Safeguarding Adults Review – Long Leys Court

Executive Summary

1 Why Lincolnshire Safeguarding Adults Board carried out a Safeguarding Adults Review

1.1 In June 2015, Lincolnshire Partnership NHS Foundation Trust notified Lincolnshire SAB of serious concerns about 12 adults with complex combinations of learning disabilities and mental health problems, some of whom also had physical health problems. The allegation was that they had been emotionally and physically abused while NHS inpatients of the Trust, at Long Leys Court, a 16-bedded assessment, treatment and rehabilitation unit where Lincolnshire Partnership NHS Foundation Trust provided all aspects of the care.

1.2 Further information gathering suggested that 43 additional adults at risk may have been subject to abuse whilst admitted to Long Leys Court. All 55 adults were reviewed against the Care Act criteria for Safeguarding Adults Reviews under section 44(4) of the Care Act 2014. 39 of their cases met the criteria and it was subsequently agreed that 12 out of the 39 individuals represented an appropriate cross-section of subjects for the review. The review was then commissioned. Long Leys Court closed to admissions for assessment and treatment in 2015.

1.3 Lincolnshire Police led a criminal investigation into a number of reported incidents which did not result in any professionals being charged with criminal offences.

2 The Safeguarding Adults Review and its terms of reference

2.1 A thematic approach was chosen for the review. This was because substantial work had taken place since 2015 to first of all make sure the adults were safe, then to establish the extent and nature of abuse and neglect at Long Leys Court, and thirdly to set up new governance arrangements. However, between 2011 and 2015, the Lincolnshire adult safeguarding system had not kept the adults at Long Leys Court safe, so the starting point for this review was to step back and reflect why this was so, and make recommendations to the Safeguarding Adults Board which could promote a safer system in the future.

2.2 The review covered October 2011 to October 2015. October 2011 was when the first of the 12 adults was admitted to Long Leys Court, and October 2015 was when the last five of the 12 moved to new placements.

2.3 The review set out to answer two questions:

What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe residential setting, free from abuse and ensuring they received good care and treatment?

How can Lincolnshire Safeguarding Adults Board promote a safeguarding system that delivers safe and person-centred care for this group of the county's residents in the future?

2.4 In order to get a full picture and help the independent reviewer address these questions, it was agreed that the organisations would analyse and reflect on the following five areas:

- Holistic practice, influence and effectiveness of the Multi-Disciplinary Team
- Commissioning and Regulatory Oversight (NHS England and the Care Quality Commission as well as NHS Clinical Commissioning Group for Lincolnshire)
- Deprivation of Liberty, Best Interests and restrictive practices
- Families, service users and Making Safeguarding Personal
- Culture, competence and attitudes towards reporting wrongdoing

2.5 Fran Pearson was, in line with the Care and Support Statutory Guidance, commissioned as suitably qualified to carry out this work and as suitably independent, having had no previous involvement with any organisations that are party to this review.

3 The adults and families at the centre of this review

3.1 The twelve adults were all from Lincolnshire, and they were all White UK residents. Seven were men and five were women. Their age span on discharge was 20 to 69 years old.

3.2 Five families contributed to this report. The rest felt they had already recounted very difficult experiences and feelings and preferred not to do so again. Those interviewed were clear that they were doing this because they wanted to reduce the chances of what happened to their loved ones happening to someone else. It is a huge 'ask' of these residents to go over, yet again, very painful events. Lincolnshire Safeguarding Adults Board would like to thank them for this and assure them that this report is more robust and credible for their input.

3.3 First of all, without minimising the abuse and neglect that 39 very vulnerable adults are now known to have experienced at Long Leys Court, the setting was also seen as positive by two out of the five families who contributed to this review. The other three families did

not feel positive about the care their relatives received. All three talked about their concern for the noticeably increased level of medication their family members were said to need on admission to Long Leys Court. Two of the three said that the one and only time their family members had ever cried was in Long Leys Court.

3.4 One father had found it a very hard decision to agree to his daughter's admission but concluded he had 'best give her a chance' of the recommended assessment and treatment there. All the families simply wanted the best care for their loved ones, but from observing their relative's behaviour, which they know down to the last detail, they still wonder and worry about what happened to them at Long Leys Court.

4 The national context of the time and its significance for this review; the context since

4.1 The period under review occurred during a time of unprecedented, and significantly increased, expectation about the duty of local partnerships towards adults with learning disabilities and complex health needs who were admitted to assessment and treatment units like Long Leys Court. In 2011, an undercover journalist exposed shocking abuse of adults with learning disabilities and complex health needs at Winterbourne View, a privately-run assessment and treatment unit in the south of England. The government responded with a series of reports, recommendations, and new processes, all of which were aimed at closing, or reducing to a minimum, reliance on assessment and treatment units. One new process central to the improvements was that of Care and Treatment Reviews (CTRs). "The Care and Treatment Review process is the quality assurance tool to enable the least restrictive environment, as close to the patients' homes / families as possible". Care and Treatment Reviews were introduced and implemented within Lincolnshire / Long Leys Court starting in November 2014.

