnership inpatient learning disability services (excluding forensic services). Of these, three concerned

allegations of physical abuse/harm and/or inappropriate restraint and related to the Chilterns/Ridgeway Unit in Buckinghamshire and three concerned allegations of physical abuse/harm and/or inappropriate restraint in Postern House in Wiltshire. Of the four which occurred in Oxfordshire (STATT and John Sharich House) three concerned a patient absconding and one an allegation of verbal abuse and physical abuse/harm. Only one of these occurred in STATT and it was a patient absconding.”

10.8 The primary care trust (PCT) had the role of overseeing the reporting of serious incidents. It was concerned both by the incidents themselves but also by how they had been investigated. It was also concerned that the failure to react appropriately to incidents meant that the service provider would not necessarily learn from them and potentially suggested bigger problems within the provider. For example, Jan Fowler, the clinical lead in the PCT at the time, told us:

“... when we reviewed SIRI processes my recollection is that a significant number of the SIRIs and the ones that caused us concern had taken place at those two places [Postern House and High Wycombe]... The Oxford ones, John Sharich and STATT, there were SIRIs but they didn't create the same level of anxiety as the ones elsewhere.”

10.9 Another person who had worked at the PCT commented about Ridgeway services:

“...to start off with, we thought it was all fine and were unaware. We became aware of it through Winterbourne, we then became aware of incidents in what we used to call the non-Oxford units, so in Postern House in Wiltshire and ... the Ridgeway Unit in High Wycombe. We became aware of these incidents and, at the time, we thought ‘oh, it's the units that are outside Oxfordshire’, and there was a kind of received view that Oxford was the centre and it was a bit special, which obviously thinks about a lot of things. It was the units that were distant from that that were problematic and that was certainly backed up by the incidents that we were getting called in.”

Comment

The trust's headquarters were at Slade House in Oxford during the Ridgeway era, leading to the view that services in Oxfordshire were at "the centre".

10.10 Concerns around serious incidents led the CCG to issue a contract default notice in 2012. A County Council commissioner told us:

"The CCG would certainly feel they had to do an awful lot of hand-holding as far as getting adequate SIRI reports from Ridgeway, and there was a lot of to-ing and fro-ing."

10.11 A current Oxfordshire CCG member told us that when the CCGs took over the role of the primary care trust, the PCT had placed the management of SIRIs by Ridgeway on their risk register. We were told that this risk was well known by the County Council and the CCG but it mostly related to the non-Oxfordshire services.

Comment

One of the impacts of the Winterbourne View scandal was to focus attention on the sort of abuse that had happened there and on restraint in particular. Oxfordshire was concerned about services in Wiltshire and Buckinghamshire, some of which related to restraint. Attention was naturally focused there. By contrast, there were fewer incidents at the services in Oxfordshire so they received less attention.

The Ridgeway services in Oxfordshire

10.12 We asked a variety of stakeholders for their views about Ridgeway at this time. Views on details differed but consensus emerged that services in Oxfordshire were neither particularly good nor particularly bad. This was especially true in comparison with the non-Oxfordshire services, where there had been a number of issues of concern, which we have set out earlier in the report.

10.13 The Oxfordshire services had had a good reputation. Ridgeway was one of only two specialist learning disability services in the country. By 2012, some people felt services had deteriorated, but not to a level that needed particular attention.

10.14 John Jackson, the director of adult social services at Oxfordshire County Council, described the services as “*pretty good, but needed to be better*” and “*good, but not great*”. Ann Nursey, a former commissioner at the County Council, said:

“I think my overall view would be that they were good but not perfect really. I think when we talked to other commissioners in other areas and looked at other services in other areas, I always felt Oxfordshire was quite lucky to have a learning disability trust that was reasonably forward-looking in its approach and did work with commissioners and did listen to the direction of travel that we would be going in. So I had a pretty positive view but also a certain level of frustration that we didn’t move far enough or fast enough with them”

10.15 Others views were more negative. Lara Fromings, a commissioner at the County Council, commented:

“I certainly think there was a level of arrogance about it, it was a specialist learning disability trust, it was one of only two specialist learning disability trusts, it used to be a forerunner in terms of learning disability provision, most of the staff that were around at that time when it was a forerunner were still there, there was, as I say, a level of, ‘we know how best’”.

In regards to STATT:

“I don’t think we had specific concerns.”

10.16 Sula Wiltshire, who had been a senior manager at the PCT, told us:

“I don’t think it was terrible; nobody ever came to me and said this is terrible, we need to do x, y. It was a service that needed to improve... it needed to improve and to modernise... there was a feel that, if you like, Ridgeway were the experts and there was no need to look beyond. That probably was a reputation that they’d gained.... It’s one of those places where it was quite good at some stage, very good

probably at what it was doing, probably quite innovative, and hung on to that without making the changes, as sometimes happens where you get clinical areas that are very good, they then don't move because they think we're very good. In my head I thought they need to be looking outwards a bit more."

10.17 Katrina Percy, chief executive of Southern Health, said:

"... the overarching picture that the board had of the services were that they were pretty old-fashioned, still quite inpatient based compared to what we had done in Hampshire, but safe".

10.18 For Julie Kerry, assistant director of nursing for South Central NHS England, however, the concerns were more significant:

"There were quality and safety concerns across the whole organisation. Bucks and Wiltshire were more vulnerable because they were further away from the centre. There was a preciousness around Oxford; it was put up as a fantastic service and it probably was 25 years ago, but it didn't feel as though it had shifted much."

10.19 Many people we spoke to highlighted the contrast between the services provided by Ridgeway in Oxfordshire and the other areas. Helen Ward, who had been a manager at the PCT, said:

"They had specialist inpatient units in Wiltshire, in Buckinghamshire and in Oxfordshire, and it was the Wiltshire and the Buckinghamshire ones that we were worried about. STATT and JSH, which are the Oxfordshire ones, are generally seen as being better from our view of having SIRIs... we weren't concerned about Oxford; we were concerned about non-Oxfordshire units."

10.20 The commissioners had a policy of focusing on locations where there were problems so they paid less attention to Oxfordshire services. Ann Nursey told us:

"We shared those views that there were concerns, but our view was that it was not as significant in Oxfordshire as elsewhere, so we stopped placing at Postern House and we had concerns about Buckinghamshire, but my own personal view was that Ridgeway originated in Oxfordshire and they still had their eye on the ball in

Oxfordshire and they maybe weren't really capable of managing services in other areas."

10.21 External reviews supported the perception of the Oxfordshire services as good enough but not great. We deal with these in more detail in the next chapter.

Comment

Most people we spoke to did not think the services Ridgeway provided were outstanding; neither did they see them as particularly bad at that time. A perception that the services had once been ground-breaking but were now declining in quality was expressed by a number of interviewees.

In general, concerns about the quality of services related to those outside Oxfordshire, although some people raised quality concerns across Ridgeway's activities.

If the Oxfordshire services were flattered by comparison with the Ridgeway services outside Oxfordshire, they were even more flattered by comparisons with Winterbourne View. Restraint practice had been a problem in other Ridgeway locations but it had not been an issue in Oxfordshire. Judged by the Winterbourne View standard, and in the context of the rest of the Ridgeway services, STATT and John Sharich house were considered adequate and therefore were not singled out for particular attention.

11. Southern Health's acquisition of Ridgeway

Reasons for the acquisition

11.1 Part of our terms of reference covers the acquisition of Ridgeway by Southern Health:

“Although not necessary to review the acquisition process it is important to note the contractual changes that happened in December 2012 and their possible impact on both the provider and commissioners.”

11.2 Southern Health formally acquired Ridgeway Partnership (also known as Oxfordshire Learning Disability NHS Trust) on 1 November 2012. Southern Health itself was the product of a merger in April 2011 of Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care Trust.

11.3 Healthcare organisations undergoing organisational change or merger/acquisition can experience significant difficulties.

11.4 The Commission for Health Improvement Investigations report *Lessons from CHI investigations 2000-2003* (2004)¹ identified merger and acquisitions as a risk factor for service failure. It said:

“A high proportion of investigations involved organisations that have had a major organisation change or merger. In these organisations, structural change was considered to have been unsuccessfully implemented or integrated at the time of the investigation.”

11.5 The Healthcare Commission *Learning from Investigations* (2008) report provided a summary review of its cases. It identified a number of common themes in trusts experiencing difficulties. In particular:

“... our investigations show that, if not carefully managed, the process of organisational change can divert management away from maintaining service

¹ http://image.guardian.co.uk/sys-files/Society/documents/2004/03/25/CHI_investigationlessons.pdf

quality. It is important to recognise that, while mergers and other organisational changes will continue to be necessary in some situations, there is clear evidence that they also bring with them a high degree of risk, if not handled appropriately by senior leaders...

“... We have found that the boards of NHS trusts we have investigated are particularly vulnerable to being consumed by the business of healthcare, in the form of mergers, reconfiguration of services, financial deficits, and targets...”

“... in our investigations, a history of recent and/or difficult mergers or restructures is a common feature.”

11.6 The process of Southern Health’s acquisition of Ridgeway is set out in a NHS Confederation *Service Redesign Case Study*, published in March 2013. The case study notes that *“a principal concern of many carers was whether, with a move to a much larger organisation, the local, personal aspect of care that they had valued would be maintained”*. It says that Southern Health had emphasised that, rather than changing front-line services or cutting jobs, the rationale behind the acquisition was to bring the stability and financial freedom of a foundation trust to Ridgeway. It describes continuity of care as *“the crux of the story”*. The aim was *“how to preserve the ‘spirit of Ridgeway’”*.

11.7 Southern Health’s due diligence¹ process was carried out during 2012, leading up to the formal acquisition on 1 November 2012.

11.8 The legal acquisition by Southern Health of Ridgeway was completed on 1 November 2012. We were told by a number of interviewees that the overwhelming reaction was relief. Commissioners had grown anxious about having services provided by a small NHS organisation in the wake of Winterbourne View, and this anxiety had grown as quality concerns had been raised over the next year. A senior manager in the PCT told us:

“Southern Health come on board and we have great hopes for Southern Health because SHA tell us they are good. Great, good, this is what we need, this is perfect. Jude Diggins was the [associate] director of nursing at that time, at Southern

¹ An investigation or audit of a potential investment. Due diligence serves to confirm all material facts in regard to a sale. (Investopedia) In this case this related to an acquisition not a sale but the same process applied.

Health. Jude was engaging with us really well; these are notes of a quality and safety meeting that were held with Southern Health on 10 June 2013. It's all pretty positive. There was an acknowledgment from Jude that there was work to be done, things had to improve. We talked about physical restraints. She sounded to me like somebody who really wanted to work with us and we could move things along, which was really good... it was somewhere that we would have wanted energy put into and, as I say, we thought Southern Health would provide that energy."

11.9 Another PCT manager pointed out that a second Panorama documentary into care home abuse (a follow-up to the Winterbourne View programme) was broadcast shortly before Southern Health took over Ridgeway:

"Then we have Panorama 2, which is October 2012 and we're all waiting for Southern Health to take over to come in and solve it all."

"A lot of store was put on 'Southern Health is going to sort it all out', and I think there was like two days between Panorama 2 and 1 November. It was very close and we were all hanging on in there until Southern Health take over and then everything is going to be fine."

11.10 The PCT's clinical governance lead said:

"Ridgeway was struggling... Southern Health had a good reputation."

11.11 Julie Kerry of NHS England took a similar view:

"Everybody was relieved and that is crucial, because everyone said 'Thank God for that. Now they will get on with their work and perhaps we won't need to worry about it.'"

Comment

One aspect of the acquisition process of Ridgeway by Southern Health was driven by concerns that Ridgeway was too small to achieve foundation trust status. However, many people saw the acquisition of Ridgeway by a larger provider as the best way of

improving services at the time. In the aftermath of Winterbourne View, a small isolated service different from most comparable services suddenly made many feel vulnerable. Commissioners and staff at the strategic health authority (SHA) were relieved when Southern Health was appointed. They saw it as having solved a difficult problem.

Process of the acquisition and the due diligence evidence

11.12 In this section we consider what Southern Health and their commissioners knew about the quality and safety of services in STATT before the acquisition.

11.13 We start by examining what they knew in 2011/12, before and just after acquisition of the services.

11.14 In this period a number of clinical, governance and safety reviews were carried out. Some were commissioned by Southern Health and some were commissioned externally and carried out independently. They found some areas of concern, mostly around governance and safety of clinical services. These concerns were principally focused on non-Oxfordshire services.

11.15 These are the reviews:

KPMG management consultants	KPMG were commissioned in November 2011 and December 2011 to carry out two limited due diligence reviews. These reviews were principally focused on organisational risk of the acquisition.
Care Quality Commission inspection (CQC)	In December 2011 CQC undertook inspections at the Slade site which comprised of John Sharich House and STATT. This inspection was undertaken as a CQC's themed inspection programme.
Deloitte LLP management consultants	Deloitte LLP carried out a quality governance integration review assessment of Oxfordshire Learning Disability NHS Trust. The assessment was commissioned on 5 April 2012 and the report is dated 30 May 2012.
Ridgeway	On 28 May 2012 an audit was carried out by Ridgeway staff of the electronic records of risk assessments and care plans

	at STATT. This examined the quality of electronic records and staff's compliance.
Contact Consulting	Contact Consulting was commissioned to undertake a quality and safety assurance review for NHS South of England (the Strategic Health Authority (SHA) covering the South of England). It was commissioned by the SHA because concerns had been raised about quality and governance. The report does not state when it was commissioned but the report is dated September 2012.
Southern Health	July to November 2012 John Stagg interim lead nurse (Southern Health) carried out a quality and safety review.
County Council	In November/December 2012 the County Council carried out a quality monitoring review of STATT and John Sharich House.

Finding

F5 The trust undertook appropriate, adequate and reasonable due diligence into the quality and safety of the services prior to acquisition. The due diligence reviews did not identify any acute concerns about the safety of services in STATT. The more acute concerns were focused on the non-Oxfordshire services.

Summary and analysis of the reviews of Ridgeway services carried out in 2011/12

KPMG due diligence reviews

11.16 Southern Health gave us a summary of these reviews. The summary states that the review focused on the risks associated with the potential acquisition of the Ridgeway services. KPMG were asked specifically to consider the following questions.

1. *“The validity of Southern Health’s rationale for the acquisition.*
2. *To review Southern Health’s proposal for the acquisition (to the extent that this had been developed at this stage).*
3. *To consider how robust Southern Health’s plans for integration and transition were.*
4. *The financial headlines of the acquisition.”*

11.17 The summary says that all four areas were green and that the plans for taking forward the actions were in line with best practice.

Comment

These reviews were conducted at an early stage of the acquisition process (before Southern Health was named as the preferred bidder). They provided no intelligence to Southern Health on the clinical quality of any particular unit and would not have been expected to.

CQC themed inspection- December 2011

11.18 On 6 December 2011 CQC undertook an inspection at Slade House, which comprised John Sharich House and STATT. The inspection was part of the CQC themed inspection programme.

11.19 CQC themed inspections¹ are “*targets to look at specific standards, sectors or types of care*”.

11.20 CQC undertook reviews of a number of learning disability services. It carried out 150 unannounced inspections of NHS, social care services and private facilities. Each provider was assessed against two standards.

- Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights².
- Outcome 7: People should be protected from abuse and staff should respect their human rights³.

11.21 The inspection report was published in March 2012 and concluded that Slade House was meeting both essential standards.

¹ <http://www.cqc.org.uk/content/themed-inspections>

² (Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010)

³ (Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010)

Deloitte review

11.22 The Deloitte review was an assessment of risks associated with the acquisition, in particular an assessment of the governance arrangements in place to monitor the quality and safety of the services it delivered. It was a high-level systems review. The reviewers spoke to senior staff and carried out a desktop review but did not visit service areas/units, or engage with staff in those areas.

11.23 Deloitte state in their report executive summary that Ridgeway had a robust governance framework. It found some risks, but none high or extreme.

Comment

The Deloitte report does not identify concerns or make any recommendations that directly relate to clinical services provided at STATT.

Ridgeway clinical electronic records review

11.24 This review took place on 28 May 2012. Southern Health provided us with a summary.

11.25 The review was carried out by two development and research nurses employed by Ridgeway as part of its clinical audit before acquisition. The review included the examination of the electronic (RiO¹) records of patients in STATT. The focus was on risk assessments and care plans.

11.26 The review found inadequate completion of electronic risk assessment entries and said staff needed to be trained on how to move from paper records to putting data into the RiO system. It also recommended developing risk assessments on RiO and other record keeping issues.

¹ RiO is an electronic record system used widely in the NHS for recording patient records.

Comment

The difficulties of moving from paper records to electronic record systems are common across all healthcare, including mental health and learning disability services. The results of this audit were not exceptional. However, the review demonstrates that the learning disability service had problems with the documentation of risk.

Contact Consulting review

11.27 The report by Contact Consulting (September 2012) was commissioned by NHS South of England (the SHA covering the South of England). They were responding to concerns about quality and governance in the former Ridgeway trust.

11.28 Julie Kerry the SHA learning disability lead told us:

“The specific clinical concerns were focussed on Postern [House] however there were well documented organisation quality and safety concerns about all inpatient services...I had open and frank discussions with Amy and Dr O’Shea about the quality, safety, governance and leadership concerns.”

11.29 The Contact Consulting report sets out in its introduction why the review was commissioned:

“...some concerns were highlighted in relation to quality of outcomes and the functioning of governance at OLDT. In particular these relate to matters of safeguarding, patient safety and organisational culture. These concerns have been subject to discussion and review between the SHA and local commissioners since August 2011. At the request of the SHA a Quality Assurance review was undertaken by Buckinghamshire commissioners, to address concerns about a specific unit; The Chilterns, in Amersham. The National Development Centre for Inclusion (NDTi) led this work. They highlighted governance and quality weaknesses and reported in September 2011. Oxfordshire commissioners also raised concerns about quality and governance and this has resulted in a contract default notice in respect of poor Serious Incidents Requiring Investigation (SIRI) reporting.”

11.30 The review was commissioned to assess quality, safety and engagement to enable the SHA to decide whether to support the transition of services to Southern Health. The report authors carried out their work by interviewing a range of senior clinical executives, clinicians and clinical managers.

11.31 The report found some concerns about organisational culture, leadership and external relationships. We highlight the following:

“There appears to have been culture within OLDT that could best be characterised as a combination of defensiveness and complacency in respect of quality, safety and risk.”

“The view of the risk of untoward events occurring within OLDT is equally varied. Some we spoke to we[re] clear about the need to be vigilant and alert, others less so. Most worrying was the statement we heard that ‘I don’t worry about our staff doing unspeakable things to our clients’.”

“The complacency of attitude does not appear to be confined to one individual. Stakeholders we spoke to said this complacency, coupled to the defensiveness of the organisation, highlighted a more deep rooted culture that some characterised as a lack of awareness and transparency.”

“OLDT has had a tendency to be insular and inward looking. This has resulted in it being unable or unwilling to reach out to other organisations to learn from and share best practice. [This aspect fits with the County Council review of STATT]”

“Some we spoke to indicated that there is a disconnect between senior leaders within OLDT and the staff delivering or managing the services in terms of the understanding of quality issues and the assurance that actions needed have been taken and are fully implemented.”

“There is, in some cases, limited understanding among some senior people in OLDT of what their services actually do and this contributes to the findings of RCAs.”

11.32 The report makes 11 recommendations, which we list in appendix G. They cover:

- programme of pro-active assurance visits;
- implementation of a Winterbourne action plan;
- refresher safeguarding training;
- increased number of staff trained to carry out investigations/reviews;
- board development sessions focused in learning disability services; and
- format of information and data regards quality and safety.

11.33 One recommendation relates to the need to understand more fully the quality of the service:

“We recommend a programme of pro-active assurance visits to all services over a prescribed period. These visits should largely be unannounced and seek to provide information and evidence about a range of clinical and managerial practice. SHFT has experience of utilising such a system of visits, alongside its mock CQC visits and would be well placed to introduce such an approach.”

Comment

This review was undertaken by a consultancy with experience of learning disability services. It identified a need for Southern Health to better understand the “clinical and managerial practice” in Ridgeway services. The recommendations from this review were incorporated into the quality and safety review carried out by Southern Health.

Quality and safety review

11.34 Southern Health interim lead nurse John Stagg carried out a quality and safety review of Ridgeway services. The review started in August 2012 and the report was produced in November 2012. This review was part of Southern Health’s due diligence governance work stream. The report took account of the work already done by Deloitte and Contact Consulting and additionally included:

- mock CQC assessments in a number of services;

- client journey/high risk patient reviews; and
- matron walk round.

Mock CQC assessment of STATT

11.35 The mock CQC inspection was carried out on 30 August 2012 by the following staff:

- clinical compliance lead for mental health (psychiatric and general adult nurse);
- clinical governance and audit facilitator (a qualified physiotherapist);
- diagnostic radiographer; and
- clinical ward manager/forensic inpatient lead from Hampshire learning disability services.

11.36 The review covered the following CQC outcomes.

- Outcome 4: Care and welfare
- Outcome 5: Meeting nutritional needs
- Outcome 7: Safeguarding people
- Outcome 8: Cleanliness and infection control
- Outcome 14: Supporting workers

11.37 The care and welfare outcome is measured against the following definition:

“People who use services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.”

11.38 The review team met with the manager, two band-three health care support workers, and spoke to one service user. They made observations and reviewed documentation.

11.39 Overall, on all the outcomes assessed they found no matters of particular note other than under the documentation section for Outcome 4, which says:

“Care plans, risk assessments and treatment plans did not match up; not all plans were reviewed on the agreed four weekly basis.”

11.40 This formed part of one of the 11 recommendations made as part of this mock CQC report.

11.41 This finding is consistent with the comment in the County Council quality review that little discussion took place in the weekly CTM meetings about the patient's treatment programme and progress.

Comment

Particular risks may not be taken into proper account if risk assessments are not included in care plans. Failing to coordinate, risk assessments treatment plans can make the purpose of an admission and treatment pathway unclear.

This was an unannounced inspection so reviewers met only staff who were present. STATT had a team of medical, psychology and occupational therapy staff but they were not present. These services are multidisciplinary, so interviewing only nursing staff is an inadequate means of quality assessment. We saw nothing to suggest that the review included interviews with families.

Client journey/high risk patient reviews

11.42 This was a selection of documentary case reviews. The purpose of the review was to assess the care a client received from referral/admission to discharge (or current stage of assessment and treatment).

11.43 The case reviews covered:

- clinical risk assessment and clinical risk management;
- clinical pathways and multidisciplinary planning;
- multidisciplinary assessment process; and
- evaluation of the patient experience.

11.44 Only one review related to an inpatient in STATT. We received an anonymised version of it. The patient was at high risk, with a need for effective risk assessments and management plans. The review indicated that overall the care and treatment of this patient were satisfactory. The questions in the care review are attached at appendix H.

Matron walk rounds

11.45 This is an assessment tool developed and used in Southern Health mental health and learning disability services. It is carried out by senior nurses and covers the following areas:

- CQC - safeguarding and safety;
- CQC- personalised care, treatment and support;
- CQC - suitability of staffing; and
- night-time practice.

11.46 The matron walk round assessments were carried out directly by John Stagg. The record of outcomes of the assessments is comprehensive. They are RAG rated (see below), though the definition for each rating is not included. It is assumed that the normal understanding applies.

- Red: Not meeting standard
- Amber: partially meeting standard
- Green: meeting standard - good practice

11.47 Ten areas were rated as red:

- medical devices are clean, stored correctly and are included on inventory;
- staff are following dress code policy and ID badges visible;
- sharp boxes signed and tagged;
- NHS number;
- allergies;
- weight recorded;
- falls care plan;
- falls checklist completed;
- ward ligature assessments have been completed in last 4 months; and

- staff have attended a ward or team meeting in the last month.

11.48 The record of the matron walk rounds amalgamates the findings so that most are not specific to a particular area. We set out below summary extracts from the findings where STATT is specifically mentioned (the following were all scored ‘amber’):

<p>Patients do not have to walk through areas occupied by the opposite sex to access toilet / bath / wash facilities</p>	<p>A review of the patients, their needs and the environment in STATT is recommended to ensure that the privacy, dignity and safety of patients can be maintained. It notes that staff support service users to help maintain privacy and dignity and the risk that this may not always be possible.</p>
<p>Patients who have self harmed have a risk assessment and a care plan</p>	<p>Evidence of good practice in both JSH and STATT. It recommends that care planning in relation to self-harm is reviewed and good practice encouraged in all settings.</p>
<p>Staff would be happy to have a member of their family treated in this ward / area</p>	<p>One member of staff felt that they would not be happy for a member of staff to be cared for in STATT because the building needed updating and maintaining. Staff think STATT needs review as a clinical care environment rather than a social care environment. The report recommends that the environment in STATT is reviewed and appropriate maintenance undertaken.</p>
<p>In the event of the discovery of an illicit substance</p>	<p>In both JSH and STATT some staff were unclear as to the process to be followed on discovering an illicit substance. This is not a common occurrence within these settings however it is a potential risk. It is recommended that the policy of dealing with illicit substances is revisited and that staff are aware of the process for managing this.</p>
<p>If a patient develops D&V [diarrhoea and vomiting] on their shift</p>	<p>In JSH and STATT staff were not always clear on procedure if a patient develops D&V during the shift. The environment and the needs of patients would make it difficult to nurse such a patient in an isolated area to reduce the risk of spread of infection. It recommends that the procedure for caring for a patient with D&V is reviewed and that all staff know what to do.</p>

11.49 The report's section "*The Review Process*" says:

"... there were no significant risks associated with quality and safety within OLDT services although there are some key themes identified which should be addressed. There are a number of recommendations for improvement which include further explorative and developmental activity."

11.50 The report includes a narrative "*Conclusions and Recommendations*" section, which we include at appendix I. The report also sets out the recommendations in a table we include at appendix J. John Stagg told us the report amalgamated all the findings and recommendations into a summary, without always identifying the particular service they related to. This gave the impression that the challenges and improvements were needed over the whole of the Ridgeway service.

11.51 The report's 14 recommendations cover:

- record keeping;
- multidisciplinary working;
- risk assessment and management;
- capacity and consent;
- physical health monitoring;
- measuring patient experience;
- clinical supervision and management supervision;
- Mental Health Act/mental health care;
- environment;
- medical devices;
- dress code; and
- learning out of concerns.

Comment

The report's summary analysis is helpful but it does not identify which improvements need to be made in which parts of the service. This is not a helpful way of carrying out

a multi-site assessment because it is important for clinicians and managers to know where they need to focus.

11.52 John Stagg provides a short overall summary in the report:

“Although there is evidence of good practice within OLDT services, there is a need to ensure consistent practice and monitoring across services; engage staff at the patient level in monitoring and improvement and increase the evidence of multidisciplinary working including the approach to address clinical assessment and treatment and clinical risk assessment and risk management.”

11.53 The quality and safety report was presented to Southern Health at a serious incident review meeting with commissioners and representatives of NHS England on 27 November 2012. The notes say:

“The quality and safety report was thought to be good but was missing an action plan to address the shortfalls. SHFT said this would come from the meeting to be held with staff on 28 November 2012. Staff will be engaged in this. SHFT will be happy to share this with commissioners.”

11.54 An action plan to address the recommendations was produced. Our copy is undated but some of the actions to be completed are recorded as “By February 2013”. Most of the responsibilities for taking forward the actions are given to service managers within the Oxfordshire and Buckinghamshire services, as well as the research and development nurses.

11.55 An update of the quality report dated 31 May 2013 set out the improvements that had been made. This was a collation of information and assurances supplied to John Stagg by local managers.

11.56 John Stagg says in the executive summary of the update report:

“Some targets were overly ambitious set at a time when the future divisional structure had not been approved to go forward. In addition, changes to the division and Southern Health as a whole could not have been foreseen, have had an impact on progress.”

11.57 He says in the foreword:

“This report is written at a time when our division is beginning a complex process of change and development. It is also a time when the division has had some focus on issues related to several SIRIs while supporting services with change. The review of the action plan devised following the quality and safety review last year, has highlighted that considerable work and improvement has been achieved, particularly by the Clinical Development Manager and Research and Development Nurses who are all based within in-patient services in Wiltshire, Oxfordshire and Buckinghamshire.”

11.58 John Stagg sets out the areas of improvement that had been achieved and concludes the foreword by saying:

“Overall this report provides assurance and information that the quality factors identified within the Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust) have been or are being addressed effectively.”

