

Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust

July 2006



*Making Social Care
Better for People*



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ISBN: 1-84562-102-6

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The Healthcare Commission

The Healthcare Commission exists to promote improvement in the quality of NHS and independent healthcare across England and Wales. It is a new organisation, which started work on April 1st 2004. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

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

- replaced the work of the Commission for Health Improvement which ceased to exist on March 31st 2004
- took over the functions relating to independent (private and voluntary) healthcare from the National Care Standards Commission, which also ceased to exist on March 31st 2004
- picked up the elements of the Audit Commission's work which relate to efficiency, effectiveness and economy of healthcare

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

We will usually investigate when allegations of serious failings are raised, particularly when there are concerns about the safety of patients or other people who use services. The purpose of our investigations is to discover whether there is any foundation to allegations of serious failings and, if there is, to uncover the cause of those failings.

Our investigations also aim to protect patients, particularly vulnerable individuals, help organisations to improve the quality of care that they provide, build or restore public confidence in services, and help the wider NHS to learn lessons about how best to ensure the safety of those using their services. Our full criteria for deciding to conduct an investigation are available on our website at www.healthcarecommission.org.uk

The Commission for Social Care Inspection

The Commission for Social Care Inspection (CSCI) was created by the Health and Social Care (Community Health and Standards) Act 2003 and began operations on April 1st 2004. It replaced the Social Services Inspectorate, the Social Services Inspectorate/Audit Commission joint review team and the National Care Standards Commission.

CSCI is the statutory regulator of care establishments in England, including care homes and domiciliary care agencies, in the public, private, voluntary and charitable sectors. Consequently, under section 31 of the Care Standards Act 2000, CSCI is permitted to inspect any premises that are used, or which it has reasonable cause to believe may be used, as a care home or for the purpose of a domiciliary care agency.

CSCI's primary aim is to improve social care by putting the needs of people who use care services first. CSCI regulates services relating to both adults and children through a process of registration and inspection. This process measures the performance of providers of social care against a set of national minimum standards determined by the Government.

CSCI has a range of functions. It:

- inspects all social care for adults and children in the public, private and voluntary sectors
- publishes annual reports to Parliament on the performance of social care and on the state of the social care market
- inspects and assesses the value for money of council social services
- holds performance statistics on social care
- publishes the 'star ratings' for council social services
- registers and inspects services against national minimum standards
- hosts the role of Children's Rights Director

For more information about the work of CSCI, visit www.csci.org.uk.

About this report

The Healthcare Commission and the Commission for Social Care Inspection are jointly responsible for this report, and for ensuring that Cornwall Partnership NHS Trust publishes an action plan in response to this investigation. The action plan will be available on the Healthcare Commission website and on the Commission for Social Care Inspection website. The South West Peninsula Strategic Health Authority will be responsible for monitoring the implementation of the actions that have been agreed.

CSCI is responsible for ensuring that all of the trust's services requiring registration are registered and inspected, and for monitoring the action plan that Cornwall County Council undertakes in response to this investigation.

The Audit Commission is leading on a joint inspection of the *Supporting People* programme in Cornwall and will also consider some aspects of the supported living services for adults and young people with a range of needs, including learning disabilities. CSCI will commission any other inspections required for other people who use the trust's services following this inspection.

This investigation has only examined the services provided for people with learning disabilities by Cornwall Partnership NHS Trust. Other organisations in Cornwall, including Cornwall County Council, that provide services for people with learning disabilities have not been investigated. We therefore report solely on the standard of residential services provided by the trust.

Throughout this report, we refer to the 'supported living services' provided by the trust because this is the term used by the trust. It is not necessarily reflective of the wider use of the term in the UK.

Executive summary

In 2005, the Healthcare Commission and the Commission for Social Care Inspection (CSCI) investigated services for people with learning disabilities provided by Cornwall Partnership NHS Trust. The investigation was sparked by serious concerns, raised by East Cornwall Mencap Society in October 2004, about the care and treatment of people living in the trust's assessment and treatment centres and supported living services. East Cornwall Mencap Society feared that failings in the quality of care and the financial management of the services were widespread and that some people might be suffering abuse. A month later the media reported that seven members of staff at the trust had been suspended from duty at Budock Hospital, one of the trust's assessment and treatment centres, and that the trust had commenced a disciplinary investigation. Five of these members of staff have since been dismissed.

The Healthcare Commission made some initial enquiries, met the five families whose concerns were referred by East Cornwall Mencap Society and, in May 2005, concerned that the trust's own investigation had still not concluded, decided to conduct a formal investigation. By September, it was clear that the overlap between health and social care meant that the investigation needed to be carried out jointly with CSCI. In October, the Healthcare Commission notified the Secretary of State for Health of its concerns about significant failings in the trust and requested that urgent action be taken to safeguard people using the trust's learning disability services while our investigation was underway. In response to our recommendations, an external team was brought in by the strategic health authority to implement immediate changes in the trust's services for people with learning disabilities.

There has been some progress by the trust since the strategic health authority brought in this external team. However, the Healthcare Commission still has concerns about the quality of services. We consider that there are significant failings in the trust's services and that further special measures are necessary to address these failings. This view is shared by CSCI.

During the investigation, the Healthcare Commission and CSCI visited every site operated by the trust, including 45 supported living services, three assessment and treatment centres, a special service for one person detained under the Mental Health Act 1983 and its services for children. We also met almost all of the people who used the trust's residential learning disability services and commissioned the British Institute for Learning Disabilities (BILD) and an experienced healthcare professional to carry out separate reviews of the trust's services.

Key findings

There are general standards of practice that apply to all health and social care services. While there are no specific performance indicators for learning disability services, there are a number of key documents, which describe best practice. These include:

- *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health 2001) – a white paper, which sets out the principles that should underpin services for people with learning disabilities: rights, independence choice and inclusion (guidance for partnership boards on how to implement the strategy has also been produced, along with clear timescales)

- *Reach-Standards in Supporting Living* (Paradigm 2002) – nine standards based on the principles of the *Valuing People* strategy, which can be used to determine whether a service is providing supported living
- *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (known as the *Mansell Report*, Department of Health 1992). The report provides guidance on the provision of health and social care services for people with learning disabilities whose behaviour is considered challenging
- *No Secrets* (Department of Health and Home Office 2000) – guidance issued by Department of Health aimed at protecting vulnerable adults from abuse
- *Care Homes for Adults (18-65) and Supplementary Standards for Care Homes Accommodating Young People Aged 16 and 17 and Domiciliary care: national minimum standards, regulations* (Department of Health 2003)
- learning disability standards developed by the former Social Services Inspectorate (SSI) for service inspections, and now used by the CSCI

Abuse

Abuse, as described in the *No Secrets* guidance, “is a violation of an individual’s human and civil rights by any other person or persons”. It may consist of a single act or repeated acts and can take the form of physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect and acts of omission and discriminatory abuse. The guidance also refers to ‘institutional abuse’ and provides the following example:

“Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an

indication of more serious problems and this is sometimes referred to as institutional abuse”.

Some individuals, as the trust has acknowledged, have suffered abuse including physical, emotional and environmental abuse. The trust’s own investigations at Budock Hospital have shown that some people using its services have had to endure years of abusive practices and some have suffered real injury as a result. For example, one person suffered multiple injuries over time, including a fractured skull after being hit by another person who used the trust’s services. Despite the development of numerous action plans, underlying problems have never been addressed and poor practice has become ingrained within the management of learning disability services and the provision of care.

Our investigation found that institutional abuse was widespread, preventing people from exercising their rights to independence, choice and inclusion. One person spent 16 hours a day tied to their bed or wheelchair, for what staff wrongly believed was for that person’s own protection. One man told investigators that he had never chosen any of the places he had lived as an adult.

More than two-thirds of the sites we visited placed unacceptable restrictions on people living there. For example, we found that some internal and external doors were kept locked by staff to restrict the movement of people from the services, instead of seeking alternative methods to address perceived problems. In one home, taps had been removed and, in another, light fittings were taken out. Arrangements to manage the finances of people in supported living services, such as the apparent pooling of their money to a shared household account and the use of people’s money to purchase communal goods and pay for improvements to homes, were also a concern. Details have been referred to the NHS Counter Fraud and Security Management Service and the Audit Commission, and the concerns are now being investigated.

During the investigation, the Healthcare Commission and CSCI referred 40 individuals

under the procedures for the protection of vulnerable adults, as set out in the *No Secrets* guidance, relating to these and other practices. The trust's failure to address adequately many of these referrals revealed systemic flaws in local procedures. For example, staff appointed by the trust to investigate such referrals were often managers who had agreed to or had been involved in implementing the practice to which the referrals related. Two referrals were made twice because of the lack of action taken by the trust following the first referral. The trust also failed to recognise that, if the Commissions had reported one instance of abuse, the trust should review its practices to ensure that such abuse was not occurring elsewhere in its services.

We found that Cornwall County Council, as leading agency for the protection of vulnerable adults, failed to adequately coordinate inter-agency arrangements in accordance with *No Secrets* guidance. This guidance requires the Council to ensure that there is an inter-agency policy in place, that training for staff is developed, and that compliance with national guidance is being checked as part of the process for audit. The role of Cornwall County Council in coordinating inter-agency referrals was insufficient and social workers were too willing to accept the opinion of staff at the trust without challenge. These arrangements improved when the director of adult social care began reporting continuing concerns directly to the chief executive.

Assessing and planning care

The trust's services did not reflect the principles of rights, independence, choice and inclusion, set out in the *Valuing People* strategy.

Assessment and treatment centres and supported living services operated by the trust did not meet best practice as detailed in the *Mansell Report* and, in some instances, these services were being provided in totally unacceptable environments. Record keeping was generally so poor that it prevented effective care from being provided. There was little

evidence of effective guidelines on handling challenging behaviour or adherence to treatment programmes. There was evidence of physical restraint being used illegally and excessive use of pro re nata (PRN) medication to control unacceptable behaviour. In two of the three centres, there were no treatment plans for those residing there. As a result, the centres had effectively become long term homes for the majority of people. In one instance, a person who was admitted to one of the trust's assessment and treatment centres for a short stay following a cataract operation died there several years later.

Within the services there was little evidence that Cornwall County Council had undertaken community care assessments of those using services, therefore it was impossible to determine if people were receiving appropriate services. This contributed to the trust effectively becoming a provider of long term, unregulated and unmonitored social care. It also meant that those using the services were being housed inappropriately. CSCI considered that the supported living services were being run as unregistered care homes, which did not meet accepted standards.

Staff working in these services were not supported to deliver modern social care. Training was poor and not considered a priority. There were very few policies and procedures developed specifically for the supported living services. Policies that did exist were not updated, reviewed or monitored. When new policies were introduced, they did not meet mandatory requirements – for example, the trust's policy relating to Criminal Record Bureau (CRB) checks was introduced three months after such checks became mandatory. Interim guidance was issued but not until the day of implementation. Staff did not receive training to support implementation.

There was also little evidence that people using the trust's supported living services, or their relatives, were routinely involved in planning their care. They appeared to have no choice over where they lived, who they lived with or who

provided their care. In order to achieve registration either as care homes or domiciliary care, services needed to improve considerably.

The review carried out by the British Institute for Learning Disabilities and a review of case notes also revealed serious deficiencies in care and in record keeping. The institute found that people using the trust's services were generally 'looked after', instead of being supported to develop their skills. This limited their ability to make informed choices and communicate their needs. These findings supported those of the investigation team.

The investigation team also identified a number of areas for improvement in the respite hospitals for children operated by the trust, including the staffing and training arrangements and the availability of suitable information for parents, carers and young people.

The role of management and other bodies

The trust had made some changes in an attempt to improve services. In early 2004, a new director of services was appointed to integrate the trust's mental health and learning disability services. The trust's model of care, as acknowledged by the director, was outdated and the changes implemented by the trust did not appear to have resulted in significant improvements to the quality and consistency of care during our visits in 2005 or 2006.

The senior leaders in the trust did not convince the investigation team that they had a strategic vision for the service, or an effective operating plan. Their governance arrangements did not allow them to monitor services effectively and their standards in terms of the quality of services were too low. The chief executive and the trust's board have struggled to accept that the trust's services for people with learning disabilities were poor. Minutes of board meetings held after the start of the investigation demonstrate that they continued to believe for some time that the services were no worse than

many others in the country. While we accept that there may be other pockets of poor practice found elsewhere in the country, this does not excuse poor practice at the trust and, in our view, the extent of unacceptably poor practice in Cornwall is unusual. A national audit of learning disability services will be undertaken by the Healthcare Commission later this year to determine the quality of services provided by the NHS and the independent healthcare sector.

The trust blamed North and East Cornwall Primary Care Trust (PCT), West of Cornwall PCT and Central Cornwall PCT for failing to commission appropriate services. While this does not lessen the culpability of the trust, the criticism is accurate. Arrangements for commissioning services were not monitored and, although there is a service level agreement between the trust and the PCTs, it covers all 'patient' services provided by the trust. It does not require the trust to collect hardly any information about learning disability services. As a result, these services have gradually deteriorated.

Other organisations have also had a role to play in the deterioration of the trusts services. Working relationships between the trust and Cornwall County Council have been poor for a considerable time. Services for people with learning disabilities were not transferred to social services, following the closure of long stay hospitals, as they were in other parts of the UK. Social services have had little involvement in the care provided by the trust, to the detriment of people with learning disabilities.

The learning disability partnership board was established in 2001 in accordance with the *Valuing People* strategy. However, the trust did not implement the principles and practices set out in *Valuing People* and the needs of those using learning disability services were not reflected in the local delivery plan. In addition, services for people with learning disabilities were not included in the strategic health authority's structure for managing performance in the trust. These services were marginalised. Patients, the public and staff were not involved

or engaged with them and the promotion and availability of advocacy services was very limited.

The merger of the former specialist learning disability trust (better known as Trecare) with mental health services to form Cornwall Healthcare NHS Trust in 1999 and the formation of Cornwall Partnership NHS Trust in 2002 has also affected the provision of services. For example, the nature of working practices among staff was a legacy from the learning disability trust. A number of staff working in the trust had worked in the previous organisations and, until 2004, a senior manager of the former learning disability trust led the service. Staff rarely visited other organisations and few new staff from other areas came to work in the trust's learning disability services. As a result, they had little exposure to other ways of working that might have encouraged improved standards of care. We found that staff at the trust were aware of the procedure for reporting abuse (as set out in *No Secrets* guidance) but were largely unaware of what constituted abuse. While the staff we met showed genuine warmth and kindness, they lacked knowledge and understanding of best practice and the principles of the *Valuing People* strategy.

Another consequence of the merger was that learning disability services became a small part of the overall service provided by the trust. They were not well resourced and lacked the expertise and qualified staff to deliver care and treatment in line with best practice. There was little evidence of multidisciplinary working and, where treatment programmes were agreed, implementation was inconsistent.

All of these factors conspired to make people with learning disabilities largely powerless to control their environments or their lives, and contributed to the poor quality of care and abuse we have described.

Key recommendations and progress

A number of immediate changes were implemented while the investigation was

underway, to safeguard people using the trust's services from further risk, including:

- the appointment of a team of specialists to lead the changes required to the trust's services and to plan for the future
- the appointment by Cornwall County Council of an additional expert in the protection of vulnerable adults to manage the investigation, action planning and recording of referrals. The council has revised and reissued procedures for protecting vulnerable adults, retrained staff and managers, and identified a senior manager with clear responsibility for this area
- improved environments in supported living services – some doors have been unlocked
- the completion of more than 200 community care assessments for all people using the trust's services (including those residing in Budock Hospital, who we considered at greatest risk of immediate harm)
- the development of action plans for the trust's assessment and treatment centres, supported living services and services for children
- the closure of one ward and some redecoration of a further two wards at Budock Hospital. The care provided in Budock Hospital has also improved as a result of greater therapeutic input and more interaction between staff and patients
- the trust has been working with an external agency to develop the skills and knowledge of staff working in these services
- strengthening of arrangements for commissioning services for people with learning disabilities

The following key recommendations by the investigation team also aim to bring the trust into line with best practice and national guidelines. The complete list of recommendations, and further detail about the trust's progress to date, can be found in the full investigation report.

Key recommendations:

- systems and processes to ensure that sufficient and effective action is taken to protect people with learning disabilities from abuse must be implemented by all parties involved, including the trust, Cornwall County Council and other voluntary and local statutory agencies
- Cornwall County Council must continue to fulfil its responsibility to carry out community care assessments and provide 'person-centred' plans for people who may require social care
- the trust must fulfil its responsibility to carry out continuing assessments of healthcare when required
- the PCTs, Cornwall County Council, the strategic health authority, the trust and the learning disability partnership board must ensure that the results of assessments are used to shape the redesign of the service
- the PCTs and Cornwall County Council, as commissioners of social care services for people with learning disabilities, must respond to the experiences of those using services and their families. Their views must be included as part of the annual planning cycle for learning disability services and performance should be measured against indicators which take account of their views
- the learning disability partnership board must fulfil its roles and responsibilities, as set out in the *Valuing People* strategy, to improve the lives of people with learning disabilities by giving them more rights, independence, choice and inclusion
- the trust must redesign services to meet the needs identified in 'person-centred' plans for those people who do not need to be placed in care homes
- the trust must make immediate applications to register care homes where the early indicators from community care assessments have indicated that people using its services need to be placed in care homes
- an application for domiciliary care registration is immediately required for the provision of personal care where people's community care assessments indicate that they do not need or choose to be placed in a care home. Plans must be submitted to show the redesign of services to support applications for domiciliary care
- the provision of personal care must be delivered in accordance with the regulations and national minimum standards for care homes or domiciliary care agencies
- funding of learning disability services under the *Supported Living Programme* should continue for people who are assessed as needing housing support. For these people, services will need to be redesigned to meet the eligibility criteria for supported living funding
- the trust must ensure that people with learning disabilities are allowed to exercise choice and control over their care and development, aided by the availability of information in a format that is easy to read and by other means
- the trust must ensure that it has the knowledge, skills, experience and commitment at all levels of the organisation to deliver services to people with learning disabilities that accord with best practice
- the trust must ensure that its workforce is adequately trained and supervised to deliver services in accordance with the principles of the *Valuing People* strategy. Services must be supported by policies, procedures and guidelines that meet best practice. The trust and Cornwall County Council must also ensure that 'person-centred' planning is carried out
- the trust must review its systems, policies and practice for managing the finances of people who use its services

Key national recommendations:

- anyone, including NHS bodies, who are running care homes or domiciliary care

agencies must immediately seek to register those services with CSCI

- every council, PCT and learning disability partnership board should review their arrangements for joint working to ensure that people with learning disabilities are offered a community care assessment, following assessment and treatment. This should result in the development of a 'person-centred' plan
- the Department of Health should strengthen the process for safeguarding and protecting adults, in accordance with the provisions of the Safeguarding Vulnerable Groups Bill
- local authorities, in their role as 'lead' agency, must ensure that local arrangements for investigating allegations of abuse and improving services are robust

Introduction

In May 2005, the Healthcare Commission decided to investigate the services for people with learning disabilities provided by Cornwall Partnership NHS Trust (the trust). The investigation was triggered by various concerns raised by East Cornwall Mencap Society.

In October 2004, East Cornwall Mencap Society wrote to the Healthcare Commission and CSCI alleging that the services provided by the trust were of poor quality and might not comply with the law. It also alleged that there were financial irregularities and that some individuals with learning disabilities under the care of the trust might have suffered abuse. East Cornwall Mencap Society described the abuse as financial, psychological, emotional, institutional and neglect, with some instances of physical abuse. East Cornwall Mencap Society had helped the families of five individuals thought to have suffered such abuse to make complaints under the NHS complaints procedures. Some of these complaints were ongoing.