4.2 In March 2014, there was a Supreme Court ruling of huge significance around deprivation of liberty in care settings. It had far-reaching implications for the health and social care sector in relation to Deprivation of Liberty Safeguards (DoLS) which ensure that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty.

4.3 In 2015 the Care Act came into force. The Act placed the principles of Making Safeguarding Personal at the centre of adult safeguarding although the principles and efforts to put them into practice predated the Act. Making Safeguarding Personal means safeguarding adults:

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety.

Key area 1

Holistic practice, influence and effectiveness of the Multi-Disciplinary Team

5.1 The multi-disciplinary NHS team at Long Leys Court was responsible for providing care and medical assessment and treatment to the adults admitted there, taking on that responsibility from other organisations at the point of admission and for its duration. This team consisted of:

- Staff on the unit, employed by Lincolnshire Partnership NHS Foundation Trust, some registered nurses, the majority non-registered workers, but all trained to work in an assessment and treatment centre
- Therapy staff – for example occupational therapists and speech and language therapists employed by the trust
- Psychiatrists and psychologists, again, specialists working with this group of adults at risk

As well as the NHS multi-disciplinary team, social care professionals from the local authority went into Long Leys Court on a regular basis. Local GPs were contracted to provide additional health services, and ambulance and police officers occasionally attended Long Leys Court in response to call-outs for their service. Advocates were commissioned to work with some of the adults there. This section focuses on the provision of care, and assessment of need, and seeks to understand why abuse and neglect could have occurred in this context.

5.2 The culture and 'feel' of the NHS multi-disciplinary team at Long Leys Court is described in the Individual Management Review by Lincolnshire Partnership NHS Foundation Trust.

> "The Multi-Disciplinary Team was seen to be inadequate in a number of reviews and reports scrutinised. These reflected 'professional polarisation', meaning that each professional practitioner would rely on their own professional identity and practice with no evidence of shared practice…
>
> The medical model of leadership and practice did not reflect Royal College of Psychiatrist standards and practice guidance during 2013-2015."

5.3 Local authority social care professionals were on the unit regularly and knew individual patients to varying degrees. The review looked into their role and influence in some detail and found that during admission, they did not have a defined role which in turn impacted on their feeling confident and influential. They did not witness any wrongdoing. When an adult with social care and support needs is living in the community, the local authority holds the responsibility for assessing their social care needs and developing a care package to meet those needs. However, on admission to Long Leys Court, as an in-patient facility commissioned by the NHS Clinical Commissioning Group, this responsibility transferred. They found it difficult to be influential given this sense of being peripheral combined with "[the] need to work within the medical model of delivery".

5.4 Overlapping issues allowed a polarised multi-disciplinary team to continue for too long. Adults with learning disabilities, mental health conditions and physical health needs are entitled to the best multi-disciplinary support for their physical health care too, under the concept of Parity of Esteem. NHS England summed this up in Everyone Counts as Making sure that health professionals are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of their mental health problem itself or because they don't get the best care for their physical health problems. The contract between the Clinical Commissioning Group and Lincolnshire Partnership NHS Foundation Trust in 2014-2015, therefore within the period under review, included that a minimum of 90% of all eligible rehabilitation patients were to have a physical health plan, and that all patients who had been in hospital for more than a year should have a physical health check at least annually. At the time, the CCG did not feel they had sufficient assurance on these indicators from Lincolnshire Partnership NHS Foundation Trust and together they agreed changes including the appointment of a Lead Nurse for Physical Healthcare. General Practitioners should have had an influential and effective role at Long Leys Court helping deliver physical healthcare, but accounts are that this did not work as a robust arrangement. There is no comparable arrangement now because service users register with a new GP if they do need to move away from their home and go into treatment and then re-register when they move back.

Key Area 2

Commissioning and Regulatory Oversight

6.1 At Winterbourne View the majority of residents were from outside the local area. The local system there did not log safeguarding incidents in a way which exposed their

extent or significance and the distant organisations who had placed the individuals did not follow them up with rigour. The governance task for the Lincolnshire safeguarding system in relation to Long Leys Court should have been less prone to these risks. This was because only a small proportion of those admitted there were from outside the county and therefore unknown to the local safeguarding system. However, this was not the case. South West Lincolnshire Clinical Commissioning Group led in commissioning the service but unlike abuse and neglect cases relating to some other assessment and treatment units, the individuals were their own patients, local people, not placed by other CCGs from outside the area. CCGs are responsible for ensuring that NHS commissioned services have effective safeguarding arrangements in place. The national regulatory body, the Care Quality Commission, also had a role at Long Leys Court, carrying out inspections to their agreed frameworks. Oversight in this review also covers the role of local partnership board arrangements to keep the group of residents at Long Leys Court 'in sight'.