11.59 John Stagg told us that it was after the Verita report into the death of Connor and the CQC visit in September that he and Southern Health came to question some of the assurances local clinicians and local clinical managers had given about improvements to practice. He felt they might not have reflected the reality of changes. The Contact Consulting report had warned Southern Health that managers did not always properly understand the quality of the services they were managing and therefore some caution should have been applied to the information received from local managers.

11.60 Amy Hobson, the divisional director who led the acquisition process with Dr Kevin O’Shea, the clinical director, told us:

“There was also a range of bits of evidence that came through to say that, on a day-to-day basis, clinical services were safe, and that feels and has felt to be quite important, in that although there were a whole range of issues that needed to be addressed there were not people at risk, at that point. It was not this sense of these were the things we’re going to try now, it was that actually these things are going to need to be sorted and they are systemic and they are longstanding and they

are all over the shop, so they are all across the breadth and depth of the Ridgeway Services.”

Oxfordshire County Council

11.61 Oxfordshire County Council conducted a quality monitoring review of STATT and John Sharich House in November and December 2012 as part of an annual quality review. The County Council monitored providers against *Valuing People Standards* (DH March 2001).

11.62 The team was led by the quality and contracts officer (social work qualified), and included two other quality and contracts officers (one social work qualified with a mental health background) and a student social worker. The team carrying out the review were from the County Council contracts team and did not include NHS professionals because the council commissions learning disability services in Oxfordshire as a delegated function from the CCG.

11.63 Twelve visits took place at varying times of the day, during the week and a weekend over four weeks. A large number of formal and informal interviews were carried out with managers, staff, advocates, current and ex-patients and family members.

11.64 We reviewed the report to see if any aspect of it directly related to the care delivered to Connor and to cross-reference any aspects from our first investigation report.

11.65 We identified the following, which were features of our first report into the care of Connor.

Weekly clinical team meetings

11.66 The quality monitoring review report covers the way weekly clinical team meetings were carried out. These meetings reviewed patients care over the past week but the reviewer notes that little discussion took place about the patients treatment and progress. The report says the way the clinical team meetings (CTM's) were planned made it difficult for community care managers always to attend.

Working with others

11.67 The report also says community team members were left out of essential communications and even discharge meetings. It says the service was insular and needed to work with others.

Overall assessment

11.68 The review found 10 standards being met and two partially met. The two that were partially met were for care plans and for working in partnership.

11.69 Care plans and risk assessments were in place but the standard was not fully met because Southern Health was instituting a new care planning system in former Ridgeway services to bring them in line with that used elsewhere in the trust.

11.70 The standard for working in partnership was not fully met because the services did not always communicate effectively with key partners such as community learning disabilities teams. Southern Health was aware of this and was planning to restructure to improve coordination between inpatient and community services.

11.71 Providers who met 10 or more standards under a rating system devised in 2011 were designated green status, meaning that there were no major concerns. This was the case for Southern Health and accordingly the inpatient services were found to be green.

11.72 The report is comprehensive (42 pages) and makes 20 recommendations. These are attached at appendix F.

11.73 Southern Health accepted the report and its recommendations, producing an action plan reviewed by the County Council in July 2013 when most actions were found to be complete.

Comment

The conclusions of the report were in line with the CQC review a year earlier. Areas were identified for improvement but nothing appeared to indicate that STATT was failing or that patients were at risk.

Finding

F6 The County Council quality and contracts review carried out in November and December 2012 was thorough. It was conducted over a number of days and the range of interviews was comprehensive and appropriate. As matter of good practice, it would have been beneficial to include NHS professionals in the team.

Comment

An examination of the reviews carried out around the time of the acquisition of the Ridgeway services shows a focus on governance, clinical safety and practice issues. The County Council review was the most comprehensive in respect of STATT because it took place over a number of weeks at different times. It included interviews with patients, families and advocates as well as attendance at multidisciplinary meetings.

The quality review by John Stagg was also comprehensive. It used a number of different types of assessment. The mock CQC reviews and matron walk rounds were unannounced and relied on interviewing staff on duty that day. They did not include meetings with members of the multidisciplinary team. Matron walk rounds and mock CQC visits are valuable tools for assessing quality, but failing to meet the whole clinical team (as the County Council review did) meant the contribution of non-nursing members was not tested; neither was the effectiveness of multidisciplinary team work.

The various reviews of the Ridgeway services did not give them a clean bill of health. The reviews raised concerns about governance at Ridgeway and whether local managers were fully aware of the quality of local services. Managers needed to improve MDT working and risk assessments and care planning. Even so no acute

concerns about the safety of services in STATT were raised by the reviews. The more acute concerns were focused on the non-Oxfordshire services.

Commissioners and other external partners expected that Southern Health would have a strategy to address the issues raised in the County Council, Contact Consulting and the Southern Health quality reviews, if not in late 2012 but as soon as possible in 2013. The next section looks at how Southern Health responded to the issues raised in the reports.

Summary

11.74 We posed a number of questions at the beginning of this section that relate to what was known about quality and safety of the Ridgeway services in 2012.

11.75 Before the acquisition and after Southern Health was named as the preferred bidder, a number of clinical, governance and safety reviews took place. Some were commissioned by Southern Health, some externally. They found areas of concern, mostly around governance and the safety of clinical services at Postern House.

11.76 The County Council review and the review by John Stagg had identified improvements the acquired services needed. John Stagg told us the issues he had identified were to be addressed by local managers supported by the two trust (former Ridgeway) research and development nurses.

11.77 STATT was not specifically identified by any of the reviews as having significant clinical, managerial or systems failures at the time of the acquisition.

12. Post-acquisition - November 2012 to July 2013

12.1 In this section, we set out what Southern Health knew at the point of acquisition and how it managed the services once it took over responsibility for them. We consider in particular:

- the leadership put in place by the trust
- the approach to engagement and communication taken by the trust
- the trust's approach to merging the services and the business plans adopted
- the trust's internally commissioned reports into Slade House
- the wider perspective of the community learning disability teams.

12.2 In order to address the overarching questions we have set out earlier, these issues are considered from the following perspective:

- What Southern Health and the commissioners did to assess risk and to mitigate any potential reduction in quality of care. In particular:
 - Did Southern Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition (if any)?
 - Did commissioners ensure that the transition to a different provider addressed known safety and quality concerns?
- Whether the location of senior trust executives in Southampton and Southern Health's geographical distance from Oxfordshire services had an impact on communication, support and oversight of services in Oxfordshire. In particular:
 - What was the impact on communication with service users and families?
 - What was the impact on staff in local Oxfordshire services?

12.3 It is not a central part of our investigation to assess the model of acquisition that Southern Health followed except insofar as it may have impacted on the services that were offered in Oxfordshire and in particular at STATT. We have therefore focussed on aspects that may have had a direct or indirect impact on services from November 2012 to July 2013.

NHS reforms

12.4 As we say in chapter 7, the re-organisation of the NHS in 2013 formed an important backdrop to the period immediately after Southern Health's takeover of Ridgeway.

12.5 Neither the County Council nor Southern Health were directly affected by the re-organisation but it was nonetheless a time of change for them. Oxfordshire County Council faced major reductions in funding from central government and carried out their own re-organisation. Southern Health was dealing with the changes arising from the Ridgeway acquisition. A County Council commissioner told us:

"... everything was transitioning, so this service was transitioning from Ridgeway to Southern Health; PCTs were transitioning to CCGs; everyone at CQC was changing; we were reorganising. Everything was in a state of flux, and I think now I would be more able to spot a really, really unsafe system because of my learning from that, and in retrospect I wonder why none of us quite saw the level of risk... I think any system that has that amount of change going on at once is unsafe, I would say, and you need some serious mitigations put in place if you can see that you're about to embark on such massive system change."

12.6 Generally, research literature acknowledges that mergers and acquisitions - at a trust or departmental level - are difficult and that the organisation is vulnerable to significant risk during change and reconfiguration. We discuss earlier in this report the dangers of mergers and acquisitions.

Quality reviews

12.7 We have set out in detail in the previous chapter what Southern Health knew about the quality of Ridgeway services at the time of the acquisition of Ridgeway. We saw evidence that commissioners and NHS England had a clear expectation that, after acquisition, Southern Health would begin to address the recommendations identified in the reviews.

Winterbourne View Project team visit - February 2013

12.8 A further external visit to Ridgeway services occurred on 4 February 2013. The national team set up to review services in the wake of Winterbourne View sent out a request asking for sample specifications for inpatient services. Oxfordshire sent in a specification after which the national team asked to visit some Oxfordshire services. This included a visit to STATT, which took place on 4 February 2013.

12.9 It was an informal visit. It appears to have been brief and to have produced no written report. John Jackson, director of adult social services at Oxfordshire County Council said the visit lasted 45 minutes, of which 15 were spent looking round the STATT unit. The County Council commissioners subsequently wrote to Southern Health about the state of the décor. John Stagg had also remarked on this (chapter 10) but it had evidently not been addressed. The CQC noted it again in their September 2013 inspection.

12.10 We saw a letter of thanks from Dr Dominic Slowie, review visit lead which says:

“I am writing to thank you for facilitating the visit to Oxford and the opportunity to meet with your colleagues, local people and families and to visit the Short Term Assessment and Treatment Team.”

“All those we met were very helpful and informative and I would be grateful if you could pass on our sincere thanks...”

12.11 The letter went on to thank the County Council for the service specification they had submitted which was: *“one of a few that stood out as it contains many key areas that we believe will be important features in a national Core Service Specification”* and praised particular parts of the specification. No mention was made of any concerns identified during the visit.

Southern Health’s actions post-acquisition

12.12 Many people had been impressed by the quality of Southern Health’s bid and were looking forward to changes in the service. The Southampton learning disability services they provided were viewed by commissioners and the SHA as outstanding.

Executive leadership

12.13 Several interviewees told us the key champions for the acquisition were Amy Hobson and Dr Kevin O’Shea. Many said Amy Hobson was Southern Health’s learning disability expert and a significant influence.

The role of Amy Hobson as divisional director

12.14 Katrina Percy, chief executive, gave us her view of the role of Amy Hobson:

“It [the acquisition] was very much clinically led by Kevin O’Shea as the clinical director, and Amy Hobson, who is a learning disability nurse by background... - that had clinical posts, and ended up in a general management managerial director-level post. They were the experts, and they were the ones who very much put the case together for the Board around clinical benefits of acquiring the services.”

“Amy and Kevin ran the whole thing with a transaction director doing all the technical sides.”

“To implement the implementation plan there was the divisional director [Amy] with Kevin [O’Shea] as the clinical director on T-0, so day one [i.e. from 1 November...].”

12.15 Amy Hobson was a key force in the acquisition of the Ridgeway services and it appears that the chief executive saw her as a key part of the managerial team taking forward the running of the newly-acquired service. Katrina Percy told us:

“Amy came to me and she was very clear that she didn’t want the transaction director to carry on. She wanted to go to normal reporting [i.e. she wanted the former Ridgeway services to be run as part of, and in the same manner, as the rest of Southern Health’s learning disability services - she did not want those services run separately or in a different way], and that she would do it. She was in control

of it, and everyone also really had a lot of confidence in her from the commissioning side, I think, up in Oxford.”

“ ... at some point into the new year that she [Amy] either was going to leave us [Southern Health as a whole] or she couldn't carry on doing this job [i.e. as Divisional Director for learning disabilities and wanted a different role within Southern Health]. She was highly talented, so we decided that we would rather keep her, and so we allowed her to apply for a different job within the organisation.”

12.16 Sue Harriman, the chief operating officer, told us:

“Bearing in mind we acquired or merged the services in November, it was quite quickly after that that Amy was talking to others in the organisation saying that, ‘She wanted a change of job.’”

12.17 Amy Hobson told us she had said in early 2012 that she did not want to continue as divisional director:

“I told Sue Harriman (her line manger) that I wanted to step away from the operational leadership of learning disability services in my one to ones during January/February of 2012.”

“I didn't want to be the operational director for them [learning disability services], predominantly because I had two small children and I had just spent a huge amount of time, in terms of the acquisition, up and down through different counties and, at that point, I also did not want to get to a point where I was not able to be in Hampshire most nights.”

“I agreed with Sue that I would step down when possible and much later that year I applied, went through an assessment centre and was successful in getting the Workforce role.”

12.18 Amy Hobson believed she had made her position clear.

“I was the operational director until I got my new job, I believe in January the following year, 2013. At that point, Lesley Munro was asked to take on the Learning

Disability Services, once I had gone, and was able to shadow me for a time or pick up the role with my support from, I believe, the middle of February 2013.”

Comment

In response to reviewing our draft report Sue Harriman said that to her recollection the conversation with Amy Hobson did not take place in January/February 2012. We have had considerable additional information from Sue Harriman and the trust detailing discussions about the changes to Amy Hobson’s job description and when she was to take over her new role. It is also clear from the evidence that she remained in that post until Lesley Munro took over.

It is however also agreed by both Sue Harriman and Amy Hobson that soon after the acquisition Amy Hobson was indicating her desire to no longer remain in that post. We have not investigated further when Amy Hobson made known her desire not to continue in the new post.

With the addition of Ridgeway services, the learning disability division now covered a large geographical area. It had previously been a small part of Southern Health’s portfolio, located mostly around Southampton. Several interviewees said that even though Amy Hobson continued in her role for a while, she did not drive, which limited her ability to spend time in the Oxford area and to be flexible about appointments: they did not see much of her.

With the knowledge of Amy’s desire not to continue in her role Southern Health should have ensured that the promised improvements to services could be delivered in a timely fashion, we address this later.

12.19 Katrina Percy told us:

“I was just going on maternity leave, but Lesley Munro got the job [as the new divisional director], and then there was a handover period and Lesley came into that role. She [Lesley] was [previously] another divisional director, so she took a sideways step [to run a different division].”

12.20 A number of interviewees told us that when Lesley Munro took on her role that she carried it out effectively but, unlike Amy Hobson, she did not have experience of learning disability services.

12.21 Katrina Percy told us:

“If Amy had carried on in her job, as I knew she had years of experience ... I think that... we would have moved them faster... she would have been able to push them faster right from day one.”

“My learning in hindsight is if you are taking on a new service, and all the knowledge is sat with a couple of people, if those people come out you are then left with a bigger gap. It was Amy who pushed me to lose the transaction director. She said she wouldn’t have that person because she could just do it herself, and then my trauma was that I lost the other person who had the detailed knowledge.”

12.22 Amy Hobson told us she was not instrumental in the decision to allow the contract of Lorraine Foley, the interim transaction director, to lapse.

“I didn’t want to report to two people and related well to Sue and so had wanted her to continue to be my main point of contact for my role. It was very complicated relating to several executive directors for different aspects of my role over that previous year. I thought that Lorraine’s contract had ended and that her leaving was always on the cards.”

Comment

The contract of the interim transaction director was a fixed term contract and lapsed at the point of the acquisition.

The role of Dr Kevin O'Shea as clinical director

12.23 Dr Kevin O'Shea was the clinical director and thus not only the clinical lead but also the accountable officer for the learning disability division. The chief executive told us:

"Amy reported to Kevin [Dr O'Shea], who in turn reported to Sue [chief operating officer]. We are very similar to every trust that the [lead] clinicians have the general managers reporting to them... the strategic leadership and service leadership is with the clinical director."

Day-to-day operations

12.24 Dr O'Shea told us of his working partnership with Amy Hobson:

"This is somebody who had been a clinician, a commissioner and a very effective divisional director. Now, you don't always get that in a divisional director; in fact, her successor, although a brilliant person in her own right, didn't have that kind of background. So we were jointly responsible and we decided that Amy would take the responsibility mostly for the day-to-day matters to do with Oxford and Buckinghamshire... and I would look after more the Southern Health bit..."

12.25 Dr O'Shea also told us he had made clear before the acquisition that he did not want to continue in his role as clinical director:

"In October, probably slightly earlier, September, I had actually talked to the chief operating officer and said that I didn't want to continue as clinical director for learning disabilities on the basis that I hadn't been able to backfill my time. I was doing clinical director role on top of a full time consultant role. It wasn't sustainable. When everything was nicely based more or less in Southern Health Hampshire, it was easy to actually get to meetings, meet people, etc., now that we were going to have significant geographical spread that was going to become impossible."

“Amy and I had a very close working relationship... I didn’t even have the time to go to all the meetings necessary, so we very much divided it and we were jointly able to run the services.”

“That was how we managed it during that period. That lasted until April 2013 when I resigned as clinical director. It then took quite a long time unfortunately to appoint my successor, I stayed on in a caretaker capacity but I was very clear in April that I just couldn’t continue to do this. It’s not that I couldn’t continue to do the job; it’s just that I felt I was spreading myself far too thinly and I felt it needed other people.”

“Now, to mitigate the fact that I wasn’t able to be as present in Oxford and Buckinghamshire as I’d like, we had arranged that the former medical director of Oxford LDT Trust, Mat Stevenson [Dr Matthew Stephenson], continued. We paid him three sessions a week to continue as the medical lead, and we had two other medics as well. We had Dr Tim Andrews and Dr Banerjee, who had been I think the assistant medical directors under the old regime, so they continued to be paid as well, so they looked after things like supervision, appraisal of the medics, providing the medical voice and the immediate clinical response those two may need. They also looked after the team that was coming into place in Oxford, which was people like Sue Chapman, Andy Martin and others, who were becoming, if you like, the focus of the team there.”

12.26 Andy Martin, head of service for the inpatient services for Oxfordshire, Buckinghamshire and Wiltshire, told us about his contacts with Dr O’Shea and Amy Hobson:

“Dr O’Shea virtually non-exists; I very rarely saw Dr O’Shea. If I did see him it was tending to be bumping into him and in his office down in Hampshire when I went down there. Amy, again, started off being quite visible but that reduced quite quickly. That was compounded by the fact that she didn’t drive. You have somebody who is responsible for taking over an acquisition of areas that are quite a big distance away from the main trust headquarters who didn’t actually drive. She had to rely on people driving her around to places and at times when you were trying to have a conversation with her she had to go because someone was giving her a lift. That was always quite difficult. There were a couple of times we wanted to have further discussions with her and the person giving her a lift had to go, that

caused a few problems. Amy also had quite a bit of sickness as well during the period between November and April. She had a couple, or three, reasonably lengthy sickness periods during that period as well.”

Comment

Both Amy Hobson and Dr O’Shea, having been key to the acquisition, had said they did not want to continue in their operational roles. Amy Hobson had difficulty because she did not drive and wanted to be at home with her children at night. Dr O’Shea was clear he could not carry out the extra responsibilities he had been given on top of his full-time consultant job.

Dr O’Shea made some interim medical arrangements but they were no substitute for having an engaged clinical director committed to making the improvements promised as part of the acquisition. They could only be described as stop-gap arrangements.

12.27 Sue Harriman told us:

“Yes, I was concerned that Kevin had also lost a bit of interest and it was a lot of work, a lot of stuff needed to be delivered, it was really important it was done at pace. Lesley did not have learning disability expertise, but was a good director, but that only works well when you pair them up, the two come together, and I was concerned about the level of support that Lesley would get.”

12.28 Dr Jennifer Dolman was appointed to take over from Dr O’Shea in September 2013. He remained in post as clinical director until September 2013, having made clear he wanted to leave.

12.29 Amy Hobson told us she knew that Dr O’Shea wanted to stand down as learning disability clinical director:

“Yes. I had discussed that with him, in terms of my position, probably something like six months earlier, but Kevin had, certainly throughout the second half of 2012, talked about stepping down and not wanting to leave anything in the lurch, but

wanting to move away from the clinical leadership role, back into a pure clinician role, yes”

Impact of the changes in learning disability leadership November 2012- July 2013

Divisional leadership presence

12.30 We received evidence from commissioners that Southern Health was slow to react having taken over Ridgeway. Ann Nursey (a former commissioner at the County Council) wrote to the chief executive of Southern Health on 19 February 2013 complaining about the lack of contact from senior managers at Southern Health. The letter says that since the acquisition *“our experience so far has been very disappointing”* and asking who is now managing the learning disability services.

12.31 Another County Council commissioner said:

“It felt as if, they won the bid, they got their contracts, they started in November and then they sort of disappeared.”

12.32 The CCG took a similar view:

“Southern Health took over and perhaps didn’t grasp these things that were there quickly enough... I don’t think they knew really what was happening on the ground.”

12.33 Katrina Percy, told us that they had been *“very held up by the Commissioners”*, she said:

“My hindsight - and please, this is in hindsight - the learning I give to Monitor to give to other people is don’t wait for the Commissioners. If they accept your tender, that’s the model of care they want. Tell the Commissioners we are now taking it that that’s the model of care you want and we need to immediately move to it in implementation.”

12.34 The County Council, when reviewing the draft report, told us:

“We do not know what Katrina Percy is referring to here. Southern Health had the contract specification and our commissioning intentions before the merger. Their own proposals reflected our intentions and having won the tender we expected them to discuss the plans and to move them forward. They did not come forward with the plans, or ask us for any other information. It is unclear what was being held up by the commissioners.”

12.35 A manager who moved from the SHA to NHS England makes the link between the changing roles of commissioners and lack of oversight of Southern Health:

“I wish we had been more explicit about the handover to commissioners to hold Southern Health to account. Southern Health need to be responsible and account for the things that they have done and they have got some things wrong and that has been exposed. My sense was that the rest of the system enabled and allowed that to happen because if they had been held to account by their commissioners for delivering the new model, I don’t think there was any sense of direction or leadership from the clinical commissioning groups saying “You’ve acquired this business. It is the new model so how are you going to do that? When are you going to do that? What will it look like?”

12.36 Ann Nursey told us at interview that soon after acquisition, communication went quiet.

“Somewhere I have a list of things that I kept from the bidding process - things we then wanted to work on with Southern Health to get delivered, and the first of those was these Intensive Support teams. Sorry, I may be going where you don’t want me to go at this point but our experience was this just didn’t start to happen when Southern Health came in, and I suppose in retrospect I wish I hadn’t given it so much time, but I gave it a little bit of time thinking, okay, well, they have to get themselves established, they have to get staff, they have to set up the systems, I won’t go knocking on their door on day one saying “me, me, me”, but at the same time after a couple of months I began to think, well, actually, surely we’re an important player here, why am I not hearing anything from them? So we started to

step up the requests for them to be participating with us in the way they had during the acquisition process in terms of trying to understand what it was we wanted.”

“By February I’d got frustrated enough to write to the chief executive and say ‘Where are you?’, at which point I discovered their chief executive had gone on maternity leave and they hadn’t actually told us.”

“I was anxious at that point. I raised that with the director and with the deputy directors, because there were other things. Other people had gone as well, and I’ve listed that in here, because Lorraine Foley, who had been our key contact, had moved on at the end of the acquisition. Then I heard the medical director had gone back to clinical work and the finance director had gone and the chief executive had gone, and i was thinking were any of the people that we had that dialogue with and who understand what we want, are any of them still there and are any of them leading this organisation?”

12.37 Ann Nursey provided us with a copy of the email she sent to Katrina Percy on 19 February 2013. It said in part:

“We heard over a week ago that Amy Hobson has left her post as director for learning disability at Southern Health, but as yet have received no communication from Southern Health to us as commissioners, nor to Lucy Butler as joint manager of the Community Teams service manager.”

“Since the acquisition of Ridgeway Partnership by Southern Health we have had no contact from senior managers at Southern Health, have had difficulty arranging meetings with Amy, and when we succeeded she was unable to attend on the day. My last 2 emails to Amy remain unanswered. As you are aware from the acquisition process, it is very important to us to establish a productive relationship and dialogue with our providers in order to maximise the benefits for our service users from the contracts we manage. Our impression of Southern Health throughout the acquisition process was that we could expect to establish a productive partnership and our experience so far has been very disappointing.”

“Please could you let us know formally who is now managing the learning disability services that we commission so that we can arrange to meet with them as soon as possible to discuss our concerns?”

“I look forward to hearing from you.”

12.38 Sue Harriman, who was about to become acting chief executive (during the chief executive’s maternity leave), replied to the email from Ann Nursey on 22 February. We quote part of the reply:

“Thank you for your recent communication raising concerns about Amy Hobson’s imminent departure from the learning disabilities services. I would firstly like to apologise for any anxiety this has caused you and acknowledge that our communication about Amy’s new post was not helpful for you. I understand that Amy has made contact with you by phone and email today and will see you in person on Monday.”

“To reassure you, Amy continues to remain as divisional director for learning disabilities and will do so until her replacement has orientated herself with the services and there is a real confidence that we have robust and sustainable business plans for 2013/14. Her replacement is one of our area directors from the South East Hampshire area, Lesley Munro.”

12.39 Amy Hobson told us she had seen the memo and understood the difficulties arising from the transition from acquisition activities to operational mode.

“Up until the October point there was still, obviously, a project structure in place, where execs were responsible for different things and, although it was not necessarily always pulled together, there were people working on different things, so there was a momentum and energy, even, and it was discussed regularly at exec meetings, which means there would have been a presence felt and contact more often with commissioners.”

“Once October came there was a sense of trying to sort out operational things, people carrying on with their day jobs, and so the numbers of times that Ann, as

the commissioner, had contact with directors and others reduced. I think she was concerned that that was something that would carry on that way.”

12.40 Ann Nursey also commented on the role of Lesley Munro:

“Lesley Munro came in very quickly and we met with her and actually all of our interactions with Lesley were very positive. She listened to what we were saying, she responded to what we said, she kept us in good touch with what was going on, so I felt more encouraged once we got to that stage. But then we were still back in the loop of, okay, now she needs to get embedded because she needs to get up to speed with all of this.”

“I suppose from where I am now, I’m looking back thinking why did we wait at all? Why were we not banging on the door in November saying “Are you on this?” But I think it’s probably with the benefit of hindsight that I’m reading the signs as being signs of major concern really.”

12.41 Sue Harriman told us:

“Lesley stepped in immediately and, in fact, there would have been a handover period of eight weeks with Lesley in post before Amy moved, except Amy did go sick for a chunk of that time. Lesley came in and, I think, probably had two weeks with Amy, Kevin was still there, Kevin O’Shea, as the clinical director. There was this, what appeared to be in that period between November and February, something that went silent for a bit.”

12.42 We asked Katrina Percy what she knew about the email:

“I don’t remember the email, but to be honest with you, I was one week off maternity leave at that point, and I don’t actually do my own emails so it could have gone straight to Sue, and I receive thousands [of emails]. There was an issue that Amy was leading it [the acquisition and transition] all the way, and then went sick pretty much as we took over the contract. She is the senior manager. She is the director in charge, so they [the commissioners] had had contact... The way that Southern Health works is slightly different to other trusts. A lot of the power and responsibilities is divested into the divisions - therefore, Amy and Kevin were

completely authorised, had the appropriate powers and were certainly senior enough to be leading the relationship with [the commissioners].”

12.43 Katrina Percy also told us:

“I have a different opinion on some of the things, I think I did differently. So I think we were very held up by the commissioners is my opinion that I can talk to you about. I would have the reverse opinion, interestingly, that the things that held things us up was we pitched for this work with a completely new model of care, and where are we now - February 2015, so another two years on from that they [the commissioners] haven’t even published the model of care that they wish to commission.”

Comment

Commissioners identified a lack of practical engagement by Southern Health divisional managers on day-to-day matters and by February 2013 they were complaining about insufficient contact from the divisional directors not board level directors.

Soon after the acquisition, significant difficulties arose in Southern Health as there were insufficient senior and experienced staff to take forward vital post acquisition actions.

Dr O’Shea made clear in September/October 2012 that he did not want to continue in post. He described his role after the acquisition and in particular after April 2013 as “caretaking”. Amy Hobson made clear that she also wanted to leave the management of the learning disability services before or shortly after acquisition. The interim transaction director’s contract also ceased on acquisition of the Ridgeway services.

All services face changes in key leadership positions. In this case, the changes came when Southern Health needed to deal with the mechanics of the acquisition. Concerns about leadership and culture in Ridgeway had been raised in various reviews prior to acquisition and these also needed addressing.

The 100 days after an acquisition or a merger are considered as a key time to set down the foundations necessary for change and improvement. In this critical time senior trust board executives should have considered how they might reinforce the learning disabilities divisional leadership as a result of the impending changes to key leaders.

Driving forward the changes set out in the acquisition bid document required senior experienced learning disability professionals. The failure to replace Amy Hobson and Dr Kevin O'Shea in a timely fashion hampered Southern Health's ability to make the changes needed.

Engagement and communication

12.44 We looked in detail at the engagement and communication strategies Southern Health applied to the acquisition.

Comment

A failure to handle these matters effectively can undermine the best procedures and processes. Poor engagement and communication can also lead to decline in quality of services.