Shortly afterwards, the Healthcare Commission was made aware of an investigation being undertaken by the trust into allegations of verbal, psychological and physical abuse at Budock Hospital, one of three assessment and treatment centres run by the trust for people with learning disabilities. A number of staff were suspended, pending the outcome of the trust's investigation and subsequent employment tribunals.

The Healthcare Commission did not wish to risk prejudicing the results of the trust's investigation by launching a formal investigation at this point, and wanted to wait for the results of a review by the Supporting

People team. Instead, we used this time to collect and examine a range of documentary evidence relating to the allegations.

In February 2005, the Healthcare Commission and an external adviser reviewed information relating to the allegations supplied by East Cornwall Mencap Society and the trust. Initial interviews were carried out in early April 2005 with the relatives of those identified by East Cornwall Mencap Society. The Healthcare Commission communicated closely with CSCI throughout this process.

A formal investigation was launched in May 2005 based on the detail discussed during those interviews, and the findings of the earlier review of information. This early work also led to joint inspections by CSCI and the Healthcare Commission in August and September 2005. A sample of services for adults and children were visited, including the three assessment and treatment units, eight supported living services and four children's services. Initially, it was difficult to get an accurate list of addresses for the supported living services from the trust.

In September 2005, both organisations agreed that the investigation needed to be carried out jointly. This was because the legal status of the services in which care was being provided was unclear and the matter required consideration by the Healthcare Commission and CSCI, in accordance with their respective legal responsibilities. As a result of this decision, all supported living services were inspected.

In October 2005, the Healthcare Commission notified the Secretary of State for Health that there were significant failings in the quality and safety of care being provided by the trust

for people with learning disabilities. The Healthcare Commission concluded, on the basis of evidence held at that time, that the welfare of some of these people was at risk and that urgent action was required to ensure their safety. The Secretary of State for Health accepted that there were significant failings.

The Healthcare Commission made a number of recommendations, the most significant being the appointment of an external team to implement immediate changes to the way services were delivered, which the South West Peninsula Strategic Health Authority agreed to implement. The strategic health authority appointed an external team, funded by the trust, to implement the necessary changes. Appendix A provides further information about members of the external team.

CSCI told the director of adult social care and the director of children's services at Cornwall County Council that urgent action was required to address the safety of those using the trust's services pending the outcome of the investigation.

The investigation

Aim

The aim of the investigation was to establish whether services for people with learning disabilities being provided by Cornwall Partnership NHS Trust met the individual needs of those using services, conformed to legal requirements and were based on best practice as described in the white paper, *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health 2001).

Terms of reference

The Healthcare Commission agreed the initial terms of reference for the investigation in May 2005. They set out to examine:

- 1 the individual allegations of abuse and poor care
- 2 the adequacy of the trust's model of service provision and the extent to which it conforms with legal requirements and best practice, particularly regarding the development of a 'person-centred' approach
- 3 the adequacy and safety of the provision of care within supported living services and the extent to which these services conformed with legal requirements
- 4 the culture of the trust's services for people with learning disabilities and the extent of engagement with people who use these services, their carers and families
- 5 the governance of services for people with learning disabilities, including strategic arrangements to assure the safety of patients and the quality of care
- 6 any other matters which the Healthcare Commission and/or CSCI consider arise out of, or are connected with, the above

The terms of reference were amended in September 2005, following the decision to conduct a joint investigation with CSCI. The amended version included an additional term of reference (number 3 above) and an amended term, number 6.

The investigation

The investigation team comprised members of staff of the Healthcare Commission and CSCI, and external advisers. The British Institute for Learning Disabilities and the Department of Health's Valuing People team provided advice to the investigation team. Full details of the investigation team are provided in Appendix A.

There were five key elements to the investigation:

- interviews
- analysis of documents
- a survey of carers and relatives
- visits to the trust
- review by the British Institute for Learning Disabilities

Interviews

The team conducted more than 140 face to face and telephone interviews and meetings from June 2005 to February 2006. Interviews and meetings were conducted with:

- staff from the trust (past and present)
- staff from the wider health and social care community in Cornwall

- people who use services provided by the trust
- carers and relatives of people with learning disabilities
- staff or representatives from other relevant organisations
- members of the public

Analysis of documentary evidence

The investigation team analysed more than 1,500 documents provided by the trust and other sources, including policies, minutes of meetings, correspondence, reports and records. The care records of a number of people with learning disabilities were examined in detail.

Survey of carers and relatives

Ninety-five carers and relatives of people with learning disabilities completed a survey of their satisfaction with services provided by the trust. A summary of the results of the survey is provided on page 56.

Visits to the trust

CSCI and the Healthcare Commission inspected eight supported living services and four services for children in August 2005. The findings led CSCI to inspect all 45 of the trust's supported living services and a property designated by the trust as a hospital service for one person, who was detained under the Mental Health Act 1983 and required treatment. The Healthcare Commission visited the three assessment and treatment centres. The first few visits were carried out unannounced or at short notice.

The purpose of the regulatory inspections by CSCI was to determine:

- if any supported living services required registration under the Care Standards Act 2000
- the need for any criminal or civil prosecution under the Care Standards Act

2000 for the failure to register in accordance with the Act

- the type of registration required by different services (for example, whether services should be registered as a care home, domiciliary care, or as a children's home)
- the need for any referrals under schemes for the protection of vulnerable adults and the protection of children and adolescents
- areas of poor or institutionalised practice

Toward the end of the investigation, the Healthcare Commission and CSCI jointly conducted follow up visits to Budock Hospital and eight of the trust's supported living houses to check on its progress.

The British Institute for Learning Disabilities (BILD)

The Healthcare Commission commissioned the British Institute for Learning Disabilities to review the quality of services for people with learning disabilities provided by the trust. The institute reviewed services in various locations, including the trust's assessment and treatment centres, supported living services and services for children.

The national context

Over the past 30 years, the approach to the provision of services for people with learning disabilities has changed significantly.

Most of the large long stay hospitals in the NHS in England have closed and the majority of people have been transferred to services in the community where they receive social care and support, rather than healthcare. Only 3,000 people with learning disabilities continue to live as inpatients in accommodation provided by the NHS. This accommodation is provided free of charge.

This shift in focus from long term healthcare in hospitals to social care in the community has been driven, particularly in recent years, by the Government's agenda to end institutional care for people with learning disabilities. It is underpinned by several key pieces of legislation, national guidance and policies.

Assessing the need for community care

In 1992, the Department of Health issued guidance on how NHS bodies should assess the healthcare needs of those with learning disabilities. Similar guidance was provided to local authorities in the local authority circular (92)15. Social Care for Adults with Learning Disabilities (Mental Handicap). Under this guidance, health and social services in Cornwall and elsewhere are obliged to carry out a multidisciplinary assessment, in consultation with parents and carers, to determine whether the NHS should provide care and treatment for an individual or whether the provision of social care would be more appropriate.

Local authorities are obliged, under section 47 of the National Health Service and Community Care Act 1990, to carry out an assessment of a

person's need for community care services if required. Section 47 of the Act also obliges local authorities to invite an appropriate NHS body (PCT or health authority) to assist with the assessment if there may be a need for the provision of healthcare services or any services under the NHS Act 1977. A person's need for healthcare is, therefore, determined through an assessment by an NHS body. Appropriate care plans should be developed, setting out the community care and other services that they need based on that assessment.

Community care may be provided in various settings, including:

- a care home provided by social services, a voluntary sector organisation or a provider in the independent sector
- as part of an 'extra care sheltered' scheme (a form of independent living with professional and home care staff on site for those who would otherwise need residential accommodation), provided by the local authority or by a registered social landlord
- a supported living house, provided by voluntary organisations or registered social landlords (residents in supported living houses are considered to be tenants)
- a person's own home

Community care services are defined in section 46(3) of the National Health Service and Community Care Act 1990 as services provided under:

- the National Assistance Act 1948 (Choice of Accommodation) Directions 1992 Part 111
- section 45 of the Health Services and Public Health Act 1968

- section 21 and schedule 8 of the NHS Act 1977
- section 117 of the Mental Health Act 1983
- section 2 of the Chronically Sick and Disabled Persons Act 1970 (included by the Court of Appeal)

Under section 3 of the Care Standards Act 2003, an establishment is a care home if it provides accommodation, together with nursing or personal care and assistance with bodily functions when required, for people who are or have been ill, have or had a mental disorder, who are disabled or infirm, or who are or have been dependent on alcohol or drugs. People managing such establishments must be registered with CSCI as care homes under the Care Standards Act.

Those assessed as requiring accommodation and personal care may be able to choose where it is provided if they satisfy criteria set out in the National Assistance Act 1948 (Choice of Accommodation) Directions 1992. They may be able to choose a care home, or a supported living service with domiciliary care. They may also be entitled to housing-related financial support under the *Supporting People* programme. This support is subject to the *Supporting People* (England) Directions 2003 (Office of the Deputy Prime Minister 2003) and the conditions of *Supporting People* programme grant.

Assessing the need for registration

The Alternative Futures case, heard by the Care Standards Tribunal in March and June 2003 and by the Court of Appeal in April 2005, identifies key issues that CSCI must consider when determining whether or not an establishment falls within the definition of a care home. These key issues include:

- to fall within the definition of a care home, the establishment must provide accommodation together with nursing or personal care
- the fact that two separate companies might

be involved in the provision of care and accommodation does not necessarily mean that the accommodation and care is not provided together for the purpose of the definition of a care home

- the existence of tenancy agreements between the provider of accommodation and people living there does not necessarily lead to the conclusion that people are residing in their own homes. The existence of tenancy agreements may mean that people are living in their own homes, but it is not determinative
- in determining whether people are living in their own homes or in an establishment that falls within the definition of a care home when tenancy agreements are in existence, the reality of the situation must be considered. Key considerations include whether they enjoy 'genuine exclusive possession' of their accommodation and have the ability or power to make real choices about their accommodation and the care that they receive

The House of Lords refused in February 2006 to grant permission for an appeal against the Court of Appeal's decision in the Alternative Futures case to proceed. The decision in this case therefore reflects the current state of the law on the definition of a care home.

Funding

In most parts of England during the 1970's, health and social services negotiated arrangements to transfer people with learning disabilities from long stay hospitals to services in the community. Initially, the cost of this transfer was supported by supplementary benefits from an uncapped Government fund for residential care (care homes and domiciliary care). However, this created an incentive for people to be placed in residential care, rather than receiving services in their own homes (which would be paid for by the local authority). It also contributed to a large increase in the number of independent residential and nursing

homes. In 1993, responsibility for allocating these funds transferred from the Department of Social Security to local government and local authorities.

The use of this supplementary benefit was abolished under the National Health Service and Community Care Act 1990. Responsibility for the financing of residential care was transferred to local authorities, while healthcare authorities were given responsibility for financing continuing care in the NHS. Under this new system, NHS bodies made an annual payment or lump sum to social services departments to facilitate the transfer of people with learning disabilities to services in the community. These payments were known as 'dowry payments'. Detailed guidance about dowry payments was issued to NHS bodies and local authorities in 1992 and 1995. Health authorities have a responsibility for arranging and funding healthcare for people who are assessed as requiring continuing healthcare in the NHS. The NHS is responsible for negotiating arrangements with local authorities for people who are discharged from long stay institutions. These arrangements must include the appropriate transfer of any resources.

No Secrets: The protection of vulnerable adults

In March 2000, the Department of Health and the Home Office published *No Secrets: Guidance on Developing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. Section 7 of the Local Authority Social Services Act 1970 requires local authorities to follow this guidance.

No Secrets guidance states that abuse takes place in many settings including those previously assumed safe or in public places. The guidance covers different forms of abuse, including physical, sexual, psychological, financial, material, institutional and discriminatory abuse, neglect and acts of omission.

Under the guidance, local communities should

have in place an inter-agency framework, which is formally agreed between all relevant agencies, to protect vulnerable adults. This framework should include:

- an inter-agency policy that sets out how allegations of abuse will be investigated, how action plans should be developed and how to monitor outcomes
- a nominated senior member of staff from each agency who leads activities relating to the protection of vulnerable adults
- a training package explaining local policies, procedures and professional practice
- a process for annual audit, to monitor and evaluate the effectiveness of local policies, procedures and practices

Social services should lead the coordination of this framework.

Valuing people

In March 2001, the Department of Health published the white paper, *Valuing People: A New Strategy for Learning Disability for the 21st Century*, setting out four principles that underpin its approach to the provision of services for people with learning disabilities: rights, independence, choice and inclusion. The white paper highlighted working in partnership as a key mechanism for improving access to health and community care for people with learning disabilities. It also outlined a series of new policy initiatives, including:

- the establishment of learning disability partnership boards in each local authority, which are responsible for overseeing the implementation of elements of the white paper relating to services for adults (including the development of joint investment plans)
- the development of 'person-centred' planning to help people with learning disabilities to exercise more choice and control over their lives

'Person-centred' planning is defined by the Department of Health as "a process for continual listening and learning, focused on what is important to someone now and for the future, and acting upon this in alliance with family and friends. This listening and learning is used to understand a person's capacities and choices. 'Person-centred' planning is a basis for problem solving and negotiation to mobilise the resources necessary to pursue the person's aspirations. These resources may be obtained from a person's personal network, from service agencies, or from a range of non-specialist and non-service sources".

Community care assessments completed by social services departments provide a record of needs from which a 'person-centred' plan should be developed. Healthcare staff should assess any healthcare needs identified as part of this process. A risk assessment and care plan should be developed based on the community care assessment. A long term 'person-centred' care plan should also be agreed with each individual and their advocates.

Services for children

The children's and young people's partnership board is the body responsible for ensuring that organisations providing health and social services meet their responsibilities in relation to children and young people.

Supporting people

In April 2005, the Office of the Deputy Prime Minister (ODPM) settled the three-year budget (2005-2008) for the *Supporting People* programme. The *Supporting People* grant is paid by the ODPM to 150 administering authorities (including Cornwall County Council) who then contract providers to deliver housing-related support to vulnerable people. The administering authority is the employer of the local *Supporting People* teams and they are located in housing or social services departments. In Cornwall, they are located within social services.

A commissioning body (a partnership of local housing, social, health and probation services) sits above the administering authority and plays a key role in advising and approving decisions on priorities, decommissioning services and the local *Supporting People* strategy. The ODPM has not changed the grant conditions or the eligibility criteria. However, concerns were raised about services in some areas that were not considered to be good value for money. The two processes that are now underway are:

- administering authorities were required to conduct a review of services, and develop an action plan, by April 2006 to ensure that they were of good quality, were strategically relevant and value for money. A five year strategy had to be completed by all local authorities by March 2005
- the Valuing People support team advise that partnership working and the pooling of knowledge and resources will be essential to deliver high quality 'person-centred' services to people with learning disabilities.

The Audit Commission has been charged with carrying out *Supporting People* inspections of all administering local authorities within a five-year period. A timetable has been drawn up which also allows for re-inspections, where serious concerns over performance arise, and for inspections at the direction of the Secretary of State for Health where the ODPM has concerns over progress and performance.

The Audit Commission commented: 'Informal feedback from participating administering local authorities says the inspection process had helped to refocus attention on key priorities, emphasised the need to improve partnership working, exposed the need to develop clear action plans and performance monitoring and, perhaps most importantly, highlighted the absence of meaningful service user involvement in the development and delivery of the programme.'

Reach standards in supported living

In 2002, Paradigm (an international consultant, training and development agency, whose purpose is to promote inclusion and person-centred approaches for people with learning disabilities and development and intellectual difficulties) published the *Reach-Standards in Supported Living*. These standards are:

- 1 I choose who I live with
- 2 I choose where I live
- 3 I choose who supports me
- 4 I choose how I am supported
- 5 I choose what happens in my own home
- 6 I have my own home
- 7 I make friendships and relationships with people on my terms
- 8 I am supported to be healthy and safe on my terms
- 9 I have the same rights and responsibilities as other citizens

Reach standards are based on the principles of the *Valuing People* strategy and should be achieved in all supported living services. These standards can be used to:

- assess whether a service provides supported living
- help individuals and families to test whether a service provides supported living
- help commissioners to design and develop services
- help providers and those involved in regulation to assess whether a service provides supported living and needs to be registered

They are not 'national minimum standards' or regulatory standards. However, CSCI supports their use as measures for supported living services. The Valuing People team also supports the use of these standards and is helping to fund the development of a revised set.

The local context

The last long stay hospital in Cornwall closed in 1995. In most parts of England, health and social services negotiated new arrangements for commissioning and providing services for people with learning disabilities who no longer required healthcare in hospitals. However, the negotiations between the NHS and Cornwall County Council did not result in the transfer of dowry monies or the agreement of new arrangements for people living in or moving to supported living services in the community. These services continued to be provided by the trust.

Under this arrangement, those considered unsuitable for supported living services by the trust, but still requiring healthcare, were moved to assessment and treatment centres. These centres were established by the trust to provide short term care for people with learning disabilities. The trust initially developed a number of small houses in the community for people with learning disabilities to live in. At the time, this was innovative. The trust later designated these homes 'supported living services'.

About Cornwall Partnership NHS Trust

Cornwall Partnership NHS Trust was established in April 2002 to provide specialist services for people with mental health problems, people with learning disabilities, and people dealing with drug and alcohol misuse. Prior to this, the trust operated as Cornwall Healthcare NHS Trust. Cornwall Healthcare NHS Trust was formed in 1993. It merged in 1999 with Trecare NHS Trust (originally called Cornwall and Isles of Scilly Learning Disabilities NHS Trust).

The trust serves approximately 500,000 people

who live in Cornwall, as well as an additional 750,000 visitors during the summer. It covers an area of 1,370 square miles and its headquarters are located in St Austell. It employs approximately 2,500 staff; around 600 of these people are employed in services for people with learning disabilities. They provide care and treatment for approximately 200 people in their residential services.

In October 2003, a new integrated mental health service was formed with Cornwall Social Services under section 31 of the Health Act 1999. This new service positioned the trust as the main provider of integrated health and social care services for adults of working age with mental health problems in Cornwall and the Isles of Scilly. However, no similar integrated partnership arrangement was in place between the trust and Cornwall County Council for learning disability services. The Healthcare Commission reviewed the trust's mental health services in 2005 and found them to be generally good. This review did not examine any services for people with learning disabilities.

The PCTs in Cornwall spend £18m each year to provide services for people with learning disabilities. These services include:

- assessment and treatment centres at Budock Hospital in Falmouth, Westheath House in Bodmin, and Tamarisk in Redruth
- an individual specialist treatment service for one person in Redruth
- local teams who provide specialist healthcare in the community to people with learning disabilities

The trust also provides care and support for people living in 45 houses in the community,

which it describes as supported living houses (prior to 2003, these services were described as supported domestic homes in which the trust provided care). Comhome Limited, a charitable trust established in 1987, owns 38 of these houses. Local housing associations own five and district councils own the remaining two.

People who live in supported living houses have access to a range of benefits, including income support, mobility allowance, disability living allowance with a severe disability premium, and housing benefits. They also receive money from the *Supporting People* programme, which helps to meet people's needs for housing support. This funding is provided to people who live in the community. The conditions of the *Supporting People* programme define support services that relate to housing as those "which are provided to any person for the purpose of developing that person's capacity to live independently in accommodation or sustaining his capacity to do so". The trust was awarded the transitional housing benefit in 2002, which led to them being awarded supported living funding in 2003. This funding totals £1.87 million annually and is managed by the trust.

In a letter to the investigation team, dated November 18th 2004, the trust's chief executive said that the trust considered all of the people in supported living houses to be tenants, even though some did not hold a tenancy agreement.

The trust said that it believed that resources and services were effectively monitored to ensure that the care provided in its supported living houses was of a good standard. The trust also said that its supported living houses did not need to be registered as care homes because nursing and personal care was provided separately from accommodation.

The director from the trust who had overall responsibility for services for people with learning disabilities at that time wrote to the investigation team in August 2005 advising that he believed that some people who had used the trust's services had suffered abuse. He did not believe that the model of care used by the trust was abusive but he did accept that it was inadequate.

