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

Members will no doubt have heard of this investigation through media reports. Lynnda Roberts, NASHiCS Vice Chair presents a summary of the report and considers learning points for health and safety within the care service. The full report is available on the CSCI website.

Summary

In 2005, the Healthcare Commission and the Commission for Social Care Inspection (CSCI) investigated services for people with learning disabilities provided by the 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 centre and supported living services.

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 and other services. The investigators 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. These include:

- Reach Standards in Supported Living (Paradigm 2002)
- Services for People with Learning Disability and Challenging Behaviour or Mental Health Needs (Known as the Mansell Report). (Department of Health, 1992)
- No Secrets (Department of Health and Home Office 2000)
- Care Homes for Adults (18 – 65) and Supplementary Care Standards for Care Homes Accommodating Young People Aged 16 and 17 and Domiciliary Care: National Minimum Standards Regulations (Department of Health 2003).

The report identifies that many of the requirements of these documents were not put in place and that there were significant shortcomings in the arrangements for the assessment and care of people with learning disabilities.
More than two thirds of sites visited placed unacceptable restrictions on people living there. There was evidence of physical restraint being used and excessive use of pro re nata (PRN) medication to control unacceptable behaviour.

During the investigation the investigators referred 40 individuals under procedures for the protection of adults. The Trust’s failure to adequately address these referrals revealed systematic flaws in local procedures.

The investigation found that Cornwall County Council, as leading agency for protection of vulnerable adults, failed to adequately coordinate inter-agency arrangements.

Staff were not supported to deliver modern social care. Training was poor and not considered a priority. Those policies that did exist were not updated or reviewed.

There were serious deficiencies in record keeping.

The investigators produced two pages of key recommendations including:

- the appointment of specialists to lead the changes required
- the appointment of an expert in the protection of adults
- the strengthening of arrangements for commissioning services for people with learning disabilities.
- person centred assessments
- redesign of services to a person centred approach.

**What are the implications of the report for Safety Practitioners in Social Care?**

The report identifies that the delivery of person centred care has not been demonstrated to the investigators. Person centred care means that care providers have to make decisions about the care of individuals which reflects their desires, wishes, rights, choices and values.

It is everyone’s right to live as full and diverse a life as possible and this includes the taking of some risks and as safety practitioners in the field of social care we must give advice which is based on risk assessment and not risk aversion. Health and Safety advisers should encourage lateral thinking to enable service users and their carers to consider risky activities and to find ways to undertake those activities in as safe a way as practicable. We should never assume that a person cannot do something because of a disability. On the contrary, we should assume that they can until the risk assessment demonstrates that an activity carries too high a risk to the service user.

As services develop, this will inevitably mean changes to the traditional role of carers with a narrowing of differences between health care colleagues and social carers. Policies such as supervision of medication, personal care and risk assessment should reflect and support the changes in care provision.