12.45 We saw documents that covered the acquisition and associated communications. We record here some relevant extracts.

Ridgeway transition programme - April 2012

12.46 This document was produced after Southern Health was announced as the preferred bidder in March 2012. The document “...provides the objectives, structure and methodology” for the integration of the learning disability services. It sets out Southern Health's overall aim “...to become the leader in the field of delivering learning disability services in the UK, and to be the first choice provider for people with learning disabilities.”

12.47 The document provides a high-level overview of what needed to be done to integrate the services. It sets out its success criteria:

1. *“Successful transaction on or about 1 December 2012;*
2. *Staff morale is high and all staff members have a clear understanding of the vision and benefits to users of the new organisation;*
3. *Stakeholders feel informed and engaged, and are positive about the process and outcome; and*
4. *Zero adverse impact upon the quality and safety of Ridgeway and Southern Health services as a result of transition.”*

Communications and engagement workstream - implementation plan as at 30 August 2012

12.48 This document is a comprehensive action plan of 10 key tasks, such as:

- *“Ongoing communication & engagement around integration*
- *Support HR workstream on consultation events/communications*
- *Plan and implement RW ‘Roadshows’ Part 2*
- *Create and implement brand strategy for integrated services.”*

12.49 It is a comprehensive communication document, though all timetabled tasks cease at acquisition day.

Ridgeway transition implementation plan

12.50 This document is in action plan format and was updated on 26 October 2012, just before acquisition. Many of the actions (other than those marked as ongoing) were recorded as starting and finishing before acquisition.

12.51 The document included the following sections:

- *“External Governance Assessment*
- *Transition Programme and Operational Assurance*
- *Design New Integrated Governance Approach*

- *Test Integrated Governance Approach*
- *Preparing Risk based Clinical Reviews”*

Chronology of acquisition, transition and implementation-July 2011- July 2013

Summary of acquisition, transition and implementation

12.52 Southern Health also provided us with the two documents listed above that were prepared for this investigation. They summarise the work that Southern Health carried out for the acquisition.

12.53 The summary document supports what Dr O’Shea told us (set out below), namely that Southern Health strategy was to take forward the acquisition in four phases.

- “Phase 1 Engagement and Information*
- Phase 2 Stabilisation and Harmonisation*
- Phase 3 Enquiry and Formulation*
- Phase 4 The Future and Delivery”*

12.54 The following is from phase 3 of the summary document:

“During this phase, Southern Health focussed on really understanding the former Ridgeway services. Prior to the acquisition the opportunity to do this was more limited - because it was based on the access and information provided during the bid phases.”

“Southern Health was seeking to understand the local environment from various perspectives including available resources (material and human), sustainability of service elements, commissioning intentions, political landscape, clinical models, need for change and change priorities. During this period there was considerable activity which included informal contact with staff and a lot of site visits by trust senior managers.”

“Southern Health had emphasised during phase 1 that it would not be implementing any substantive changes prior to consultation with the staff - therefore, there was not a significant amount of division-specific communication to staff from Southern

Health during this phase. The focus was more on communication from staff to Southern Health to understand the landscape.”

“Again, the normal trust processes and procedures were applied to the former Ridgeway services (as described in phase 2). Information and updates were provided to the senior managers at the ordinary divisional meetings - with the anticipation that this would be cascaded down to staff in the services in the usual manner.”
[This is referred to by trust staff as the ‘business as usual’ approach which we cover in the next section]

“Behind the scenes, the senior management team within the learning disability division were using the information that was being gathered to formulate a proposal for the services going forwards.”

12.55 The following is from phase 4 of the summary document:

“This phase commenced in April 2013 when Southern Health's proposal for the future of the services was published and a formal consultation launched. During phases 2 and 3, the senior management team of the division had been preparing the Learning Disability Division Development Plan for 2013 - 2016.”

“This phase was not able to progress as had been intended due to difficulties with gaining commissioner support for the re-allocation of funding to allow the proposed service re-design to go ahead.”

12.56 The County Council in responding to the draft report told us:

“... there was no dialogue taking place about this and we have not heard this discussion referred to before.”

Comment

Southern Health also supplied us with a large number of copies of newsletters and communications sent out before and after acquisition. Southern Health had a comprehensive strategy for communication and engagement with people with learning

disabilities, their families, staff and other stakeholders before acquisition. This included a range of workshops, joint planning with Ridgeway managers and other activities.

The strategy for communication and engagement after acquisition is summed in the phrase 'business as usual', which is mentioned in phase 3 above. The effectiveness of this strategy is dealt with in the next section and some of its impact in later sections.

12.57 Dr O'Shea gave us information about how Southern Health planned its engagement with staff from Ridgeway. It details the different phases of engagement that Southern Health followed. We summarise his information below.

12.58 In phase one, Dr O'Shea told us:

"Once we were identified as the preferred bidder there then began a series of events involving staff meetings, site visits, visits as part of due diligence and a communications approach all of which is outlined in the project work stream documents for communication and engagement. In addition all of the work streams involved staff from OLDT from all levels of the organisation as appropriate."

12.59 In phase two, Dr O'Shea told us:

"This was essentially the phase, in November and December 2012, which sought to ensure the "nuts and bolts" of running a service were in place and functioning... As I identified at the interview we were concerned that any proposal for significant change should be based on a clear plan for the future so that engagement with staff could offer a degree of certainty and clarity."

12.60 In phase three, Dr O'Shea told us:

"This took place during the period January to March 2013. There was no significant change issue during this period rather we were seeking to understand the local environment from various perspectives including available resources (material and human), sustainability of service elements, commissioning intentions, political landscape, clinical models, need for change and change priorities. During this

period there was considerable activity which included informal contact with staff but the purpose of ensuring a minimal disruption approach...”

Comment

Phase three was the period when the business plan was being prepared. It also coincided with Amy Hobson’s preparing to stand down, the handover to Lesley Munro and little local presence from Dr O’Shea. It was in this period that the commissioners complained about lack of contact from Southern Health.

The work to prepare the business plan was necessary but this should not have been at the expense of engagement with families, staff and commissioners. It was also paramount that divisional level managers assured themselves that the quality of services did not deteriorate.

12.61 In phase four, Dr O’Shea told us:

“This began in April 2013 and involved the publication of the development plan which outlined a clear plan for the future, underlined our commitment to the development of services, identified how the services could become more effective and sustainable and this plan obviously had its own engagement and consultation process.”

12.62 Amy Hobson gave us her view on engagement:

“There was definitely engagement activity. I do not think it was enough. I do not think it was evaluated, as a process as it was happening, so in other words ‘Are we winning? Is it working?’ I think that there was a growing sense that it was pretty much always the same people going up and engaging and that that did not help, so the sense of ‘You are very far away and you don’t care about us,’ just became worse, I think.”

“I know there was a lot of engagement done. I just do not think it was enough and I do not think, necessarily, it came across as always completely sincere. I think the

fears remained for people and I also think, looking back on it - hindsight is a wonderful thing - there were some very stressed Ridgeway staff who were making things, possibly, quite a lot worse for their colleagues, telling them quite a lot of horror stories about Southern Health, that at the time we did not realise were being told. I think there was a counter-agenda going on at the same time as a positive engagement one, and I think that that turned things into quite a soup, particularly, probably, for ground level staff.”

12.63 Sue Harriman told us:

“We were aware that Southern Health was miles away... I think there was definitely something around the executive team not being present, walking the site and the wards on a daily basis... I think it had been an organisation that had been very small, very local and, of course, the HQ was on the same site, I think people used to often wander around, it probably had a nice family feel to it, and this felt a bit faceless.”

12.64 The assessment and treatment manager, whose role included the Slade House services, told us:

“The irony of it is that Andy and I and other service managers had to arrange the consultation meetings with our staff team, even though we were the ones that were at risk... ”

“They wanted to change things, they didn’t ask us what our clinical views were, which is shameful. How can you have a whole team of people that have worked in learning disabilities for decades, who have a really good reputation, and not want to know what they think and how they get from here to here, and not ask for their support?”

12.65 Commenting on our draft report Lesley Munro responded to these views with a written response. The following is an extract:

“... when I came into post, we had the away-day as I came in. As I said, that was very much launching our business plan, launching our vision, launching our strategy to around 100 members of staff. It was a fairly significant chunk, and that was from

all the counties that we provided services in. In addition, there were other away-days that were led by both Jennifer [Dr Dolman - current Clinical Director] and myself. Invariably one of us got hauled away, but the away-days always happened. I'm trying to think how many we had. We probably would have three or four of them."

Comment

We are aware that during the period up to April 2013 senior staff were preparing the business plan. We comment on that event later. The point the assessment and treatment manager made to us was that she did not feel that Southern Health were engaging with existing staff to make a contribution to the plan. Also our understanding is that Dr Jennifer Dolman did not take up her post until September 2013. We have not received any details of away days that took place after the one in April 2013 and prior to Connor's death.

12.66 Sue Harriman told us:

"I think as the process and as time has gone by and the different conversations I have had, I have had these light-bulb moments where I have realised, 'Yes, we did underestimate that', and not just the culture of the organisation and its history and how affected it had been by its history, but actually the culture of Oxford, actually the commissioning culture and how Oxford works as a bundle of services. There was that sense, 'You cannot get the learning from an established learning disability service if there is 100 miles in between and you just go over a couple of times a week'."

Finding

F7 The communication and engagement strategies Southern Health put in place for the period up to the acquisition were of a high quality and comprehensive. The approach taken to communication and engagement with Ridgeway staff after acquisition was inadequate

and failed to ensure that the natural concerns of a staff group taken over by a large and distant trust were properly addressed.

‘Business as usual’

12.67 Several interviewees said that the approach taken to merging the Ridgeway and Southern Health learning disability services after acquisition was a ‘business as usual’ model.

12.68 Sue Harriman, the chief operating officer (in post at the time of the acquisition and who became acting chief executive at the beginning of March 2013 after Katrina Percy, chief executive, went on maternity leave) told us that:

“I think Katrina took a decision to do the post-implementation as a ‘business as usual’, so to implement those actions into divisional business plans and monitor those actions through normal mechanisms, which is through the executive performance review process, ultimately, or through the divisional performance review process. The milestones, outcomes, metrics were then all amalgamated in either the quality dashboard or the operational dashboard.”

12.69 Sue Harriman told us:

“There is probably another piece of hindsight bias that says, ‘Should Lorraine [the transaction director] have stayed for another four months?’, because Lorraine, clearly, had owned the whole process, and then she could have carried on in there, as I describe, a T minus 6 plan, you countdown and go, right, now it is, if you like, a ‘mobilisation plan’. A decision was taken to run it as ‘business as usual.’”

12.70 Katrina Percy told us:

“So we ran it as what we call a “T minus 6’. We ran a six-month running process, so we were ready to go live, go live, not start the acquisition process on day one i.e. we began working with the Ridgeway services 6 months prior to the formal acquisition date, to enable the acquisition date to be any actual start date for the new organisation. Amy and Kevin ran the whole thing with a transaction director

doing all the technical sides. So they were absolutely deeply embedded in it. Effectively, we could go to 'business as usual' on day one, and they could run it as part of the learning disability service i.e. as part of the wider Southern Health learning disability services as opposed to a separate division, albeit it is not a very big division in our trust, learning disability services."

12.71 A number of other interviewees confirmed that this was the approach taken by Southern Health and Southern Health confirmed this in the document *Chronology of Acquisition, Transition and Implementation - July 2011-July 2013* (trust chronology) supplied to us. The trust chronology states:

"As has been explained in a number of interviews, upon the date of acquisition, Southern Health took the decision to operate the entirety of the learning disability division services (including the former Ridgeway services) on a 'business as usual' basis; i.e. to encourage integration, the acquired services were treated the same as all of the other services in Southern Health's existing learning disability division."

"This means that those services formed part of the learning disability division's ordinary assurance processes to monitor quality, safety and performance - i.e. there were no extraordinary measures put in place to monitor the quality and safety of the former-Ridgeway services."

12.72 Southern Health held a range of meetings that dealt with performance, quality and safety of the newly formed Learning Disability Division. The Southern Health chronology document has the following information about the meetings:

- *"Divisional management team meetings*
- *Divisional Service Board meetings*
- *Divisional quality and safety group*
- *Divisional performance review meetings"*

"The divisional management team meetings (chaired by the divisional director and attended by heads of service, service managers and heads of profession) - where updates on what was going on within the division were discussed. These were deliberately held in Newbury to allow maximum attendance by both Ridgeway and Hampshire staff."

“There was also the divisional service board (chaired by the clinical director and attended by representatives from all the services) - where strategic issues, summary of the merger and where it was going, feedback from quality and governance and information to be cascaded down from the Board was discussed. The DMT and DSB alternated fortnightly.”

“A Divisional Quality and Safety group was chaired by the clinical director. It was the second part of the divisional service board (with the same attendance). Received a quality and safety report from John Stagg which included a review of SIRIs and action plans and other assurance tools such as modern matron walk round tools. Feedback from Southern Health-wide quality and governance committee was shared. The division would consider its submissions for the forthcoming trust-wide quality and governance committee.”

*“The outcomes from the divisional quality and safety group fed in to **Southern Health-wide Quality and governance committee chaired by the chief operating officer and director of nursing** on a 1-2 monthly basis. In turn, there would be headline/exceptional reporting from this committee to the board. These meetings had specific rotating topics - e.g. medicines management or physical health.”*

*“In April 2013, the Southern Health-wide quality and governance committee was split into 2 separate meetings to ensure adequate time for discussion of the agenda items. **The quality improvement and development forum** was established and was chaired by an executive director. This fed in to a **new quality and safety committee as a sub-committee of the board**. This arrangement continues to this date.”*

*“In addition to this, Southern Health also has **divisional performance review meetings (DPRs)**. These involve the divisional management team attending a ‘check and challenge’ session with members of the executive team. Southern Health’s Information Team provide performance data reports in advance of the meeting and matters such as finance, workforce and quality are discussed with a different focus each meeting.” (bold is our emphasis)*

Comment

This structure of the business meetings appears robust and addresses the management of performance and quality and safety assurance. Such a structure requires confidence that the quality of the information being supplied upwards from the local service managers to the trust board can be relied on.

12.73 The Contact Consulting report made some important statements that raised a question over whether the information being supplied by local managers to directorate managers was an accurate reflection of the reality of performance. This report was published in September 2012 before acquisition in November. It said:

“Some we spoke to indicated that there is a disconnect between senior leaders within OLDT and the staff delivering or managing the services in terms of the understanding of quality issues and the assurance that actions needed have been taken and are fully implemented.”

“There is, in some cases, limited understanding among some senior people in OLDT of what their services actually do, and this contributes to the findings of RCAs.”

“The view of the risk of untoward events occurring within OLDT is equally varied. Some we spoke to we[re] clear about the need to be vigilant and alert, others less so. Most worrying was the statement we heard that “I don’t worry about our staff doing unspeakable things to our clients.”

“The complacency of attitude does not appear to be confined to one individual. Stakeholders we spoke to said this complacency, coupled to the defensiveness of the organisation, highlighted a more deep rooted culture that some characterised as a lack of awareness and transparency.”

12.74 One of the recommendations from Contact Consulting was for a series of:

“... pro-active assurance visits to all services over a prescribed period. These visits should largely be unannounced and seek to provide information and evidence about a range of clinical and managerial practice.”

12.75 Contact Consulting was clear that not only did senior executives need assurance about clinical practice but also managerial practice because:

“... Some we spoke to indicated that there is a disconnect between senior leaders within OLDT and the staff delivering or managing the services in terms of the understanding of quality issues and the assurance that actions needed have been taken and are fully implemented.”

12.76 John Stagg produced a report in May 2013 covering progress on the implementation of the recommendations from his quality and safety report. His report relied on information and assurances from various local managers. He told us that it was only after the unannounced CQC inspection in September 2013 that he and senior divisional staff realised the assurances he had been receiving were not accurate or lacked sufficient evidence.

12.77 Sue Harriman told us:

“One of my overarching reflections was about we came at it in a very, almost, process-driven way, so we almost audited them within an inch of their life, before and after and then, on top of that, we insisted that they do more audits and they have more of an audit culture, and it was like ‘You will do this, you will do that’. There is such a rich source of information about what does and does not happen and were we missing the softer parts, were we missing the bit that actually said, ‘Has anyone really sat down with these guys on day one and said, ‘How do you feel?’”

“I think some of it was around the people part, the softer part, the bit that makes a registered practitioner fill in a form and to say ‘Is everything is okay?’, ‘Okay,’ when it is not okay. That bit we had really missed somewhere in the mix, that this was a group of people who, clearly, felt or were behaving as if they were totally disenfranchised.”

Comment

This reflection by Sue Harriman is important as it identifies part of the reason why ‘business as usual’ was insufficient in ensuring a successful first 100 days approach to

the acquisition. Having a range of assurance committees was necessary but what was also needed in the early months of the acquisition was a more person centred approach.

12.78 Katrina Percy told us:

“Did we underestimate how hard it is with the geographical spread? I am not sure that we underestimated how hard with the geographical spread. I think the thing that we underestimated is going from a tiny organisation to a big one. The chief exec in their organisation was more junior than Amy in ours, if you see what I mean, but had a different job title.”

“...but overall we knew the service was old-fashioned and we needed to move it to a new model which would be less bed intensive, but it needed to in a way that didn't effectively belittle people who have been working really, really hard all those years.”

“I have had an equal amount of frontline people, external people, internal people tell me both sides of that call. You should have done it faster or you should have done it slower. In fact, if you read our CQC report, one of the things that people say is that we push change quite fast in this trust.”

Comment

At first glance, a ‘business as usual’ methodology for a small newly acquired service may appear appropriate if that service is mature and relatively problem-free. The due diligence and quality assessments before acquisition did not identify significant concerns about clinical practice. Though significant signs of a lack of confidence in local leadership, the effective governance of serious incidents and particular difficulties about care issues at Postern House were identified.

With hindsight, the ‘business as usual’ approach was not successful. The CQC inspection in September 2013 bears this out as does an independent management consultant review commissioned by Southern Health into managerial performance. We provide details of these reviews later in this section.

Finding

F8 The post-acquisition model of ‘business as usual’ adopted was flawed because significant concerns had been raised about the quality of management in Ridgeway. Southern Health divisional managers needed to fully engage with managers and clinicians in Ridgeway to ensure that the board level executives could rely on the reports they were receiving.

Business plan

12.79 Dr O’Shea, told us that the first three months of 2013 were mostly taken up with developing the business plan, which was launched in April 2013:

“We then did the practical stuff and then I think quite deliberately we took those first three months of 2013 to develop a very clear strategy for where we’re going with it so that we could give people some certainty. I think it was important because I think people were feeling the grief of losing an organisation. I think we often underestimate the kind of collective grief there is around losing an identity, losing various people, and remember, they had started losing senior managers from again very early 2012 when the chief executive I think went in January 2012; John Turner, who was director of nursing and operational services, went in June/July. Some people that they had felt would continue to be involved in some way just left, we needed to identify who was there and how to work with them.”

12.80 Katrina Percy told us about the need to get the commissioners in Oxfordshire to sign up to a plan that depended less on beds and more on community-based services but that to do this needed them to invest financial resources. This additional funding was needed because Southern Health did not receive transitional funding when acquiring the service.

12.81 The County Council when reviewing the draft report told us:

“The plan for less reliance on beds and for more community-based services was part of the specification and our stated commissioning intentions. We were not being asked to ‘sign up’ to an idea; it was what we were commissioning.”

12.82 Katrina Percy told us as part of her reflection on the acquisition:

“I think that the other bit I would have done is negotiate more money [from the SHA - bridging/dowry finance]... I now would have gone back and argued for probably £10 million to come with it to oversee the first two years. Much like as has happened with Hampshire Hospital’s acquisition...”

“I think, in a sense, we knew that we were taking on an old troubled trust, and that is why I am saying that my hindsight learning would be don’t wait for the commissioners. If they have commissioned your new model, they had service-users and everything engaged in it, get on and do it. That would be my first thing. We couldn’t because the money was tied up in the beds so we couldn’t afford to shift the model of care till the commissioners agreed to start funding the new model. That is why we didn’t, by the way.”

12.83 Dr O’Shea confirmed that the financial position on taking up the Ridgeway services was a problem for Southern Health:

“There was a deficit of about 1.7 million which Ridgeway had as an unresolved deficit. There were no real plans to recover it. Because the SHA was about to be abolished in the April after we took over, we were told we had to have plans in place for the recovery the 1.7 million deficit because there was no bridging finance arrangement. In previous mergers where there’d been a deficit, the SHA or District Health Authority would often offer bridging to allow you time to recover.”

“There was a lot of engagement work during that period. There were also issues around being able, I think, to give people an understanding of what it was going to actually mean for them and, to be fair, it was very difficult to do that until we’d had an opportunity to look at these states, (sic) to look at the deficit reduction, to look at what we were going to have to do. I think what we then said was ‘the

business development plan becomes our change management plan and there is a personnel human relations side of that'. We give people some certainty."

Comment

Senior managers were mostly engaged with preparing the business plan between 1 November 2012 and 23 April 2013 when it was launched. This plan was important to begin the process of changing the model of care to a less bed-based model, to bring in the promised intensive support teams and to balance the finances. Senior divisional managers should have also been engaging with staff to understand how they felt about being part of a new trust. In addition they needed to address concerns raised in the Contact Consulting report and those identified by the SHA.

Business/development plan launch

12.84 The business plan (titled: *Learning Disabilities Development Programme 2013-2016* (23 pages)), was launched at Newbury Race Course on 23 April 2013. The goal of the document is listed as:

"In order to meet the needs of patients and service users and commissioners over the next three years Southern Health must simultaneously achieve three stretching goals:

- Improving clinical outcomes for patients, service users and their families*
- Improving the experience patients, service users and their families have of our services, treating them as customers, with dignity and respect*
- Reducing the costs of our services so that we deliver better value and live within our means."*

12.85 A number of clinical work streams are set out in the document.

1. Access to generic services (detail still being developed)
2. Challenging behaviour
3. Forensic services

4. Quality improvement

12.86 The following is from the implementation section of the plan:

- *“Structures, roles and processes will be established by the end of March 2013*
- *“A programme of quality review of services utilising existing tools e.g. Matron Walk Round Tool; Spot Check Audit, CQC & Mock CQC data; Community Nursing Review; Professionals Standards audit etc. This will be agreed by the end of March 2013 - it will be a 3 month review process.*
- *“A roll out plan of Quality & Safety Road Shows will be planned from 1st April 2013 to all services over a 2 month period.”*

Comment

The development programme sets out in broad terms a well thought-out plan for the next three years, though some items were already overdue by the time it was published.

Announcements of leadership changes

12.87 Dr O’Shea announced at meeting where the business plan was launched that he was stepping down as clinical director. Amy Hobson, while involved in the launch of the consultation, was also handing over to Lesley Munro as the new divisional director.

Launch of consultation of staff changes in the learning disability division

12.88 The Southern Health chronology document states that at that meeting:

“A Consultation on Changes in Learning Disabilities Division was provided to sit alongside the publication of the Learning Disability Division Development Plan 2013 - 2016.”

12.89 The consultation document sets out in detail over 34 pages the changes to roles and functions to support the development programme and to ensure financial viability of the learning disability services. It is a comprehensive document explaining a rationale for change linked to the development programme.

12.90 We set out a number of quotes from the document to illustrate the impact that its publication may have had on staff:

“It is inevitable that some posts will no longer be required whilst the service redesign will mean that other posts are created giving new opportunities for staff.”

“All clinical posts will be aligned to the geographic model. There are currently clinical posts that do not align with a specific county as a result these posts will not be in the new structure. These posts are:

- *2 x development nurses*
- *professional lead posts.”*

“Subject to the outcome of this consultation and its timescales, it is proposed that these changes will be implemented within phase one of the programme.”

“There are also managerial posts that currently are not aligned to the geographical model and will not be in the future proposed structure:

- *head of specialist health services (phase 1)*
- *assessment and treatment services manager (phase 2)*
- *specialist health services development manager (phase 1).”*

“Subject to the outcome of this consultation, it is proposed that these changes will be implemented in phase one and two of the programme.”

“There will no longer be uni-professional lead roles within the division. The most senior members of each profession may at times be asked within their existing role to advise managers and clinical leaders on professional issues. They will also be expected to offer professional supervision to more junior colleagues. In line with the other clinical divisions within SHFT, there will be a new post of head of quality,

nursing and AHPs created which will offer professional leadership to all nursing and AHP staff within the division.”

“The post of business support manager will not exist in the new structure and the functions of this role will be transferred to the appropriate corporate division or another post holder within the LDD (This is currently a vacant post).”

“Business Development project managers will reduce from two posts to one post.”

“The job description of the business development project officer will be expanded to include support for service improvement.”

“It is proposed that, subject to the outcome of this consultation that these changes will be implemented within phase one of the programme.”

12.91 The Southern Health chronology document says:

“During divisional management team meetings, all managers were made aware of the proposed launch date of the consultation and were expected to disseminate this to their teams.”

12.92 Andy Martin, head of service for the inpatient services in the former Ridgeway localities, told us that he believed he was not allowed to share the content of the changes proposed in the consultation.

12.93 The assessment and treatment manager was responsible (alongside other duties) for Slade House, including the STATT. She gave us her view of the event in April 2013 that launched the development programme and the consultation programme.

“April came, we had another big event at Newbury Racecourse, and at that point they again hadn't spoken to us personally and they put out a consultation document, I think at five o'clock the previous evening, for staff. In front of the whole division they put up our job roles and showed us that we wouldn't be there, including two of my research and development nurses that we didn't know they were going to do, so we had tears and upset. It was a very difficult day.”

12.94 Andy Martin, told us:

“As far as I was aware at that stage we were at the stage of ‘you do not share this document until you are told and it will come out to share it’. I was surprised when we got launched because we hadn’t heard that it had been finalised, I didn’t even know because I hadn’t picked up an email. The email had gone out in the evening, 5.00, 6.00. I hadn’t picked up my email and I walked into an event with people saying the consultation doc is out; ‘what?’ ‘When?’, ‘last night’, ‘alright, okay.’ There was a number of people there that had no idea, I knew my job was going because I’d been involved in the process but other people had no idea and a great thing about in front of 100-odd people, you suddenly find out your job’s gone. It didn’t make people feel great and there was total lack of clarity about when things were going to be done and there were different phases.”

12.95 Amy Hobson told us:

“The October situation, in terms of people not knowing about the model, when the model was presented or talked about again; we knew, at that point, that we had had management meetings with all of the people from Southern Health and the Ridgeway Services, where we had talked about each general manager discussing it with their own teams individually and talking through the consequences. Only one team manager did not do that, which is the services that [the assessment and treatment manager] ran, so Andy Martin did not discuss it with [the assessment and treatment manager] and they did not tell their staff, so their staff, when they came along in October, were the group of people who did not know anything about it. The other service managers, even the ones in Ridgeway, talked to their teams about it.”

12.96 Amy Hobson’s reflection on launching the consultation by email the night before the away day discussing the future development plan is clear:

“I think that what happened in April was a Southern Health error that never should have happened, and there is no other way of describing it.”

Comment

The consultation affected a number of people, some having the prospect of losing their job or significant role changes. Launching the consultation at the same time as the business plan and as major changes to the senior leadership were being announced was a significant mistake. Ridgeway staff had just been acquired by a large trust and had had little contact with senior Southern Health directors. This is likely to have made it difficult for some staff to focus on the business of the day and may have had an impact on their morale.

Southern Health internal commissioned report

12.97 The CQC carried out an unannounced inspection of Slade House in September 2013. The outcome was that four areas required action and six required enforcement action. We discuss the visit in detail later in this section.

12.98 After the poor CQC inspection, Southern Health commissioned Jane Bray, an area manager in older people's mental health services, to carry out a review to find out why the services had failed so badly.

12.99 This report includes a useful observation of the STATT at a time close to Connor's death.

12.100 The report is a comprehensive review and looks at the details of the CQC inspection, at the way the service was managed and led, and what impact the way the acquisition had taken place may have had.

12.101 We quote here a small amount of the report.

“Outcomes of Investigation: root causes and contributory factors

7.1 Culture

- *The practice of moving senior staff when problems arose did not assist in maintaining safe, quality services in the former Ridgeway Partnership. A number of the issues were significantly stressful and*

demanding to deal with. SHFT may not have realised the degree of strain amongst its new senior management team.