Local government in Cornwall

Local government in Cornwall has three tiers:

- Cornwall County Council (the council)
- six district councils
- 203 parish and town councils

Cornwall County Council is responsible for the provision of social services for adults and children who live in Cornwall. This responsibility is split between two departments: the department for adult social care and the department for services for children, young people and families. The statutory responsibility for the provision of social care services for children with learning disabilities lies with Cornwall's children and young people's partnership board. Responsibility for their healthcare needs rests with the PCTs.

In accordance with the Department of Health's *No Secrets* guidance, the department for adult social care is the lead agency for the protection of vulnerable adults in Cornwall. As the lead agency, it is responsible for ensuring that there are effective multi-agency arrangements in place to protect vulnerable adults.

The council and healthcare organisations have failed to agree joint commissioning strategies to provide care in the community for people with learning disabilities. As a result, the council had little involvement with services provided by the trust. It had only carried out a few community care assessments in accordance with the Act and care plans were generally limited to a specific service, such as day care.

The council employs a team to manage grants from the *Supporting People* programme and to ensure that the council complies with the conditions, directions and guidance related to this programme. In July 2005, the team reviewed the supported living services provided by the trust and found that they did not meet the criteria for eligibility into the programme. The *Supporting People* commissioning body for Cornwall accepted the team's recommendations and, in

September 2005, decided to withdraw the trust's £1.87 million annual funding within two years.

South West Peninsula Strategic Health Authority

Strategic health authorities were created in 2002 to manage the local NHS on behalf of the Secretary of State for Health and are governed by the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 as amended.

Shifting the Balance of Power within the NHS, published by the Department of Health in July 2001, gives strategic health authorities responsibility for creating a coherent strategic framework for the development of services across the full range of local NHS organisations and managing the performance of all local NHS trusts and PCTs within its geographic boundaries. This includes managing performance across organisational boundaries and networks to secure the best possible outcomes for patients, including those with learning disabilities.

Primary care trusts (PCTs)

There are three PCTs in Cornwall:

- North and East Cornwall Primary Care Trust
- West Cornwall Primary Care Trust
- Central Cornwall Primary Care Trust

These PCTs are responsible for assessing the healthcare needs of their local communities and commissioning appropriate services to meet those needs. PCTs work cooperatively and may appoint a particular PCT to lead the commissioning of certain services.

Cornwall learning disability partnership board

The *Valuing People* strategy set a deadline of October 2001 for the establishment of learning

disability partnership boards in NHS trusts (in addition to existing structures for inter-agency planning for learning disability funding). Learning disability partnership boards are required to operate within the framework of the Health Act 1999. Section 31 of the Health Act permits the NHS and local authorities to pool their resources, delegate functions and transfer resources from one organisation to another (commonly referred to as Health Act flexibilities).

It is the responsibility of the chief executive of the local council to ensure that the learning disability partnership board is in place and has appropriate membership. These boards should be chaired by a senior local government officer or elected member and should include representatives from health and social services, education, the employment service and Jobcentre Plus, as well as people with learning disabilities and their carers. The boards are responsible primarily for:

- developing and implementing the joint investment plan
- overseeing the planning and commissioning of comprehensive, integrated and inclusive services that provide people in their local community with a genuine choice of services
- ensuring that people are not denied access to local services by a lack of skill and experience
- the use of flexibilities under the Health Act 1999
- ensuring that there are arrangements to help young people with learning disabilities to make a smooth transition to life as an adult

The chief executive of Cornwall County Council chaired the learning disability partnership board in Cornwall until January 2006, when this responsibility was transferred to the director of the council's department for adult social care. Membership of the board includes a range of statutory and voluntary agencies although attendance is not always regular. Two carers are full members of the board. From September

2004, the project manager of the panel for carers and people with learning disabilities attended as their representative.

The allegations

In its letter to the Healthcare Commission and CSCI in October 2004, East Cornwall Mencap Society expressed concern about:

- the legality of the care being provided by the trust in supported living services and the means by which the trust had avoided regulation
- excessive and inappropriate expenses being charged to those using supported living services, and a lack of financial accountability
- the appropriateness of the relationship between the trust and Comhome Limited (which provides accommodation to the majority of people living in the supported living houses)
- the way the trust had handled complaints from relatives and from East Cornwall Mencap Society
- the poor, and sometimes neglectful and abusive, quality of care that was being provided to people in some supported living houses and assessment and treatment centres

East Cornwall Mencap Society complained that the trust was contradicting best practice by essentially dictating where people with learning disabilities lived, who they lived with, how their money was spent, and who cared for them. It provided details of five cases that it believed illustrated its concerns. East Cornwall Mencap Society also feared that these five cases might reflect the experiences of other people with learning disabilities who used the trust's services.

In this section, we provide details of four cases identified by East Cornwall Mencap Society. All of these families had been involved with

services provided by the trust (and its predecessor) for at least six years. Their complaints spanned several years, covered a number of issues, and had not been resolved to their satisfaction.

Given that the complaints were at various stages of the NHS complaints procedure and, in view of the difficulty of investigating matters which date back some considerable time, we confined our examination of these individual allegations to a review of the documentary evidence provided by East Cornwall Mencap Society and the families involved, and the information held by the trust. In particular, we examined correspondence provided by the families involved in each case, files relating to the complaints held by the trust and individual care records, where they were available.

Case W

Case W was provided by East Cornwall Mencap Society to illustrate the difficulties that some people had experienced with respite care. We noted a lack of involvement by senior managers in this complaint, which was clearly difficult for staff to resolve locally.

Background

W is a middle-aged man who has cerebral palsy. He has had epilepsy since he was a baby and is looked after by his elderly mother at home. He uses a wheelchair, cannot communicate verbally, and needs significant support with all aspects of personal care.

W used to receive respite care in one of the trust's supported living houses. This care was provided regularly, but the arrangements were ad hoc. This suited W, but caused problems for the other three people living in the house. They

were responsible for covering the full cost of the house when W wasn't there and, when he was there, the trust had to arrange for additional staff to provide the level of support he needed.

Complaint

Since the early 1990s, there have been frequent disagreements between W's family and staff from the trust regarding the severity of W's epileptic seizures and (from January 2004) his risk of aspirating food and fluids because of problems with swallowing. Staff from the trust believed that the number of seizures could be reduced by a change in medication, and that the risk of aspirating could be removed by introducing percutaneous endoscopic gastrostomy (PEG) feeding (through a tube to the stomach).

W's family disagreed with both of these recommendations and the disagreements have escalated. W's GP supported the family's view that PEG feeding was unnecessary. However, the family agreed to let W undergo an assessment and test to determine his risk of aspirating. Just prior to this, W had an epileptic seizure, which the family say meant that the results were flawed.

Having completed the assessment and test, staff remained concerned about W's risk of dying from a seizure or aspirating unless he was fed by PEG. The trust refused to provide further respite care based on the results. The last period of respite care W received from the trust was in December 2003.

During 2005, the family reluctantly agreed to a change of medication for W after being told that staff would monitor the change very carefully. Frequent visits to W's home and regular telephone contact were agreed with the trust, but the majority of the visits and the telephone contact did not take place.

The family said that the frequency of W's seizures increased following the change of medication, so it was changed back. In September 2005, a specialist registrar at Royal Cornwall Hospital, who had been treating W,

concluded that there was a risk of aspiration for W, but that his overriding concerns related to W's quality of life, the views of his mother as the primary carer and the view of the GP who has the best knowledge of the situation.

A number of different meetings have been held involving W, his family and staff from the trust, including an appointment at an epilepsy clinic. However, the provision of respite care has not been resolved. This situation has left the family with a lack of confidence in the trust and, while they would like W to have access to respite care, they would prefer that he received it from another provider.

Case X

Case X illustrates the concerns of the East Cornwall Mencap Society about financial management in the trust's supported living services. The Healthcare Commission also noted, after reviewing the notes of meetings, that staff frequently raised concerns about the suitability of accommodation for the residents in X's supported living house.

Background

X is a middle-aged man who has a severe learning disability. He can walk but his ability to communicate verbally is limited. X lives in one of the supported living houses owned by Comhome Limited.

X is described by Comhome Limited as a paying tenant. He pays £51 per week using his housing benefit. Comhome Limited said that a signed tenancy agreement was unnecessary because X had been granted possession and paid rent. The people living in the house were responsible for replacing the furniture and redecorating the interior. The landlord was responsible for ensuring that there was hot and cold water, heating and bathroom fittings. These arrangements were highlighted in an exchange of letters between the solicitors working on behalf of X and the trust.

An undated assessment concerning X's need for

household-related support recorded that he was entitled to housing benefit, disability living allowance, disablement allowance and income support. His mother dealt with these matters and transferred money to X and the house account. The team leader monitored these accounts and helped to reconcile and file bank statements to maintain X's personal and household finances.

Complaint

X's family had a number of concerns about his financial contributions to the household expenses and first made enquiries to the trust in 1999.

In 2002, a two-night holiday was planned for X. When the holiday was discussed with X's family, the total cost on the application form was £260. However, when X's family received the final invoice, the cost was £751.40. This figure includes costs for staff, which had not been in the initial figure.

In 2004, the family's solicitor contacted the trust to request the accounts for annual household expenditure for the period of X's residence and information relating to the purchase and cost of running of a vehicle for the house.

The trust said that they had some difficulty supplying the requested accounts because of the period of time covered by the request, and the apparent lack of formal accounts. However, the trust did send some information to the solicitor.

The solicitor contacted the trust again in April 2005 to request a further breakdown of expenditure and commented that the copies of the household accounts showed that their client's contribution consistently exceeded actual expenditure. The solicitor included the following table, showing credit and cumulative credit over three years.

Year	Credit £	Cumulative credit £
2001 – 2002	1,145.27	1,145.27
2002 – 2003	391.92	1,537.19
2003 – 2004	306.87	1,844.06

The trust acknowledged that they had difficulty collecting the information requested. It was not able to supply the requested information about household accounts in a timely manner. The trust's contributions to the household expenditure appeared to be logged informally. The trust's original contribution to the household account of £52 per month for staff was increased to £115 per month in 2004/2005, but the trust was unable to establish how the original figure was calculated.

Case Y

Case Y illustrates East Cornwall Mencap Society's concerns about possible abuse at the trust, including in a supported living house and at Budock Hospital.

Y is a young man with a moderate learning disability who lived in one of the trust's supported living houses for seven years but spent part of each week at home with his family. Y is an active young man with reasonable verbal communication skills. He benefits from structured activities but requires close supervision.

Background

There were a number of unresolved issues, dating back several years, between Y and his family and staff at the trust.

Prior to moving into the supported living house, Y had been an inpatient at Budock Hospital. After Y had left the hospital, a member of staff from Budock Hospital had told Y's mother that Y had been sexually assaulted on two occasions. In addition, when Y was living in the supported living house, a member of staff had allegedly struck him.

Y's family were officially informed by the trust in September 2003 that there had been an incident involving their son, which had resulted in a member of staff being suspended. They were not told the nature of the incident but were told that an investigation had taken place and the member of staff had been moved from the

house to another position in the trust. A report of the investigation stated that no incident report had been completed. There were some notes in a book, known as the 'handover' book, but the report said that these were difficult to read. Two months before, Y had complained that he was frightened of this member of staff and the family requested that he was moved from the house. Their request was turned down. Another member of staff resigned, citing the trust's failure to satisfactorily resolve the incident in which Y was physically assaulted and provide feedback, as a reason for his resignation.

Following a number of incidents, Y decided that he no longer wanted to live at the supported living house. He moved out of the house at the end of 2004 to live at home with his parents who are both in poor health.

Complaint

Y's family made a formal complaint to the trust in January 2004. They told the trust that they believed Y had been physically abused and bullied for more than a year by a member of staff from the trust. They also reported the allegations that Y had been sexually assaulted at Budock Hospital.

The trust told Y's family that they had investigated the alleged physical assault at the supported living house, but had found no evidence to support the allegation. Although the member of staff had been moved to another part of the trust, the family was informed, in a letter dated February 11th 2004, that this should not be "considered as a disciplinary penalty". The trust's record of the investigation states that the member of staff received a formal warning.

The trust said that it had found nothing to substantiate the allegation of sexual abuse and asked Y's parents to provide the name of the member of staff who had made the allegation. The Healthcare Commission noted that there was no reference in Y's records relating to his capacity to consent to sexual activity. In 1998, a counsellor noted that his common sense approach should protect him from unwanted

advances from others. In 2005, a psychologist assessed him as having a severe learning disability with a mental age of four to five years. The trust said that the incident had been referred to social services under the procedure for the protection of vulnerable adults.

Y's family were dissatisfied with the investigation carried out by the trust. They complained that the trust did not discuss the matters with Y with the support of an advocate. They also complained about the financial arrangements in the supported living house, the legal status of the people who lived there, and they expressed dissatisfaction with aspects of Y's care.

An independent review was held to consider their complaints. The panel concluded that communication between the trust and the family had been severely damaged and that, although the trust had tried to resolve the matter, it had failed to recognise the potential for serious conflict. There was no evidence that Y had been bullied or assaulted but there was evidence that his clinical care had fallen below the required standard. The family's complaint has now been referred to the Health Service Ombudsman.

Case Z

Case Z was provided by East Cornwall Mencap Society to illustrate concerns about the quality of care provided at Budock Hospital. The trust explained that no care records were available for examination because they had been lost. However, some incident reports were available.

Background

Z is a young man who has severe learning disabilities. He also has epilepsy and other health conditions. He is unable to speak and is cared for by his parents at home. Z had been dependent on his comforters (pieces of bedding which he carried around with him) for a number of years.

Z was twice admitted to Lamorna Ward at Budock Hospital for changes to his medication

to control his epilepsy, once in 1999 and again in 2002. Before he was admitted, Z's mother spoke to two staff about his needs and preferences. His community nurse also wrote a letter outlining his needs. Z's family understood that he was to be observed 'one to one' (one member of staff always dedicated to his care) and the notes of incident reports support this view.

Z's family were dissatisfied with aspects of his care on both occasions and, in March 2003, complained to the trust.

Complaints

During his first admission, Z sustained an injury to his finger, which resulted in an acute admission through the local A&E department and an overnight stay in hospital. Z's family was told by the trust that staff had not seen the accident and had assumed that it was caused by another resident shutting Z's finger in a door.

Z's community dentist told the family that Z had not had his teeth cleaned during his stay at Budock and that staff were reprimanded for this during a visit to Budock. The trust did not address this complaint specifically, but told Z's family that he had been given a bath each day and received attention to his hands and nails during both admissions. The trust told the family that staff would be instructed to pay more attention to cleaning people's teeth.

Z was admitted on a second occasion, accompanied by his social worker who informed staff of Z's needs and provided them with a list of his possessions, which his family said were labelled. They complained that the majority of his possessions were lost and not returned. The trust recompensed the family for the estimated value of the items that had been lost but did not provide any explanation. Items that were precious to Z were permanently lost to him. Subsequent letters from the family reported that Z's possessions had also been lost during the first admission. The value of these possessions was also reimbursed by the trust.

Z's comforters were taken from him during the second admission and locked away during the

day. The trust explained that bedding, including Z's comforters, was removed each day for washing. Staff thought that Z had not appeared upset by it.

Z's family complained that they felt that Z's mental state had deteriorated and that he was found during a visit slapping himself, tearing off his fingernails and wearing dirty clothes. Z's family said that his toenails had not been cut, were curled over and had become infected. Members of staff disagreed and said that his mental state had remained stable. However, two members of staff later acknowledged during a meeting with the family that the personal care Z had received was not good enough and that instructions from Z's community nurse had not been acted on. They said that this was because of changes in staff.

The trust told Z's family that a number of changes were being made to Lamorna Ward and sent two letters detailing their progress. The family, however, were not confident that the necessary changes were being made.

Investigations by the trust

In November 2004, East Cornwall Mencap Society alerted the Healthcare Commission to an article in the local press, which stated that seven members of staff had been suspended from Budock Hospital, following allegations of verbal abuse and the possible neglect of patients. The trust reported these allegations to the multi-agency adult protection group in accordance with adult protection procedures and investigated them through its disciplinary procedure. The Healthcare Commission examined the records of this investigation, as well as records relating to investigations in 2001 and 2003.

The disciplinary investigation in 2004

The trust's records showed that, in August 2004, a member of staff from another part of the trust worked a shift on Lamorna Ward at Budock Hospital had raised a number of concerns, including allegations that patients were being physically and psychologically abused. The trust investigated the allegations and suspended seven members of staff. Five of these members of staff have since been dismissed, one was reinstated and one resigned with disciplinary proceedings still to be completed.

We did not re-investigate the individual allegations, some of which remain subject to disciplinary hearings. However, we have considered, through a review of the trust's investigation and related files, whether the trust had identified all of the services and people who may have been affected by the allegations.

We considered the investigation by the trust to be reasonably robust in identifying and reporting the inappropriate actions of individuals. The investigators from the trust had tried to identify the cause of the problems at Budock Hospital.

For example, they identified a number of factors that may have contributed to the problems, but these were not outlined in the final report and there was no evidence that any action had been taken to address them. In addition, although the trust took disciplinary action against a number of staff, it failed to produce an action plan to address any systemic problems. An action plan from another investigation in 2003 had identified similar failings, but the plan was never reviewed or revised.

The documentation we reviewed indicated that the trust suspected that some staff had abused patients at Budock Hospital. However, the trust did not arrange any assessments (for example, psychological assessments) or support for those suspected to have suffered the abuse and it did not seek to identify others who were no longer on Lamorna Ward but might have been affected.

Records showed that members of staff had reported their concerns on various occasions to the clinical specialist for the assessment and treatment centres, team leaders, the hospital manager and the locality manager. Staff also commented during interviews carried out by the trust about what they perceived to be shortcomings in the management and delivery of care, including the lack of regular team meetings, a lack of leadership, long hours of working, poor implementation of guidelines, and the general culture on the ward.

Earlier investigations at Budock Hospital

The investigation team noted that many of the contributory factors identified during the disciplinary investigation in 2004 had been identified by the trust in 2001 and 2003.

In early 2001, an investigation by the trust highlighted deficiencies in care at Budock Hospital and found that qualified staff were not providing appropriate leadership. A corresponding action plan included steps to implement a structured system of clinical supervision, which would require a senior member of staff to supervise the staff accountable to them. These members of staff would then repeat the process with their own staff or team at the hospital. The hospital manager was listed as the person responsible for ensuring that the action plan was implemented satisfactorily.

In a supplementary report, the investigators at the trust expressed serious concerns about the 'dysfunctional' team on Lamorna Ward, which they believed was caused in part by 'management's insistence' on advertising and offering only part-time employment to unqualified support workers. In their view, this reduced the calibre of applicants and left staff competing for sufficient hours of work. The investigators also commented on the lack of recent appraisals of staff and the over-reliance by managers on informal means of resolving problems with performance.

In November 2003, a member of staff wrote to a senior member of staff at the trust expressing concerns about 'cultural abuse and institutional working' at Budock Hospital. The same member of staff had also expressed their concerns to a team leader, without apparent effect.

In December 2003, a member of staff alleged that patients were being physically and psychologically abused on Lamorna Ward. These allegations were withdrawn, but the trust carried out an investigation in April 2004 because of the serious nature of the allegations.

Sixteen of the 26 staff interviewed during this investigation complained about the style of management exhibited by the hospital manager. A subsequent investigation by the trust resulted in the manager's relocation. The trust's investigators recognised that staff were 'burnt out' and that there had been 'interpersonal difficulties' on Lamorna Ward, including a deterioration of the relationship between the hospital manager and the clinical specialist working in the assessment and treatment centres. The investigators concluded that the hospital manager had not ensured that appropriate structures and systems were in place to maintain safe and professional standards on the ward. They found that a lack of structured clinical supervision at all levels had led to a lack of clarity about the aims, expectations and roles within teams. They also found no evidence of adequate arrangements by the hospital manager to monitor the work of the team leaders.