- *Senior managers worked hard however their increasing range of responsibilities led to a reduced level of support and leadership notably on STATT and JSH.”*

Comment

When the assessment and treatment manager returned from sick leave in January 2013 she moved to focusing her managerial time on the non-Oxford services due to difficulties in those services, so less of her time was available to John Sharich House and STATT.

12.102 Further relevant extracts from the report

“Transaction and post transaction

The lack of robust local management support for STATT and JSH appears to have continued since transaction occurred, despite various quality initiatives led by others not in a direct line management relationship with the ward manager...”

“The governance arrangements which prevailed post transaction did not readily enable communication and a change in culture due to the top down approach, and apparent lack of empowerment for front line staff. A good example of where the disconnect became apparent during the investigation was with regards the post transaction process of review and amalgamation of policies.”

Comment

This report reveals clinical and managerial issues that should have been addressed after acquisition that were not identified with the speed and urgency necessary.

Local Oxfordshire management arrangements

12.103 The assessment and treatment manager described her role to us at the point of the acquisition:

“I was at that point transferring to the organisation, the assessment and treatment services manager. My role covered Wiltshire services, which was Postern House, and it covered the Oxfordshire inpatient services, which is John Sharich House and STATT, and the assertive outreach team, which was a community-based service, and it covered the Buckinghamshire services, which were in Amersham but then moved subsequently to the Ridgeway Centre and included an assertive outreach team and an intensive support team. I was an 8B.”

12.104 Andy Martin was responsible for all of the inpatient services that were part of Ridgeway at the point of transfer to Southern Health. The assessment and treatment manager reported to him, as did the manager of the forensic services.

12.105 After acquisition, Andy Martin reported at first to Amy Hobson, who was divisional director for learning disabilities. From the end of March 2013 beginning of April 2013, that changed to Lesley Munro.

12.106 The assessment and treatment manager had been on sick leave and returned to work in January 2013. At this point she was based at Postern House because critical issues needed her attention. She was less available for management support to the JSH and STATT.

12.107 A charge nurse Slade House had been appointed as the unit manager, covering the JSH and STATT. This was his first managerial appointment. The assessment and treatment manager continued to supervise him but his day-to-day support was to be provided by Andy Martin, who was still based at Slade House.

Comment

The combination of the assessment and treatment manager being based at a unit remote from Oxford and the continuing uncertainty around future changes to roles had

an impact on the level of support available to the unit manager for JSH and STATT, who was in his first managerial post.

12.108 Andy Martin joined the service in 1994. From 2007 to 2009 he was an acting director covering the Oxford services. He became head of specialist health in 2009. The assessment and treatment manager reported to him and they shared an office on the Slade site. He retired in October 2014.

12.109 When the assessment and treatment manager's management focus became Postern House, Andy Martin's became the newly-opened Ridgeway Centre in High Wycombe in Buckinghamshire, 25 miles from his base.

Independent management investigation reports

12.110 At the beginning of October 2013, (following the poor CQC visit in September 2013 and other emerging issues, including informal feedback from service commissioners at the County Council) Southern Health commissioned independent investigations into management performance.

12.111 The investigations were carried out by Lesley Humphrey, a healthcare management consultant and carried out in the latter part of 2013. The first draft report were available in January 2014.

12.112 In the following paragraphs we select a number of quotes from the two investigation reports.

The reports observation of the STATT

12.113 Whatever the reasons for the failings found in the September CQC inspection, the independent management investigation report shows a service in decline.

“These services have lived through, and are still experiencing, a lengthy period of instability and uncertainty.”

12.114 The following quotes from the independent management investigation provide an overview of the some aspects of the service and STATT:

“Conclusion

It appears that there was a lack of systems and processes to provide assurance on how teams were functioning: information was not available or easily available, despite [the assessment and treatment manager’s] efforts, and there were no committee or meeting structure above [the assessment and treatment manager’s] Monthly Managers meeting.”

“Conclusion

...there was a lack of higher level coordinated support to deliver the service safely through the operational consequences of the merger, couple with a culture of helplessness.”

“There were very few, if any formal processes for review and sign off of action plans over the past 12 months. This is symptomatic of a service in crisis-there were many comments of these services moving from crisis to crisis in the last two years. (our emphasis) Improvements would be seen in individual areas when ... managers were parachuted in, but with no underpinning governance structure failures in other areas were not spotted before further crisis occurred. In this, as in many other areas there was a sense of the team being rudderless, without guidance and structure during a period of confusion.” (our emphasis)

“Whilst there is evidence of high level work-stream planning for the merger, there was no evidence of any systematic embedding of this within these services.”

“This level of local transitional planning was compounded by an apparent lack of central coordinated planning for migration of the Ridgeway services into the SHFT operational processes. For instance, in addition to the loss of performance data and lack of access to SHFT IT operating systems there were significant differences between both the content and availability of policies and procedures.”

“The evidence gives the impression of complete chaos leaving staff feeling uncertain and distressed.” (our emphasis)

“The confusion, chaos and distress of this whole situation were clearly highlighted during these interviews. Whilst it is clear that some problems were the result of a failure by SHFT to plan effectively for migration into existing systems and processes it would also appear that some problems resulted from high level planning inadequacies locally within the service.” (our emphasis)

Comment

Some of the problems this independent investigation found can be attributed to how the service was managed locally. The pre-acquisition quality reviews had provided warnings.

Finding

F9 Southern Health was taking over a long-standing service and the approach to the post-acquisition period lacked a viable strategy to mitigate the negative effects of significant organisational change. In particular they lacked:

- a communication strategy that was as effective after the acquisition as before it, so that as far as possible staff concerns during the immediate months after the acquisition were listened to and acted on; and
- an enhanced presence of Southern Health senior executive leaders meeting with staff, families and commissioners in the former Ridgeway area in the year after acquisition.

Summary

12.115 The failure to ensure that services did not decline as a result of the acquisition was the responsibility of Southern Health board-level senior executives. Contact Consulting and the SHA and commissioners had expressed concerns about Ridgeway services. They had indicated:

- that local managers' understanding of the quality of local services was variable;
- that the response to SIs and the required learning from investigations was inadequate;
- that the service was old-fashioned and needed improvement; and
- that improvements to the working relationships between the community teams and the STATT were needed.

Oxfordshire community learning disability teams

12.116 Much of our report is directed towards the quality of the services at STATT, though Connor and his family also received services from the Oxfordshire learning disability community teams. We held a focus group with staff from the three Oxfordshire learning disability community teams. It was attended by team nurses, psychologists, the team manager, occupational therapists and a higher trainee in psychiatry and learning disabilities.

12.117 The meeting covered issues that related to the teams' work with families and services users. It also addressed how the teams felt about how effective the post acquisition arrangements had been. The following is a summary of the views of attendees.

STATT

12.118 Some attendees had worked in inpatient services and were familiar with STATT. They felt that staff in STATT never had a clear understanding of the role and function of the learning disability community teams.

Acquisition

12.119 The community service was small and tightly knit before the acquisition. The Southern Health takeover was not a positive experience, though some staff were encouraged to meet colleagues in the south at the time of the acquisition.

12.120 After Southern Health took over, communication to staff was minimal. At the time of writing this has changed and they now receive a lot of electronic communications

(email) from the division lead. The nursing leads meet monthly (Oxfordshire and Buckinghamshire) and every quarter in a combined meeting with Hampshire nurse leads. Nursing leads have come to Oxfordshire to help with changes, but from a 'vision and values' perspective there has been little progress.

12.121 The team described some tension between the clinical models used by Southern Health and those used in Oxfordshire. For example, Hampshire has leads for the health facilitation role, which Oxfordshire does not. The south does not have integrated teams but Oxfordshire does. Southern Health's medical model sometimes weakens the link to social services. Joint commissioning gives a more cohesive service.

12.122 The Oxfordshire team receives many directives and consultations however it is not clear what happens to the feedback they give. Changes are not clear. Regular changes are unsettling.

12.123 None of the attendees were familiar with the learning disability improvement plan. This may be related to terminology or because it has been discussed only at a senior level. The organisation covers a large area, which can make attending some meetings difficult.

Admission

12.124 Admission has become more difficult. This is because the local admission unit is in High Wycombe and the criteria for admission has become more stringent.

Transition

12.125 The quality of provision is widely variable. The teams do so much crisis work in the community that they lack the resource to do good preparatory work for 16-year-olds. Such work takes place only in instances of high risk or in high-profile cases. None of the attendees had seen a Southern Health learning disability transition plan. A new pathway came out a few weeks prior to our interview with the team.

Epilepsy

12.126 A lot of work has been done by the trust since Connor died in relation to epilepsy e.g. the epilepsy tool kits, epilepsy map, embedding practice etc. A huge drive to provide epilepsy training to all nursing staff and occupational therapists was carried out at the end of 2013.

Comment

Our focus group meeting covered many of the issues we would expect community learning disability teams to have to face. They work in a multidisciplinary setting and need to prioritise their work within the resources available.

The team said that the distance from Southern Health's main base and area of work was a barrier to developing a sense of corporate identity. The inadequate amount of engagement with senior leaders was raised by the team. The teams identified the need to ensure that clinical pathways and clinical models are discussed to ensure that the best clinical policies from Ridgeway and the best from Southern Health are developed, not just the implementation of former Southern Health models.

External visits to STATT 2013

CQC unannounced inspection September 2013

12.127 The CQC undertook an unannounced inspection of Slade House in September 2013 (after Connor's death). It included both John Sharich House and STATT. The inspection report criticised both units but highlighted failings at STATT to be of more significant concern. In contrast to the themed inspection in late 2011, inspectors reported of STATT "*... there were several areas of concern that required urgent action*".

12.128 The unannounced inspection covered 10 regulations, including those reviewed as part of the themed inspection. A Mental Health Act commissioner, pharmacist and a specialist (typically someone with experience of working with the client group) were

part of the inspection team. Of the 10 regulations inspected, 4 required 'action needed' (including Regulation 11) and 6 required 'enforcement action' (including Regulation 9).

12.129 Action was needed on:

- Regulation 11 (safeguarding people who use services from abuse);
- Regulation 13 (management of medicines);
- Regulation 17 (respecting and involving people who use services); and
- Regulation 18 (consent to care and treatment).

12.130 Enforcement action was undertaken in relation to the following regulations.

- Regulation 9 (care and welfare of people who use services):
 - specifically in relation to safely planning and delivering care, and a failure to act in accordance with people's wishes during treatment.
- Regulation 10 (assessing and monitoring the quality of service provision):
 - no system in place to review and monitor the quality of service provision, nor monitor and mitigate/manage risk.
- Regulation 12 (cleanliness and infection control):
 - infection control guidance not being followed; unclean environment.
- Regulation 15 (safety and suitability of premises):
 - premises were deemed to be unsafe/unsuitable for staff, people who use services, or visitors.
- Regulation 16 (safety, availability and suitability of equipment):
 - emergency equipment not maintained; not enough equipment, creating an unsafe environment.
- Regulation 20 (records)
 - Accurate, patient records must be maintained and stored securely.

Comment

Full details of the CQC report are available on the CQC website¹. It sufficient to say here that the failures it identified were serious. They covered both the environment and the way that care was planned and delivered.

12.131 Another follow-up CQC inspection took place in March 2014. STATT was closed at the time. John Sharich House was assessed and noted to be meeting six of the seven standards against which it was assessed. The exception was compliance with Regulation 17 (respecting and involving people who use services) for which further action was still required.

Contrasts between previous assessments and the September CQC inspection

12.132 We discussed the different outcome of the inspections carried out in 2011 and 2013 with the head of hospital inspections for mental health in the London region. She explained that the models of inspection used for the inspections in 2011 and 2013 were different. She said thematic inspections were conducted periodically and looked at specific themes across a range of providers. The thematic inspection conducted in December 2011 related to safeguarding.

12.133 She explained that at the time of the 2013 inspection, a generic inspection model was used in which inspectors had a portfolio of providers that included NHS services, adult social care, GPs and dentists. She added that the inspection model was more detailed than that of a thematic inspection:

“... these were more comprehensive, these were much more thorough, in-depth inspections, they were not just looking at themes, and they were doing a full inspection of the service. The inspections were given the discretion about which areas they wanted to look at... they looked at 10 different outcomes for that [September 2013] inspection, that was quite an in-depth inspection... actually it was quite unusual, but that inspection took place over three separate days... that was obviously a very in-depth inspection.”

¹ www.cqc.org.uk

12.134 She commented - taking into account the generic nature of the inspection model - that the inspection of STATT in September 2013 was “*not a typical inspection for the period of time*” given the length of inspection and the variety of advisors involved.

Comment

The inspections undertaken by CQC in December 2011 and September 2013 produced starkly different findings. This was due in part to the nature of inspection and regulatory changes at CQC. However, the deterioration in service in less than two years is clear. The reasons for this are less so. Connor died in July 2013 and it would be a reasonable assumption that this led to the unit being subject to more rigorous scrutiny in the September 2013 inspection.

12.135 In December 2013 Oxfordshire County Council undertook a review of its own inspection of STATT to explore why the CQC identified significant concerns in contrast to the County Council’s positive inspection 9 months earlier.

12.136 The County Council noted that the STATT had undergone a difficult summer between the two reviews. Connor and a former service user had died. A number of long-term staff left. The review found a number of reasons why the two agencies produced different inspections, including the patient group, patient experience, cleanliness of the units, environmental faults and local management control.

12.137 The report noted that the County Council review focused on the service user experience and the service was monitored against the 12 standards used in all learning disabilities reviews at the time. By contrast, the focus of the 2013 CQC review was on clinical, environmental, and service user experience.

12.138 The causes of some of the differences were relatively easy to see (such as a fall in cleanliness after the cleaner had left and not been replaced) while others were more complex.

12.139 The council's report suggested that the differences could be explained by a combination of changes in the services provided and by changes in perception. Service changes may have resulted from Southern Health's take-over of the service and the council suggested that the service had deteriorated over this period, in part because Southern Health was less engaged and responsive than Ridgeway. Changes in perception were driven by changing attitudes towards Southern Health as a provider, and due to Connor's death.

12.140 It concluded:

“At the time of the County Council review, Southern Health was managing the specialist services to a satisfactory standard. In the nine months that followed, quality of provision appears to have deteriorated, and CQC therefore discovered the service to be failing in the standards they monitored.”

Comment

Nine months is a relatively short time for a service to deteriorate to the extent that the STATT did. Whether this is due to the level of scrutiny applied in the latter inspection or if the service did in fact substantially decline in less than a year as suggested by the County Council is uncertain.

Whatever factors led to the poor September 2013 CQC inspection report, the reality was that the service in September was not meeting the required standards as assessed by independent professionals.

13. Care provided to Connor

Transition

13.1 Our terms of reference ask us to:

“Review the events leading up to Connor’s admission, including transition management and planning from children to adult service.”

13.1 We set out in appendix K the background and legislation around transition. Ample practice guidance has been available since 2001 to help individuals with learning disabilities to transition to adult services.

13.2 The Care Act (2014) along with the Children and Families Act (2014) now puts into legislation what agencies must do to transition people with learning disabilities from children services to adult services. The Care Act details that assessments should be person-centred, taking into account the young person’s wishes and views. The act takes into consideration a number of factors related to transition, including the role of the carer, capacity, timescales and co-operation between professionals and other organisations. In the case of the latter, the Act says that when multiple agencies are involved, having a key worker coordinating the person-centred care can be helpful.

13.3 In parallel with the introduction of the Care Act, the Children and Families Act was introduced in September 2014. Part 3 of the Act primarily concerns individuals with special educational needs and disabilities up to the age of 25. It focuses on:

- preparing for adulthood;
- personalised budgets;
- coordinating assessments and Education, Health and Care (EHC) planning;
- developing a local offer; and
- engagement/participation of children, young people, parents and carers.

13.4 The Act says planning for young people should begin from year 9 (age 13 - 14) at the latest.

13.5 Oxfordshire learning disability community teams told us at our focus group on 9 February 2015:

“Transition - the quality of provision is widely variable.” And that “None of the attendees has seen a Southern learning disability transition plan. A new pathway has been developed which came out in the last couple of weeks.”

Comment

Our interviews with families show that some statutory services still have work to do to ensure that transition is properly planned and effectively executed. We believe that without a strategy that includes specific learning disability targets and/or goals, transitions for people with learning disabilities will continue to be sub-standard.

Southern Health took too long to produce a transition plan and implement a transition pathway. This period is the subject of recent statute and guidance. It is a time of high anxiety for people with a learning disability and their families and carers.

13.6 Our terms of reference also asked us to look at Connor’s transition from children to adult services.

13.7 We examined transition in our first investigation. Our findings were:

“F21 The involvement of the community team with CS’ mother could have been better in terms of communicating options to the family, but S4 provided a mostly satisfactory service and she was sensitive to the pressures in the family.”

“F22 The working relationship between the unit and the community team has not always been good. The community team has not felt appropriately involved and engaged in processes such as those around discharge planning. These difficulties continue at the time of writing the report.”

13.8 In preparation for this current investigation, Oxfordshire County Council commissioned an independent investigator to review Connor's transition to adult services. The review did not take evidence from Dr Ryan, Connor's mother.

Comment

It is always appropriate when carrying out a review into a serious incident, whether or not it has led to death, to involve the families or carers. This may be limited to explaining the process that will be used, or in other cases and where appropriate, taking evidence from families or carers.

13.9 The investigator's methodology was to carry out a review of records and included interviewing nine staff from learning disability services, children's services and the John Watson School.

Comment

Connor's family should have been key participants in the review because transition from children services to adult services involves the whole family. The involvement of the family, together with the staff interviews, would have improved fairness and transparency.

13.10 The County Council sent a draft of the report to Dr Ryan for comment. Dr Ryan responded with comments on the draft and these were passed to the investigator. He then produced a response to her comments and made amendments as he felt appropriate.

13.11 The family has rejected the report because of the way it was produced and because of some aspects of its content. At the time of writing, the report remains a matter of dispute.

13.12 We received the final report on 10 July 2015, accompanied by a table with Dr Ryan's comments and the investigator's response. The investigator and Dr Ryan do not agree on a number of points.

13.13 We know that Dr Ryan would like us to disregard this report but we do not believe that this is appropriate. The report (27 pages) provides a detailed chronology of contact with Connor and his family.

13.14 The terms of reference of the investigation were:

"To review the events leading up to CS's admission to hospital, in particular;

- a) The planning and transition from Children's to Adult social Care,*
- b) The alternatives to admission,*
- c) The contact between adult social care, CS's family and school,*
- d) Preventative intervention offered before hospital inpatient admission was sought,*
- e) The actions by adult social care to subsequently promote discharge planning for C'S."*

13.15 The report summary deals with transition, direct payments and discharge planning. The summary paragraph on transition says:

"8.1 My overall assessment is that the provision and offers of care management and community support services was in line with the known and assessed needs of CS, in the context of those services being delivered through direct payment being administered by SR. I consider it to be most unfortunate that closer engagement with the family was not achieved, and that the potential contributions of key professionals and services such as the OT, the clinical psychologist and the respite centre, were not tested out in practice during the period prior to CS's admission."

13.16 The report's findings quoted above in relation to transition are similar to those in our original investigation.

13.17 The report makes six recommendations which we attach at appendix L.

13.18 The County Council commissioned report continues to be a matter of dispute between Dr Ryan and the County Council. Our terms of reference ask us not to re-investigate matters from the first report and we believe that doing so would not change our overall conclusions. We do not intend to make further comment on the report.

Legislative environment

13.19 In this section we consider the legislative environment under which STATT was operating. In particular, we consider how the Mental Health Act is used with individuals with a learning disability and its impact on deprivation of liberty. We also consider the impact on personal choice of the Mental Capacity Act (2005). The following section of the terms of reference is relevant to this section:

“To fully review the use and application of the Mental Capacity Act (MCA) and the Mental Health Act (1982) during Connor’s admission.”

13.20 The Department of Health interim Winterbourne View report noted:

“Health and care staff and providers do not always understand fully the legal framework for placing people into hospital settings where their liberty is constrained.”

Mental health legislation

13.21 Connor was admitted to STATT as an informal patient in March 2013. Two days later, he was detained under Section 2 of the Mental Health Act 1983 (MHA). The MHA is the primary piece of legislation used in the rights, assessment and treatment of people with a mental health disorder¹.

¹ <http://www.nhs.uk/nhsengland/aboutnhservices/mental-health-services-explained/pages/thementalhealthact.aspx>

13.22 Admission under Section 2 is based on the following criteria:

- the patient is suffering from a mental disorder of a nature or degree which warrants detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- the patient ought to be so detained in the interests of his/her own safety or for the protection of others.

13.23 The detention order is made by an approved mental health professional (a social worker or similar professional with particular training), supported by two medical certificates, one of which must be from a doctor specially trained and approved under the Act (generally a psychiatrist).

13.24 The Section 2 detention remains in effect for the maximum 28 days and cannot be renewed. If detention under the MHA were to continue, it must be under Section 3. The criteria for such admissions are broadly similar to those under Section 2, but with a greater emphasis on the availability of treatment for the individual's disorder. Further, Section 3 allows the detention of people with learning disability only if it is 'associated with abnormally aggressive or seriously irresponsible conduct'. This was not the case with Connor, and no Section 3 application was made. Connor remained in STATT as an informal patient.

13.25 Connor was not permitted to leave STATT without permission while he was under Section 2 and he could be treated for his disorder without his consent. Other decisions about his care were governed by the Mental Capacity Act 2005¹ (MCA). This legislation allows decisions in an individual's best interests, when he or she does not have the capacity to decide.

13.26 The MCA also has a mechanism to deprive an individual of liberty when a person lacks capacity to decide whether to stay somewhere and where to do so would be in his or her best interests. That, like the MHA detention, involves independent assessment of the individual's situation. This process started in Connor's case shortly after the expiry of the MHA detention, but the independent assessor did not consider that Connor's care was intrusive enough to require an order.

¹ <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/mental-capacity.aspx>

13.27 We asked Professor Peter Bartlett, Nottinghamshire Healthcare NHS Trust professor of mental health law, to review Southern Health’s Mental Health Act and Mental Capacity Act policies and to consider whether they were appropriately used in Connor’s care. His full advice is set out in appendix M. We summarise it below.

13.28 Following the second stakeholder event where we set out our initial findings and invited comment and response we received a request from Dr Ryan’s solicitor for a copy of Professor Bartlett’s full advice. The solicitor then responded to the advice with a number of comments challenging some of the conclusions. This response we sent to Professor Bartlett and he reviewed his report and made some amendments. The final version was then sent back to the solicitors. In their final response to us on this point they say:

“I note Professor Bartlett’s responses. I would be grateful if those matters set out in our letter of 25 June could be considered by the panel when preparing its final report as it will be apparent that my clients do not agree with Professor Bartlett’s view and consider that the failure to comply with and to apply the MCA was significant in Connor’s case.”

13.29 We have considered carefully the response from Dr Ryan’s solicitors (on her behalf) and the final version of the report from Professor Bartlett, which took into account the comments made by Dr Ryan’s solicitors. Professor Bartlett is an eminent lawyer nationally and internationally renowned for his expertise in this field. His report provides an analysis of the legal issues and how these related to Connor’s care. Professor Bartlett conducted a number of telephone interviews, including an interview with Dr Ryan, reviewed Connor’s case notes and other relevant documents and has considered the response from the family’s solicitor. We therefore accept the advice he has given.

Summary version: Professor Bartlett’s advice

Introduction

13.30 This section of the report presents the key points to emerge from the expert review of the legislative environment and how these may have impacted on the care of Connor or his family (Mental Health Act 1983 and the Mental Capacity Act 2005 inclusive of Deprivation of Liberty Safeguards (DoLS)). This review responds to two questions:

- 1) How the Mental Health Act 1983 is used with individuals with learning disability and its impact on deprivation of liberty and whether individuals are detained unlawfully.
- 2) The use of the Mental Capacity Act 2005 and how it impacts on choice.

Background

13.31 The law in regard to the MCA and DoLS has developed considerably since 2014. However, we consider it as it was between Connor’s admission to STATT on 19 March 2013 and his death on 4 July 2013.

Review process

13.32 A number of Southern Health policies were considered as part of this legislative review. The focus was on those directly related to the Mental Capacity Act or the Mental Health Act. Alongside these policies, the relevant codes of practice that practitioners are obliged to have regard to were also included.

13.33 The best-interest assessor who conducted the DoLS assessment on 12 May 2013 was interviewed, as was the DoLS manager and Connor’s mother.

Mental Capacity Act and Deprivation of Liberty policies

13.34 The Southern Health approach is to combine the DoLS and MCA into one policy. The 2012 and 2014 policies appear to be broadly accurate and appropriate, but a few substantive comments are made.

Strengths	Gaps
Generally the MCA policies provide a good overview	Some additional cross referencing to the code of practice
Some concrete responsibilities re DoLS are included	MCA policy leaves uncertainty regarding overall responsibility for ensuring that the MCA is

	<p>followed at the various levels of the organisation.</p> <p>Not clear who on the ward is responsible for making those determinations, and who is to be contacted in the organisation to ensure that appropriate action is taken.</p> <p>Application to the Court of Protection is not clear which agency should commence the application LA or Health</p>
	<p>MCA policy does not mention the MCA provisions regarding restraint in the policies. Is mentioned in reference to DoLS but not outside the DoLS context</p>
	<p>IMCA the phrasing is misleading.</p>
	<p>Engagement of advocates outside the mandatory circumstances is not covered</p>
	<p>The MCA 2012 policy was not helpful in identifying when a DoLS could be said to be occurring corrected in the 2014 policy.</p>
	<p>Clearer guidance on eligibility might be appropriate</p>
	<p>Trust policy states that the provision of an IMCA is for people who do not have family or friends who can be consulted. This needs to be updated to reflect Section 39D of the MCA as provision of an IMCA goes beyond this.</p>

Recommendation

R2 In light of the comments from Professor Bartlett and the new Code of Practice, Southern Health should update their Mental Capacity Act and DoLS policies to provide clearer guidance about:

- overall responsibility for implementation;
- MCA provisions concerning best interests in the context of restraint;
- the determination of deprivation of liberty;
- the eligibility requirement; and
- the provision of independent mental capacity advocates.

Implementation of the law and policies

13.35 Two formal assessments of Connor’s capacity during his time at STATT took place. The first, on 16 April, concluded that he did not have capacity to decide whether he should continue to reside at STATT; the second, on 21 May, decided that he did have capacity to consent to medical treatment, in particular risperidone.

Comment

The fact that the conclusions differed is not necessarily problematic: capacity is decision- and time- specific, and the assessments concerned different decisions more than a month apart. The April assessment appears convincing. It notes that Connor’s anxiety prevented him from ‘thoroughly thinking through’ his current situation and the consequences of leaving the ward. Professor Bartlett’s report concluded that Connor lacked capacity to make the relevant decision at that time and that this seems “coherent and defensible” under the MCA.

13.36 The May assessment is more problematic. Where the April assessment said Connor could communicate his views, this seems to have been a significant difficulty in the May assessment. It seems that the assessor in May was unable to determine Connor’s ability, noting that the relevant issues were ‘difficult to establish’.

13.37 It is not clear from the report how much that flowed from Connor’s lack of understanding, or his inability to communicate, or his choice not to communicate. Notwithstanding the absence of evidence written on the assessment form, the assessor answered ‘no’ to the four key questions on the assessment, whether Connor was able to understand, retain, use or weigh, and communicate the relevant information. The reasoning is not recorded on the form.

13.38 The failure to understand, retain, use and weigh or communicate information should have been clearly evidenced on the form. There also appears to be a failure to distinguish between a refusal to communicate which is not the same as an inability to communicate.

13.39 As the assessment form correctly states, the inability to do any one of these would mean that Connor lacked capacity; nonetheless, the assessor said he did not lack capacity. That decision is not consistent with the previous responses. The assessor provides the following explanation:

“Connor would not communicate in any manner that helped us gauge if he would be happy to consent to taking risperidone. However, since commencing medication, he has been happy to take it.”

“In the case of commencement of risperidone, Connor’s parents were included in the discussions and their opinions sought. This was due to their knowledge of Connor and his presentation. It also gave them the opportunity to discuss the difficulties as they saw them. They were very helpful in our assessment of the use of risperidone.”

13.40 If this statement is meant to explain why a finding of incapacity was not made, it suggests a basic misunderstanding of the Mental Capacity Act. Capacity under the MCA is a matter of understanding and processing the relevant information so as to make the decision. Whether Connor was or was not ‘happy to take’ his medication is not relevant to his capacity to do so, nor are the views of his parents regarding the desirability of the medication. These factors would be relevant to determining Connor’s best interests, but that question arises only if a finding of incapacity had been made. If Connor had capacity to do so, as the assessment states, he had the right to make his own decisions about medication.

13.41 However the assessment form is read, it does not suggest a clear understanding of the MCA.

13.42 The clinical record of 16 April includes a brief reference to Connor's capacity to decide whether to remain on STATT, but no reference in the notes to the assessment of his capacity in May. Apart from the ambiguous statement noted above, the records contain no formal best-interests assessments or formal decisions regarding best interests that refer to the Act.

13.43 Little detail is included about the reasons for those decisions. There was little further in the notes as to how frequently capacity assessments were carried out, who was in charge of them and what was entailed. Southern Health's policies do not identify who is responsible for implementing MCA, but instead place this as a responsibility for all staff.

Comment

The risk of this approach is that matters that are everyone's responsibility become no one's responsibility, and do not happen.

13.44 The MCA expects that all reasonable efforts should be made to elicit the actual view of the individual, taking into account the nature of his or her disability. The notes make clear that by the time of the CPA review on 10 June 2013 staff and Connor's family disagreed on whether the staff's understanding of Connor's wishes reflected his actual wishes. Both parents visited Connor many times but their views were not recorded in details until the CPA review on 10 June.

Comment

This suggests that this aspect of the MCA was inadequately followed. Whilst there was no legal requirement to appoint an independent mental capacity advocate (IMCA), even if the person lacking capacity or their close family requests it, it may have been appropriate in this case.

Deprivation of Liberty Safeguards (DoLS)

13.45 Connor remained on STATT as an informal patient after his initial admission under Section 2 of the MHA.

13.46 The best-interest assessor was interviewed as part of this legislative review. The best-interest assessor's practice was almost certainly consistent with those of other competent best-interest assessors at the time. The conclusion being that based on the standards of practice at the time, no criticism can be made of the decision of the best interest assessor. However, appendix M provides further content in relation to the best interest assessment in light of 2014 decisions (*Cheshire v West*) that has an impact on future DoLS decisions.

Mental Health Act

13.47 Connor was detained under Section 2 MHA on 20 March 2013. There is no criticism to be made of the processes used in this detention. There is no suggestion that the decision to admit Connor was arrived at lightly. The Section 2 detention lapsed on 17 April 2013 and he became an informal patient.

Comment

The use of MCA in this case raises issues of relevance for Southern Health NHS Foundation Trust. It may be advisable to improve on the relevant policies to ensure that the gaps are addressed.

This review raised questions about the scope of regulation provided by these frameworks (details in appendix N) and these should be considered nationally as part of the DoLS reform process.

Findings

F10 The decision of the best-interest assessor that Connor was not deprived of liberty was consistent with the law and the practice of best-interest assessors at the time.

F11 The approach to the MHA by the staff of STATT appears to have been consistent with law and practice at the time.

F12 The use of both DoLS and MHA were consistent with professional practice at the time.

Epilepsy management

13.48 One of the factors we identified in our first report into Connor's care was the failure of the team to properly risk assess his epilepsy. This led to having in place a plan for him to be observed every 15 minutes while he was in the bath. This approach to safety around bathing breached national guidance on risk management for the care of individuals with epilepsy and was not how Connor's mother had cared for him at home.

13.49 Epilepsy management was considered as a quality priority and identified as such in the *Ridgeway Partnership: Quality Accounts 2011/2012*. The following is an extract from that document.

Service User Safety	Reported Progress:	Additional Action for 2012/2013
Priority 1:		
Reduce the risks to the health and well-being of service users who have epilepsy	Accident and incident statistics for social care are reported on a monthly basis and comparisons can be drawn between 2010/11 and 2011/12. Statistics demonstrate that there has been an overall reduction in the number of reported Accidents and Incidents relating to seizures over this time. An audit of training delivered in 2011-12 has been completed and the	Completion of audit of epilepsy management plans

	<p>training need for 2012-13 has been calculated and planned for. Due to changing priorities within the Learning Disability Teams (LDTs) in response to Commissioning targets and the BeeHive Project, there has been a limited capacity to undertake the Audit of Epilepsy Management Plans. This target will be carried over to the 2012-13.</p>	
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13.50 The following is a quote in the report from the PCT:

“NHSO [NHS Oxfordshire] is disappointed to note that some of the priorities for the year 2011/12 were not met, or were met only partially. In particular the work around improving the treatment and management of epilepsy, identified for 2011-12, was not completed and has been carried forward to 2012-13.”

13.51 Southern Health had produced a 41-page document entitled *Epilepsy in People with a Learning disability map* (Version 1 2012). The document provides a range of information about epilepsy. The map is based on the National Institute for Health and Care Excellence (NICE) guidelines. It had not been implemented in STATT at the time of Connor’s death, as we noted in our first report. Even so, it is the responsibility of individual regulated professionals to be aware of NICE guidelines, irrespective of whether they are contained in local policies.

13.52 We asked Southern Health for an explanation of the implementation of the epilepsy map. Southern Health provided us with a covering letter and a briefing paper which they had already shared with the Health and Safety Executive and the police.

13.53 We provide here some extracts to help understand the context and significance of the Southern Health’s rolling out of the epilepsy map.

13.54 The following quotes come from the covering letter supplied with the briefing paper:

“[...] has explained that the audit of epilepsy management plans was added to the 11/12 Clinical Audit Plan as the end point of a larger project which was seeking to establish in the first instance, which patients on the various caseloads had a diagnosis of epilepsy. This was primarily focussed on community teams. The numbers of patients in in-patient units with epilepsy was very low (for eg. on STATT in the 11 months prior to Connor’s death, there had only been 1 other patient with epilepsy and they had only been on the ward for a matter of hours before being discharged).”

“At the time, a new electronic record RiO had been introduced which did allow for capturing of data about various diagnoses in community patients. Diane explained that as the system was so new to staff, this was not being captured consistently and she wanted this issue to be resolved in order that a sample could then be selected for audit. This did not happen in 11/12 and in fact remained a problem in the first 3 quarters of 12/13. Updates provided to Ridgeway’s research and development committee in Q1, Q2 and Q3 of 12/13 (prior to acquisition) describe the ongoing problem with the consistent capturing on the RiO system of patients with a diagnosis of epilepsy. This issue with RiO was not in relation to the actual clinical entries but in relation to staff entering the diagnosis into the correct drop down (as well as in free text) such that electronic searches would pull all the relevant records.”

“It is important to note that whilst clinical audit is an important quality tool, it is a retrospective process. Opportunities for quality improvement in ‘real time’ is also available to teams through clinical supervision, 1:1s between staff and managers, peer reviews, matron walkabouts etc.”

13.55 The following quotes come from the briefing paper Southern Health supplied:

“The epilepsy toolkit is not a formal trust policy. It is a collation of tools that supports the epilepsy map, which is a specific clinical pathway. There is an important distinction between trust policies and the numerous other documents

¹ A matron from the former Ridgeway Partnership who was responsible for clinical audit at the time in question.

available to staff, including clinical and non-clinical guidance notes. The majority of Trust policies were adopted by Ridgeway staff on acquisition (i.e. November 2012) and some subsequently rolled out in accordance with a plan developed by a pre-acquisition workstream chaired by the Chief Medical Officer. However, it would not have been practicable to introduce the hundreds of clinical and non-clinical guidance notes, standing operating procedures, toolkits, templates, information packs, support tools etc. all at one go. All professional staff would be expected to use their clinical training, experience and qualifications to guide competent clinical practice.” (our emphasis)

“In addition, the epilepsy toolkit was designed to be used with a clinical strategy and clinical pathway approach that was in place in the Hampshire learning disability services. Those clinical strategies and clinical pathways in the Hampshire learning disability services differed significantly to the model in the former Ridgeway services. This meant that before the toolkit could be fully rolled out, there needed to be a significant piece of work undertaken to change the clinical strategy and clinical pathway in the former Ridgeway services. The planned roll out of the new pathways of care for the former Ridgeway services (which the toolkit supported) was a significant piece of work planned over the period of at least a year post acquisition.”

13.56 This summarises the work done by Southern Health before the acquisition.

“June 2012

John Stagg (Lead Nurse for the Learning Disability Division at that time) asked [...] to undertake an epilepsy project for a period of 6 months, 2 days per week. [...] is a community learning disability nurse with a specialist interest in epilepsy. She has the ENB N45 (Nursing Care of the Individual with Epilepsy) qualification, and is a member of the epilepsy sub group. One aspect of the project was to review the assessment tools for epilepsy already being used across the Division and to develop a package of epilepsy assessments that would be used consistently.”

“The objectives of the project were focused in Hampshire as this was prior to the acquisition of the former Ridgeway Services and were set as:

- 1. To support the development of the epilepsy Pathway/ Map and associated*

documentation (this term included the epilepsy toolkit).

- 2. To support the development of the nurse competencies for epilepsy.*
- 3. To develop the skills and competencies of nurses within Southern Health NHS Foundation Trust in relation to epilepsy.*
- 4. To develop an approved set of training materials for use by nurses.*
- 5. To assess the local demand for epilepsy and rescue medication training to private providers (and if necessary write a proposal for this).*
- 6. To investigate the need for an epilepsy specialist nurse to work with people with learning disabilities within Southern Health NHS Foundation Trust.”*

13.57 This is the key work done by Southern Health after acquisition.

“13 Jan 2013

A nursing competencies workshop occurred, originally planned for Hampshire services only, but nurses from Oxfordshire and Buckinghamshire services were also invited as they had just joined the division. This would have been the first time the nurses in the newly acquired services had heard about the 6 areas of clinical practice, epilepsy being one of them. The presentation had no specific slides on the epilepsy toolkit, but copies of the nursing competency document were handed out and this would have made reference to the epilepsy map and toolkit. The epilepsy map and toolkit would have been discussed. Nurses from some of the newly acquired teams would have been present at that time.”

“May 2013

By this time the initial settling in period for the teams had passed and [...] was beginning to contact and meet formally with the senior nurses. One of the first meetings was with the Oxfordshire Community Teams’ senior nurses in May. The epilepsy map and toolkit were shared and the actions were simply for the senior nurses to consider the epilepsy map, competencies and toolkit and to share with teams as appropriate.”

“Jan 2014

An additional launch of the nursing competencies was carried out as a workshop for nurses within the north (Oxfordshire and Buckinghamshire) teams. This PowerPoint is attached and has a set of slides relating specifically to epilepsy. The nursing

competency document has a section relating to epilepsy which reflects the content of the epilepsy map.”

“November 2014

All of the clinical maps, including epilepsy, were officially launched across Oxfordshire and Buckinghamshire.”

“Epilepsy training

A full programme of epilepsy training for all learning disability division staff was started during the last quarter of 2013.”

“Prior to this time, training on epilepsy was available to all staff, mainly delivered in a bespoke fashion by a number of the epilepsy clinical area of practice group members (for Hampshire) or by some of the community learning disability nurses in Oxfordshire. This training was not mandated, which is the norm for post registered staff, but was undertaken in response to professional development needs and continuing professional development. It was also not administrated via the learning and development team and hence there is no record of the training upon individuals training records.”

“The training delivered from August 2013 involves the following as mandatory:

- A full day training for all nurses and occupational therapists.*
- A two-hour session for all other clinical staff (psychologists, speech and language therapists and physiotherapists) was added to the programme in August 2014. These two hour sessions were available twice a month.*
- Bespoke sessions focused around specific teams are made available if required. Medical staff maintain their epilepsy knowledge and skills in line with their annual appraisal and revalidation.*
- Refresher sessions. The frequency of the refresher courses has been agreed based upon the guidance provided through the trust’s learning and development team.”*

“The epilepsy clinical area of practice group review all new guidance as it becomes available and would ensure any training needs in relation to new guidance is met; providing bespoke sessions to teams if necessary outside of the refresher updates. At

the current point in time (June 2015), all nurses and occupational therapists have completed their training. The rest of the health staff are continuing to attend the 2 hour sessions. Compliance with this training is monitored via the learning and development team with regular update reports being circulated to heads of service. The overarching compliance monitoring occurs through divisional performance meetings.”

“Conclusion

There was nothing in the due diligence and quality reviews carried out pre-acquisition that raised the issue of epilepsy as a red flag issue for the former Ridgeway Trust. The toolkit is intended to supplement knowledge that registered nurses will have acquired whilst still in training. Hampshire staff, former Ridgeway staff and staff in other trusts have been caring for patients with epilepsy without such a toolkit for several years.” (our emphasis)

“There were a significant number of clinical and non-clinical tools, templates, guidance documents etc which Southern Health Trust had which Ridgeway didn’t. It would not have been practicable or reasonable to roll these out all at the same time immediately post- acquisition. Acquisitions of this nature can be de-stabilising for staff and the trust took the approach of trying to maintain consistency and continuity for former Ridgeway staff whilst getting to know more about the services and gradually rolling out pathways and processes which were established in Hampshire services.”

Comment

Southern Health’s strategy for introducing a number of clinical pathways and maps was appropriate. The only indicator that epilepsy might be an area of concern was identified in the mock CQC visit to Postern House in Wiltshire. The quality review report says on page 11:

“An epilepsy care plan was viewed. The inspector was not able to determine neither the type of epilepsy nor the type of seizure and staff were unsure how this should be recorded.”

Finding

F13 Southern Health's strategy for introducing a number of clinical pathways and maps was appropriate.

STATT clinical team

13.58 The clinical team responsible for Connor's care covered the care of people with epilepsy in their basic training. All registered staff have a professional duty to keep up to date with national clinical guidance, as well as following local trust policies where they are available.

Finding

F14 The clinical decisions of the qualified and registered health professionals at STATT around the care of Connor's epilepsy and risk management as set out in our first report were inappropriate and unsafe. They were not caused by a failure to have in place appropriate epilepsy policies or trust guidance.

Action plans

"Assessment of Southern Health's action plans in response to CQC inspection and Verita's investigation into the care of Connor"

13.59 Monitor (the regulator for foundation trusts) imposed enforcement undertakings for breaches of four conditions of Southern Health's licence following the publication of the September CQC report and the Verita report into Connor's death. The CQC and Verita reports imposed additional tasks to the action plan (some mandatory, some voluntarily undertaken by Southern Health), placing a greater burden on the service.

13.60 The Southern Health executive team decided that the execution of the existing action plan, plus the extra tasks resulting from the CQC and Verita reports, required

additional (external) resource to ensure the plan was 'fit for purpose' and that it was efficiently and effectively implemented. Trust senior executives felt that meeting the burden solely from internal resources would take up too much senior time and attention, to the possible detriment of other areas of operation. A 'specialist healthcare advisory practice' - MBI Healthcare - was commissioned to review and refine the existing plans, provide implementation support and provide communications and reassurance to commissioners and regulators - essentially to provide executive oversight of the action plan.

The action plan

13.61 We did not see earlier versions of either the main trust action plan or any of its constituent parts before a publication dating from early 2015 (incorporating some elements from November 2014). We therefore, comment on the current strength, applicability and state of completion of the action plans. Tasks and actions contained in the plan covered a time from the end of 2013 (due completion date) until the end of 2015 (due completion date).

Summary

13.62 The action plan is clearly structured, with separate sections relating to five distinct work streams.

1. Turnaround
2. Progression
3. 'Business as usual'
4. Verita
5. CQC

13.63 Each of these areas is divided into individual issues. In each case, these issues are specific, measurable, achievable, realistic and time-scaled (SMART) and, in the case of the CQC and Verita sections, directly address problems identified by the inspection/report respectively. All articulate the issue to be addressed, the actions to address it and the benefit that will result.

13.64 Each task has a clear explanation of what evidence is needed to demonstrate progress (or completion) and a date when it is due. The sections relating to the CQC inspection and the Verita report (though not the three earlier work streams), assign overall responsibility for the task to a named individual. In order, presumably, to maintain coherence and consistency across the work streams, if any element of the turnaround, progression or ‘business as usual’ streams feeds into the CQC or Verita plans, this is noted. Finally, each action is rated on a standard RAG scale (red, amber, green) in order to track progress.

Programme quality governance

13.65 A comprehensive governance structure¹ was implemented to provide oversight and accountability for the work in the learning disability division, with meetings held at intervals and at varying levels of seniority as appropriate.

Name	Frequency	Short term or ongoing
Learning disability executive-led assurance group	Weekly (Monthly chaired by NED)	Short term (scrutiny now takes place as ‘business as usual’ as part of divisional performance reviews)
Learning disability divisional director, clinical director and MBI rep meeting	Weekly	Short term
Learning disability divisional senior management team meetings (operational)	Weekly	Ongoing
Learning disability divisional service board	Monthly	Ongoing
Learning disability quality & safety meeting	Monthly	Ongoing

¹ Data provided by Southern Health

Learning disability service performance review (now called area performance reviews)	Monthly	Ongoing
External: risk summit and oversight meetings	Externally determined	Short term

13.66 We were provided with minutes of meetings from these groups, which appeared comprehensive and recorded actions focused on outcomes. Effective completion of individual tasks (and, therefore, the wider action plans) was the clear priority of the groups.

Evidence base

13.67 The trust provided us with comprehensive notes on the evidence base for the successful progress or completion of tasks.

13.68 Based on the documentary evidence we received we found clear congruence between the ‘evidence requirement’ for each task in the action plan and the evidence actually recorded or submitted.

External assurance

13.69 In April 2014, Southern Health commissioned Professor Michael P Kerr (professor of learning disability psychiatry and honorary consultant neuropsychiatrist, Cardiff University and Abertawe Bro Morgannwg University Health Board) to review Southern Health’s action plans and assess their fitness for purpose. In a positive assessment, we highlight the most pertinent conclusions from his report.

- *It is my opinion that the plans are comprehensive in their scope; addressing all areas of concern raised by CQC and Verita.*
- *It is my opinion that the plans are an adequate response to these [CQC and Verita] concerns.*
- *It is my opinion that the plans have appropriately placed the individual with a learning disability central to the delivery of care.*

- *It is my opinion that the plans have provided an appropriate focus on the quality and efficacy of the care provided.*
- *It is my opinion that the plans have provided an appropriate focus on the use of audit and supervision to monitor the quality of the care provided.*
- *Southern Health NHS Foundation Trust have developed a timely response to the concerns raised. This response is comprehensive and will, I believe, lead to the necessary changes.*

Finding

F15 The learning disability divisional action plans developed in 2014 are of a good quality, comprehensive in their scope and linked directly to the issues CQC and Verita identified, post Connor's death. Southern Health recognised a potential shortfall in capacity at the oversight level of the plans and responded by commissioning external experts (MBI Healthcare). They combined this with the commissioning of an external review of quality. This demonstrates that they recognised the problems and acted to address them.

14. Conclusions

14.1 Earlier in our report we set out our evaluating test for assessing the evidence as:

- Did the way learning disability services were commissioned or managed contribute to the preventable death of Connor?

14.2 We formulated three key questions to address the evaluation test.

- 1 What did Southern Health and their commissioners know about the quality and safety of services in STATT before the acquisition?
- 2 What processes did Southern Health and the commissioners put in place to assess risk and to mitigate any potential reduction in quality of care?
- 3 Did Southern Health have appropriate leadership and quality systems to take forward and manage services after acquisition and to address known quality issues identified before acquisition (if any)?

14.3 We also reflected on the following questions.

- Did commissioners ensure that the transition to a different provider addressed known safety and quality concerns?
- Did the location of Southern Health's senior executives in Southampton and the trust's geographic distance from Oxfordshire have an impact on communication, support and oversight of the services provided there? In particular, did this impact on service users, families and staff in Oxfordshire?

14.4 We set out here the conclusions that we believe address the main points of the ToR and which the evidence allows us to make.

Conclusion 1

14.5 The County Council, commissioners of the STATT, carried out a quality monitoring review of the STATT in November/December 2012. An action plan was produced by Southern Health and this was reviewed by the commissioners in July 2013. The commissioners also reviewed the update of the Southern Health quality and safety review in May 2013. The commissioners chased up Southern senior managers in the first few months of the contract to get them to be more engaged with the regular contract review meetings.

14.6 There is no evidence that acts or omissions of commissioners contributed to the inadequate care received by Connor that led to his preventable death. We set out our rationale for this in our overall conclusion below.

Conclusion 2

14.7 Quality reviews carried out before acquisition or at the point of acquisition did not find that STATT had acute clinical, managerial or systems failures. In contrast, concerns were focused on the non-Oxfordshire services where patient safety risks had been identified.

Conclusion 3

14.8 An overreliance on a 'business as usual' approach to this acquisition was not appropriate. Southern Health should have ensured that any deterioration in the quality of services could be identified quickly and through processes that Southern Health could place their confidence in.

Conclusion 4

14.9 The post-acquisition process by Southern Health was not effective because:

- the two key managers with an experienced learning disability background did not want to be part of managing the new services;

- the trust had not put in place sufficient and timely actions needed to begin to address the cultural change required of an established learning disability service joining a large mental health and community trust with a small learning disability service;
- the trust did not evaluate or address the known concerns about the quality of local leadership; and
- local managers were also dealing with a number of significant issues existing in non-Oxfordshire services.

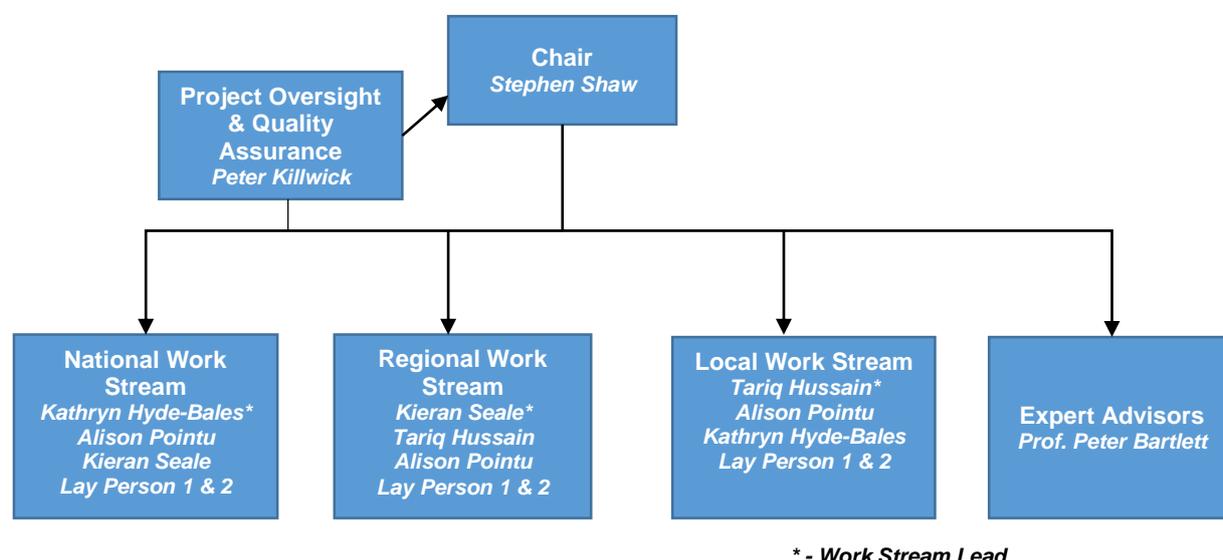
Overall conclusion

14.10 In our first report we took the view that the key issue in Connor's care was poor practice by clinical staff. We have not seen anything during our work on this second investigation to change that. While we have identified deficiencies in the way Southern Health carried out its post-acquisition actions and that these had an impact on staff (as the independent reports commissioned by Southern Health in late 2013 show in relation to the Oxford services) there is no evidence that these affected the clinical decisions or team working in STATT, as they related to the care of Connor.

14.11 If Southern Health had carried out their post-acquisition actions more effectively this may have identified weaknesses in the way staff in the STATT were working. We have not seen evidence which would allow us to conclude that this would have prevented the poor decisions around Connor's care.

14.12 The failures in care during Connor's inpatient admission were not caused by managers or commissioners. The clinical staff failed to carry out procedures and processes that were their responsibility and within the competence and knowledge expected of registered health professionals. Principally, clinical staff did not work effectively together and follow NICE guidelines regarding the care of individuals with epilepsy.

Independent investigation team structure and biographies



Chair

Stephen Shaw

Stephen’s career spans the voluntary and public sectors. He is best known for his ten years as Prisons and Probation Ombudsman for England and Wales. As well as overseeing his office’s complaints and fatal incidents work, he led sensitive and high-profile investigations including the inquiry into the 2002 fire and riot at Yarl’s Wood immigration removal centre and the investigation into the death in 2004 of Harold Shipman. In 2006-08, he chaired the first public inquiries into ‘near deaths’ (suicide attempts resulting in life-threatening injuries).

After stepping down as ombudsman in 2010, Stephen was appointed chief executive of the Office of the Health Professions Adjudicator. In that role he helped plan the replacement of the General Medical Council’s ‘Fitness to Practise’ hearings with a modern tribunal consistent with other parts of the administrative justice system. The OHPA start-up operation was commended by the Office of Government Commerce as “being run extremely well”.

Stephen currently chairs the Independent Advisory Panel on Non-Compliance Management that advises the UK Border Agency on safe methods of restraint. He is also a member of the tribunal of the National Federation of Property Professionals that adjudicates upon complaints against estate agents, letting agents, auctioneers and valuers.

Stephen's work with Verita has included co-leading a review of consultant team working in a large and troubled NHS histopathology service and a comprehensive governance review within a trust. Stephen is an experienced lecturer, public speaker, and trainer, and has published widely. He was made a CBE in 2004, and in 2010 received the Perrie Award for lifetime contribution to criminal justice.

Core team

Alison Pointu

Alison is a recently retired executive nurse with a varied nursing career that spans 35 years. Alison is regarded as a knowledge expert in learning disabilities, providing advice and support to the London Strategic Health Authority, Cabinet Office, NHS England and the Department of Health.

She is a very credible clinician amongst her peers and an advocate to patients and their families, championing the needs of those that are vulnerable.

Alison spearheaded one of the first acute liaison projects, which influenced the National Strategy for learning disabilities. These changes brought benefits and improvements in patient outcomes. This work was cited as good practice in various publications. Alison also designed a programme of quality improvement through a series of observational visits to commissioned services across the whole patient pathway.

Alison has completed a Masters in Health Science (Learning Disabilities Studies) and is currently in the final stages of writing up her thesis of a qualitative research study with women with learning disabilities that will lead to the award of Doctor in Health Research.

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability having worked in that field for over 20 years. He has also worked in mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Tariq was the lead investigator on the first Verita investigation into Connor's death.

Kathryn Hyde-Bales

Kathryn joined Verita as a senior consultant in 2012. She previously worked at the Care Quality Commission (CQC), and its predecessor organisation, the Healthcare Commission. During this time she primarily held roles in investigation teams, working and leading on a number of projects. Her last role at CQC focused on managing the provision of analytical support to standalone projects and regional teams within CQC, covering the NHS, independent and social care sectors.

Kathryn was an investigator on the first Verita investigation into Connor's death.

Kieran Seale

Kieran is legally trained and an experienced consultant whose career encompasses local government, government agencies and the private sector. He has spent the last five years working in NHS commissioning. He was involved in the setting up of four central London Clinical Commissioning Groups, advising on areas such as governance, risk management and conflicts of interest.

Peter Killwick

Peter has worked in consulting for over 20 years, covering a wide range of strategic and operational issues in a wide range of sectors including healthcare, government, automotive, financial services, manufacturing, retail and telecommunications. His areas of particular expertise are in project managing teams, developing operational strategy, operational performance analysis and complex investigation.

Expert advisors

Professor Peter Bartlett

Peter Bartlett is the Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law, Faculty of Social Sciences.

Following two degrees in philosophy at the University of Toronto, Peter Bartlett read law at Osgoode Hall Law School of York University, Canada. After his call to the bar in 1988, he served as Law Clerk to the Justice of the Ontario High Court and then as research associate to the Ontario Enquiry on Mental Competency. He obtained his doctorate in 1993, and joined the School of Law at the University of Nottingham, where in April 2005 he was appointed to the Nottinghamshire Healthcare NHS Trust Chair in Mental Health Law.

Professor Bartlett's research interests are primarily in the area of mental disability (including both psycho-social disability/mental illness and learning disability), both in England and Wales and internationally. He has provided advice regarding law reform in Lesotho and Bosnia and Herzegovina, and for six years (four as chair) served on the board of the Mental Disability Advocacy Center (MDAC), a human rights organisation based in Budapest. His research interests include the Mental Health Act 1983 (England and Wales), the Mental Capacity Act 2005 (England and Wales), and the European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities. He is also interested in the history of law and psychiatry, particularly in England.