The trust's investigators did not comment on the role of those responsible for managing the hospital manager or the arrangements at senior level for assuring the quality of care or managing the performance of staff. However, there was a note in the hospital manager's personnel file expressing concern about his style of management before he was transferred to Budock Hospital. The trust's investigators did not enquire about what action had been taken to monitor his performance.

The clinical psychologist for Budock Hospital noted that Lamorna Ward was a bleak and difficult place to work. Staff tended to stand around, talking to each other, waiting to react to the actions of those on the ward. Staff were extensively trained in the use of restraint, but had little other training. They did not welcome 'outsiders', such as psychologists, and used restraint and medication almost exclusively to deal with patients on the ward. The clinical psychologist was also concerned about the way in which staff had responded to a person who was exhibiting challenging behaviour. However, he did not raise this concern with the

appropriate managers because he did not believe that they would take action.

The Healthcare Commission noted that 18 members of staff, interviewed by the trust during these investigations and the investigations undertaken in 2004, reported that they witnessed 64 incidents of poor or abusive care between October 2000 and October 2005. These instances of poor or abusive care were recorded in personnel files, correspondence, and notes from investigations. These incidents included staff hitting, pushing, shoving, dragging, kicking, secluding, belittling, mocking and goading people who used the trust's services, withholding food, giving cold showers, over zealous or premature use of restraint, poor attitude towards people who used services, poor atmosphere, roughness, care not being provided, a lack of dignity and respect, and no privacy. All those living on Lamorna Ward were subject to this type of behaviour but two individuals were targeted frequently.

Reviews of care records

The Healthcare Commission commissioned the British Institute for Learning Disabilities to assess:

- the quality of care provided by the trust in some of its supported living services
- compliance with the requirements of the *Valuing People* strategy

The institute examined the care of 25 people selected from nine of the trust's supported living services, one specialist service, and one children's service. The institute examined care records, interviewed staff and people using the trust's supported living services, and observed the environments in which they lived.

As the scope of our concerns increased, an additional review was commissioned and undertaken in November 2005. During this second review, BILD and an external adviser (with a background in clinical and senior management in services for people with learning disabilities) examined the care records of a further 24 people who were living, or had previously lived, in assessment and treatment centres run by the trust.

The purpose of care records

Good care records should provide the following information in one file for each person who uses the trust's services:

- an holistic care plan, including the person's future aspirations, preferred routine, likes and dislikes, the activities in which they participate and a plan for their development (this information should also provide staff with clear guidance on how to provide appropriate care for the individual)
- an up to date and clear daily record of what is happening in the person's life. This

information should be used to inform any proposed changes to the person's care plan

- copies of assessments, including assessments of risk, that have been carried out for that person
- copies of plans outlining modifications to the person's treatment or behaviour where relevant
- copies of letters or reports from professionals in health or social care

The first review

Supported living services

The British Institute of Learning Disabilities interviewed 25 people who used the trust's supported living services, examined their care records, observed the homes in which they lived, and discussed the care that they received. The review compared their quality of life to a list of outcomes that are recognised as important by people with a learning disability. These outcomes include:

- involvement in choices and decisions about their care and treatment
- opportunities for taking part in activities that they value
- involvement from friends or family
- encouragement to take as much control of their own lives as possible

The institute found that the quality of management in the supported living services varied, according to the skills and values of the manager of each service. Physical care was adequate, but people were generally 'looked after' rather than receiving the support they needed to develop their skills. This limited their

ability to make informed choices and to communicate their needs.

There was a 'risk averse' culture within services, which prevented people from taking considered risks. This again limited the opportunities for development and left people with little or no control of their lives.

There was no system for care planning or process for assessment, which looked at the lives of each individual in an holistic way. There was little expectation that people using these services would develop and move on.

The quality of care plans varied and, in some houses, did not exist. Some had not been updated since they were set up; others lacked detail. Records relating to medication, the assessment of risk, and health and support were often kept in several different files.

Activities for those in supported living services were limited. Only a few people took part in regular placements at college or had the opportunity of continued learning and development. There was little opportunity to develop relationships or meet new friends, and residents were not encouraged to take part in domestic chores.

There were some examples of good practice in the supported living services, such as a specialist home which demanded high levels of commitment from staff; comprehensive records in one home, and innovative practice in another home involving staff and residents (who all required high levels of personal support). However, in general, staff had few expectations of those using the supported living services.

Assessment and treatment centres

The British Institute of Learning Disabilities did not consider that the trust's assessment and treatment centres met the needs of the people living in them. They had become long term residential placements. At best, they were 'holding compounds' for those considered too difficult to accommodate anywhere else; the worst centres were considered 'extremely abusive'. The quality of the buildings and their

surroundings were extremely poor and the people living in the centres were not offered the opportunity to learn different behaviours. The standard of record keeping by these centres was unacceptable (with the exception of records relating to people detained under the Mental Health Act 1983). There was no evidence of a 'person-centred' approach to planning or of any plans to discharge people into more suitable accommodation.

The second review

The British Institute for Learning Disabilities and an external advisor examined the care records of 24 people as part of the second review. The review found that a variety of filing systems were used by the trust to store care records. Information about each person was filed in different areas, making it difficult for staff to identify specific information quickly or for new staff to gain an understanding of the needs of those using the service. There were frequent gaps in the records, ranging from one day to several weeks, and it was almost impossible to identify when clinicians had visited or when medication had been changed.

Details of incidents were held for all people included in the second review and each form was completed in triplicate. However, incidents noted in care records, and any action taken by staff, were not always recorded on incident forms. There was no evidence of steps taken to minimise the risk of an incident occurring again. For example, one person suffered multiple injuries over time, including a fractured skull after being hit by another person who used the trust's services.

Incidents

There were a disproportionate number of incident forms completed when compared with the number of people using the supported living services. Many of the incidents involved extreme violence between residents and the severity of some incidents raised considerable cause for concern. Often these incidents involved visits to

the A&E department of a hospital.

The number and severity of incidents recorded does not accord with the trust's general duty of care to protect vulnerable people. It was not possible to identify the policies and procedures of the trust in relation to the completion of accident or incident forms, antecedent, behaviour and consequence (ABC) charts or behaviour management forms. This prevented incidents and appropriate events from being reviewed and analysed, and prevented services from improving.

The total number of incident forms recorded in services for people with learning disabilities (approximately 200 people) was:

- 3,380 (2002/2003)
- 3,300 (2003/2004)
- 3,100 (2004/2005)
- 1,744 (from April 2005 to October 2005)

The high number of incidents was in itself cause for concern, although it is accepted that some incidents may have been reported more than once where more than one person was affected. However, of greater concern was the lack of effective systems for learning from these incidents.

Medication

The examination of records held by the trust showed a high level of administration of pro re nata (PRN) medication. PRN medication is prescribed for occasional use and should only be administered when necessary, for example, to control epilepsy or exceptionally challenging behaviour.

The administration of PRN medication was not always entered on medication charts and the reason for its administration was not always identified. Often it was given to a person who was 'not sleeping' or 'wouldn't settle'. There appeared to be an expectation that people would become disruptive, so PRN medication was given rather than identifying issues as they arose

and managing challenging behaviours in more appropriate ways. In one incident that was recorded, a person was given PRN medication because he was impatient for his dinner and became distressed. The medication caused the person to become too sleepy to eat his dinner at what staff considered to be 'the right time'.

Behavioural records and the use of physical restraint

If completed appropriately, behavioural records can be used to identify and understand different behaviours, so that staff can adopt a more 'person-centred' approach in their dealings with people with learning disabilities.

There were very few behavioural records available for people with learning disabilities. Of those that were reviewed, some did not record when PRN medication was administered or when an incident involving aggression between two people who used the trust's services occurred. They showed that staff were not appropriately trained to complete behavioural records, to ensure that they had the right information to manage behaviour of people with learning disabilities. They also indicated that physical intervention or restraint was rarely used or recorded. However, this contradicts reports by staff that restraint was used frequently in services for people with learning disabilities.

Care plans

All people with learning disabilities in the trust's assessment and treatment centres should have a care plan, with clear goals and an accompanying programme. Care plans allow staff to ensure that the care they provide is consistent and helps people to develop to their potential.

There were no relevant care plans or action plans on file for people in the trust's assessment and treatment centres. As a result, challenging behaviour escalated, leaving residents with a poor quality of life and little to no opportunity for change.

There was also a lack of long term planning which prevented people who had resided at the assessment and treatment centres for unacceptable lengths of time from being discharged. The trust's records demonstrated a lack of empathy or compassion by staff to those living in the centres. In contrast, however, the records of the music therapist were always of a positive nature, anticipating the best, rather than the worst, from those using the trust's services.

The trust's records showed a lack of activity and stimulation for those living in assessment and treatment centres. This created an atmosphere of extreme boredom and contributed to an increase in challenging behaviour among those using the services. On many occasions, it was recorded that overcrowding, aggression and noise exacerbated the challenging behaviour exhibited by residents. In fact, the records showed that the environment in the assessment and treatment centres had directly contributed to the deterioration of the mental ill health of some individuals. In one instance, the epilepsy specialist had directly related the stressful environment in a centre to the severity of the epileptic seizures of a resident, and recommended that they be moved urgently to a more suitable environment. The recommendation was made more than 12 months before our investigation. However, there was no evidence that it had been acted on in any way.

Comments of the external adviser

The external adviser involved in the second review noted that, as people moved within the trust's services, new records of case notes were established, with some key information about the individual and their care and treatment missing. This information would have helped to ensure that they received the best possible care regardless of where that care was being provided. The records of case notes were poorly compiled and disorganised, and records of assessment or care planning were usually incomplete.

There was little evidence in the care records of:

- systematic 'person-centred' planning
- any real engagement of relatives or family members in this process
- the use of advocacy services
- the consistent use of formal assessments of risk
- where formal assessments of risk were available, action plans focused on proactively managing risk rather than preventing particular behaviour
- treatment plans being used consistently as part of planned care

The content of the files indicated that doctors and nurses mainly delivered services. However, there had recently been an increase in occupational therapy and these records were of a higher standard. Clinical psychology was very limited.

There was evidence in the records of case notes that people using the trust's services had made complaints or raised issues. They included requests for review under the Mental Health Act 1983, which seemed to have been properly recorded and addressed. Other complaints or concerns were recorded, but there was no consistent recording of what action was taken in response.

There was evidence that medication was administered to deal with challenging behaviour, but it was difficult to judge the appropriateness of this approach because of the quality of recorded observations of people's behaviour. Recorded observations were often subjective and/or limited in content.

There is evidence, in some cases, of extensive efforts particularly by nurses and medical staff to address people's needs on a day to day basis. What appears to be missing, however, is a treatment philosophy that is focused on the needs of the individual and consistently applied.

Assessment and treatment centres

The joint investigation reviewed the provision of services for people with learning disabilities in four assessment and treatment centres run by the trust (including the hospital service for the person detained under the Mental Health Act 1983). The Healthcare Commission focused, in particular, on Budock Hospital, one of the assessment and treatment centres, because of the scale of concerns about people living there (outlined in previous sections of this report).

Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (known as the *Mansell Report*), published by the Department of Health in 1992, recommended that hospitals offer people with learning disabilities (who exhibit challenging behaviour or have mental health problems) short term and highly focused assessment and treatment. The report states that these services should be commissioned on an individual basis and should seek to promote a 'person-centred' approach.

With the exception of the specialist service in Redruth, the assessment and treatment centres run by the trust do not accord with best practice. The centres primarily provide long term accommodation for people with learning disabilities. All of the people living in the centres are categorised as inpatients. Some have lived in this style of accommodation for many years.

The environments in which services are provided are unacceptable and are described in more detail later in this chapter. Although only one person in the four centres is detained under the Mental Health Act 1983, the centres were locked (including some internal doors), restricting the freedom and movement of those using these services.

In two of the three centres, no inpatients had assessment and treatment plans. In the third centre, these plans were not based on a 'person-

centred' approach. There was evidence from care records of excessive use of PRN medication. Some individuals received PRN medication very regularly. The trust's medication policy required this practice to be reviewed, but there was no evidence that the policy was being adhered to.

Care and responsibility (physical restraint) techniques were routinely used, but de-escalation techniques (used to try to calm and distract a person to prevent the use of physical restraint) were not. The trust told us that it maintains records of the use and duration of physical restraint and demonstrated that it had records from January 2005 onwards for individuals within the assessment and treatment centres.

The organisation of and the standard of reporting in care records for people in the assessment and treatment centres was unacceptable. Records were not maintained adequately and often information was split between several files. It was difficult to obtain a picture of the person, their needs and preferences, their treatment programmes and their progress.

The number and range of therapeutic services available to inpatients was limited. There is only one clinical psychologist employed by the trust to work with adults with learning disabilities in all of its services. The British Psychological Society recommends a minimum of eight clinical psychologists for services for people with learning disabilities in areas with a population of 500,000 (the population of Cornwall).

There had been a number of internal inquiries and disciplinary investigations of services provided in the trust's assessment and treatment centres in recent years. The trust had not used the information from these investigations to introduce appropriate systems and processes to prevent similar incidents from occurring again.

There was evidence that people living in supported living houses lost their place when they were admitted to an assessment and treatment centre, even for a short period of time. This occurs in spite of claims by the trust that people living in such houses are considered tenants. In some instances, people who have lost their place in a supported living house have also lost their benefits, causing them to remain as inpatients in the assessment and treatment centres for many years. In one instance, a person who was admitted to one of the trust's assessment and treatment centres for a short stay following a cataract operation died there several years later.

Budock Hospital

Budock Hospital was established in 1987 as an assessment and treatment centre. It is still referred to by the trust as an assessment and treatment centre, although many people in the hospital have lived there for a number of years. Until recently, a number of staff had also worked in the hospital for considerable periods of time or had been re-located to the hospital from other services operated by the trust.

The investigation team made three visits to Budock Hospital: one visit was carried out at short notice and two were unannounced. We reviewed statements from staff for evidence relating to Budock Hospital. These statements were made to the trust's investigation team directly or as part of investigations it carried out between 2001 and 2004.

The hospital is a single storey building set back from the road among the derelict buildings of a former workhouse. The hospital is isolated with restricted views from the road. The surrounding area is overgrown; there are no landscaped areas or gardens. The building is arranged in a quadrant around a square and a bare concrete courtyard.

The hospital has three wards: Veryan Ward, Mylor Ward and Lamorna Ward. These wards have interconnecting corridors. There is a small, fenced grassed area behind Lamorna Ward, which is used

by inpatients on that ward and as a smoking area by staff. The fourth part of the quadrant is office space and is used by the clinical specialist.

Budock Hospital has a reputation among some staff as a place for people with learning disabilities who are considered difficult to manage. It is also considered a place where staff are moved if they have performed badly. There has been a tendency in the trust to move staff to the hospital following disciplinary investigations or if they require closer supervision. As a result, some staff view being transferred there as a type of punishment. Some members of the senior management team told the Healthcare Commission that they were not proud of the facility.

For several years, the trust had discussed closing Budock Hospital, and moving the service to different accommodation, because of its poor physical environment. However, no date was agreed for its closure. A plan for the re-provision of Budock Hospital had been produced, but it did not form part of the trust's overall strategic plan for services for people with learning disabilities. The trust said that they were having difficulties obtaining agreement for the proposal from commissioners of the service. There was no evidence that the proposed plan had been reviewed to ensure that it met with best practice and no evidence that those using the service had received a recent assessment to identify what they required from the service and where and how it should be provided.

At the time of our visits, only one person was detained at Budock Hospital under the Mental Health Act 1983. Despite this, all external doors and a number of internal doors in the hospital were locked. The Healthcare Commission also found locked doors during its review of the trust's mental health services and recommended in February 2005 that the trust should review the use of locked doors in all of its inpatient units.

Veryan and Mylor wards

The investigation team found that Veryan and Mylor wards were in reasonable decorative order, although both looked institutional. Veryan Ward was too small for the nine people who lived there. During the investigation, three inpatients on Mylor Ward were moved to new accommodation, leaving one person on the ward on his own because the trust had difficulty finding him a suitable home. There was no evidence that the inpatients had been consulted prior to their relocation, or that they were assessed in accordance with the *Valuing People* strategy on 'person-centred' planning.

Some of the people on these wards had come from the long stay hospital operated by a predecessor trust. There were virtually no therapeutic services provided on these wards and no structured activities during the day, which should have formed part of their treatment plans. However, interaction between staff and inpatients appeared to be appropriate in terms of dignity and respect.

Lamorna Ward

Lamorna Ward was markedly different from Veryan and Mylor wards. It was poorly decorated and the environment was unstimulating, bare and depressing. The majority of internal doors were locked.

The kitchen could not be used to prepare meals because of its poor state of repair. All the meals for inpatients were prepared off site and reheated. These meals have to be kept at a set temperature and served within a specific period of time. Only staff used the kitchen during our visits. However, since our investigation began, the kitchen on Lamorna Ward has been repaired and upgraded.

Apart from very basic furniture, there were no personal effects or ornaments on display on the ward. The beds were stripped of all bedding and there were no curtains at the windows. Staff said that this was because people tended to remove or destroy things. One bedroom contained only a chair and the person using that bedroom slept on the floor.

The investigation team met all of the inpatients on Lamorna Ward. We did not see staff involve the inpatients on Lamorna Ward in any purposeful activity or engage with them for activities other than personal care. Communication between staff and the people living there was limited. Boards had been placed on the walls in bedrooms for photographs or to help inpatients to communicate: all but one was empty.

Some inpatients were able to listen to music playing in their rooms. However, generally the care we observed was considered no more than 'containment', providing virtually no stimulus or activities for the people living there. Statements from staff suggested that the situation has been like this for a considerable time. The activities cupboard contained a single annual. On two occasions, all staff (apart from one qualified member of staff in the office) were in the garden and no one was watching or engaging with the inpatients. On a third occasion, however, the team observed staff helping inpatients to get up in the morning and have breakfast.

The activities log on the ward indicated that everybody had been out on the day of our short notice visit. However, previous logs demonstrated that inpatients rarely left the unit. Staff told the investigation team that the trust tried to ensure that there were seven staff on the ward during the day, so that inpatients could be taken out, but there were as few as three staff on the ward on occasion.

There was little evidence of input from, for example, occupational therapists and psychologists, or of structured activities during the day. The eight men living on Lamorna Ward did not appear to get along and incident reports show that there has been friction between them, sometimes resulting in physical violence. A woman was previously on this unit. Supervision of staff and appraisal was not robust on Lamorna Ward and staff received little training.

Records were disorganised to such an extent that they could not be used to ascertain a person's needs and preferences, their treatment

guidelines or risk assessments, or chart their progress. It was also difficult to ascertain how many times physical or chemical restraint had been used. Staff had to rely on verbal handovers.

There was evidence that people living in supported living houses lost their place when they were admitted to an assessment and treatment centre, even for a short period of time. This occurs in spite of claims by the trust that people living in such houses are considered tenants. In some instances, people who have lost their place in a supported living house have also lost their benefits, causing them to remain as inpatients in the assessment and treatment centres for many years. In one instance, a person who was admitted to one of the trust's assessment and treatment centres for a short stay following a cataract operation died there several years later.

The adult treatment unit at Tamarisk

The adult treatment unit at Tamarisk houses four men who were transferred from Budock Hospital. The unit is a chalet bungalow, surrounded by fields and is owned by Comhome Limited. There was no evidence that the men living in the unit received any assessments or treatment. The unit was effectively acting as their home but the environment did not meet their changing needs, including their reduced mobility. It was sparsely furnished, although the bedrooms had been personalised.

We found no evidence that the service had been planned using a 'person-centred' approach. We were also unable to find any information available in an easy to read form for those living there. Information on how to complain was locked in an office.

Westheath Treatment Centre

Westheath Treatment Centre provides accommodation for nine people, although it was designed to accommodate six. The centre is poorly decorated. All external doors and doors to the bathroom, kitchen and laundry were kept locked.

Staff at the centre told the investigation team that it was overcrowded and that they would prefer to accommodate a maximum of eight people. The trust said that the overcrowding was linked to the lack of community services for people with learning disabilities and challenging behaviours. During our visit, a member of the investigation team had to go through a person's bedroom to gain access to a toilet. We were told that it was sometimes necessary to go through this bedroom at night to gain access to another person's bedroom. Two people had lived at Westheath Treatment Centre for a number of years.

There was evidence of some planned activities for people in the centre, including supervised involvement in household tasks. A local college was involved in providing activities for people in the centre until 2005, but staff told us that this service was stopped when funding was withdrawn.

We were told that a multidisciplinary team, which met twice a month, led the process for assessment and treatment. Staff used a care plan, which they considered to be 'a person-focused' system. However, the plan did not conform fully to the guidance relating to 'person-centred' planning outlined in the *Valuing People* strategy. The level of involvement of inpatients and carers in planning appeared low.

All information of interest to inpatients and their carers was kept in a locked office. There was a notice outside the office that advised people to ask staff for leaflets, but it did not say what leaflets were available or what information they provided. In addition, these leaflets were not available in an easy to read form.

Supported living services

There are 45 supported living houses in Cornwall and a property designated as a hospital for one person detained under the Mental Health Act 1983. Six different providers own these houses. Comhome Limited is the largest provider of housing for the trust, providing 38 of the 45 supported living services for adults as well as the property used as a hospital by the trust. Penwith Housing Association owns three houses, and Habinteg Housing Association, Western Challenge (housing association), North Cornwall District Council and Caradon District Council each own a house.

Comhome Limited was established in 1987. The former chief executive of Trecare NHS Trust became Comhome's chief executive when he resigned from his post with Trecare NHS Trust. Prior to this, he served on the board of the Trecare NHS Trust and its charitable company for four years.

The trust is responsible for providing personal care and housing support to all people living in the 45 supported living houses in Cornwall. These people were moved to supported living houses because the trust believed that they no longer needed access to 24-hour nursing and medical care. The majority of supported living houses provide accommodation for four to five people. Initially, a qualified nurse managed each service. But, over time, carers with national vocational qualifications (NVQ) have replaced a large number of the nurses. Nursing care is provided by community district nurses and residents visit their local GP for medical care and prescriptions. If they require access to a consultant, they go to their local hospital.

CSCI informed the trust in December 2005 that it considers 44 of the 45 supported living houses to be unregistered care homes because

accommodation was being provided together with personal care. According to Department of Health's *Domiciliary care: national minimum standards regulations* (2003), the term 'personal care' includes four levels of care:

- 1 assistance with bodily functions such as feeding, bathing and going to the toilet
- 2 care falling just short of assistance with bodily functions, but still involving physical and intimate touching, including activities such as helping a person get out of a bath and helping them to get dressed
- 3 non-physical care, such as advice, encouragement and supervision relating to the care in level one and two, such as prompting a person to take a bath and supervising them during this
- 4 emotional and psychological support, including the promotion of social functioning, behaviour management, and assistance with cognitive functions

The provision of level one or two personal care described above requires registration as a domiciliary care. The provision of any of these four levels of personal care together with accommodation may require registration as a care home. The majority of adults in the supported living houses required level one or two personal care. Others required only level three and four personal care. Assistance with bodily functions was available when required.

CSCI invited the trust and housing associations to make an application to register on December 13th 2005. The housing associations provided evidence to show that the trust was running the services. The trust agreed that they were providing personal care and housing support. On January 13th 2006, the trust responded to CSCI's invitation, stating its intention to give

notice to the PCTs to stop providing supported living services (from April 1st 2006). The trust proposed to separate housing support and personal care, and was willing to consider domiciliary care registration until its contract to provide services finished.

CSCI considered that the services must be redesigned, based on the assessed needs of people who use them, or registered as care homes.

Choice and control

The trust said that all people living in the supported living houses were tenants living in their own homes. None of the providers was able to produce copies of tenancy agreements for the investigation team, although the presence or absence of a tenancy agreement does not determine whether a person is a tenant. Comhome Limited provided the team with a copy of a letter to the residents of its supported living houses which, they said, created a tenancy. However, there was no evidence of an assessment of each individual's capacity to form an agreement.

Most people living in the supporting living houses lacked choice and control over their care and treatment. Only a few were able to express their views and take some control of the day to day running of the house – these people clearly stated that the supported living house was their home. Most were unable to choose where they lived or who with, and gender was not always considered when people were moved to a particular house. One man told investigators that he had never chosen any of the places he had lived as an adult. Some residents shared bedrooms. In many houses, staff slept in the lounge at night and used other areas of the house to store records and medication.

Staff from the trust worked on a 24-hour rota in all supported living houses, except one. People living in the houses were not routinely involved in the selection and recruitment of staff responsible for providing their care and support. Staff said that this was because most residents could not take part in the formal interview.

However, there was no evidence that any attempt had been made to involve them in the process in any other way. In addition, they had no control over the dismissal of staff and could not refuse entry to the house.

In many of the houses, it was evident that the residents had not chosen to live there, had no involvement in decisions about who else lived in the house, and did not retain any right to occupy a particular room. Managers from the trust decided who moved into each house and each room.

The needs of those using supported living services predominantly dictated where they were placed. When their care needs changed, or if they required a different level of care, they were often moved to another home. For example, when the needs of one resident changed so that they required care from night staff, no arrangements were made in their existing house to meet this changing need. The person was simply moved to a different house, which already employed staff to provide care at night. This approach was explained by budgetary constraints, even though the person had lived at the house with the same people for a number of years.

Monthly reports indicated whether people in supported living services liked living where they were placed. Although these reports were not always completed, the ones that were showed that a number of people were unhappy about where they lived. Despite this, no one was given the opportunity to move. There was also no overarching strategy for the provision of housing for supported living services.

There were many instances where the needs of some people clearly impinged upon the needs of others. The investigation team had significant concerns about restrictive and institutionalised practice in 60% of the supported living services for adults with learning disabilities. The investigation team made a number of referrals relating to these services to the manager for the protection of adults at Cornwall County Council. However, the inter-agency framework for

dealing with such referrals was inadequate. There were no adequate mechanisms in place for investigating the protection of adults in the trust or for dealing with or monitoring institutionalised and abusive practices in the supported living services.

Restrictive practices

In the majority of supported living houses, staff, rather than residents, held the keys. Most bedrooms could not be locked. The only doors that could be locked were controlled by staff and used to restrict the movement of those living in the houses. In some of the houses, external doors and some internal doors were kept locked. This prevented people from freely entering and leaving and often restricted their access to communal areas, which they had a right to enter as tenants. Stable-type doors were also widely used to restrict movement. Staff said that these restrictions helped to reduce risks to safety.

The quality of accommodation in the supported living houses varied. Some were adequately furnished and clearly met the needs of residents. Others felt more like an institution. Some houses were cramped and issues relating to health and safety were identified in a few of them.

Staff seemed unaware that it was unlawful to detain people against their will. In one house, all of the taps had been removed (apart from the tap in the kitchen), so that only staff were able to turn the water supply on. Staff said that they had been removed to stop one of the tenants from causing a flood in the house. They were not aware of the unacceptable restrictions this placed on others living there. In two homes, no hot water was available from the taps in the wash basins. In another house, all of the light switches had been removed and only staff were able to turn lights on or off.

Institutional practices were widespread in the majority of the supported living houses. Such practices include restricting people's abilities to choose what food they eat and when, restricting

opportunities to engage in social activities, and setting the time that people go to bed and get up in the morning. These practices were evident during early visits by the investigation team to supported living houses, in interviews with staff, and in the findings from the British Institute for Learning Disabilities review and the review by the council's Supporting People team. They are also detailed in the findings of inspections by CSCI.

Interactions between staff and people who used these services were generally observed to be kind in nature, but were not in accordance with best practice. For example, people were 'cared for' rather than enabled and empowered by staff to be as independent as possible. Staff, rather than residents, opened the door to inspectors in most houses and frequently failed to ask residents if the inspectors could enter. In some houses, residents drank from plastic cups while staff drank from cups made from china.

Examples have already been provided in this report of the 'risk averse' culture in some supported living houses, such as the removal of taps or the locking of doors. In another instance, one person had their arms tied to a wheelchair for up to eight hours each day, to prevent the person from harming himself.

Staff employed in supported living houses

When the supported living houses were established in 1987, a qualified nurse still managed each house, even though those living there no longer required 24-hour healthcare. Over the years, these nurses were replaced by other staff, such as people with level two and three national vocational qualifications (NVQ). Qualified nurses were primarily employed as 'cluster coordinators' and were responsible for a number of houses. Only one or two houses were still run by a qualified nurse. Senior support workers, usually with level three NVQ, were in charge of most supported living houses.

Some relatives and carers told us that they believed the reduction in qualified staff was responsible for the deterioration of the quality of

these supported living services. In addition, relatives and carers appeared unsure about the purpose of the services and the team found no evidence of any forums for relatives and carers, who were interested in receiving more information, discussing their concerns or seeking clarification.

Staff had difficulty accessing training other than specific training for an individual health problem. Access to routine training courses and updates run by the trust, including training on the protection of adults, was minimal and health and safety training was not evident in many establishments. There was little evidence of supervision and no evidence that senior managers or cluster coordinators monitored or reviewed the practice of staff working in supported living houses.

Quality of care

The primary type of care provided by the trust's staff in supported living houses was social and personal care, not nursing care. However, all senior support workers had access to the qualified cluster coordinators, district nurses or an on call nursing team at night.

There was little evidence of holistic assessments community of care or person centred care plans were in place. Those living in supported living houses generally had care records and the trust's 'person focused' system was in place in some houses. However, the care and support needs of each individual were rarely recorded in this system and there was little evidence of person-centred planning within the care records. Records for each person were often stored haphazardly and were not held in one place. In addition, a number of operational policies and procedures had not been adapted for the use of unqualified staff working in supported living houses.

Individual care records did not contain a review of options to minimise risk and promote welfare and independence. Access to community services through the process for managing and

assessing care was not evident.

Those using supported living services (and their carers and relatives) rarely used advocacy services. This is discussed in more detail on page 56.

Medication

A policy on the administration of medicines to people living in supported living houses had been developed by the trust and ratified by its director of nursing. However, there is no date on the policy, which means that there is no way to determine when it needs to be reviewed.

The policy provides guidance to members of staff, who are not qualified nurses, on the administration of prescribed medicines to people living in the supported living houses. However, the policy requires staff to contact a qualified nurse for permission to administer PRN medication. It also requires qualified nurses to sign records relating to the administration of medication.

The policy states that staff need to be competent in the administration of medication, but it does not clarify how this should be achieved and what training is available. The policy also fails to set out the process for determining whether PRN medication is actually necessary, other than by telephoning a qualified nurse for permission.

During interviews, some members of staff said that they had received very little training in the administration of medication. In some instances, this training equated to just one supervised session. A number of staff said that they received no training before they began administering medication unsupervised. Unqualified staff also sometimes carried out invasive procedures, such as PRN rectal treatments, and some staff said that they did not contact cluster coordinators or the on call team at night to obtain permission.

The storage of medication was also a concern in most supported living houses. Cluster

coordinators signed medicine charts without checking the accuracy of the charts.

Funding and household budgets

The investigation team did not conduct a detailed examination of the financial arrangements for supported living services or of the individual finances of people who used these services. However, the team referred some concerns to the Audit Commission and the NHS Counter Fraud and Security Management Service, which holds the legal remit for investigation into fraud and corruption within the NHS. These concerns are now being investigated.

Staff from the trust had considerable control of the finances of those living in supported living houses. The investigation team noted that, in some instances, their money was used to pay for items such as an extension to the house, meals for staff, communal furniture, general maintenance, and car and transport costs.

We had some concerns about aspects of the management of household budgets, including the management of the personal finances of people who lived in these houses and, in particular, the pooling of their money into household accounts. Although each resident had their own bank account, there was no evidence that they were able to handle and manage the money in these accounts. Statements from household accounts confirm that some people were paying more than others, but there was no rationale for this division of cost. Other concerns included:

- charges that were determined by the level of benefits a person received – for example, the higher the level of benefit they received, the greater their contribution to the running costs of the house
- the use of money from people's savings to pay for communal goods
- people who received the mobility allowance having to share their vehicle with the other people in the house
- inadequate monitoring of people's savings and of the level of benefits to which they were entitled
- people living in the house paying for a high proportion of the expenses for staff
- people living in the house paying for improvements to the home which should have been covered by the landlord – in one instance, a person's housing benefit was reduced because they were deemed to have part ownership of the property after paying for improvements
- disputes in some houses about maintenance and who should pay for it – in one case, the hot water thermostat was faulty for more than a year; in another, the bath would not tilt
- some people having to pay for their own continence supplies because they did not have access to community supplies

A number of staff also expressed concern that they had not received adequate training to manage household budgets and associated costs and, although a finance handbook was available to staff, it was not a training manual. Staff said that they were unclear what expenses residents were responsible for – for example, whether residents should pay for food for staff while they were on duty, for the expenses of staff incurred on outings, and for costs for overtime following outings with residents or when they had been involved in activities.

Services for children

The trust owns, manages and employs staff in four services for children with learning disabilities: Gwyn Dwr, Roston, Layland and Moorland Road. Each service provides care and accommodation, designed specifically for children. Three of the services provide respite care. The fourth service provides long term care and accommodates two children under section 20 of the Children Act 1989. These services operate from domestic style bungalows, with some adaptations.

Eligibility for admission to these services, and the need for ongoing care, is assessed by multi-agency reviews carried out every six months. Those who use these services range in age, from two and a half years to 20 years. Seven adults are waiting to be found suitable placements in other services.

The trust does not have a strategic plan for the provision of services for children. However, it has been managing a project to combine children's services provided at Gwyn Dwr and Roston in one unit with 10 beds. In November 2004, the chief executive of the trust notified all health and social care officers in Cornwall of statutory changes and proposed strategic changes to the services it provides for children with learning disabilities. The chief executive highlighted the need for stronger links with acute services for children with complex and multiple disabilities, and the need to consider whether the trust was the most appropriate provider of accommodation and care for children.

In January 2005, the Cornwall learning disability partnership board agreed to discuss a joint agency paper, which set out the wider issues for respite services for adults and children, and agree a way forward at its next meeting. Cornwall Social Services agreed to

arrange a meeting to discuss issues specifically relating to children. Neither of these actions occurred, nor is there any evidence that senior managers in the trust took any further action, other than enquiring once about the progress of the partnership board and the Cornwall Social Services.

Communication

There was no written information available on site about the provision of services for young people or their carers. Parents had helped to raise funds for the services and had paid for items, such as a sensory garden and a ball play pen for the houses, but there were no formal groups set up to encourage them to become more involved in the running and development of the services. In addition, staff had not pursued different ways of collecting the views of parents, in order to improve the quality of its services.

Staff

Qualified nurses work in the children's services during the day and support workers cover night shifts. Support staff were usually employed on part time, 30-hour contracts and levels of staffing were often low.

The investigation team was told that staff had to work split shifts to accommodate closures during the day while the children attended school. Staff also said that they often had to work before and after attending a full day of training, which is not considered to be good employment practice.

Staff in these services said that they felt isolated from the rest of the trust. Senior managers rarely visited and staff could not

identify the director who was responsible for services for people with learning disabilities. There was limited evidence of a multidisciplinary approach to providing care.

Despite this, staff provided valuable support for children with special needs, and their families and carers. The investigation team observed good interaction between staff and the children and young people who use these services. However, there was little 'person-centred' planning and there was no evidence of external audit or systematic monitoring of the services.

Staff were supervised in some services, but this was considered optional by staff in other areas.

Training

Compulsory and essential training was provided to staff. However, external training (outside the county) had been suspended and some compulsory training was only being provided every three years because of budget restrictions. Staff in one of the children's services said that they were unable to attend compulsory training during 2005 because all of the places had been taken. Staff also said that the trust did not provide any training to support the implementation of new policies.

Child protection

Although there were 'named' individuals in the trust who were responsible for dealing with child protection in Cornwall, the names of these people had not been adequately communicated to staff. The trust used the child protection policies and procedures of Cornwall County Council (dated 2001) but a number of staff had not attended training in child protection and some were uncertain of the procedure to be followed in the event of an incident.

There was no evidence that staff were aware of, or could access, the council's child protection website for information regarding

children who are at risk. Since April 1st 2002, all new staff working in children's services are required to undergo a check by the Criminal Records Bureau to establish whether they have any previous convictions that might prevent them from working with children. Two members of staff working in the children's services had not been subject to this check.

The Healthcare Commission and CSCI did not make any referrals for the protection of individual children. However, some concerns were reported to Cornwall Children's Authority, as the lead agency for child protection, and the trust. For example, the use of baby alarms, locks and stable doors to restrict access was widespread in the children's services, with no documentation to describe the rationale for these practices. In addition, the accommodation provided by the trust for children and young people did not meet the needs of those using these services. Boys and girls were sharing double bedrooms in some instances. Space is very limited and, although staff have gone to a lot of effort to make their environments colourful and stimulating, the properties are poorly decorated, particularly on the outside.

Leadership, governance and management of services for people with learning disabilities

Planning strategically, assuring quality and managing performance

Planning strategically, assuring quality and managing performance is not only the responsibility of the trust but also of the wider health and social care community. The quality of care provided by a trust may also in part reflect the performance of other organisations, including PCTs, strategic health authorities and local authorities.

The executive team at the trust did not demonstrate that they understood the values set out in the *Valuing People* strategy or the extent to which services provided by the trust complied with or deviated from best practice. The trust had no strategic plan for services for adults with learning disabilities and these services were not included in the local delivery plan.

There was a lack of systematic and effective processes for managing the performance of services for people with learning disabilities. The trust's board did not prioritise these services and the executive team relied on 'ad hoc' incident reports and feedback from managers and staff to assure itself of their quality.

The responsibilities of PCTs

The three PCTs in Cornwall collectively contribute £18 million to the trust for services for people with learning disabilities. A report by the Audit Commission in August 2005 on the commissioning of such services highlighted a number of significant issues, including:

- an absence of a systematic and proactive approach to commissioning
- no long term planning

- no 'active' commissioning – it was unclear who was responsible for leading commissioning and this lack of clarity could result in duplication and gaps in services
- no arrangements to monitor and measure the effectiveness and quality of services in line with best practice and value for money guidance
- lack of information to inform future developments in services
- no method of evaluation
- no agreed criteria for continuing healthcare
- reliance on historic models of provision or influenced by how the providers perceive the services should be delivered rather than best practice

The PCTs acknowledge that they lack expertise in the field of learning disabilities. They employed one manager with responsibility for commissioning mental health, drug and alcohol and learning disability services. However, this manager did not have recent experience in the field of learning disabilities or the capacity to effectively cover this remit. The focus of the role was on the provision of services for people with mental health problems.

The role of the strategic health authority

When good performance management is in place and operating well, it should ensure that the services that are delivered are safe, that the needs of the people using services are being met, and that they are of high quality and good value for money. The system for managing the performance of healthcare services for people with learning disabilities in Cornwall was inadequate.

The strategic health authority did not adequately monitor the quality and effectiveness of these services. It stated that it was surprised that a trust that had received a good clinical governance review by the Healthcare Commission in 2005 would have problems, such as those highlighted by the current investigation, even though the review by the Commission did not include services for people with learning disabilities. In addition the trust had been awarded two stars by the Healthcare Commission and was a first wave mental health foundation trust applicant.

There is also evidence that the strategic health authority failed to exercise its responsibility to manage adequately the performance of the PCTs in relation to the commissioning of services for people with learning disabilities. The PCTs have a service level agreement with the trust, but this agreement is generic and covers mental health, drugs and alcohol services, children's services and learning disability services. The only information collected regularly for learning disability services was the number of occupied beds and the number of cases held by community staff. The PCTs did not monitor the quality and effectiveness of services or hold regular meetings with the trust to scrutinise how they were being delivered.