Summary of documents provided to investigation

Southern

- Complaints SHFT April 2014
- CS Report Publication Statement Easy Read FINAL
- Piggy Lane CQC Inspection report 24/30 April 2014
- Professor Michael P Kerr 29 April 2014 A Review of the current Learning Disability Action Plan
- Action plan 1st Verita investigation
- Winterbourne view action plan
- Summary - Deloitte quality governance Review
- Summary - Deloitte Board Governance Review
- Turnaround plans former Ridgeway Trust
- Summary of external clinical expert view on plans
- Commissioned services by locality
- Various schedules from contract with OCC
- March 2013 BAF paper to Trust Board
- May 2013 BAF paper to Trust Board
- July 2013 learning disability Divisional structure
- Current learning disability Divisional Structure
- Minutes of Board meetings
- MCA policy in place in July 13
- Current MCA policy
- Transition Protocol for Young People from learning disability CAMHs Oxon to Adult learning disability Services
- Information sharing agreement
- Learning disability care pathways
- Learning disability Restriction & Restraint Code of Practice
- Briefing note on role of MBI consultants
- New learning disabilities plan 16 7 2014
- Dementia map
- Epilepsy toolkit_nov12
- Epilepsy_map_nov12

- Southern Health Action plan May 2013
- Southern Health response to action plan June 2013

Acquisition and implementation documentation

- Chronology of Acquisition Transition and Implementation - July 2011 - July 2013
- Summary of Acquisition Transition and Implementation - July 2011 - July 2013
- Quality Improvement -Project Initiation Document (30 July 2013)
- Consultation on Changes in Learning Disabilities Division
- Governance Workstream Implementation and Challenge Meeting Agenda
- Learning Disabilities Development Programme 2012-2016
- Governance and Assurance Workstream Implementation Plan - October 2012
- Ridgeway Transition Programme Workstream 1 (Governance and Assurance) -1 May 2012
- Ridgeway Transition Programme Brief - April 2012
- Quality & Safety Review Report
- Summary, Analysis, Recommendations and Actions from Clinical Quality Review
- Deloitte Quality Governance Integration Review
- Governance Workstream Implementation and Challenge Meeting Presentation
- Recommendations and Actions from Clinical Quality Review May 2013 update
- Report to Quality & Safety Committee Oxford Learning Disability Trust (Ridgeway) Policies to be Extanted - October 2012
- Southern Health NHS Foundation Trust Response to OLDT Quality and Safety Assurance Review (October 2012, March 2013 and June 2013)
- Our Integration FAQs
- Joining Together Briefing
- Briefing Guidance for Managers
- Briefing Script for Managers
- Case Study for NHS Confederation
- About Us Guide
- Information and Consultation Document on the Acquisition
- Trust's Journal on Integration
- Your Career Guide
- Social Care Staff Briefing

- Second Integration Update Newsletter
- Your Division Guide
- Communication and Engagement Implementation Plan - 30 August 2012
- Communication and Engagement Workstream - 15 February 2012
- Feedback Questionnaires from Roadshows
- First Integration Update Newsletter
- Fifth Integration Update Newsletter
- Findings' Presentation - September 2012
- First Post-Merger Weekly Bulletin - November 2012
- Getting Started Guide
- Roadshow Presentations
- Timeline Briefing

Monitor

- Monitors enforcement undertakings (April 2014)
- Southern health response to Monitor

National guidance

- Maintaining and improving quality during transition: safety, effectiveness, experience. Part 1 - 2011-12 (National Quality Board)
- A guide for clinical commissioning groups and other commissioners of healthcare services on commissioning for compliance, April 2014
- Valuing people now
- Valuing people

NHS England

- SHFT Oversight meeting 16/6/14
- SHFT Oversight meeting 24/4/14

- Delivering Effective Specialist Community Learning Disabilities Health Team Support to people with learning disabilities and their families or carers

OCC

- Specialist Health Services contract
- STATT and JSH Quality monitoring report from Nov/ Dec 2012
- Comparison report done by Oxfordshire County Council comparing CQC report and Quality Monitoring
- Health and Wellbeing Board report July 2014
- Confidential briefing to MP's May 2014
- Confidential briefing to MP's June 2014
- Confidential briefing to County Councillors May 2014
- Letter from John Jackson to Dr Ryan re Mental Capacity Act April 2014
- Mental Capacity Act view email from Amy Allen (DOLs Manager) April 2014
- Letter of thanks from Dominic Slowie when he was a member of the National Commissioning Board -Learning Disabilities Core Service Specification Project, following a visit to STATT (Assessment and Treatment) in Oxford in Feb 2013. Dominic is now the National Clinical Director for Learning Disability
- National Commissioning Board recognition email Jan 2013.
- Strategic Health Authority commissioned quality review done by Contact Consulting Sept 2012
- Oxfordshire action plan from regional review July 2013
- Southern Health Action plan May 2013
- Southern Health response to action plan June 2013
- Learning Disability Commissioning and Contracting Team contract management and quality monitoring process document
- Quarterly contract meeting information
- Quarterly monitoring reports and follow up - recent amendments to quarterly contract management minutes are to insert comments for clarity no change to content. Quality Assurance from Sept 2014 was led at a regional level at regional meetings led by NHS England rather than at a local Oxfordshire level.
- Quality monitoring toolkit overview summary sheet and score sheet
- Contract default information

- The learning disability commissioning Strategy 'The Big Plan' - developed fully with service users and family carers
- The admissions process - direct response to Winterbourne Action Plan
- Pre placement checklist - direct response to Winterbourne Action Plan
- CCG and OCC safety culture report Sept 2013
- Winterbourne Plan to Health and Wellbeing Board July 2014
- Terms of reference of the multi-agency, multi-professional inpatient monitoring meeting
- Cabinet Report - Merger/ Acquisition of Ridgeway Partnership NHS Trust Jan 2012
- Letter sent to Chief Executive, Katrina Percy in Feb 2013 due to lack of senior management engagement
- Response to above letter from Acting Chief Executive, Sue Harriman
- Engagement improved in April/ May following the appointment of Lesley Munro - notes of keeping in touch meeting July 2013
- Joint Management Group report - this is the same report that went to the Health and Wellbeing Board that you already have [not supplied?]
- Short breaks statements for families with disabled children in Oxfordshire. Nov 13
- Oxfordshire County Council - Children's disability team, Connor Sparrowhawk chronology

Additional documents received at interviews

- A guide to the fairer charging scheme
- Budget allocation letter
- Carers assessment form
- Country transition minutes 5-12-12
- Country transition minutes 12-6-13
- Dommie Ray emails
- Employability & Personal Development Traineeship Leaflet
- learning disability Crisis care plan
- Lessons learnt by Oxford City learning disability Team
- Letter from Ben Jackson - transition example
- List of contacts
- Recommendations & actions from clinical quality review May13
- Support plan

- What is learning disability leaflet

Oxfordshire learning disability partnership board

- Easy Read LDPB Agenda 19th Nov 2014 - Final
- How it works Dec 12
- Learning Disability Partnership Board Membership 2014-15, 10th Dec 2014
- Learning Disability Partnership Board summary 10th Dec 14

Post interview docs

- Letter sent to Andrew Hall in March 2012
- Commissioning intentions 26 Sept 2011

Safeguarding Oxfordshire

- Department of Health Statement of Government Policy on Adult Safeguarding
- Meeting with Donald McPhail 22/09/14
- Safeguarding Standards for Commissioners
- The governance of adult safeguarding: findings from research into Safeguarding Adults Board
- Terms of Reference & Responsibilities of Member Organisations
- Oxfordshire Safeguarding Adults Board - Annual Report 2011-2012
- Communication Plan
- The Oxfordshire Safeguarding Adults Board Business Plan 2013-2014
- Safeguarding Policy May 2013

Transition

- Impact of mergers of NHS Trusts - BMJ - 3rd Aug 2002
- Maintaining and improving quality during the transition: safety, effectiveness, experience Part One - 2011-12

West Hampshire

- WHCCG Board 28 March 2013 Minutes APPROVED
- WHCCG Board 23 May 2013 Minutes APPROVED
- WHCCG Board 25 July 2013 Minutes APPROVED
- WHCCG Board 26 September 2013 Minutes APPROVED
- WHCCG Board 28 November 2013 Minutes APPROVED
- WHCCG Board 30 January 2014 Minutes APPROVED
- WHCCG14-051 - Minutes of Board Meeting held on 27 March 2014
- WHCCG14-074 - Minutes of Board Meeting held on 29 May 2014
- West Hampshire CCG Annual Report and Accounts 2013-14 (2)
- WHCCG13-128 - Quality Scorecard (November 2013)
- WHCCG14-009 - Quality Scorecard (January 2014) (1)
- West Hampshire CCG - Summary of Governing Body Minutes
- MH Slides
- SHFT learning disability In-Patient Services Update
- The-new-ld-plan-1672014
- Dementia map
- Epilepsy toolkit_nov12
- Epilepsy_map_nov12
- Hampshire Intensive support service specification 1415 SCHEDULE 4
- learning disability community team (Hampshire) 4
- learning disability In-Patient Beds service specification4 15SCHEDULE 3
- Mental health map
- WV stocktake Hampshire submission July 13 (2)docx amended (2)_(HF000005013885)
- Notes on West Hampshire Documents

Winterbourne View

- Winterbourne View Concordat-data-slides - August 14
- Winterbourne View Joint Improvement Programme - stocktake of progress - executive summary

- DH concordat programme of action
- Transforming care - A national response to winterbourne view hospital

Oxfordshire CCG

- The functions of a clinical commissioning group
- CCG Assurance Framework - November 13
- CCG Assurance Framework 2013-14 - May 13
- Notes from BMHO Programme Board 19 September 2013
- OCCG_FINAL_Prospectus_A4_310513_Web_spreads (1)
- Oxfordshire CCG strategy for 201415-201819 and implementation plan for 201415-201516
- Oxford CCG - Operational plan-March-2013
- Paper-14.24-Assurance-Framework-March-2014_02
- Paper-14.60-Quality-and-Performance-Report
- Paper-14.67-OCCG-Sub-committee-Minutes
- RCGP learning disability Commissioning Guide v1 0 2012 09 24 FINAL
- UKSC_2012_0068_Judgment
- 140423-Slade
- Annual Report + Accounts + Governance Statement
 - Annual-Report-Section-1
 - Paper_14.35_-_Annual_Governance_Statement2
 - Paper_14.53_-_10Q_Oxfordshire_CCG_Accounts_6-6-141
- Governing Body Papers
 - Oxfordshire CCG 2013.03.28-OCCG-Shadow-Governing-Body-Minutes - March 13
 - Oxfordshire CCG - 2013-05-30-Governing-Body-Minutes - May 13
 - Oxfordshire CCG - 2013-06-11-Governing-Body-Minutes - June 13
 - Oxfordshire CCG - Paper-14.55-2014.05.29-Governing-Body- May 14
 - Oxfordshire CCG 130926-Paper-39-Governing-Body-minutes - July 13
 - Oxfordshire CCG - _2013__09__26_Governing_Body_Minutes_- Sept 13
 - Oxfordshire CCG - Paper-14.01-Minutes-28.11.2013-Governing-Body-Nov 13
 - Oxfordshire CCG - Paper-14.18-Governing-Body-Minutes- 30-January-2014

- Oxfordshire CCG - Paper_14.33_-_2014_03_27_Governing_Body_minutes1 - March 14
- Oxfordshire CCG -Governing-Body-Draft- minutes - May 14
- 2013-07-25-Paper-23b-AF-Executive-Summary-for-Governing-Body-17-7-13
- 2013-07-25-Paper-23c-Assurance-Framework-for-Governing-Body-17-7-13
- Health & Wellbeing Strategy
 - Oxfordshire_Joint_HWB_strategy_final
 - Oxfordshire's joint health & wellbeing strategy
- Correspondence with Dr Ryan

Interviewees

Southern Health

- Katrina Percy, chief executive
- Simon Waugh, chair
- Sue Harriman, former chief operating officer
- Andy Martin, former head of service for inpatient services for Oxfordshire, Buckinghamshire and Wiltshire
- Jenifer Dolman, clinical director
- Amy Hobson, former operational director for the learning disability services
- Lesley Munro, former divisional director for learning disabilities
- Heath Gunn, associate director for learning disabilities
- Kevin O'Shea, former clinical director for learning disabilities
- Nicky MacDonald, interim head of service
- John Stagg, lead for quality improvement
- Andy Irvine, MBI consultant
- Assessment and treatment services manager
- Team manager, South Learning Disability Team
- Team manager, North Learning Disability Team
- Band 6 charge nurse
- Community nurse

Oxfordshire Clinical Commissioning Group

- Sula Wiltshire, director of quality and lead nurse
- Richard Green, clinical director of quality
- Ian Bottomly, programme manager for mental health and joint commissioning
- Gareth Kenworthy, chief finance officer
- Helen Ward, senior quality manager
- Assistant finance officer and CSO

Oxfordshire County Council

- John Jackson, director of adult social services
- Andrew Colling, quality and contract service manager, joint commissioning
- Robyn Noonan, service manager for the operational and disability service
- David Proudfoot, operations manager, community learning disability team
- Ann Nursey, former lead commissioner for adult services
- Lara Fromings, commissioning manager
- Disabled children's service manager
- Disabled children's team manager
- Transition care manager
- Senior practitioner, city learning disability team
- Deprivation of Liberties assessor
- Deprivation of Liberties manager
- Social worker

Other

- Sir Stephan Bubb, CEO, ACEVO
- Zandrea Stuart, improvement adviser, Winterbourne View Joint Improvement Programme
- Hazel Watson, mental health and learning disabilities lead, NHS England
- Jane Ray, head of hospital inspection for mental health, CQC
- Michelle Stickland, head of learning disabilities, West Hampshire CCG
- Andrea O' Connel, director of Quality, West Hampshire CCG
- Donald McPhail, independent chair, Safeguarding Adults Board
- Jan Fowler, Director of nursing and quality, NHS England Thames Valley
- Julie Kerry, Assistant director of nursing, NHS England Thames Valley

Appendix D

Chapter 7-Health & Social Care Act guidance relevant to learning disability services

We list below the regulations that were applicable to the above services and relevant to this investigation¹:

Regulations of the HSCA 2008	Details of the regulation
Regulation 9 (care and welfare of service users)	Service users and others at risk must be protected from unsafe or inappropriate care and treatment.
Regulation 10 (assessing and monitoring the quality of service provision)	A system must be in place to ensure that services are monitored and assessed to protect the service user from unsafe or inappropriate care and treatment.
Regulation 11 (safeguarding service users from abuse)	Arrangements must be in place to safeguard the service user from abuse
Regulation 14 (meeting nutritional needs)	Service users nutritional and hydration needs must be met
Regulation 15 (safety and suitability of premises)	The premises must be safe and suitable for the service user
Regulation 16 (safety and suitability of equipment)	Arrangements must be in place to ensure equipment is appropriate and maintained
Regulation 17 (respecting and involving service users)	Service users are engaged, involved and supported in their care and treatment
Regulation 18 (consent to care and treatment)	Arrangements must be in place obtain consent and act accordingly based on this
Regulation 19 (complaints)	A system must be in place for the handling and management of complaints
Regulation 20 (records)	Accurate, patient records must be maintained and stored securely.
Regulation 21 (requirements relating to workers)	An effective recruitment system must be in place to recruit qualified and appropriate individuals, registered with the relevant professional body. A system must be in place to report individuals to

¹ In the interest of brevity we have excluded regulations that though applicable to the service are not immediately relevant in the context of this review e.g. Regulation 13, management of medicines

	the relevant professional body if they are found to no longer be fit to work.
Regulation 22 (staffing)	The provider should ensure that there is an appropriate number of qualified, experienced staff in place.
Regulation 23 (supporting workers)	A system must be in place to ensure that staff have access to training, development, appraisal and supervision
Regulation 24 (cooperating with other providers)	A system must be in place to ensure the service user is protected when care and treatment is shared by providers.

Care Quality Commission (Registration) Regulations 2009	Details of regulation
Regulation 16 (notification of death of service user)	The registered person must inform the CQC of the death of a service user
Regulation 17 (notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983)	The registered person must inform the CQC of the unauthorised absence or death of a service user detained (or likely to be detained) under the MHA
Regulation (notification of other incidents)	The registered person must notify the CQC of any serious incident or injury

Family and service user chapters eight and nine- reference articles

- Beresford, B. (2004), On the road to nowhere? Young disabled people and transition. *Child: Care, Health and Development*, 30: 581-587
- Department of Health (DoH) (2003) *Getting the Right Start: National Service Framework for Children Emerging Findings*. TSO, London, UK
- Department of Health (2001) *Valuing People: A strategy for people with learning disabilities in the 21st Century*. HMSO, London.
- Department of Health (2009) *Valuing People Now*. HMSO, London.
- Forbes, A., While, A., Ullman, R., Lewis, S., Mathes, L. & Griffiths, P. (2002) *A Multi-Method Review to Identify Components of Practice Which May Promote Continuity in the Transition from Child to Adult Care for Young People with Chronic Illness or Disability* [WWW document]. Report for the National Coordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). The Florence Nightingale School of Nursing and Midwifery, King's College, London, UK. URL <http://www.sdo.lshtm.ac.uk/continuityofcare.htm>
- Grant, G. Whittell, B. (2000) *Differentiated Coping Strategies in Families with Children or Adults with Intellectual Disabilities: the Relevance of Gender, Family Composition and the Life Span*. *Journal of Applied Research in Intellectual Disabilities*, 13, 4, 256-275
- Grant, G. and Ramcharan, P. (2001), *Views and Experiences of People with Intellectual Disabilities and Their Families. (2) The Family Perspective*. *Journal of Applied Research in Intellectual Disabilities*, 14: 364-380
- Grove, B. 2001. *Connecting with connexions: early findings from the Lewisham learning disability pilot*, London: Kings College.
- Heslop, P., Mallett, R., Simons, K. and Ward, L. 2001. *Bridging the divide: what happens for young people with learning difficulties and their families?* Bristol: Norah Fry Research Centre.
- Hudson, B. (2006) *Making and missing connections: learning disability services and the transition from adolescence to adulthood*. *Disability & Society*, 21, 1, 47-60
- Mansell, J. (2010), *Raising our sights: services for adults with profound intellectual and multiple disabilities*, *Tizard Learning Disability Review*, 15, 3, 5 - 12

- May, D. 2000. Becoming adult: school leaving, jobs and the transition to adult life”. In Transition and change in the lives of people with intellectual disabilities, edited by: May, D. London: Jessica Kingsley.

Chapter 11- Recommendations from Oxfordshire County Council quality review report November/December 2012

Admission and discharge

- The service needs to work in a way that promotes recovery and earlier discharge
- Information recorded needs to include more detail in the recording especially in regards to who a person is
- The organisation needs develop the input from these services into community support upon patient discharge

Therapies and treatments

- Support staff need to have greater understanding of treatments and therapies provided and to become actively involved in these areas.
- Where skills are in need of developing relating to independence (where appropriate) for discharge these are implemented into a person's care plan and actively promoted by the team

Activities

- There is a need for unit staff to complete ordinary, everyday activities on the units with patients such as cookery I baking and similar as opposed to such activities occurring only with OT involvement: via the meaningful activities care planning process.
- Individual or group activities such as sensory stimulation to be included in support planning (where appropriate) that stimulates and is used a therapeutic intervention and can be completed with staff on the units: cookery I baking, art that moves way

from drawing, PAT dogs or similar, model making, craft that links to producing work and similar

Staff

1] Training

- There is a need for all staff to receive additional communication training that includes information surrounding behaviour, effective listening, tools, accessible information and similar
- For the organisation to look at developing training that includes regular sessions on Mental Health and Autism.

2] Supervisions

- Recordings need to be made of each supervision provided and this information needs to define what was discussed inclusive of training needs or levels and action points (if appropriate) to demonstrate effective staff management

3] Staff rota

- For the organisation to review the need for staff to complete 12 hour shifts to ensure their health and well-being is maintained

4] Team Meetings

- For team meetings to occur at a level and frequency that meets the needs of the units and recordings made
- For the teams to look at ways in which full team meetings can occur across a year which enable all staff to attend at least one annually

- CTM information: Staffs to ensure that they are aware of outcomes recorded at CTMs and record why actions are incomplete. Staff to ensure their knowledge is current.

Organisation/Partnership

- The organisation to continue improve their communication and partnership working with Joint Commissioning and other professionals in relation to reporting and sharing information

Environment

- The quiet areas are in need of greater utilisation (where appropriate)
- Gardens need to be regarded as a therapeutic area where people can involve themselves in an activity as part of their weekly activities or in an ad-hoc manner as well as being an area for relaxation (sensory).
- The TVs and Music equipment to be housed in a less antiquated presentation
- For the organisation to review the food budget to enable- more choice at meal times and additional opportunities for people to take part in baking and similar.
- For Southern Health to look at the internal appearance (decor) of both units in regards to their presentation and purpose

Chapter 11- Recommendations from Contact Consulting review

The following are the recommendations of the review carried out by Contact Consulting in September 2012.

Based upon our conclusions we offer the following recommendations for consideration by the SHA in partnership with OLDT and SHFT.

- 1. We recommend a programme of pro-active assurance visits to all services over a prescribed period. These visits should largely be unannounced and seek to provide information and evidence about a range of clinical and managerial practice. SHFT has experience of utilising such a system of visits, alongside its mock CQC visits and would be well placed to introduce such an approach.*
- 2. We recommend that the Trust, with SHFT provide assurance to the SHA and commissioners that there exists a clear action plan to implement changes as a result of the Winterbourne View review report recommendations and to show that the lessons learned from those reviews is being disseminated and implemented in practice across the organisation.*
- 3. We recommend the delivery of a refresher Safeguarding training course for all staff, irrespective of seniority, with a focus on how and when to report, what constitutes a Safeguarding incident and how Safeguarding as an approach links with SIRIs rather than being seen as a separate concept.*
- 4. We recommend that the pool of people available to conduct reviews, RCAs and other investigations should be expanded to address the issues of capacity and to introduce a greater degree of internal independent scrutiny. Whilst the acquisition will assist with this, bringing with it a larger number of additional staff, particular attention will need to be paid to the skills and experience required to carry out these reviews in the learning disability service.*
- 5. We recommend the delivery of a Board development session (or sessions) for SHFT NEDs and Executives that focuses on learning disability services. The key themes*

might include current policy imperatives and service development plans nationally, the nature of services being provided by OLDT currently and an overview of the Safeguarding and SIRI issues pertinent to learning disability services. Such a programme should then be delivered to other staff, including senior managers and unit/team managers.

- 6. We recommend that SHFT governance and information staff engage swiftly with their counterparts at OLDT, to develop a clear set of information and data in relation to quality and safety that should be reported to the Board. This should include consideration of the format for such reports and how it can be most effectively presented to the Board so that they can interpret it and as a consequence, ask the right questions of senior managers and gain more robust assurance about incidents, actions and outcomes.*
- 7. We recommend that OLDT staff, along with colleagues from SHFT should engage with other similar organisations and develop relationships that enable the sharing of good practice and learning to create a more outward looking set of services. It may be that the SHA can take role in making connections between organisations across the South of England and further afield.*
- 8. We recommend that clinical and managerial leaders from both OLDT and SHFT, with support from the SHA where appropriate set aside time to review, plan and develop service models that will be sustainable, meet the changing needs of the client group and reflect national health and social care priorities.*

In particular we suggest that thought be given to the role of assessment and treatment services, given the recommendations of the reviews into Winterbourne View. There is need for a clear care pathway that integrates inpatient and community services across health and social care that places greater emphasis on effective clinical and managerial leadership.

- 9. We recommend that work be done with OLDT and SHFT to ensure that in future, disciplinary action is no longer the default first line response to a SIRI or Safeguarding issue. We recognise that in some cases such action will be necessary, but alternatives that enable appreciative enquiry and create a culture of pro-active*

reporting and transparency, coupled with effective learning are critical to changing the current culture.

10. In light of recommendation five, we further recommend that SHFT should review current training requirements within learning disability services currently provided by OLDY. Once complete this review the findings should contribute to the development of a co-ordinated and comprehensive range of training and development for staff working in learning disability services.

11. We recommend that a short programme of refresher development workshops be conducted with operational staff focusing on principles and approaches to care delivery and responses to incidents that mean Control and Restraint use is reduced. (Contact Consulting has experience of providing similar sessions for SHFT in the past and would be pleased to assist in this instance if that were felt to be appropriate.

Chapter 11- Client journey/high risk patient reviews

Questions covered:

- What is the reason for referral/ admission?
- What is or has been the MDT assessment process?
- What is the clinical pathway or pathways being used to support the patient? E.g. SOTP, Epilepsy, CB,
- What is the agreed MDT plan of care including CPA?
- What risk assessment processes are in place including risk management plans - include any related to specific issues e.g. HCR 20?
- How are risks managed with the patient and others?
- What are the expected outcomes of intervention and how will they be evaluated?
- What are the plans for discharge (if in-patient)?
- How is the patient journey evaluated e.g. patient questionnaire, survey, carers survey etc.
- How many medicines omissions or delayed medicines are recorded/ reported?
- How many episodes of self harm have been exhibited by the patient?
 - Are they recorded?
 - Are they reported?
- Is there a care plan?
- How many episodes of violence and aggression are/ have been exhibited in the last month?
- Is there a care plan/ management plan for violence and aggression?
- When was the management plan/ care plan reviewed?
- How often is PRN medication used and how many times is rapid tranquilisation given?
- Has the patient been harmed during any restraint including treatment on the spot and requiring medical attention (how many times been to A&E following restraint)?
- Has this patient been screened in relation to slips trips and falls?
- Does this patient require a faller's assessment and management plan?
- Have they fallen or had a near miss?

Chapter 11- Quality and safety report - John Stagg

Conclusions & recommendations

The outcomes from the different activities undertaken as part of this review identify that there are several key themes which should be considered for improvement. It should be noted that throughout this review there is significant evidence of good practice and assurance of safe care. In addition it is also emphasised that OLDT staff involved in the review processes did so willingly and openly. The experience from the Mock CQC Inspection Team and John Stagg was that they were made welcome and supported by staff at all times during their visits. The key themes are considered against external review recommendations, potential trends identified by OLDT related to SIRIs and relevant recommendations made within the Winterbourne View '*External Review by Debra Moore Associates*' published in October 2011, which is available within appendix 6.

Key Themes Identified from this Review:

1. **Record Keeping:** Both electronic and secondary paper file records require to be up to date and matched against risk assessment and care plans. It was difficult to ascertain other professional assessments and intervention and there was a lack of joined up MDT working evident within risk assessments and care plans. The transfer from paper to electronic records is reported by staff to be difficult and in some areas lacks appropriate support. There is evidence of better practice within areas where Research & Development nurses have provided support e.g. Postern House. However the review of records such as care plans, assessments and risk assessments is not always timely.
2. **Multidisciplinary Working:** There was a lack of evidence to support adequately integrated MDT/ multi-professional or multi agency care plans, particularly within community settings. The use of CPA within the community appeared to be particularly limited. The overall plan for MDT assessment and treatment was difficult to identify which also included appropriate reasons for admission/ referral. Within the Chilterns Unit good practice was evidenced by appropriate electronic and secondary files. The detail of the patient's clinical journey through assessment and

treatment was limited in all areas in relation to the whole MDT approach. This means that what is going to happen/ has happened or is happening to the patient is difficult to track. There may be insufficient evidence to demonstrate to commissioners (and other partners) the process for the patient i.e. the clinical assessment and treatment processes which is being purchased, the anticipated outcomes and the progress for the patient.