Working in partnership with Cornwall Social Services

Historically, the relationship between the trust and Cornwall Social Services in relation to the provision of services for people with learning disabilities was poor. The relationship has improved since the appointment of the new director of adult social care in January 2004, but this legacy continued to affect progress. There was a lack of effective partnership working and little evidence of involvement by staff from the department of adult and social care in the provision of care within the assessment and treatment units and supported living houses. This is demonstrated by an absence of holistic community care

assessments. There was also little interaction between staff from health and social care assessment in planning services or in the day to day delivery of care.

In October 2005, Cornwall County Council undertook an audit of case files to determine if any requests for community care assessment had not been addressed. The audit found two requests made in 2003 that had not been carried out. The audit also established the number of people using the trust's learning disability services who were known to the department of adult and social care. Of the 177 people with learning disabilities identified by the audit, nine had no records. Auditors said that they found it difficult to match paper and electronic records. However, the audit confirmed that all referrals under the system for the protection of vulnerable adults since April 2003 had been acted upon. It is unclear how many children with learning disabilities were known to the Council between 2000 and 2005.

The audit examined care plans for 34 adults who used the day care facilities run by Cornwall County Council. The care plans did not provide an holistic view of the needs of each person. They did not include an assessment or a 'person-centred' plan, and they only related to day care activities.

The review by the *Supporting People* team

The council's supporting people team carried out a review in July 2005 to determine whether funds provided under the *Supporting People* programme were being used appropriately.

The team found that the conditions of the Supporting People grant were not being met. The funding was intended to promote or maintain independent living for people with low or moderate support needs. However, people who used the trust's supported living services had moderate to severe learning disabilities and the level of support being provided by staff went beyond the provision of housing-related support. The *Supporting*

People grant was being used for social, domestic and healthcare activities, which was not its intention. The *Supporting People* team recommended that the grant be withdrawn over a reasonable period of time to allow the trust to develop contingency plans for the funding of these activities.

The team also had a number of significant concerns, common to all of the houses they visited, including:

- poor attention to health and safety procedures, particularly fire safety
- inadequate assessment of risk, including the absence of Criminal Record Bureau checks for staff working alone with vulnerable adults
- concerns about the trust's procedures for managing the finances of those living in supported living houses
- the lack of independent advocates for all those living in supported living houses

The team highlighted some particular cases for concern. For example, in one supported living house, one of the residents displayed aggressive behaviour. The other people living in the house had to lock their bedroom doors at night to prevent the resident from entering and staff slept downstairs in a locked lounge. Staff were advised that they should not go upstairs at night and should telephone the 'on call' service to obtain assistance in the event of an incident. Staff also removed the taps on the wash basin and bath, so the only source of water was a shower. Those living in the house, including one person known to smear faeces, were unable to wash their hands, even before eating.

The *Supporting People* team referred this matter in accordance with No Secrets guidance but there was no evidence of any inter-agency actions taken in response to the referral and no concerns about individuals were reported under procedures for the protection of vulnerable adults. There was no evidence that the people living in the property were referred

to the department for adult and social care for community care assessments. The director for adult social care later reported the matter to the investigation team because the failing appeared to be systemic. However, the department for adult social care did not report these issues to the trust or request that any action be taken by the trust.

Assessing the need for community care

Cornwall County Council had not carried out any community care assessments of people using the trust's learning disability services under section 47 of the National Health Service and Community Care Act 1990. The council stated the trust had not made referrals for such assessments. However, the council should have been aware that assessments were required when applications for transitional housing benefits and later the *Supporting People* grant were awarded. It should have also been apparent to the council that some people appeared to be in need of community care because they were also receiving day care services from the council's department for adult and social care and therefore required a full assessment.

CSCI and the Healthcare Commission asked Cornwall County Council in August 2005, during the course of this investigation, to carry out by March 31st 2006 community care assessments of all people using the trust's learning disability services. Assessments for people living in Budock Hospital commenced in October 2005; assessments of supported living services only commenced in February 2006. In February 2006 carers were advised of their rights to receive an assessment of their needs. Seventy-seven family carers completed self assessment forms; however it is unclear how many carers assessments have been completed by the council's department for adult social care.

There was no process agreed locally to identify the continuing healthcare needs of people using the trust's services and the trust did not appear to have carried out any assessments of

healthcare needs. CSCI and the Healthcare Commission have asked that these assessments also be carried out where required by March 31st 2006.

The learning disability partnership board

A number of internal and external sources told the investigation team that Cornwall's learning disability partnership board, which was chaired by the chief executive of the council, had been ineffective for a long time. An independent facilitator has been helping to review and amend the operation of the board since April 2005.

Minutes from meetings of the board suggest that it has been operating broadly within the requirements of the *Valuing People* implementation guidelines (Department of Health 2001), with some exceptions. The minutes record discussions but decisions are unclear and actions are not highlighted. This makes it difficult to track key areas in which progress has been slow, such as the implementation of the *Valuing People* strategy which includes overseeing the planning and commissioning of comprehensive integrated services that offer people choice, health actions plans, 'person-centred' planning, direct payments and employment. It had not been clear who had the lead responsibility for implementing those elements of the *Valuing People* strategy or taking forward priorities agreed by the board.

Structure, management and accountability for services for people with learning disabilities

Services for people with learning disabilities became a directorate within the trust, following the merger of Cornwall Healthcare NHS Trust and Trecare NHS Trust in 1999. It has operated largely in isolation, despite sharing some clinical governance systems and processes with the trust's mental health services. To address this issue, a common leadership structure and a new meeting

structure was implemented in the trust in 2004. However, staff still expressed feelings of isolation during interviews with us.

The director of services and modernisation was responsible for services for people with learning disabilities, but during this investigation that responsibility has now moved to the director of nursing. He reports to the chief executive and is supported by the newly appointed director for change. Three locality managers have managerial responsibility for learning disability services. There are also a number of clinical specialists with managerial responsibilities in learning disability services, although there was no 'lead' nurse.

The trust has focused largely on its services for people with mental health problems and given low priority to learning disability services. From April 2002 to April 2005, only two papers relating specifically to learning disability services were presented at meetings of the trust's board. In addition, few staff knew who represented learning disability services on the board and staff told us that senior managers were seldom seen in services.

Few meetings of the learning disability management team were minuted. Members were informed of developments in the trust that impacted their work, but there was little evidence of discussion of areas of concern, monitoring, or proactive management.

Minutes from meetings of the learning disability clinical management team indicated that issues were not discussed and resolved during these meetings. The team was informed about changes to services for people with learning disabilities, such as the provision of occupational therapy, speech and language therapy and psychotherapy, and about any problems, but few actions arose from these meetings. For example, the head of occupational therapy raised a problem with the provision of equipment in November 2004. However, this was still unresolved in April 2005 and there had been no discussions about how to improve the situation. The need for

more therapies at Budock Hospital was raised in March 2004, but it was only revisited in July 2005. In fact, Budock Hospital was only mentioned on three occasions: to note the completion of first investigation in April 2004, to note the proposals being put forward for its use, and to advise that more therapies were needed. There was no mention in the minutes of the meetings of the learning disability clinical management team of the second investigation that commenced in August 2004, which resulted in the suspension of seven members of staff.

The purpose of the modernisation and recovery board was to oversee the implementation of the modernisation projects for both mental health and learning disability services. However, there was little reference to learning disabilities in the minutes. Only five of 11 meetings refer explicitly to services for people with learning disabilities. The terms of reference for this board were written in April 2004 and list the priorities for modernisation in the trust. These include:

- a review of supported living services
- learning disability partnership/integration
- integration of children's services
- 'person-centred' planning/care planning approach
- integration of learning disability treatment services (this was added to the priority modernisation projects list on May 28th 2004)

There was no evidence that these priorities had been achieved.

Policies and procedures

The trust submitted a significant number of policies that were used in services for people with learning disabilities. Very few of these policies were developed specifically for supported living services.

The investigation team was told by staff that the trust did not provide training to support

the introduction of new policies and that the auditing of the implementation of existing policies was very limited. A number of key policies were significantly out of date, including the care and responsibility (control and restraint) policy (due for revision on April 3rd 2003), the operational policy for children's services (due for revision on April 3rd 2005), and the supported living situation for adults with learning disabilities (operational policy for supported living services), written by the preceding trust in 1996 and not updated.

The outdated operational policy for supported living services did not reflect the principles of the *Valuing People* strategy or include the *Reach* standards. This means that the policy framework through which staff were expected to deliver services promoted an outdated model of care.

Staffing

The majority of staff working in services for people with learning disabilities, including the supported living services, were employed part time, although many were routinely expected to work more than their contracted hours. As a result, they were not entitled to full holiday, sickness and pension benefits. Senior managers in the trust acknowledged that they needed to address this matter, but were finding it difficult to identify how many staff were affected.

Staff were not employed to work specifically in the supported living services. Some staff moved between the assessment and treatment centres and the supported living services. We recorded more than 30 instances relating to shortages of staff. There were shortages of staff in most disciplines in the learning disability services, resulting in a reduction of activities for those using services.

The induction of staff

Senior managers knew that not all staff attended the corporate induction within the first six weeks of employment. Some

members of staff had waited up to a year to attend. Staff told us that corporate induction did not properly address the needs of new staff joining the services for people with learning disabilities. For example, only 10 minutes is allocated to values and attitudes and little emphasis is placed on *No Secrets* guidance. All areas in the trust were expected to provide new staff with a 'local' induction. Senior managers said that this was happening, but in an unstructured manner.

Training for staff

The *Valuing People* strategy set targets to increase the number of staff qualified to work with people with learning disabilities. By April 2002, all new staff should be registered for qualification with the learning disability award framework and, by 2005, 50% of clinical staff should have achieved a level two NVQ. However, the learning disability award framework was not mentioned in the trust's learning and development prospectus from September 2004 to December 2005. And, although we found evidence that a number of care staff had achieved level 2 NVQ, there was no information available to us to confirm that 50% of clinical staff had achieved this level.

The trust provided compulsory, essential and vocational training to staff. All staff were required to attend compulsory training, specific groups of staff were required to attend essential training, and attendance at all other training was determined by individual personal development plans. The trust's records of attendance at training indicated that a number of staff had not attended the compulsory training. In some areas of the service, such as Budock Hospital, non-attendance was high. A number of staff working in the supported living houses said that they needed training on financial issues, but it was not available. Information collected by the trust was not used to increase attendance at training in areas of the trust where attendance was low.

The trust recently decided to update some compulsory training every three years, instead

of annually. This includes training in food hygiene, assessment of risk and incident reporting, and training on the Mental Health Act 1983. Some staff said that they found it difficult to gain access to compulsory training. They said that, apart from compulsory and essential training, all other training had been temporarily suspended because of budgetary restrictions.

Appraisal and personal development plans (PDP)

The trust's policy for the appraisal of staff, published in 2004, stated that all staff were required to have a personal development plan and an appraisal each year. However, this was not the case. Some staff said that that they were not aware of the trust's policy. Those who had recently received an appraisal and had a personal development plan complained about the quality and the lack of follow-up action.

The development of staff was hindered by the lack of a strategic plan for services for people with learning disabilities. The service was unable to identify aims and objectives for individuals, which support its overall aims and objectives.

The trust provided some supervision to staff, although it was not mandatory. Supervision is provided on a 'cascade' basis, where the senior member of staff provides supervision to those who are accountable to him/her, these members of staff then repeat the process with staff who are accountable to them and so on until all staff have been included in the process.

Some staff told us that they had received supervision, but the frequency of this supervision varied considerably from once a month to once in several months. Others said that they had not received supervision. Some staff said that clinical and managerial supervision were undertaken together in one session because of time restraints. There had been no routine supervision in Budock Hospital for three to four years, despite the number and seriousness of the investigations carried out by the trust.

Communication

Communication between staff and people with limited communication skills who used the service was limited. We found no evidence that other methods of communication were being used routinely across the services, although the British Institute for Learning Disabilities identified that one house was using 'widget' symbols, which is a form of communication using line drawings. Another house was planning to develop detailed and informative pen pictures.

The trust produced a policy for communicating with people who used services, carers and relatives in March 2003, which set out how the trust will involve them in discussions and decision-making. However, the investigation team found no information available in an easy to read form, which was produced by the trust, apart from the complaints procedure. There was no written information about the services provided by the trust that were available for those who use the services, their relatives and carers.

During the investigation, a number of staff said that they felt isolated within their areas of work. Although the trust said that all staff would receive IT training, a significant number of supported living houses had no computer or, if they did have a computer, it was not linked to the trust's intranet. All staff had been issued with an e-mail address but many could not access the trust's computer system. Some staff said that they found the monthly newsletter and briefing paper by the trust very informative and helpful.

Advocacy

Advocacy is rooted in a specific relationship between the advocate and the person who requires advocacy. It uses the tools of representation, negotiation and persuasion to bring about beneficial changes in a person's life.

The majority of people did not have access to advocacy services. Staff who we interviewed were largely unaware of the advocacy services

that were available and some did not know what advocacy was. Although the trust had contributed funding for advocacy services, it was not promoted within services. No information was available for people on how to access advocacy. Some staff said that they did not see it as their responsibility to help people with learning disabilities to access an advocacy service to support them in making decisions.

Survey of people who use services and their carers

As part of this investigation, a survey was sent to all people currently using, and those who were known to have previously used, the trust's supported living services, assessment and treatment services and children's residential and respite services. Ninety-five of the 237 questionnaires that were sent out were returned. The questionnaire asked for people's views on:

- access to activities
- access to healthcare
- financial arrangements
- the attitudes of staff
- making a complaint
- the quality of care
- the process for planning care
- attending meetings linked to the planning of care
- involvement of people who used services

Generally, respondents to the survey were satisfied with the service that was being provided and the attitude of staff providing care. However, there were a number of areas where people did express concerns, including:

- financial arrangements, including arrangement for charging
- lack of daytime activities
- shortage of staff

- implementation of the procedure for complaints
- lack of involvement of people in the process for planning care

‘Person-centred’ planning

In 2002, the trust introduced a ‘person-focused’ system, an adaptation of ‘person-centred’ planning, to meet the requirements set out in the *Valuing People* strategy.

In March 2005, the trust produced findings of an audit of the implementation of the person-focused system within the 45 supported living houses. The findings showed that only 21 of the 45 houses had attempted to implement the system and the quality of implementation varied. Staff in the trust had apparently taken no action in response to the findings of the audit. In addition, we found no evidence that health action planning had been implemented by June 2005 (as required by the *Valuing People* strategy), although the trust said that it was being piloted in the community.

Daytime and social activities

There were limited opportunities for people to participate regularly in daytime and social activities. A few people attended college on a regular basis and some people attended weekly classes and groups outside of the trust, but a high number of people had no planned activities. Staff said that they tried to take people out as often as they could but risk assessments restrict this because of the lack of staff that were available. If staff did take a person out, that person was often responsible for any expenses incurred. For example, they would have to pay for the member of staff’s lunch as well as their own. This means that financial circumstances also restricted what people could do.

There was little evidence of people being involved in activities in their homes. A number of people attended their local Gateway club, which is organised through the Mencap Society, but they often had to leave early

because staff were due to go home. This restriction reflected the needs of staff, rather than the needs of those using services.

Safety and protection

The protection of vulnerable adults

The Healthcare Commission and CSCI referred 40 people to Cornwall County Council under the scheme for the protection of vulnerable adults. These referrals were made on behalf of people in the assessment and treatment centres and supported living services. They were made because we found evidence of:

- locked environments preventing people from leaving an area against their wishes
- physical abuse
- assault by other people using the services
- prolonged physical restraint, restricting liberty and freedom of movement
- injuries occurring during periods of reduced observation
- the covert administration of medication
- health and safety concerns related to some people being locked in bedrooms during the night
- the use of CCTV in supported living houses

Arrangements to implement *No Secrets* guidance

The department for adult social care had an identified ‘lead’ person for adult protection. The trust, until recently, did not. Attendance by trust at the *No secrets* multi-agency working group was poor. The minutes of 14 meetings of the group showed that the trust was in attendance on only eight occasions. On some occasions, the trust was not represented, even though it was required to present an item to the group.

The trust’s operational policy for the protection of vulnerable adults was out of date and arrangements in Cornwall to protect vulnerable

adults were inadequate. The trust failed to address effectively or speedily many of the 40 referrals made by the investigation team.

For example, in August 2005, G, who is deaf, blind, cannot speak and uses a wheelchair, was found strapped to his wheelchair for up to 16 hours during the day and to his bed at night, to prevent him from hitting his head and face. Inspectors from CSCI noticed that G's care plan had not been reviewed since April 2004 and regular reviews had stopped in 1998. G received a high level of funding, which should have paid for his own carer during the day and at night, and the care plan stated that G might need to be restrained for short periods of time. However, we found that G's hands were usually tied to his wheelchair for most of the day. G appeared to enjoy having his hands free, which was a conditioned response to having his hands tied. Inspectors had formally reported G's situation under the system for the protection of vulnerable adults, when it came to their attention in August 2005. However, when inspectors returned in November 2005, G's care had not been reviewed and his situation and care plan remained unchanged. In February 2006, inspectors saw that some small changes had been made, but considerable work was required to improve the situation. In April, when inspectors visited again, G had been unrestrained for two months.

There was no one on the trust's board, and no senior manager, responsible for overseeing and managing the referrals relating to potential abuse. There was also no effective local monitoring of potentially abusive situations and no adequate governance arrangements in place that could have identified such situations. The referrals were passed to the council's department for adult protection, who reviewed the practices with those responsible. This process was not of objective, impartial or effective. There was no effective interagency mechanism or process for reporting back to the referral agency or to senior managers in the trust.

The absence of an appropriate person to lead adult protection in the trust contributed to the lack of a robust system to deal with issues of concern. The integrity of the investigations was compromised by the lack of independence of local investigators who failed to recognise issues of adult protection or recommend appropriate solutions. This was evident in all cases including systemic and institutional abuse.

For example, the investigation team referred the case of one resident in a supported living house whose bedroom door was locked at night, imprisoning him and presenting a risk in the event of fire. The solution by the trust was to replace the full bedroom door with a stable door; he was still locked in and the risk remained. Another person was referred because they appeared to be receiving an enema three times a week to relieve constipation. The solution by the trust was to seek the advice of a consultant nurse in continence care from the local PCT who advised the trust to substitute enemas with suppositories. There was no consultation with a dietician or physiotherapist to identify the underlying cause of the constipation.

In many cases, there were no dates for completing actions in the action plans. As the lead agency the council failed to effectively coordinate local interagency policy procedures and practices, and failed to ensure robust adult protection arrangements were in place that resulted in positive outcomes for those using services, which complied with the law and best practice.

Criminal Records Bureau (CRB) checks

On February 14th 2005, it became mandatory for all NHS organisations to check the suitability of new employees to work with vulnerable adults. The national guidance for the NHS states that only new staff recruited for adult's services require a CRB check. New staff cannot work with children at all unless they have undergone a positive CRB check at the 'enhanced' level.

The trust's own policy, written in May 2005, stipulates that new staff in adult's services must be supervised if they are not cleared by CRB. The trust provided data on the CRB checks that had been carried out for new staff working in services for people with learning disabilities. Since February 14th 2005, five members of staff who had not undergone a CRB check had carried out unsupervised sleep-in shifts in supported living houses. One member of staff had worked unsupervised without confirmation of CRB clearance, although the form had been sent to the CRB.

The trust supplied the Healthcare Commission with a list of staff employed in its respite services for children with learning disabilities since September 1st 2004. One person who started working for the trust on October 14th 2004 had not been cleared by the CRB and had worked one to one with a child. Another new member of staff had not been cleared by the CRB but had worked in the trust's children's services under supervision, since March 6th 2005. None of these situations comply with national guidance or the trust's own CRB policy.

Management of risk

The risk register for the learning disability directorate focused on risks to staff and property rather than risks to those who use the services. In particular, the risk register covers the safety of premises and fire safety. The management of risks for people who used the trust's services tended to focus on the prevention of particular behaviours, rather than managing risks in a way that would allow the person to develop and learn more appropriate behaviours.

Although the required actions recorded in the risk registers had review dates, people were not identified to ensure they were implemented.

As was found in the review undertaken by the British Institute of Learning Disabilities, the trust's culture was overly risk averse and staff tended to respond to potential risks by taking

action which restricted or curtailed the rights of those using the service and did not balance the risks sufficiently against the benefits and potential for development. Examples of this type of approach included the locking of internal and external doors and the removal of taps and light switches.

Analysis of incidents

The trust has a policy for reporting incidents and there were folders containing incident forms in the assessment and treatment centres and supported living services. However, staff were not always clear about what they should report and when. For example, our investigation team saw one person became frustrated and kick a member of staff. The member of staff did not record the incident because she did not think the action was ill intentioned, but it could have provided important information about the triggers for challenging behaviour. This information could have helped staff to see whether the person's challenging behaviour was escalating or whether the treatment programmes were effective.

The board received reports of incidents that occurred in the trust. These reports did not distinguish between services for people with learning disabilities and services for people with mental health problems. However, the reports did demonstrate that the trust was aware in 2004 that staff were not reporting all incidents. The most frequently reported incidents related to violence and aggression.

On November 1st 2005, the Healthcare Commission asked the trust to supply details of all incidents that had occurred in any premises in which it delivered services for people with learning disabilities, and had resulted in an internal inquiry, between January 1st 2000 and October 31st 2005. The information supplied by the trust was incomplete and contained inconsistencies. For example, details of an incident in August 2004, which had resulted in a member of staff being dismissed, were not provided by the trust. This

information was supplied to the Healthcare Commission by another source.

Of the incidents reported by the trust, 77% failed to indicate whether relatives or carers had been informed and, in many cases, dates for internal inquiries and disciplinary investigations were not provided. In 17% of incidents, staff were reportedly moved to a different area of the trust following the incident.

The process for complaints

Reports to the trust's board about complaints, and follow up discussions, focused on meeting targets for response times and failed to consider the quality and volume of complaints or the satisfaction of the complainant.

Information about complaints was available in an accessible form, but the process was not promoted effectively and did not cater for people who had more challenging communication needs. During our visits, we saw only one area in the learning disability directorate which had information on how to complain in an easy to read form that was easily accessible to people using the services and their carers and relatives.

The trust's board acknowledged that the number of complaints and compliments was lower than expected. Staff told us that those using services, and many carers and relatives, were not aware of the process for complaints. In addition, the trust often exceeded the target response time of 20 days.

Managing the performance of staff and the disciplinary process

Internal investigations or inquiries were carried out by the trust in relation to 57 members of staff in the learning disability service, who were involved in 46 incidents between January 2000 and October 2005. Actions taken by the trust resulted in:

- 26 members of staff still employed by the trust (10 in the same location, 11 moved to a different location and five in an unknown location)

- 21 members of staff no longer work for the trust (12 dismissed, three ceased employment due to ill health, two resigned and four left for an unknown reason)
- six members of staff were currently being investigated or suspended so the outcome was unknown
- no details were supplied for four members of staff

Despite the seriousness of some of the incidents, a significant number of cases were handled informally by the trust rather than through the formal process for managing performance or its disciplinary procedure. Staff believed that colleagues were often treated leniently. They were also concerned that staff were simply moved following an incident, rather than being disciplined or the problem being addressed. The investigation team was told that there was poor support for staff who raised concerns.

Conclusions

In October 2004, East Cornwall Mencap Society informed the Healthcare Commission that it was seriously concerned about the quality of services provided by the trust to people with learning disabilities in Cornwall. It feared that failings in the quality of care and the financial management of the services were widespread and was concerned that some people might be suffering abuse. A month later the media reported that seven members of the trust's staff had been suspended from duty at Budock Hospital, one of the trust's assessment and treatment centres, and the trust had commenced a disciplinary investigation.

The Healthcare Commission made some initial enquiries, met the five families whose concerns were referred by East Cornwall Mencap Society and, in May 2005, concerned that the trust's own investigation had still not concluded, decided to conduct a formal investigation. By September, it was clear that the overlap between health and social care meant that the investigation needed to be carried out jointly with CSCI. In October, the Healthcare Commission notified the Secretary of State for Health of its concerns about significant failings in the trust and requested that urgent action be taken to safeguard people using the trust's learning disability services while our investigation was underway. In response to our recommendations, an external team was appointed to implement immediately the necessary changes in the trust.

During the investigation, the Healthcare Commission and CSCI visited every site operated by the trust, including 45 supported living services, four assessment and treatment centres and its services for children. We also met almost all of the people who use the

trust's learning disability services and commissioned the British Institute for Learning Disabilities (BILD) and an experienced healthcare professional to carry out separate reviews of the trust's services.

We found that the concerns expressed by East Cornwall Mencap Society were justified. Assessment and treatment services did not meet with best practice as detailed in the *Mansell Report* and in some instances were being delivered in totally unacceptable environments. The assessment and treatment centres had effectively become long term homes for the majority of people staying in them. For example, a person who was admitted to one of the centres for a short stay following a cataract operation died there several years later. In these centres, as in other services, there was little evidence of effective, accessible guidelines on handling challenging behaviour or adherence to treatment programmes and an over-reliance on PRN medication to control behaviour. Record keeping was generally so poor that it prevented effective care. People using these services had little opportunity to develop their potential or to move to another service.

In the trust's supported living houses, staff were not supported to deliver modern social care. Issues of choice, dignity, enablement and development for people with learning disabilities were not understood or fostered. Training for care staff was poor and not considered to be a priority. The trust's financial arrangements for people living in these houses were unclear. We have referred our concerns about this aspect of the service to the NHS Counter Fraud and Security Management Service and the Audit Commission. These concerns are now being investigated

The investigation team also identified a number of areas for improvement in the trust's services for children, including staffing and training for staff and the availability of suitable information for parents, carers and young people.

The reviews carried out by the British Institute for Learning Disabilities, and the findings from the review of case notes, revealed serious deficiencies in care practices and record keeping. This supported the findings of the investigation team. Some individuals, as the trust has acknowledged, have suffered abuse, including physical, emotional and institutional abuse.

The trust was effectively providing long term unregulated and unmonitored social care, not healthcare. CSCI considered that the trust, which provided housing support in addition to personal care, was running the services as if they were care homes. However, they were not registered as care homes and there had been no application for registration by the trust or the organisations providing housing (either as care homes or domiciliary care agencies). In addition, the services did not meet registration standards.

A lack of community care assessments contributed to inappropriate housing and the provision of unregulated social care, which was of an unacceptable standard. Such assessments should have been carried out for everyone who used the trust's services, in order to determine the level of care that they required. They are now being undertaken at our insistence. Registration, as care homes or domiciliary care, could only be granted when the needs of those using the services had been determined and services had improved to the required standards.

The trust had made some changes in an attempt to improve services. In early 2004, a new director of services was appointed and given responsibility for integrating mental health and learning disability services. The new director acknowledged that the trust's model of care was outdated but did not introduce any changes that improved the quality of services.

Senior leaders at the trust did not convince the investigation team that they had a strategic vision for the service or an effective operational plan. Their governance arrangements did not allow them to monitor the quality of the service effectively and they set the standards of care too low. The chief executive and the board of the trust have struggled to accept that the trust's services are poor. Minutes from board meetings demonstrate that they persisted in their belief that the learning disability services were no worse than many others in the country even after the investigation started. While we accept that there may be other pockets of poor practice elsewhere in the country, this does not excuse poor practice at the trust. In our view, the extent of unacceptably poor practice in Cornwall is unusual.

Our investigation, and the investigations carried out by the trust at Budock Hospital, has highlighted the years of abusive practices, and in some cases real injury, suffered by some people. For example, one person suffered multiple injuries over time, including a fractured skull after being hit by another person who used the trust's services. Another person spent up to sixteen hours a day tied to their bed or wheelchair for what staff believed in good faith was for that person's own protection. One man told the investigators that he had never chosen any of the places he had lived throughout his adult life. The practice of moving people from home to home at the trust's choosing meant that people have lived unsettled lives, often with people they do not like or who are incompatible.

During the investigation, we referred 40 people under the procedures laid down in the Department of Health's *No Secrets* guidance for the protection of vulnerable adults. The trust's failure to address these concerns adequately when checked by the Commissions revealed serious and wide reaching flaws in local procedures.

Cornwall County Council, as the leading agency for the protection of vulnerable adults,

failed to coordinate effective inter-agency arrangements. The council did not play a sufficiently active role in managing referrals, and many social workers were too ready to accept, without challenge, the opinion of staff at the trust.

The trusts own arrangements to protect vulnerable adults were also inadequate. Although staff were aware of the procedure for reporting abuse, they were largely unaware of what constituted abuse. In addition, there was no senior manager in the trust with clear responsibility for the protection of vulnerable adults. Investigations by the trust did not always adequately separate the role of the manager responsible for the home from the role of the investigator, and managers did not monitor the outcomes of investigations to ensure that abusive and poor practice had stopped.

Our analysis of the trust's investigations at Budock Hospital reveals that the trust had saw abuse as something that resulted from individual deviant behaviour. It had not addressed the underlying problems in the culture, policies and practices that had created a climate in which abuse could take place. The trust had failed to consider whether people who had previously used its services might have been exposed to abuse. It also failed to recognise that it should review its practices to make sure that such practices were not occurring in other parts of the trust. For example, we found that doors continued to be inappropriately locked in some services, despite previously requesting that this practice should cease.

We conclude that senior executives at the trust failed to ensure that the quality of services provided to people with learning disabilities was adequate. They failed to protect people from abuse and prevented services from developing effectively. They denied people with learning disabilities opportunities that should be available to them, leaving a number of people in inappropriate accommodation with insufficient activities and virtually no control over their own lives.

Some people have suffered serious and prolonged abuse.

The trust's supported living services do not operate in accordance with the principles of the *Supporting People* programme. As a result, £1.8 million in funding, awarded under the *Supporting People* grant, will be withdrawn from the trust over the next two years. The service falls far short of the standards set out in the *Valuing People* strategy and, in some cases, it infringes human rights – for example, the unlawful detention of people and, in some instances the repeated exposure to physical abuse. It was clear to the investigation team that none of the trust managers responsible understood what a good model of care for people with learning disabilities should look like or recognised how far short their service actually fell.

The trust has blamed the three PCTs in Cornwall for failing to commission appropriate services for people with learning disabilities and, while this does not lessen the trust's culpability, the criticism is accurate. Responsibility for the conditions found by our investigation team lies with the trust as the provider of the services, with the PCTs as commissioners of the services (as indicted by the Audit Commission), with the learning disability partnership board, which is coordinated by Cornwall County Council and has evidently failed to oversee the implementation of the principles of the *Valuing People* strategy by the trust, and with the strategic health authority which is responsible for managing the performance of the trust and the PCTs. The system for managing the performance of residential services provided by the trust for people with learning disabilities was inadequate. The strategic health authority did not adequately monitor the quality and effectiveness of these services, nor did it manage adequately the performance of the PCTs to commission good quality services for people with learning disabilities.

The learning disability partnership board was not effective in promoting the establishment of

good partnership arrangements between the different agencies to support the trust's services for people with learning disabilities.

This situation has not happened overnight. It is, in part, the result of years of historical wrangling between trusts and social services departments. This has contributed to the stagnation of a service that had once been at the forefront of development, with the early closure of its long stay hospital and the introduction small community homes, supported by short-stay assessment and treatment centres. Poor relationships prevented services from being transferred to the local social services department, as happened elsewhere. This also prevented sufficient involvement of Cornwall Social Services in the care provided by the trust, to the detriment of people with learning disabilities. People using the trust's learning disability services have missed out on the valuable skills of social workers and the benefit of external scrutiny and challenge.

All agencies failed to agree and implement the necessary arrangements and funding for community care assessments. Assessments of continuing healthcare needs and 'person-centred' plans were also largely absent. There was no evidence that the needs of carers had been assessed.

Although relationships are reported to have improved, and the trust and the department of adult and social care report that they have tried to introduce changes to working practices, we found few tangible benefits for people with learning disabilities within trust services.

The merger of the former specialist learning disability trust (known as Trecare) with mental health services to form Cornwall Partnership NHS Trust had two consequences. The first, which was a legacy from the learning disability trust, is the nature of working practices among staff.

Cornwall is geographically isolated and the turnover of staff is low. A number of staff

currently working in the trust had worked for Trecare and, until 2004, a senior manager of this organisation had led services for people with learning disabilities at Cornwall Partnership NHS Trust. Staff rarely visit other organisations and few new staff join the service. As a result, staff have had little exposure to different ways of working. Unfortunately, those who did had little influence in services.

In addition, little training and the practice of unqualified staff predominantly learning by observing their peers, has meant that practices, some of which were very poor, have become ingrained. Our investigation team was impressed by the genuine warmth and kindness of many of the staff they met, but struck by their lack of knowledge of best practice and the principles of the *Valuing People* strategy. Many did not even recognise the phrase.

The second consequence of the merger was that services for people with learning disabilities became a small part of the overall service provided by the trust. The trust has focused on its mental health services (for which it has developed a good reputation) and, more recently, on its application for status as an NHS foundation trust. Although some information about services for people with learning disabilities is presented to the board, it has not received the degree of attention required to bring about necessary improvements.

Learning disability services have not been well resourced. The trust and the PCTs lack the expertise to operate these services effectively. There is only one clinical psychologist working in services for adults, a shortage of psychiatrists qualified in learning disabilities, a lack of qualified nurses specialising in handling challenging behaviour, and too few therapists. Staff have not made best use of specialist resources, where these have been available. Therapists report that they feel unwelcome at some sites, while other staff did not appear to recognise that referrals could or should be made. There was little evidence of

effective multidisciplinary teamwork and, where programmes had been agreed, they were not always carried through. Most significantly, clinicians did not appear to have a positive influence on the culture of the service.

The voices of people who use the trust's learning disability services are seldom heard. Advocacy and therapy services, which can help people to communicate, is very limited and has not been a priority. People who use the services are not empowered. Staff make decisions about too many aspects of people's lives, such as whether they can open a front door to walk outside of their own volition, use a china cup or a plastic beaker, go out, how they spend their money, and who they live with.

The trust had not developed a systematic approach to ensure that people with learning disabilities, their carers and families were engaged with services. And, while our survey indicated that families were generally satisfied with the care being provided and thought that staff were kind and homes reasonably comfortable, it is clear that the trust has done little to inform them about the principles of the *Valuing People* strategy or other standards of care that should be in place. Some families described the trust's response to their complaints as very poor. The trust have done very little to actively involve people with learning disabilities and their relatives in the planning of their care.

Our investigation of the trust's residential learning disability services has identified a whole system failure. The mechanisms that should have protected people living in the trust's services failed: the trust's managers and the board, who are directly responsible for the quality and safety of care, failed; the PCTs, who are responsible for commissioning safe and good quality services, failed to do so; the strategic health authority failed to discharge its responsibility to manage effectively the performance of the trust's learning disability services and the PCTs' commissioning function; and the local system for adult protection failed to protect vulnerable adults as it should.

There was little evidence that managers actively engaged staff in plans to develop services, or in decisions about those they cared for. Staff appeared ill informed about our investigation and appeared to have scant involvement in community care assessments, 'person-centred' planning or preparation for the future. Over the years, some staff have demonstrated considerable bravery and have spoken out. Some continue to champion the rights of individuals, but it has been difficult to achieve lasting change and staff have not been encouraged to act as advocates for those in their care.

All of these factors have conspired to make people with learning disabilities largely powerless to control their environments or their lives, and have made the poor care and abuse we have described possible.

Recommendations

Special measures for services for people with learning disabilities provided by the trust

The Healthcare Commission is required to report significant failings found in the course of its reviews and investigations to the Secretary of State for Health, the Welsh Assembly Government and Monitor (independent regulator of NHS foundation trusts), as appropriate.

In October 2005, during the course of this investigation, the Healthcare Commission reported to the Secretary of State for Health what it considered to be significant failings in services for people with learning disabilities at the Cornwall Partnership NHS Trust. In response, an external team, appointed by the South West Peninsula Strategic Health Authority, was established to undertake urgent improvements to the trust and to ensure that plans were developed for the future of the services.

There has been some progress by the trust since the strategic health authority brought in this external team. However, the Healthcare Commission still has concerns about the quality of services. We still consider that there are significant failings in the trust's services and that special measures are necessary to address these failings. This view is shared by CSCI.

The Healthcare Commission recommends the following two special measures:

- 1 That an external team should remain in place, at least for the next 12 months, in order to:
 - oversee the quality of the services provided to people with learning disabilities

- work with the strategic health authority to ensure that the action plan relating to the redesign of the service, which has been agreed between the trust, Cornwall County Council and the local PCTs, is properly implemented, in line with agreed time scales
 - ensure that sufficient transitional funding, both from health and social services bodies, is available to sustain changes and improvements to services
- 2 That, in light of the significant failings, there needs to be an external review of the performance and membership of the trust's board to ensure that it is able to discharge its responsibilities to an acceptable standard

In addition to the special measures, the Healthcare Commission and CSCI also make the following recommendations.

National recommendations:

- anyone, including NHS bodies, who runs care homes or domiciliary care agencies must immediately seek to register their services with CSCI
- every council, PCT and learning disability partnership board should review their joint working arrangements to ensure that community care assessments, including risk assessments, (resulting in a 'person-centred' plan) are offered to those who have completed their assessments and treatments
- all strategic health authorities must ensure that NHS bodies that provide services in a housing association or in premises in the independent, voluntary or charitable sectors apply for registration with CSCI immediately

- supported living funding should be paid to individuals and managed at a local level rather than by the providers of services. (note: further national recommendations regarding safeguarding adults are made on p69).

Governance arrangements

The trust:

- must ensure that medical, nursing and therapeutic care is provided in accordance with best practice throughout its learning disability services
- should review its present system of governance and performance management to ensure appropriate reporting of issues and appropriate management action is taken in all areas of operational practice
- chief executive should consider whether the standard of practice of any clinicians falls below that of reasonably competent practitioners and, where appropriate, refer them to the relevant professional body
- must fulfil its responsibility to carry out healthcare assessments when required, to do so by the PCTs, to determine the continuing healthcare needs of people with learning disabilities

Cornwall County Council must continue to fulfil its responsibility to ensure that community care assessments are completed for people with learning disabilities, in accordance with the National Health Service and Community Care Act 1990.

The learning disability partnership board:

- must fulfil its roles and responsibilities as set out in the *Valuing People* strategy, to promote the rights, independence, choice and inclusion of people with learning disabilities
- immediately review its composition and arrangements for governance, to identify how it has failed to ensure the effective

implementation of the *Valuing People* strategy within the trust's services and to ensure it is implemented effectively in the future. As part of this, the learning disability and partnership board must ensure that the minutes of meetings are clear about the decisions that were reached, who is responsible for taking actions forward, and by when and oversee the implementation of the joint commissioning strategy

- implement its joint investment plan

North and East Cornwall PCT, West of Cornwall PCT and Central Cornwall PCT must:

- include learning disabilities in the local delivery plan
- develop a joint commissioning plan, which includes indicators of performance related to best practice (for example, *Reach* standards, *Valuing People* targets and the actions recommended by the Audit Commission relating to value for money) and overseen by the learning disability partnership board
- include indicators of performance in their service level agreements which can be used to monitor the quality of services provided to people with learning disabilities

Redesigning services

When commissioning services, the PCTs and Social Care Commissioners must respond to the experiences of people with learning disability and their families. Their views must be included as part of the annual planning cycle for learning disability services, and indicators of performance should take account of their views.