3. Risk Assessment & Risk Management: The overall MDT approach to clinical risk assessment and risk management was poorly evidenced in some areas. In in-patients this seemed to be led by nursing staff and in the community risk assessment and management was very limited indicating a potential lack of adequate risk management of high risk patients within the community. This was due to poor evidence within electronic records and a lack of access to secondary files and other professional/ clinical records. Within in-patients there was evidence of good risk assessment in some areas, but for some patients there was a lack of consistent record keeping. There was a common failure to match the electronic record to the secondary paper file so that the electronic record at times lacked the detail contained within paper records. The risk assessments did not always evidence the clinical assessments which would inform risk and risk management. The medium secure service demonstrated better risk assessment and management linked to clinical assessment.
4. Capacity & Consent: This has been a recurring theme in terms of recording capacity and consent identified both by the CQC and during this review period. This was noted both in relation to community and some inpatient settings.
5. Physical Health Monitoring: There was evidence of good practice in some areas where the Health Action Plan (HAP) had been extended to include more complex health needs. There was evidence that a patient was experiencing a significant change in health which required referral to other professionals and/ or further assessment and care planning. The lack of physical health care plans could lead to potential risk and where this occurred.
6. Nutrition: This was an area specific to some patients needs in terms of ensuring a comprehensive assessment and care plan where nutrition was identified as a need. There was one patient who reported he was unable to eat some foods in line with

his religious needs. The patient did not complain but never the less, raised this with the reviewer and reported that he felt his diet was limited as a result and accepted the limitation.

7. Clinical Pathways/ Evidence Base: There was limited evidence of joined up MDT working which reflected a clinical pathway or clinical map which identified clinical outcomes to measure assessment and treatment particularly within community settings. Although in-patient services followed the 'in-patient pathway', it was difficult to ascertain the 'tool box' of assessment and treatment processes available to patients according to their needs and the approach taken by professionals and the team. For example:
 - A patient with epilepsy did not have a care plan which stemmed from a comprehensive epilepsy profile which detailed seizures, risks, affect and effect of medication, the aims for the nurses and the patient in providing care. Expected outcomes for the patient were unclear so could not be measured/ evaluated.
 - A patient with mental health needs did not have assessment data included e.g. mental state exam or mini mental state exam, PASS-ADD etc. the care plan lacked detail related to treatment including medication, and outcomes or use of a Wellness Recovery Action Plan (WRAP).
 - A patient with needs related to behaviour had no record of the model of approach being taken e.g. Applied Behavioural Analysis, Person Centred Active Support etc.
 - There was evidence that other outcome measures such as HONOS-learning disability are utilised.
8. Measuring Patient Experience: There was an inconsistent approach to measuring patient experience particularly in community learning disability teams. There was evidence of good practice in some in-patient areas.
9. Clinical Supervision & Management Supervision: There was evidence that identifies that both types of supervision are limited due to frequency, regularity, recording and staff training. There were no other methods of clinical supervision identified other than where a psychologist would be made available for group supervision following an incident. Staff reported a lack of reflective supervisory methods and there seemed to be a reliance on management supervision alone.

10. Mental Health Act/ Mental Health Care: There was evidence that the MHA is not implemented consistently across all services in relation to policy for locked doors, policy for observation, policy for Section 17 leave arrangements (monitoring, recording and signing patients out for leave and on return from leave). There was appropriate evidence within the medium secure service but this was not consistent in all areas with a deficit of appropriate practice in some areas.
11. Environment: Maintenance in relation to a safe environment was an issue in some areas but also in relation to ligature assessment and management. Ligature assessment and management policy has not been consistently applied across services.
12. Medical Devices: There was inconsistent management of medical devices in terms of on-site inventory, monitoring, calibration and maintenance. Postern House demonstrated the best practice which could be mirrored within all areas.
13. Dress Code: There was evidence that not all staff followed a dress code which meets standards required to support good practice in relation to patient safety, infection prevention and control as well as presenting a professional image. In one example there was evidence that the member of staff had not considered the way they dressed in relation to personal safety and the needs of patients within the unit. There seemed to be a cultural issue related to dress code which failed to challenge or correct this type of deficit.
14. Learning Out of Concerns: This is an area reported by staff, some of whom felt that they were not informed of outcomes from investigations including the learning from disciplinary investigations. Changes in practice were not felt to always impact at the staff/ ward level. There was also commentary that staff felt changes in practice e.g. changes to shift patterns to accommodate breaks (a positive change) was not evaluated in terms of overall impact e.g. the time period for hand over and staff meetings. In addition some staff reported that they felt that audit outcomes were not shared and they did not feel involved in review and improvement processes. There did not seem to be an ongoing and regular review process to monitor whether standards were being maintained that was led, owned and implemented by staff to

achieve continuous monitoring and improvement. Staff reported that governance systems were applied to services but that they did not feel part of the process.

Comparison with external Review & Winterbourne View Recommendations:

The themes identified within this review mirror or further evidence some of the findings identified from the SHA review and the potential SIRI themes identified by OLDT. In addition some of the themes are also reflected within the recommendations made by Debra Moore Associates in their review of Winterbourne View.

Chapter 11- Summary recommendations of the John Stagg quality and safety report

<p>Rec 1 Record Keeping</p>	<p>It is recommended that the use of RiO and secondary files could be reviewed to ensure that all information is consistently recorded and available to all clinicians. There is an opportunity to utilise and further develop RiO guidance to ensure that its use is consistent and meaningful. In addition the use of secondary files to record information which cannot be recorded onto RiO should be standardised. The standards applied to clinical record keeping should be done consistently across the service and there is an opportunity to collaborate with staff in SHFT to develop consistent practice that supports Learning Disability clinical assessment and treatment.</p>
<p>Rec 2 Multidisciplinary working</p>	<p>It is recommended that the MDT approach to practice is reviewed to ensure that the collaborative approach to assessment and treatment is clearly documented and reflected within MDT plans and CPA. In addition all clinicians should be able to access all relevant clinical records.</p>
<p>Rec 3 Risk assessment & risk management</p>	<p>It is recommended that clinical risk assessment and management processes are reviewed to ensure consistent approaches and record keeping. The 5x5 risk assessment process although effective has not translated well across to the RiO risk assessment record. The clinical risk assessment approach in community teams needs to be improved, particularly where patients are presenting risks to themselves or others and/ or have complex needs. A collaborative approach to clinical risk assessment and management should be evidenced within records. Care plans should be updated in line with changes to risk assessment and management plans.</p>
<p>Rec 4 Capacity and consent</p>	<p>It is recommended that the actions to ensure that capacity and consent is recorded for all patients should be rolled out across all services to ensure a consistent approach where this applied particularly where patients are subject to the MHA.</p>
<p>Rec 5 Physical Health Monitoring</p>	<p>It is recommended that the Physical Assessment and Monitoring policy recently launched within SHFT is rolled out across all OLDLT services. This would also link to other relevant policies such as the Slips Trips & Falls Policy. This would ensure that physical assessment is clinically recorded in a consistent way and that when monitoring is required this is also recorded in a more appropriate way. Appropriate care plans should be devised in relation to physical health care. Learning disability staff within</p>

	SHFT have benefitted from more focussed training in relation to physical assessment and monitoring and training needs should be considered for OLDT staff accordingly.
Rec 6 Nutrition	It is recommended that nutrition focussed assessments are completed for all in-patients and appropriate application of nutrition assessment should be considered for community patients. The use of the MUST tool should be used consistently across services.
Rec 7 Clinical pathways/evidence base	It is recommended that the ongoing work related to clinical pathways continues and that clinical pathways or maps are developed to provide a consistent approach to assessment and treatment. This would also help to inform focussed training development in line with appropriate expectations of competence for professionals and ensure consistent recording of assessment and treatment processes. The evidence base exists in both SHFT and OLDT and a consistent approach would help to identify the packages of care/ assessment and treatment made available to patients which will help inform commissioners/ partners of what assessment and treatment is being purchased, expected outcomes and time frames.
Rec 8 Measuring patient experience	It is recommended that the patient experience is evaluated in a consistent and meaningful way. There was evidence of good practice which could be further developed in partnership with SHFT colleagues to ensure that the experiences of service users are gathered regularly and help to inform the agenda of continuous improvement.
Rec 9 Clinical and Managerial supervision	It is recommended that arrangements for both clinical and management supervision are reviewed to ensure that both can occur on a regular basis every month. The review could include the different models and formats of supervision which could be available.
Rec 10 MH Act/MH care	It is recommended that a review of policies related to observation, section 17 leave and locked doors is undertaken with regard to the responsibilities of nurses in caring for patients detained under the MHA. Areas of good practice should be modelled consistently across the service.
Rec 11 Environment	It is recommended that a review for the management of the environment is undertaken which includes regular safety reviews and ligature assessments with appropriate development or management plans put into place.
Rec 12 Medical devices	It is recommended that the medical devices policy is reviewed to ensure that appropriate inventory, maintenance and calibration occurs of medical devices. The practice at Postern House could be replicated in

	each service with a member of staff designated as the 'lead' for medical devices.
Rec 13 Dress code	It is recommended that the policy related to dress code is reviewed to ensure that it is appropriate to the clinical environments and that staff are aware of the various rationales related to the implementation of a dress code policy.
Rec 14 Learning out of concerns	It is recommended that regular internal reviews and checks are undertaken which involve staff at the ward level e.g. Conducting the monthly Matron Walk Round Tool, undertaking care plan audit etc which engages staff and allows them to develop improvements as a team within their own clinical environments. Learning from investigations, audit and reviews should be shared regularly in both formal and informal ways which involve staff and patients at the ward/ team level so they may be engaged in team led development and improvement with appropriate facilitation and support.

Chapter 13- Legislation and background regards transition from school to adulthood for people with learning disabilities.

The white paper *Valuing People: a new strategy for learning disability for the 21st century* (2001); identified the transition from school to adulthood as difficult for individuals with learning disabilities. It highlighted that often there may not be clear plans for the individual after school. The white paper sets its objective in relation to transition as:

“As young people with learning disabilities move into adulthood, to ensure continuity of care and support for the young person and their family; and to provide equality of opportunity in order to enable as many disabled young people as possible to participate in education, training or employment.”

It goes on to outline that:

“Young people with learning disabilities... must be invited to and attend annual reviews of all year 9 pupils with statements of SEN [Special Education Needs]; and [Connexions service personal advisors] will work with the school and other relevant agencies to draw up the transition plans.”

The paper highlights the role of person-centred planning and effective links between children and adult services (and the role of learning disability partnership boards) in effective transition services. It should be noted that the white paper lacked statutory levers to implement change.

Valuing people now: a new three-year strategy for people with learning disabilities (2009) built on the 2001 White paper. It further emphasises the difficulties associated with transition, highlighting the difficulties young people face in relation to leaving school, further education and employment. It notes the role of the year 9 review and person-centred transition planning, recommending:

“all partnership boards to ensure that by 2012 all young people with statements of Special educational need who have learning disabilities have person centred reviews from age 14 to 19 that actively involve the young person and their family.

“valuing people regional team will work with the transition Support programme to support all local areas to achieve minimum standards in transition planning and support.

“all transition plans and year 9 reviews where appropriate to contain a section on health needs and start the development of a health action plan.”

Comment

Valuing people now was designed to run until 2012 - there was no new strategy beyond this. The government reasoned that moving forward the Health and Social Care bill would encapsulate learning disabilities.

The 2001 and 2009 editions of Valuing People are archived on the department of health website. We believe that the removal of Valuing People was a missed opportunity to drive forward local plans through local partnership boards. At a local level a number of principles remain (e.g. partnership boards) and have been used to drive forward local plans.

Pathways to getting a life: transition planning for full lives (2011) details person-centred transition planning and outlines four pathways:

- employment;
- housing;
- health; and
- friends, relationships and community.

It outlines what should be happening in relation to each pathway from year 9 (the beginning of transition planning) until after the age of 16 years old (including years 10 and 11). It highlights the challenges faced by people who use services, their families and practitioners in transition, particularly in relation to education, children and adult services working together. It notes that transition can become ‘lost’ between children and adult services given the lack of clarity as to who is responsible for what and making sure things happen.

It emphasises the role of family in transition and the use of personalised budgets (planning for which must begin early).

Comment

Despite key guidance being in place for transition since 2001, there were in fact no statutory requirements on health and social care providers in relation to its provision for the period examined in this investigation. Policy and guidance set out what should - not must - have happened. This changes with the introduction of the Care Act (2014).

The Care Act (2014) concedes that *“Historically, there has sometimes been a lack of effective planning for people using children’s services who are approaching adulthood.”*

The Care Act says that a transition assessment should take place at a time suited to the young person and when the local authority is confident it is able to meet the individual’s care and support needs. There is not a prescribed age for when this assessment should happen, though the exception to this is:

“... young people with special educational needs (SEN) who have an Education Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood must begin at year 9.”

The act says that a transition assessment:

“... should support the young person and their family to plan for the future, by providing them with information about what they can expect. All transition assessments must include an assessment of:

- *current needs for care and support and how these impact on wellbeing;*
- *whether the child or carer is likely to have needs for care and support after the child in question becomes 18;*
- *if so, what those needs are likely to be, and which are likely to be eligible needs;*
- *the outcome the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.”*

The Act details that the assessment should be person centred, taking into account the young person's wishes and views. The Act takes into consideration a number of factors related to transition including the role of the carer, capacity, timescales, and co-operation between professionals and other organisations. In the case of the latter, the Act details that in the case of multiple agency involvement it can often be helpful to have a key worker coordinating the provision of person-centred care.

In parallel with the introduction of the Care Act, the Children and Families Act (2014) was introduced in September 2014. Part 3 of the Act focuses on individuals with special educational needs and disabilities up to the age of 25. It focuses on:

- preparing for adulthood
- personalised budgets
- coordinating assessments and Education, Health and Care (EHC) planning
- developing a local offer
- engagement/participation of children, young people, parents and carers.

The Act emphasises that planning for young people should begin from year 9 at the latest.

Chapter 13- Recommendations of the independent report commissioned by Oxfordshire County Council into Connor's transition from school to adult services.

Recommendations

That recording practice be maintained at the standards required by the guidelines published by the Learning Disabilities Team in January 2012 and updated in September 2012. That guidance sets out a clear policy for the separate recording of the various services assessed, provided and offered, key events in the service user's life, and an account of how the service user and their family have been involved in assessment and planning. This then provides for maximum transparency between staff and service users, and promotes learning and development.

That in all cases of young people with additional needs aged over 18 both at school and receiving continuing support from the Adult Services, regular direct contact is maintained between Adult Social Care Services and the school staff in accordance with an agreed plan. Adult Social Care Services should also inform parents that they will communicate direct with the school. Schools are the agency who see a young person daily and they have a great deal to offer the assessment and planning process.

That transitions care managers should routinely consult all the Children's Services electronic records at the point of transition, paying particular attention to core assessments, children in need plans and statements of special educational need. As from September 2014, children and young people with additional needs will have Education, Health and Care Plans, although it will take some time for that to be in place for all relevant children. All designated Adult Social Care staff working in the area of transitions must be made aware that there is read only access to Children's Services electronic records.

That the option of introducing targeted intervention from challenging behaviour nursing service should be assessed at the earliest possible stage, where there is evidence that the service may be helpful in safeguarding the service user and/or their family.

That where material is placed on a web based platform with regard to a social care case, the Council should state clearly that officers are not required or expected to refer to that material as part of their case management responsibilities. Users of the service and their carers must be advised to communicate with the officers direct. A statement setting out the OCC policy in that area to be included in an information leaflet for service users and carers.

That where a self-directed support programme is in place, the support planning must include an agreed plan between the care manager and the service user and their family for the provision of financial returns and an agreed schedule of information regarding the services being purchased where direct payments are being made. Any need for additional complementary services can then be assessed in the light of that information in a holistic way.

Chapter 13- Sparrowhawk Legal Enquiry: The Use of the Mental Health Act 1983 and the Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards)

Introduction

This report considers the application of the Mental Health Act 1983 (the 'MHA'), and the Mental Capacity Act 2005 (the 'MCA') (including the Deprivation of Liberty Safeguards - the 'DoLS') in the care and subsequent death of Connor Sparrowhawk.

The law, particularly as regards the MCA and the DoLS, has developed considerably since the events of concern to this enquiry, most significantly with the Supreme Court decision in *P v Cheshire West and Chester Council, P and Q v Surrey County Council* [2014] UKSC 19, and in terms of lessons to be learned in the present, those developments should be taken into account. Insofar as this report concerns the actual decisions made by individuals, however, the law must be considered as it was understood to be between Mr Sparrowhawk's admission to STATT on 19 March 2013 and his death on 4 July 2013, taking into account the judicial precedents in effect at that time.

Sources considered

The following policies of the Southern Health NHS Foundation Trust have been forwarded for consideration in this report:

- Mental Capacity Act Policy and Guidance, SH CP 39, version 1, ratified 25 September 2012 (the policy in place at the time of the events)
- Mental Capacity Act Policy and Guidance, SH CP 39, version 2, ratified April 2014 (the policy currently in place, updated following the *Cheshire West* decision above)
- Mental Health Act 1983 (as amended) Scheme of Delegation, SH CP 95, version 3 (in effect at the time of the events, and remaining in effect)

The MCA policies are considered in some detail below. A systematic study of the policies relevant to the MHA was not undertaken, as this would have involved a large-scale review of many of the Trust's policies. Such a large-scale review is outside the scope of the current study.

In addition, practitioners are obliged to 'have regard to' the relevant Codes of Practice. For purposes of the present report, these are as follows:

- Mental Health Act Code of Practice, Department of Health, 2008 (in effect at the time of the events)
- Mental Health Act Code of Practice, Department of Health, 2014 (which takes effect on 1 April 2015)
- Mental Capacity Act Code of Practice, Department of Constitutional Affairs, 2007 (in effect at the time of the events, and still in effect)
- Mental Capacity Act Deprivation of Liberty Safeguards Code of Practice, Department of Justice, 2008 (in effect at the time of the events, and still in effect).

Further, the best interests assessor that conducted the DoLS assessment on 12 May 2013 was interviewed, as was the DoLS manager and Mr Sparrowhawk's mother. The DoLS manager was on maternity leave throughout Mr Sparrowhawk's admission, but was able to confirm standard practices both at the time of the events and currently.

MCA and DoLS Policies

The Trust approach combines DoLS and the MCA into one policy. This is certainly not objectionable, and may indeed be desirable. The House of Lords has recently criticized the implementation of the DoLS in part on the basis that too frequently it is divorced from the

main MCA and its ethos of empowerment.¹ The inclusion of the DoLS in the MCA policy should in principle work to limit this criticism.

As regards the MCA generally, both the 2012 and 2014 policies appear to be broadly accurate and appropriate, but a few substantive comments are warranted.

The policies are brief, relative to the Code of Practice and the legislation (particularly as relates to the DoLS). This has its advantages: Trust staff members would reasonably be expected to comprehend the policies. They generally provide a good overview. For detail, staff members are referred early on to the MCA Code of Practice.² While that is a sensible approach, it would also be sensible to reinforce it through the policies with some additional cross-referencing to the Codes of Practice in the remainder of the policies, lest the connections between them be lost.

The section of the policy that defines duties and responsibilities provides some concrete responsibilities relevant to the DoLS, but for the main MCA indicates merely that ‘all staff have a duty of care to act within the Mental Capacity Act and have regard to the Code of Conduct [sic - Code of Practice?]’.³ While this is certainly correct, it leaves open the question of who has overall responsibility for ensuring that the MCA is followed at the various levels of the organization. That is certainly relevant on the ward, but contacts should also be more clearly identified at other relevant points in the organization. For example, it is now clear that in the event that an application to the Court of Protection is likely to become necessary, it is for the Health Authority or Local Authority (as the case may be) to commence the application⁴ - a point that should be made expressly in the policies. It is not at all clear in the policies who on the ward is responsible for making those determinations, and who is to be contacted in the organization to ensure that appropriate action is taken.

The chart in appendix 4 of version 1 and appendix 3 of version 2 is misleading insofar as it suggests that if there is a holder of a lasting power of attorney that covers the decision, the decision may nonetheless be made by the care staff. While this is the case if the holder of the lasting power of attorney has made no decision (see MCA, s 6(6)(a)), the more helpful understanding is that contained in para 5.8.7 of the version 1 and 5.8.8 of version 2, that it

¹ House of Lords Select Committee on the Mental Capacity Act 2005, (2014). *Mental Capacity Act 2005: Post-Legislative scrutiny*, HL (2013-14) 139, para 254, 258.

² 2012 policy, para 1.4; 2014 policy, para 1.4.

³ 2012 policy, para 4.4; 2014 policy, para 4.4.

⁴ See, eg., *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP); re DoLS, see *AJ v A Local Authority* [2015] EWCOP 5.

is the holder of the power of attorney that makes the decision. These appendices further do not include a reference to court-appointed deputies. The chart in these appendices is generally helpful, in that it reduces a considerable amount of information to a workable scheme; but the information should be clarified in these respects. The matter is of peripheral relevance in the present case, since Mr Sparrowhawk had neither a lasting power of attorney nor a court-appointed deputy.

There is no mention of the MCA provisions regarding restraint in the policies. The MCA defines restraint as using or threatening to use force to secure the doing of an act which the individual (P) resists, or restricts P's liberty of movement, whether or not P resists. Restraint may only be used if it is reasonably necessary to prevent P from suffering harm, and is a proportionate response to the likelihood and severity of the harm.¹ To the credit of the Trust, this provision is included with reference to the DoLS specifically, but not to restraint outside the DoLS context. That is a notable omission that ought to be rectified.

As they relate to IMCAs, the policies are unfortunately phrased, in that they could sensibly be interpreted to say that an IMCA must be provided for serious medical treatment decisions only if the individual will be in hospital longer than 28 days, or in a care home more than 8 weeks.² This is not correct: there is no minimum period of admission required for the mandatory appointment of an IMCA when serious medical treatment is proposed (and, as the policies correctly state, there is no non-professional carer to be consulted as to the individual's best interests).³ Further, while the legislation requires advocacy in the specific situations noted in the policies, it does not restrict the discretion of Trusts to engage advocates outside these mandatory circumstances. This can be helpful sometimes, both to meet the objectives of the legislation and to stop small tensions escalating; it might be appropriate for this discretion to be noted in the policy.

The policies as they concern DoLS are notably brief. In some ways this is an advantage: a serious difficulty with the DoLS is that the complexity of their drafting, and an advantage of the minimalist approach of the policies as drafted is that Trust staff can get the overview of the DoLS that they would not necessarily get anywhere else. That is a real advantage. Nonetheless, there are ways in which the policy could be improved.

1 MCA, s 6 (1)-(5).

2 2012 policy, para 5.7.2; 2014 policy 5.7.2.

3 See MCA, s 37.

- The 2012 policy refers early on to the ‘Deprivation of Liberty Safeguards - Ministry of Justice 2007’.¹ I take it this is meant to be a reference to the DoLS Code of Practice, and is corrected to reflect that in the 2014 policy. That lack of clarity in the 2012 policy is regrettable, since the DoLS legislation was itself passed in 2007, and a reasonable staff member would not have necessarily realized that there was a Code of Practice. The 2014 wording is certainly preferable. Looking to the future, the Trust will no doubt be aware that the new Mental Health Act Code of Practice (2015) contains a chapter on deprivation of liberty under the MCA, which also should be cited when the policy is redrafted. The comparable chapter in the previous MHA Code of Practice is referred to in the existing policies, but not in the context of deprivation of liberty. Particularly given the focus of the new chapter, it would be sensible to incorporate it when the policy is revised.
- The 2012 policy was not helpful in identifying when a deprivation of liberty could be said to be occurring. This is admittedly a complex matter (see the specific comments on Mr Sparrowhawk’s case below), but the policy does not provide much support. The statement that ‘situations where complete control is exercised over a person’s care and/or movements would be unacceptable’ is quite properly corrected in the 2014 policy to state that such a situation is not necessarily unacceptable, but does constitute a deprivation of liberty.² The 2014 policy has been amended to take account of the Supreme Court decision in *Cheshire West*, but in a relatively cursory fashion. The Trust should consider whether more specific guidance can be provided. If it is thought that this is too difficult for a Trust-wide policy, which will inevitably be required to cover a multitude of contexts, it might well be helpful for the Trust to provide more specific guidance for specific wards or specific sorts of patient as to how deprivation of liberty is to be understood. Even after *Cheshire West*, the legal situation remains problematic; it would be sensible to do what can be done to assist ward staff.
- As this is a policy designed for hospitals, clearer guidance on the application of the eligibility requirement might well be appropriate.

¹ Para 2.2.

² 2012 policy, para 5.17.2; 2014 policy para 5.17.2.

- The policy regarding provision of IMCAs refers only to people who do not have ‘family or friends who can be consulted’.¹ Section 39D of the MCA also makes it clear that the duty to provide an IMCA in the situation of a deprivation of liberty extends well beyond this. The policy should be amended to make this clear.

Recommendations

R1 The policies of the trust relating to the Mental Capacity Act and the DoLS should be re-visited in light of the above comments and the new Code of Practice. In particular, clearer guidance regarding overall responsibility for implementation, the MCA provisions regarding best interests in the context of restraint, the determination of deprivation of liberty, the eligibility requirement, and the provision of IMCAs is appropriate.

Implementation of the law and policies

General Mental Capacity Act

The adequacy of the assessment, programmes and treatment offered to Mr Sparrowhawk during his stay at STATT were disputed by his family. These matters were discussed in the original 2014 report into Mr Sparrowhawk’s death,² and will not be reconsidered here. The degree to which the MCA adds an additional layer of scrutiny to the general standards of care required by medical and social services law is limited. It does not require a service provider to make an array of care options available to a person lacking capacity, any more than would be required for a person with capacity. At the time of the events in the present case, this point was unclear;³ but it has now been settled by the Court of Appeal.⁴ In the present case, however, the facts do not appear to raise a separate issue on this point. The case law tends to concern either the degree to which financial factors may be taken into account in deciding what services are to be offered, or the degree to which health authorities and local authorities must account for their choices of services and offer alternatives for consideration when the matter reaches the Court of Protection. In this

¹ 2012 policy, para 5.17.6; 2014 policy para 5.17.6.

² See Hussain and Hyde-Bales, ‘Independent investigation into the death of CS’, (London: Verita, 2014), chapter 12.

³ See, eg., *A Local Authority v PB* [2011] EWHC 502 (COP); *ACCG v MN* [2013] EWHC 3859 (COP).

⁴ *ACCG v MN* [2015] EWCA Civ 411.

case, there is no indication in the materials that financial factors were significant in decisions about what care would be given to Mr Sparrowhawk, and the matter never proceeded to formal legal proceedings. A discussion of the treatment offered would therefore be little more than a repetition of the discussion in the 2014 report.

There appear to have been two formal assessments of Mr Sparrowhawk's capacity during his time at STATT. The first, on 16 April, concluded that he did not have capacity to decide whether he should continue to reside at STATT; the second, on 21 May, appears to decide that he did have capacity to consent to medical treatment, in particular Risperidone. The fact that the conclusions differed regarding capacity is not necessarily problematic: capacity is decision and time specific, and the assessments concerned different decisions and were performed more than a month apart. The April assessment, on its face, appears convincing. It notes that because of his anxiety, Mr Sparrowhawk was prevented from 'thoroughly thinking through' his current situation, and of the consequences of leaving the ward. On that basis, the conclusion that Mr Sparrowhawk lacked capacity to make the relevant decision at that time seems coherent and defensible under the MCA.

The May assessment is much more problematic. Where the April assessment had stated that Mr Sparrowhawk was able to communicate his views, this seems to have been a significant difficulty in the May assessment. It would seem from that the assessor in May was unable to determine his ability with certainty, noting that the relevant issues were 'difficult to establish'. It is not clear from the report how much that flowed from Mr Sparrowhawk's lack of understanding, or his inability to communicate, or is choice not to communicate. Notwithstanding the absence of evidence on the face of the form, the assessor answered 'no' to the four key questions on the assessment - whether Mr Sparrowhawk was able to understand, retain, use or weigh, and communicate the relevant information. That is a problem on the face of the form: the failure to understand, retain, use and weigh or communicate information should be clearly evidenced on the form itself, and a refusal to communicate is not the same as an inability to communicate.

As the form correctly states, the inability to do any one of these would mean that Mr Sparrowhawk lacked capacity; nonetheless, the assessor stated that he in fact did not lack capacity. That decision is not consistent with the previous responses. The assessor provides the following further explanation:

“Connor would not communicate in any manner that helped us gauge if he would be happy to consent to taking Risperidone. However, since commencing medication, he has been happy to take it.

“In the case of commencement of Risperidone, Connor’s parents were included in the discussions and their opinions sought. This was due to their knowledge of Connor and his presentation. It also gave them the opportunity to discuss the difficulties as they saw them. They were very helpful in our assessment of the use of Risperidone.”

If this statement is meant to explain why a finding of incapacity was not made, it suggests a basic misunderstanding of the Mental Capacity Act. Capacity under the MCA is a matter of understanding and processing the relevant information so as to make the decision: whether Mr Sparrowhawk was or was not ‘happy to take’ his medication is not relevant to his capacity to do so, nor are the views of his parents regarding the desirability of the medication. These factors would be relevant to determining Mr Sparrowhawk’s best interests, but that question only arises if a finding of incapacity had been made: if Mr Sparrowhawk had capacity to do so, as the assessment states, he had the right to make his own decisions about medication.