The PCTs, Cornwall County Council, the strategic health authority, the trust and the learning disability partnership board must:

- ensure, as a matter of urgency, that the results of community care assessments shape the redesign of its services. The redesign must take account of the needs of each individual and the different types of care

they require. This may include the provision of long term or respite care in a registered care home or the provision of care by registered domiciliary care agencies for people in their own homes

The supported living funding of learning disability services should continue for those people who are assessed as having housing support needs. For those people services will need to be redesigned to meet the supported living eligibility criteria.

The assessment findings, which will provide evidence for the proposals for the redesign, and the timetable for implementation, must be shared with CSCI to ensure that the services comply, where necessary, with registration requirements, standards and inspection regimes. When services have been redesigned, the trust or new providers of services will need to confirm the new arrangements as a matter of urgency with CSCI. Applications for registration as domiciliary care agencies or care homes will be required, when personal care is needed.

Registration of services

The trust must:

- make immediate application for registration as care homes for people who require placement in a care home (based on assessments carried out by the March 31st 2006). For other people requiring personal care, an application for registration as a domiciliary care agency is immediately required

Services will need to be provided in accordance with the regulations and national minimum standards for care homes or domiciliary care agencies. (*Care Homes for Adults (18-65) and Supplementary Standards for Care Homes Accommodating Young People Aged 16 and 17* and *Domiciliary care: national minimum standards, regulations*, published by the Department of Health in 2003) Applications for registration may be obtained from CSCI or accessed on the CSCI website at www.csci.org.uk. Where registration as a care home is required, staff, management

and premises must be fit for this purpose. For domiciliary care agencies staff and the manager must be fit for the purpose. Staff must be trained and supported.

The supported living funding of learning disability services should continue for those assessed as requiring housing support. Services will need to be redesigned for these people to meet the eligibility criteria.

The PCTs, Cornwall County Council, the strategic health authority, the trust and the learning disability partnership board must:

- work together to ensure that people with learning disabilities who withdrew from the trust's care are identified and offered community care assessments, and assessments for carers if requested. The learning disability partnership board must oversee this and receive progress reports

The redesign of services must be accompanied by a clear improvement plan or operational plan, which:

- takes account of the needs and choices of people using the services, as identified by the community care assessments
- is sufficiently resourced
- sets standards, based on best practice, for staff and people using the trust's services, including an appropriate time in which to achieve these standards
- incorporates measures to monitor the outcomes of care and treatment, and to achieve a change in the culture of learning disability services
- is understood fully by staff
- includes training for staff and support for and by managers
- is appropriately registered

The PCTs, strategic health authority, the trust and Cornwall County Council must ensure that:

- services for people with learning disabilities are properly resourced, financially and in

terms of the level of clinical or therapeutic support that is available, to enable changes to be delivered effectively now and in the future

- a workforce strategy is developed to ensure staff have the knowledge, skills and competence to support the immediate needs of people with learning disabilities and plans for the future
- all staff are trained to communicate appropriately with people with learning disabilities
- they work together effectively, as partners, to deliver services and enabling positive outcomes to people with learning disabilities who live in Cornwall

Safeguarding vulnerable adults

At a local level

The learning disability partnership board and the strategic health authority (in its role as manager of performance) should:

- be active
- receive reports on matters relating to the protection of adults with learning disabilities
- satisfy themselves that the system is robust, that sufficient and effective action is being taken to address individual and underlying problems, and that these actions improve the lives of those affected by abuse and inappropriate standards of care

The trust must:

- ensure that representatives of the board and senior management who 'lead' on the protection of vulnerable adults are properly trained and informed of their specific roles and responsibilities for that work
- establish mandatory training for staff on procedures for protecting vulnerable adults
- ensure that allegations relating to the protection of vulnerable adults are

appropriately referred under the multi-agency procedures.

- ensure that complaints relating to the protection of vulnerable adults are investigated by a member of staff who is not directly responsible for the service in question
- ensure that issues relating to the protection of vulnerable adults are identified from incident reports and complaints, and are acted upon by a member of staff in accordance with *No Secrets* guidance

At national level, the Department of Health should strengthen the process for protecting adults, in accordance with the Safeguarding Vulnerable Groups Bill to:

- require referrals from the NHS to the new barring scheme currently known as the protection of vulnerable adult list
- enable retrospective referrals to the new barring list from the NHS
- require the publication of an annual report from the multi-agency adult protection and safeguarding committees, as part of their ongoing responsibilities for assessing and managing performance
- require staff in the NHS to also be checked against the new barring scheme

Local authorities, in their role as lead agency for the protection of vulnerable adults, must ensure that arrangements for investigating allegations of abuse and improving services are robust. These arrangements must include:

- impartial and independent investigation by staff who have been trained in the protection of vulnerable adults in circumstances where it is not appropriate for the care provider to investigate
- clear allocation of roles and responsibilities for all agencies and staff
- appropriate timescales
- a high quality reporting system

- identification of appropriate action for improvement
- effective arrangements for scrutinising and monitoring services, including procedures for checking whether matters have been put right
- a defined process by which local authorities as the lead agency, can, and does, challenge and report on the the quality of work undertaken in relation to an allegation of abuse. For example, through formal reporting complaint to the trust, strategic health authority, police, the Nursing and Midwifery Council, the Healthcare Commission and CSCI
- an annual audit and report to monitor the effectiveness of the work of adult protection committees

Empowering people who use services

The trust must:

- widen opportunities for people who use its services to exercise choice and control over their own care and develop services to meet their needs
- provide an external advocacy service to help people to articulate their own opinions and choices
- provide adequate information about proposed improvements to people who use services and their carers in a form that is easy to understand
- ensure that information about its process for handling complaints is readily available and easily understood, and that the system is robust and responsive

The trust's board should maintain a programme of visits, at the invitation of those using the trust's services.

The PCTs and Cornwall County Council must ensure that advocacy services are adequate.

Clinical practice and service delivery

The trust must:

- as a priority, develop a programme of training, supervision and support for staff, which helps them deliver care in accordance with the principles of the *Valuing People* strategy
- ensure that staff attend compulsory and essential training to enable them to fulfil their roles and responsibilities
- ensure that each person using the trust's learning disability service is offered a health action plan and receives help to develop this plan
- ensure that care plans and risk assessments are holistic, covering all aspects of a person's life, and that they are updated and used regularly by staff to deliver effective care
- revise policies and procedures which are out of date, bringing them into line with best practice
- develop and use a unified system for compiling care records, and ensure that records are properly maintained
- ensure that staff are better prepared to deliver care, including:
 - adequate handovers
 - access to well organised and informative records
 - support and supervision from trained staff
 - training in the principles of the *Valuing People* strategy
 - greater involvement of staff in decisions about people who they care for routinely
 - understanding when and how to make referrals for therapeutic and clinical support

The trust must also review and revise its use of physical restraint and PRN medication to control challenging behaviours. In particular, it must:

- ensure that relevant policies conform to best practice
- staff are trained in the use of restraint, using recognised training courses. The training should include proper recording of incidents and the use of restraint as part of an agreed treatment plan with appropriate input from professionals in psychology. Staff who work with people with challenging behaviour should receive priority for this training
- immediately cease the inappropriate use of locked doors

Together, the trust and Cornwall County Council must ensure that 'person-centred' planning is completed in accordance with relevant guidance and is of a good standard.

Finances

The trust must:

- review its systems, policies and practices relating to the management of finances for people who use its services, ensuring that they are lawful and in accordance with best practice
- ensure that staff are trained to manage finances and that appropriate financial systems are in place to help people with learning disabilities to manage their money and to reduce the risk of financial abuse

The Commissions

The Healthcare Commission and CSCI will carry out the following actions in response to the findings of this investigation.

The Healthcare Commission will ensure that the safeguarding of vulnerable adults is incorporated within its overall strategy and processes for assessing the performance of healthcare services. CSCI already undertake this work as part of its assessment of the performance of councils and service inspections.

CSCI will continue with their responsibilities to ensure the safeguarding of vulnerable adults and children in their inspection of registered services, service inspections and the performance assessment of councils until April 2007. After this date, CSCI will continue with the inspection of registered services, service inspections of councils and the annual assessment of performance of Cornwall's department of adult social care and all other adult care departments in England.

In April 2007, responsibility for annual assessment of performance of children's services will transfer to the Office of Standards in Education (Ofsted) and the children's support advisors at the Department for Education and Skills (DFES), based in regional government offices. Ofsted will carry out inspections of children's services every three years.

CSCI and the Healthcare Commission will continue to develop a protocol for safeguarding adults with organisations that commission services in health and social care.

The Healthcare Commission and CSCI will strengthen their evaluation of local arrangements for safeguarding vulnerable adults through the development jointly of indicators of performance and the collection of data against which services will be assessed. The Commissions will engage with all organisations that commission health and social care services for people with learning disabilities, to determine what actions are taken to ensure the safety and quality of the services that they purchase.

The Healthcare Commission will also lead an audit of services for people with learning disabilities. This will require all organisations providing such services to the NHS to assess themselves against a specified criteria. The outcome of this audit will determine what further action is required of the Healthcare Commission and CSCI.

Progress since the start of the investigation

The external change team, brought into the trust by the strategic health authority, was in place by November 2005 and has been able to drive forward a number of positive changes. These changes are based on a series of recommendations made by the Healthcare Commission and CSCI throughout this investigation to the trust and Cornwall County Council.

The main recommendations (apart from those relating to the safety of particular individuals) were:

- that Cornwall County Council should complete community care assessments for every person who uses the trust's learning disability services
- that the trust and the council should improve their processes for protecting adults

These changes were necessary to safeguard people using the services from further risk of abuse and to lay the foundations for the establishment of best practice.

The recommendations were accepted by the organisations. However, progress has not been achieved as swiftly as the Commissions, or the external change team, would have liked. The Commissions have had to maintain an exceptional level of monitoring and surveillance and press for improvement throughout the investigation. As late as April 2006, the Commissions continued to express concerns about operational matters and the lack of a fully effective system to safeguard those using the trust's services. This was due in part to the trust's denial of the seriousness of the situation. It was also a reflection of the extent of improvement that was required to the provision of health and social care.

The following improvements have been achieved.

In response to the concerns identified by the Healthcare Commission, the strategic health authority established a multi-agency steering group, comprising advocates, carers, representatives from the external change team, the chief executives of the trust and PCTs, and the director of adult social care. The group oversees the development and implementation of action plans to improve the services, provided by the trust, for people with learning disabilities.

The change team has worked with the trust, the PCTs and Cornwall County Council and has made good progress, at strategic level, in developing action plans and introducing new structures for staffing (including joint appointments between health and social care). The team was originally appointed for six months but this period has recently been extended by the strategic health authority.

Detailed action plans have been developed for the assessment and treatment services, the supported living services and the services for children. These plans include the immediate actions that were required while the investigation was underway as well as the long term actions that would enable the services to meet best practice. The immediate actions were to ensure that people received services in acceptable environments and to significantly reduce the risk of abuse.

Cornwall County Council has completed community care assessments of every person who uses the trust's learning disability services. The information from these assessments will form the basis of 'person-centred' plans. Early indications are that a small percentage of people will require a care home placement. Information about a new process of self

assessment for carers has been distributed by the council to carers and relatives of people with learning disabilities. They have also been offered interviews with social workers by contacting them by telephone. Information from these assessments will be used to develop packages of care and will ensure that the needs of carers are taken into account when developing services. The council has agreed that it will give priority to meeting the cost of the community care needs of people with learning disabilities (who have undergone assessments during this investigation) in 2006/2007.

CSCI considered that the supported living services provided by the trust were being run as unregistered care homes. However, without appropriate assessments and 'person-centred' plans, it was not possible to determine each person's individual housing and care needs. The information available from the assessments completed by the end of March 2006 is now being used to develop 'person-centred' plans for each individual. The plans will determine their future needs for housing and care.

One ward at Budock Hospital has closed and the environments of the other two wards have been improved through re-decoration, the addition of soft furnishings, the introduction of a sensory room (which provides a range of auditory, tactile and visual stimuli), improvements to the courtyard, and the fitting of a new kitchen. The care provided within Budock Hospital has also improved. There has been an increase in the input from therapists, such as occupational therapist. The investigation team also saw improvements in interactions between staff and people using the trust's services. The trust has given a firm commitment to closing Budock Hospital, and ensuring that alternative suitable care is provided, by December 2006.

The environments within the supported living houses have improved. Some of the locked doors that the investigation team saw during earlier visits have been unlocked. The trust has been working with Paradigm, the organisation responsible for the development of the *Reach* standards, to develop an understanding among

staff of what constitutes a good supported living service. A number of staff have visited services in Liverpool to observe best practice. The trust has also reviewed compulsory and essential training for staff in its learning disability services and will introduce changes to ensure this training reflects the needs of those using services. Following the start of this investigation there has been a significant increase in finance training available to staff working in the supported living services.

A number of changes have now been made to improve processes for the protection of vulnerable adults. Cornwall County Council has appointed an additional member of staff to manage the investigations, action planning and record keeping in relation to the protection of vulnerable adults. The council has completely revised and reissued its procedures and recording standards in this area, and has retrained all care managers, general managers and administration managers. Additional administrative staff are available to help manage meetings about the protection of vulnerable adults, and recording is maintained in accordance with the revised standards. Recruitment of an independent chair for these meetings is underway. Governance for the protection for adults has improved as a result of a new detailed work plan for the adult protection committee. For the first time, social, health and probation services, and the police, jointly fund training.

The trust has now identified a senior manager with clear responsibility for the protection of vulnerable adults and has agreed that managers with responsibility for any service involved in an investigation under the protection of vulnerable adults scheme will not participate in the investigation. The chair of the trust holds fortnightly meetings to oversee the implementation of action resulting from these investigations. The trust now reports on a weekly basis on the progress of individual action plans for each referral under the protection of vulnerable adults scheme and any systemic issues identified from the referrals.

The leadership of the trust has been strengthened by the appointment of a new chief executive and the reallocation of responsibility for the learning disability service.

Since January 2006, the director of adult social care in Cornwall has chaired the learning disability partnership board. New reports and records have been introduced and are produced in an easy to read form. Six people from the new Get Real team are full members of the board and it is intended that one of these people will co-chair future meetings. County-wide elections were held to elect the Get Real team. The Get Real team, and its name, was requested by people with learning disabilities in Cornwall to identify suitable members for the learning disability partnership board.

In January 2006, the PCTs in Cornwall strengthened their arrangements for commissioning services for people with learning disabilities. There is now a chief executive with lead responsibility for commissioning and a director of commissioning representing the three PCTs in this regard. These positions are supported by a head of service improvement for learning disabilities and mental health services, and a service improvement manager specifically for learning disabilities. A continuing healthcare coordinator has also been recruited and will be involved in determining whether a person requires health or social care services. The three PCTs in Cornwall have committed additional funding of £2.29m for 2006/2007, through the local delivery planning process, to ensure that action plans for improving to the trusts' services for people with learning disabilities are delivered.

The department for adult social care in Cornwall Social Services established a commissioning and partnerships unit in September 2005, which employs four commissioning managers who commission services for people with learning disabilities. The commissioning and partnerships unit has made progress in a number of areas since its establishment.

In response to the trust having given notice of its intention to terminate its provision of the supported living services, the unit has prepared procurement programmes to commission new providers of services in Cornwall. The unit is also now responsible for chairing the weekly decision-making panel, which approves the relocation of, or new packages of care for, people currently residing in the trust's assessment and treatment units. The unit is involved in developing the programme of work for the learning disability partnership board as detailed in the *Valuing People* strategy, and taking forward the programme of modernisation of the trust's day services. The unit has recently formed a close working relationship with the service improvement team within the PCTs, as part of plans to develop a joint approach for the commissioning of health and social care services. This includes action to improve primary health care, access to general hospital care, integrated mental health services and special multi-disciplinary teams for people with learning disabilities. A nurse consultant has been recruited to lead the primary care and hospital work streams from the action for health framework and will also provide expert clinical advice to specialist services. The PCTs and the department of adult social care have jointly recruited the change director who will lead the service transformation.

A draft joint commissioning strategy for people with learning disabilities has been developed (available in an easy to read form) with all organisations represented on the partnership board. A housing strategy, which was originally presented to the learning disability partnership board in September 2003, is now being updated. An action plan for the strategy is also being developed. These projects are being led by the lead commissioner for learning disability services in the commissioning and partnership unit and the service improvement officer for learning disability services from the PCTs. However, the learning disability partnership board has overall responsibility for ensuring the development and implementation of these strategies

The Commissions do not underestimate the amount of work needed to achieve an adequate level of service for people with learning disabilities in Cornwall, but the progress reported above will go some way towards redressing the balance for those who have endured poor care and abuse.

Acknowledgements

The two commissions wish to thank everyone involved in this investigation for their help and cooperation.

Appendix A - The investigation team

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Support for the investigation team was provided by:

- investigation coordinator, Healthcare Commission
- analyst team, Healthcare Commission
- inspectors from the Commission for Social Care Inspection
- the external change team
- British Institute for Learning Disability
- Valuing People support team
- an external adviser

Appendix B - Interviews

The investigation conducted over 140 interviews. This includes face to face and telephone interviews. The following information is a breakdown of those interviewed.

Interviews at stakeholder events

Users of services

Relatives and carers

Current and former employees of the trust

Advocacy service representatives

Housing providers

NHS staff

Interviews with staff of the trust during site visits

The chief executive and executive/deputy directors

Chair and non-executive directors

Senior managers

Clinical middle managers

Team leaders

Senior support workers

Support workers

Therapy staff

Complaints staff

Community staff

Other interviews

Executive/directors from South West Peninsula Strategic Health Authority

Executive/directors from the local primary care trusts

Appendix C - Documents received and sources of information

A summary of the documents received by the Healthcare Commission while conducting the investigation is given below. More than 1,500 documents were submitted to the Healthcare Commission during the course of the investigation. The majority came from and related to:

- Cornwall Partnership NHS Trust
- East Cornwall Mencap Society
- Cornwall County Council
- other sources

Cornwall Partnership NHS Trust

Details/profile of the trust and its services – annual reports, structure charts including management structure and risk register

Staff policies, guidance and strategies. Minutes from staff meetings. Staffing figures and monitoring records. Staff rotas from selected sites, as well as grievance and disciplinary reports, job descriptions and staff handbooks

Minutes and some supporting papers from trust committees and group meetings - these include minutes from meetings of the trust's board, governance committee and audit committee, and reports from learning disability management meetings

Business, action, joint investment and modernisation plans

Details of incidents and complaints
Health action plans and records for people using the service

Tenancy agreements and correspondence with Comhome Limited

Correspondence between Cornwall Partnership NHS Trust and people who use services, advocates, carers and relatives

Details regarding training and information management

Minutes of engagement groups with people who use services

Minutes of operational groups – including the protection of vulnerable adults group, *No Secrets* steering groups, inpatient practice development group, adult inpatient steering group and acute care forum

Plans and documents, including HR files and internal investigation interview transcripts, relating to Budock Hospital

East Cornwall Mencap Society

Correspondence with people who use the trust's services, carers, advocates and relatives

Correspondence with Cornwall Partnership NHS Trust and Cornwall County Council

Cornwall County Council

Minutes of meetings of the Learning Disability Partnership Board joint investment plans and annual reports

Other sources

Numerous letters and information from stakeholders, relatives, carers and staff

Reports from external organisations

Minutes from Cornwall & Isles of Scilly Health and Social Care Community Local Implementation Team Mental Health Advisory and Implementation Group

The local district councils, Charter for People with Care needs in Cornwall 2005

Procedures and information from Oxford Learning Disabilities NHS Trust

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formats and languages on request.
Please telephone 0845 601 3012.

This publication is printed on paper made
from a minimum of 75% recycled fibre

ISBN 1-84562-102-6



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