However the form is read, it does not suggest a clear understanding of the functioning of the MCA.

There is a brief reference in the clinical record of 16 April to Mr Sparrowhawk’s capacity to decide whether to remain on STATT, but no reference in the notes to the assessment of his treatment capacity in May. Apart from the ambiguous statement noted above, the records contain no formal best interests assessments or formal decisions regarding best interests that refer to the Act. That raises a question about the degree to which the MCA had been integrated into the daily practices of the unit. There is a reference in the notes, following a question by Mr Sparrowhawk’s mother, that capacity assessment was ongoing and on a decision-specific basis (as is required by law), but there is little further in the notes as to how frequent capacity assessments were, who was in charge of them, and what was entailed. As noted above, the Trust policies do not identify individuals particularly responsible for ensuring the implementation of the MCA, instead identifying MCA compliance as the responsibility of all staff. The risk is that matters that are everyone’s responsibility become no one’s responsibility, and do not happen. The 2014 Verita report into Mr

Sparrowhawk's death criticized the absence of specific professional responsibility in the unit and that this affected Mr Sparrowhawk's care.¹ That buttresses the concern as to whether the MCA was properly implemented at STATT.

Some hesitancy is appropriate in drawing conclusions as to the effects of this, however. On many of the day-to-day decisions, Mr Sparrowhawk appears to have been co-operative. In that event, whether the situation is understood as a competent individual exercising choice, or decisions being taken under the MCA in the best interests of an individual lacking capacity, the activity remains legal. In the events where Mr Sparrowhawk did not comply with what was proposed for him (eg., occasional refusals to participate in planned activities, refusal of meals), it may well be the case that the staff viewed the prospect of further pressure to engage would not be in his best interests, even if Mr Sparrowhawk lacked the relevant capacity at the time and the statutory best interests test therefore would apply. Consistent with this, the notes do make clear that the staff made attempts to understand Mr Sparrowhawk's wishes and feelings on these occasions, and acted consistently with them. Such wishes and feelings are, of course, a central part of the statutory test.

There is some question from the discussion with Dr Ryan, Mr Sparrowhawk's mother, of whether the understanding of the staff in fact reflected Mr Sparrowhawk's wishes, and whether adequate consideration was given to the forms of communication typical of people with Mr Sparrowhawk's disability. That is consistent with the law: the Act expects that all reasonable efforts should be made to elicit the actual views of the individual, taking into account the nature of his or her disability.² It is difficult to tell from this distance how far that is a fair criticism in Mr Sparrowhawk's case, although certainly by the time of the CPA review on 10 June, it is clear from the notes that there was a difference of views on the point between staff and Mr Sparrowhawk's family.

The MCA also requires that the views of 'anyone engaged in caring for the person or interested in his welfare'³ be taken into account in determining the best interests of the individual lacking capacity. That is both to determine the individual's best interests generally, and in particular to ascertain the individual's past and present wishes and feelings.⁴ In this case, that would include consultation with Mr Sparrowhawk's parents. While it is clear from the clinical record that both parents visited Mr Sparrowhawk on

¹ Hussain and Hyde-Bales, findings F19 and F20.

² See, eg., MCA, s 3(2); 2008 Code of Practice para 3.10, 5.39.

³ MCA, s 4(7)(b).

⁴ MCA, s 4(7).

numerous occasions, it is only at the CPA review on 10 June that the views of the parents are recorded in any detail in the notes.¹ For decisions in which Mr Sparrowhawk was taken to lack capacity, the clinical notes do not suggest that this aspect of the MCA was adequately followed.

There are suggestions in the original report into Mr Sparrowhawk's death that there were tensions between his family and the staff at STATT. It does not appear from the notes that at any time, the appointment of an advocate for Mr Sparrowhawk was considered. Mr Sparrowhawk's mother indicated that she had specifically requested the appointment of an IMCA for him, but that this was refused. The notes do not refer to this. There was no legal requirement to appoint an IMCA for purposes of the MCA generally, because Mr Sparrowhawk's parents were clearly appropriate people to consult regarding his best interests. Nonetheless, even when not legally mandatory, the appointment of an advocate can sometimes assist in the resolution of disputes. Particularly when it is requested by the person lacking capacity or a close family member to that person, it ought to be considered seriously.

While it would seem that the implementation of the MCA was not optimal, it is less obvious how much this adds to the understanding of the circumstances surrounding Mr Sparrowhawk's death. The key issue as regards the death was the adequacy of the supervision arrangements related to his bathing, in particular as necessitated by his epilepsy. The 2014 report by Verita has already criticized the Trust for failing to implement relevant tests and precautions relevant to his epilepsy, and failing appropriately to use the knowledge of his parents in this regard. Regarding the former, one would expect this recommendation to apply equally to persons with and without capacity. As noted above, the primary role of the MCA is not to establish different rights to treatment for people lacking capacity: standards of treatment are essentially the function of broader law relating to medical standards and rights to health care. Regarding the latter, assuming Mr Sparrowhawk lacked the capacity to decide on the development of his care (which seems likely, but on which there is no formal finding in the notes), the MCA does create a duty on the care providers to consult with his parents as to what they considered to be in his best interests. While the adequacy of those consultations is criticized in the 2014 report, the Trust staff were aware of the parents' view that Mr Sparrowhawk was affected by epilepsy. Such consultations are only a part of the determination of best interests, however. Mr

¹ The failure adequately to engage with Mr Sparrowhawk's parents is criticised in Hussain and Hyde-Bales at finding F13 and recommendation R4, R10.

Sparrowhawk's wishes and feelings, and, perhaps most significantly here, the medical assessment of the situation are also relevant. The 2014 report finds that Trust staff did not adequately respond to the possibility that Mr Sparrowhawk was affected by epilepsy. That finding is not disputed here, and seems to be the pivotal point. It is not clear what the MCA adds to the general law on that point.

Deprivation of Liberty Safeguards

Mr Sparrowhawk was initially considered for a DoLS order shortly after his initial admission, but was instead detained under s 2 of the MHA. That expired on 17 April 2013, and for reasons to be discussed below the decision was taken not to apply for a s 3 admission. Following an altercation with a member of staff on 2 May, Mr Sparrowhawk was restrained, and the decision was taken to apply for a DoLS order. The best interests assessment for this order occurred on 12 May, and the BI assessor found that Mr Sparrowhawk was not deprived of liberty within the terms of the statute and case law. The DoLS order was therefore refused, and Mr Sparrowhawk thereafter remained at STATT as an informal patient, not subject to DoLS.

The best interests assessor was interviewed as background for this report. He spoke frankly and I believe honestly about the events. I was further impressed by his understanding of the relevant case law, his professionalism and his sensitivity to the relevant issues. Inevitably, with the passage of almost two years, his memory was not perfect on all points.

The DOL processes involve the completion of six assessments:

- Age: the person must be over the age of 18 years
- Mental health: the person must have a mental disorder
- Mental capacity: the mental disorder must be such that the person lacks the capacity to decide whether to be accommodated in a hospital or care home for the purposes of receiving relevant care or treatment
- Best interests:
 - The accommodation proposed must be such as would deprive the individual of liberty; AND
 - The accommodation must be in the best interests of the individual (essentially as defined by the remainder of the MCA).

- Eligibility: this requirement determines whether the MHA or the DoLS should be used, when admissions are to a facility within the scope of the MHA.
- No refusals: the individual may not be admitted for treatment that is within the scope of a valid and applicable advance decision to refuse treatment (not relevant in the present case)

The best interests assessment must be carried out by a best interests assessor (a social worker or similar professional); the mental health assessment must be carried out by a doctor (usually a psychiatrist). In either case, the assessor must meet the qualification standards contained in the DoLS legislative scheme. The remaining assessments may be carried out by either assessor, but the eligibility assessment may only be carried out by an assessor with appropriate qualifications under the MHA.

DoLS assessors are provided by the Local Authority. Oxfordshire County Council would appear to have suitable systems in place to ensure that BI assessors are properly trained. In this case, the assessor had at the time successfully completed the relevant training programmes for certification as a BI assessor, and has continued a programme of annual refreshers, including at least two policy update meetings per year and monthly supervision sessions. At the time of the events, these monthly sessions were a group event; they are now on an individual basis with the assessor's supervisor. The assessor was well-versed in the relevant law (both of the time and more recent developments) suggesting that this process is working well.

There are issues that arise as to the ways in which the assessments were organized. As part of the mental health assessment, the assessor must 'consider how (if at all) the relevant person's mental health is likely to be affected by being a detained resident' and notify the best interests assessor of his or her conclusions in this regard. The best interests assessor must in turn take these into account in the best interests assessment. The DoLS processes thus anticipate that a mental health assessor will attend either before or along with the best interests assessor. Reflecting what would appear to be a common practice nationally, that was not done in this case. Instead, as happened here, local authorities send out the BI assessor first, on the basis that if a deprivation of liberty is not occurring then the application may be dismissed more expeditiously (and with some financial saving, as mental health assessors are paid per visit). In the event that a DOL was found to be occurring, the mental health assessor would have been sent out later. While the logic of this is clear, it is not what the statute anticipated. There is some risk that the conclusions of the mental

health assessor regarding the effects of deprivation of liberty will be given short shrift, as the BI assessment will have already been done in draft before the mental health assessor does his or her assessment. Admittedly, it would be possible for the BI assessment to be amended after the fact, with an additional visit by the BI assessor if necessary. It is not clear how often this occurs.

On balance, it seems unlikely that the absence of the mental health assessor had a significant effect on Mr Sparrowhawk's death. To have an effect, the mental health assessor would have to have spotted that the provisions regarding Mr Sparrowhawk's epilepsy were inadequate, and raised this with STATT staff. That would in turn have to have triggered a different response to the epilepsy by STATT staff. While conceivable, this is highly speculative. It assumes first that the assessor would have the requisite expertise to spot the epilepsy issue (a highly doubtful proposition), and that he or she would have been engaging in an overall assessment of care including care of the epilepsy in a situation where the DoLS scheme directs assessors to be focused on matters relevant to deprivation of liberty (see further below).

No criticism can be made of the BI assessor on this point. Unlike the mental health assessor, the BI assessor is by definition not a physician. The issues regarding epilepsy were in their nature clinical, and there is no reason to expect the best interests assessor to have identified them.

Was the best interests assessor correct in his view that Mr Sparrowhawk was not deprived of liberty? The relevant law at the time was primarily that contained in the Court of Appeal decisions in *P (MIG) and Q (MEG) v Surrey CC* [2011] EWCA Civ 190 and *Cheshire West and Cheshire Council v P* [2011] EWCA Civ 1257. Both these cases were overturned on appeal to the Supreme Court in 2014, and the concepts of 'relative normality' and 'absence of practical alternative', pivotal in the Court of Appeal reasoning, are no longer part of the law. The analysis of their use by the best interests assessor therefore has little relevance for future practice: the law has changed. In understanding the events surrounding Mr Sparrowhawk's death, however, it is the law that applied at the time that must of course be considered.

Pivotal to the relevant test in 2012 was the issue of 'relative normality' - the notion that a deprivation of liberty ought to be determined by comparison to the conditions of care of 'an

adult of similar age with the same capabilities and affected by the same condition or suffering the same inherent mental and physical disabilities and limitations’.¹

In his BI assessment, the BI assessor noted that the ward was locked, but consistent with the relevant guidance and the Code of Practice [paras 2.19, 2.23] noted that this was not determinative of a DOL. He noted that Mr Sparrowhawk was receiving support for aggression-related difficulties, but there had been only two instances of aggression since his admission, one based on a misunderstanding. He noted that Mr Sparrowhawk was subject to 10 minute observations, and 1:1 access to the community, noting that this was for his safety, and consistent with others with a similar level of cognitive impairment and behaviour. He had not attempted to leave the unit. On this basis, the best interests assessor took the view that ‘the intensity and duration of the restrictions required to keep Mr Sparrowhawk safe and to assist with personal care ... do not amount to a deprivation of liberty’.

In his approach to the question and his conclusion, the views of the BI assessor were almost certainly consistent with those of other reasonably competent best interests assessors at the time. In his interview with me, it was clear that the assessor had approached the matter as one of relative normality, consistent with the Court of Appeal decision in *Cheshire West*. The statistics indicate that DOL was found only rarely at this time - in 2012/13, there were only 669 DoLS applications granted for people with learning disability in all of England,² suggesting a very narrow reading of the test of deprivation of liberty. The courts were also adopting a narrow reading. *C v Blackburn with Darwen BC* [2011] EWHC 3321 for example also concerned a man with learning disability and epilepsy. Unlike Mr Sparrowhawk, the individual in that case had made numerous attempts to leave the institution in which he was held, eventually resulting in an attempt that broke down a door; he was held nonetheless not to be deprived of liberty on the basis that what he wanted, an unconfined life in the community, was ‘not realistically possible due to the extent of his difficulties.’³ By the standards of practice at the time, no criticism may be made of the decision of the BI assessor.

The professional and court approach of the time does point up the limitations of the relative normality approach. The choice of comparator in this model is problematic. Were

¹ *Cheshire West* [2011] EWCA Civ 1257, para 86.

² Health and Social Care Information Centre, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England): Annual Report, 2013/14* (London: HSCIC, 2014), figure 11.

³ [2011] EWHC 3321, para 26.

professionals to consider someone just like the subject of the application to decide whether a deprivation of liberty was occurring? If so, either the relevant accommodation was the sort of environment where people of this sort ought not to be (in which case the DoLS order would presumably not be given, as it would almost by definition not be in the individual's best interests to be there), or it was the sort of environment where such people ought to be (in which case the order would also be refused on the basis of no deprivation of liberty). Either way, it is difficult to see how DoLS orders could be justified in any but exceptional cases, and that does not seem to have been the intent of the legislation. Nonetheless, that does seem to be the approach used by the profession and the courts in this period. This starts to raise the question of what the DoLS should be understood to do, a question that will be considered in more detail below.

It is perhaps appropriate to wonder at the plausibility of the accepted approach by the courts and the professionals at the time, even on its own terms. The relevant comparator might be taken to be a man with mild learning disabilities, epilepsy and autistic traits. At the time of the assessment, Mr Sparrowhawk was kept on a locked ward, subject to 10 minute observations, given 20mg of Fluoxetine and .5 mg of Risperidone to control his behaviour, not permitted outside the institution except under 1:1 supervision, and not permitted to see his brother. The question here is not whether these measures were appropriate. It is instead whether, in the language of the Court of Appeal, this is the 'normal' life that a person with mild learning disabilities, epilepsy and autism could reasonably expect?

The circumstances also point up how far professional practice as led by the courts had departed from the Code of Practice on the DoLS. The Code identifies the following as indicative of a deprivation of liberty:

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.

- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.¹

Mr Sparrowhawk clearly met the second and third of these criteria. The records indicate that he was also not permitted to see his brother, raising issues as to the sixth of these criteria and separate issues under Article 8 of the ECHR. While at the time of his DoLS assessment Mr Sparrowhawk does not appear to have been resisting his admission, he was taking medications that had sedative effects. A deprivation of liberty finding under these criteria is much more plausible than under the criteria used by the courts and profession.

As noted above, all this is to some degree academic for future practice in the light of the Supreme Court decision in *Cheshire West*. The test of deprivation of liberty is now whether the individual is ‘under continuous supervision and control and [is] not free to leave’.² This broader test is reflected in significantly greater use of the DoLS orders made overall, increasing from 7,600 for all of 2013-14 to more than 12,048 and 9445 in the two quarters commencing in April and July 2014, immediately after the *Cheshire West* decision had been decided.³ This suggests that professional practice has changed as a result of the Supreme Court decision. As noted earlier, Mr Sparrowhawk was kept on a locked ward, allowed to leave the ward only on 1:1 supervision, and subject to 10 minute observations at the time of his DoLS evaluation. Now, it seems very likely (as the BI assessor agreed) that he would be taken to be deprived of liberty.

Would this make a difference to the outcome in his case? That is a question about the nature of the DoLS safeguards, how they are structured and what they are meant to do. The DoLS are currently under re-consideration by the Law Commission, so engaging with this question is relevant not merely to the future practice of the Trust, but also the overall shape of the DoLS under any new legislative framework that may arise.

¹ DoLS Code of Practice (2008), para 2.5.

² *Cheshire West*, [2014] UKSC 19, para 49.

³ Health and Social Care Information Centre, Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England): Annual Report, 2013/14 (London: HSCIC, 2014), p 26; Health and Social Care Information Centre, Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England), Deprivation of Liberty Safeguards (DoLS) Quarterly Return, Quarter 2, 2014-15. These figures are for all DoLS applications, not just learning disability. Separate figures for learning disability are presented only annually, but there is little doubt that they will show a rise consistent with the overall picture.

As drafted, the DoLS do not appear to be designed to be overall assessments of the care of the individual lacking capacity. They instead focus on whether that individual is deprived of liberty, and whether the proposed conditions by which deprive the individual of liberty are in his or her best interests. Certainly, conditions may be put on the deprivation of liberty by the DoLS order, on the advice of the DoLS assessors, but those conditions are to be expressly related to the deprivation of liberty. Thus the mental health assessor is required to ‘consider how (if at all) the relevant person’s mental health is likely to be affected by being a detained resident’.¹ This falls a long way short of any suggestion that the mental health assessor should provide a view as to the overall care provided, or the individual’s physical healthcare: his or her role under the DoLS is to ensure that the individual is suffering from a mental disorder, and to comment on how detention would affect the individual’s mental health. Neither of these would encompass the circumstances of care surrounding Mr Sparrowhawk’s epilepsy, which in the end would appear to have been the cause of his death. Any representations that a mental health assessor would have made on that matter would have been outside the terms of his or her legal role. It is not something that the mental health assessor would be expected under the DoLS to comment on.

The role of the best interests assessor is more ambiguous. Unlike the mental health assessor, he or she is to consult the managers of the hospital or care home in question, and have regard to any relevant needs assessment and any relevant care plan, as well as any recommendations made by the mental health assessor,² before setting any conditions of their own relating to the deprivation of liberty, which are in turn carried into the final order. This engagement with the care plans and needs assessments suggests a somewhat broader role than the mental health assessor. This is certainly an arguable reading, but leaves open the question of why the range of documents above is to be consulted prior to deciding on conditions, if the conditions cannot extend into the care of the individual.

In Mr Sparrowhawk’s case, the conditions that might have made a difference might well have been more restrictive than what STATT had proposed, for example, continuous supervision of Mr Sparrowhawk in the bath rather than 10 minute observations. It is not to my knowledge ever addressed in the jurisprudence or academic literature whether the DoLS allow assessors to set conditions that will result in more restrictive deprivations of liberty than are proposed in the original application. On the one hand, it might be the case that they are in the best interests of the individual, suggesting that they would be within the

¹ MCA, sch A1, para 36(a).

² MCA, sch A1, para 39(2),(3).

ethos of the MCA and in particular the best interests test, and might therefore be allowed by the statute. On the other hand, the DoLS were introduced in response to an ECHR decision to limit the role of the state in depriving individuals of their liberty. It would be profoundly ironic if the safeguards against over-intrusive deprivations of liberty could themselves result in a more intrusive deprivation than would have been the case had they not been used at all.

In any event, the DoLS Code of Practice makes it clear that the increased latitude of the best interests assessor to set conditions on matters of care generally, rather than deprivations of liberty specifically, are limited:

The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they may make recommendations around contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, which - if not dealt with - would mean that the deprivation of liberty would cease to be in the person's best interests. The best interests assessor may also recommend conditions in order to work towards avoiding deprivation of liberty in future. But it is not the best interests assessor's role to specify conditions that do not directly relate to the issue of deprivation of liberty.

Conditions should not be a substitute for a properly constructed care plan (see paragraph 2.7 on good practice for care planning). In recommending conditions, best interests assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the hospital or care home from responding appropriately to the person's needs, whether they remain the same or vary over time. It would be good practice for the best interests assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment, and to make clear in their report whether the rejection or variation of recommended conditions by the supervisory body would significantly affect the other conclusions they have reached.

The message from the Code is that assessors should restrict themselves to matters concerning deprivations of liberty, rather than overall care. The matters of relevance in Mr Sparrowhawk's death were more about conditions of care than deprivation of liberty; if the Code view is adopted, they would have been outside the scope of the conditions that could properly be set by the BI assessor.

Whether the Code adopts the appropriate approach is a matter that falls outside the scope of this review, raising issues of what interests the DoLS are meant to protect, what they are to do, whether they should be restricted to matters relating to Article 5 alone, and how they interact with other mechanisms such as inspections to ensure appropriate overall standards. Those are issues that should properly be dealt with in the current discussions relating to the reform of the DoLS; Mr Sparrowhawk's case does point up their potential importance.

Mental Health Act

The use of the Mental Health Act is analytically much less complex.

Mr Sparrowhawk was detained on 20 March 2013 using s 2 of the MHA. There is no obvious criticism to be made of the processes used in this detention. The relevant substantive elements of the statute state:

2(2) An application for admission for assessment may be made in respect of a patient on the grounds that

- (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

Mr Sparrowhawk's learning disability constituted a mental disorder within the meaning of s 1 of the Act. The Trust staff were of the view that this was of a severity that warranted detention, a view given credence by the increasing difficulties experienced by his family in caring for him at home, and his increasingly difficult behaviour at school. Following admission, Mr Sparrowhawk's medications were adjusted, suggesting that at least some assessment did occur, followed by medical treatment. It would seem that this did improve his behaviour in the period in question. Detention under s 2 should be the least restrictive

alternative available,¹ but the background notes of this case show considerable attempts to avoid the admission, and this criterion must be taken to be met. There is no suggestion that the decision to admit Mr Sparrowhawk was arrived at lightly.

The Trust administration reminded the staff at STATT in a timely fashion that the section 2 detention would lapse on 17 April 2013. Section 2 may be used only once, and the staff of STATT instead considered application for a detention under s 3, the detention section that is available when a section 2 expires. The substantive criteria under s 3 differ from those under s 2 in a key respect: learning disability is considered to be a mental disorder under section 3 only if it is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person to be detained.² At the time the s 3 was considered, the staff were of the view that this element was absent from Mr Sparrowhawk's behaviour, and that s 3 was thus not available. This seems a justifiable position: the inclusion of this provision in the Mental Health Act was intended to limit the use of long-term detention of people with learning disabilities under the Act in all but manifestly necessary cases; this seems to be an example of the restriction having the effect intended.

In any event, at the time the s 3 came up for consideration, it would appear that Mr Sparrowhawk was not attempting to leave the facility and was compliant with medication. Under these circumstances, it is difficult to see that the medication prescribed to him could only be provided if he were detained, as required by s 3(2)(c).

For all these reasons, the decision not to detain Mr Sparrowhawk under s 3 of the MHA would appear to have been correct.

Further, whatever the correctness of the decision, it is difficult to see that detention under s 3 would have affected Mr Sparrowhawk's death. Once again, the relevant criteria for detention would not have directed the relevant detaining staff (an approved mental health professional and two doctors, one an expert registered under s 12 of the MHA - generally a consultant psychiatrist) to factors that were relevant in the death. These people would have been concerned with the criteria of s 3, vis whether Mr Sparrowhawk had a mental disorder of requisite severity, whether his detention was necessary for his own health or safety or with a view to the protection of others, whether the treatment he was to be given

¹ *Varbanov v Bulgaria*, Application no 31365/96, 5 October 2000 (ECHR); *Župa v Czech Republic*, Application No 39822/07, 26 August 2011 (ECHR).

² MHA, s 1(2B)(a).

could only be given if he was detained, and whether appropriate medical treatment was available for his mental disorder. This would not have raised the questions of relevance to the treatment of the epilepsy, which were the cause of death.

Eventually a SOAD - a specialist doctor dispatched by the Care Quality Commission - would have had to approve the plan for medications given for mental disorder. This would not have occurred until three months after the initial s 2 detention, so in mid-June. Epilepsy is not for the purposes of this scheme deemed to be a mental disorder, however, but rather a neurological one; so the SOAD would not have considered the appropriateness of the treatment regime for the epilepsy.

The approach of the Trust staff to the MHA therefore appears to be correct, and in any event, the MHA would not have provided a mechanism that would have affected Mr Sparrowhawk's death.

Findings

F1 The deficiencies of care noted in the Verita report of February 2014 are reflected in the implementation of the Mental Capacity Act generally - vis, issues of overall responsibility raising questions as to how far the MCA was integrated into care in STATT, and the failure adequately to engage with Mr Sparrowhawk's parents in developing a view of Mr Sparrowhawk's best interests. It is nonetheless not obvious that the issues concerning the MCA add anything to the findings of the 2014 Report as to the causes of Mr Sparrowhawk's death.

F2 The decision of the best interests assessor that Mr Sparrowhawk was not deprived of liberty was consistent with the law and the practice of best interests assessors of the period. This would not be the case following the Cheshire West decision in 2014. This case raises important questions as to what the DoLS should do, which warrant consideration by the Law Commission in its current revisiting of the DoLS processes.

F3 Consistent with common practice but inconsistent with the legislative technicalities, Oxfordshire County Council did not send a mental health assessor as part of the DoLS assessment process. It is unlikely that this had an effect on the events leading to Mr Sparrowhawk's death.

F4 The approach to the Mental Health Act by the staff of STATT appears to have been consistent with law and practice of the time.

Conclusions

The use of the MCA in this case does raise issues of relevance for the Trust. In particular, with the benefit of experience it may be advisable to improve on the relevant policies, and consideration of the notes does raise questions as to whether the MCA was implemented properly in the workings of STATT. While these shortcomings do not appear to have been significant factors in Mr Sparrowhawk's death, they do appear to be matters where care could have been improved.

The use of both the DoLS and the MHA were consistent with professional practice at the time.

Insofar as this aspect of the enquiry raises questions about the circumstances of Mr Sparrowhawk's death, the questions are in the adequacy of the legal structures. The 2014 Veritas report concludes that the death was preventable, had appropriate care planning been done regarding Mr Sparrowhawk's epilepsy. This is a matter of care planning and appropriate clinical care. Neither the MHA nor the DoLS are designed to address such questions unless, in the case of the MHA, the issue is the treatment of mental disorder with medications. That raises questions not about implementation or the behaviour of the Trust or LA. Instead, it raises questions about the scope of regulation provided by these regimes: when should professional practice be subject to external checks; how should we protect the interests of the most vulnerable in our society; how should the MHA and DoLS be understood in the context of other regulatory structures that are designed to ensure the provision of appropriate care, what interests are the DoLS and MHA intended to protect? These questions are particularly salient for the DoLS at this time, since they are currently under reconsideration by the Law Commission. Answering these questions is well beyond the scope of this part of the enquiry; but they should be considered as part of the DoLS reform process.

Chapter 13- Summary of Mental Health Act Legislation and guidance relevant to learning disability services

Legislation/guidance	
<i>Mental Health Act 1983</i>	Law that sets out the criteria for admission, treatment (and if appropriate) the detention of patients with mental health issues in a hospital setting
<i>Mental Capacity Act 2005</i>	Act designed to support and protect individuals who lack capacity or cannot make decisions for themselves
<i>Transforming care: A national response to winterbourne View Hospital¹ (DH, 2012)</i>	Department of Health paper outlining the steps that needed to be taken in response to the findings of the investigation into Winterbourne View hospital.
<i>The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care² (NICE clinical guidance 137, 2013)</i>	National guidance about how to diagnose, treat and manage epilepsy in children and adults
<i>Transition: Moving on well. A good practice guide for health professionals and their partners on transition planning for young people with complex health needs for a disability³ (DH and the department for children, schools and families, 2008)</i>	Guidance in relation to planning transition, multi-agency working, and the planning and commissioning of services
<i>RCN policy and international department - Making it work, shared decision-making and people with learning disabilities⁴ (2013)</i>	Guidance for health care professionals working in learning disabilities in relation to working together and joint decision making

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

² <http://www.nice.org.uk/guidance/cg137/resources/guidance-the-epilepsies-the-diagnosis-and-management-of-the-epilepsies-in-adults-and-children-in-primary-and-secondary-care-pdf>

³ http://www.bacdis.org.uk/policy/documents/transition_moving-on-well.pdf

⁴ http://www.rcn.org.uk/_data/assets/pdf_file/0003/526503/41.12_Making_it_work_Shared_decision-making_and_people_with_learning_disabilities.pdf