6.2 When concerns about Long Leys Court surfaced in 2015, the Clinical Commissioning Group had no previous records of concerns there. The team within the CCG that should have been monitoring the adults at Long Leys Court during their NHS inpatient admission did not do so. The CCG's analysis of how this happened was that there was a lack of proactive understanding of role by the team in question. Lincolnshire Partnership NHS Foundation Trust responded to Winterbourne View with a Learning Disability Service Action plan (2012), updated in 2013. An email exchange of February 2013 records a member of LPFT staff sending the action plan to the local NHS commissioning manager at the Primary Care Trust, the predecessor organisation of the Clinical Commissioning Group) saying: " [X] mentioned to me that you would like a copy of our Winterbourne Action plan, please find it attached…".. It does not appear this was pursued.

6.3 When the Winterbourne View scandal broke, the Safeguarding Adults Board asked for immediate assurance about what was happening to adults in Lincolnshire. The assurance data included anonymised references to the twelve individuals who are the subject of this review. There was then a decision to locate system assurance with a particular partnership board - the Learning Disability Board (which became the Joint Commissioning Board). This review found that the expectation of this partnership was well-intended but not realistic because it lacked the ability to hold the wider system to account. This was another layer on top of the multi-disciplinary team issues and the CCG's shortcomings, which when put together, left those admitted to Long Leys Court at risk.

6.4 In 2011 and 2013, Care Quality Commission Inspectors concluded, using the inspection framework of that time, that all five standards they inspected against were 'met' at Long Leys Court. That the CQC's Mental Health Act monitoring visits and inspections of Long Leys Court did not uncover any extensive lack of compliance with the Mental Health Act, and the Commission's standards of the time were found to be met during two successive care inspections there, was not unusual in terms of their inspection findings about other in-patient units where neglect or abuse was in fact happening. Because NHS oversight in Lincolnshire between 2011 and 2015 was ineffective, there was nothing in terms of volumes of reported incidents or concerns about Long Leys Court to make the CQC think their own assessment was wrong.

Key Area 3

Deprivation of Liberty, Best Interests and restrictive practices

7.1 The adults who are the subjects of this Safeguarding Adults Review were variously:

- deprived of their liberty without proper authorisation;
- not always assessed under the Mental Capacity Act when they should have been;
- restrained including chemical restraint;
- and not always referred for advocates as required under either the Mental Health Act and the Mental Capacity Act during their admissions to Long Leys Court.

7.2 Family members were greatly concerned about the effects of medication their relatives were prescribed during admissions to Long Leys Court. The full report contains the detail of their reflections. The review set out to establish what the true picture was and why, in relation to restraint and deprivation of liberties, if professionals had cause for concern, these were not raised. Care and Treatment Reviews for the twelve adults who this review is about, were a tool that named inappropriate restraint for what it was. A June 2015 review of both Care and Treatment under Transforming Care, and the Care Programme Approach for a patient detained under the Mental Health Act, showed that staff used chemical restraint inappropriately. In addition, they did not use a direct observational tool which was designed to map and pre-empt behaviour that might otherwise have resulted in chemical restraint. The same Care and Treatment Review raised concerns about staff use of seclusion and the use of prone restraint, which was being used even when the Care and Treatment Review stated that it was not to be. The Lincolnshire Partnership NHS Foundation Trust confirms the documentation within the Trust of "inappropriate use of restrictive practice which includes

chemical restraint, seclusion and physical restraint outside that of good practice and national standards. Five of the cases identified [for this Safeguarding Adults Review] reflect evidence of poor practice in this context and abuse of a vulnerable adult". Social care practitioners meanwhile thought that changes to medication were often understandable and expected, given that one of the reasons for admission to Long Leys Court was that an individual's medication may no longer be having the intended effects. However, the reflection from their organisation was that they were not always in possession of explicit information about this and nor did they seek it.

7.3 The local authority concluded: "[T]he Mental Capacity Act should have been the primary focus for eight of the service users within this review. While MCA was followed there was no evidence of consistent, embedded practice in relation to this". An example of good practice, prior to one individual's planned admission from home to Long Leys Court, was led by the local authority practitioner. Information to the review tentatively suggested that practice around Deprivation of Liberty Safeguards improved for the adults at Long Leys Court as the local system worked through the implications of the 2014 rulings. Advocacy was generally provided when needed. However the cumulative effect of factors that might have protected individuals was not effective.

Key Area 4

Culture, competence and attitudes towards reporting wrongdoing

8.1 Part of the national context was that one nurse at Winterbourne View, appalled by the abuse he witnessed had his concerns ignored by management, only to raise them with the Care Quality Commission where no action was taken. There was a culture of bullying and harassment at Long Leys Court that made it all the more remarkable that one professional did report abuse there.

8.2 The Care Quality Commission recorded one whistleblowing report in relation to Long Leys Court, on 15th May 2014. A second independent review commissioned by Lincolnshire Partnership NHS Foundation Trust, in 2017 stated that a greater number of safeguarding allegations were passed on by LPFT to the local NHS commissioners than the trust's first independently commissioned report had suggested. The discrepancy remains unresolved, as does the contention that information was passed on from the local authority cannot be traced at the Clinical Commissioning Group. In all, the volume of reported concerns is inexplicably low given what subsequently was acknowledged to have happened at Long Leys Court. In relation to this, the NHS Clinical Commissioning Group, the local authority, and

Lincolnshire Partnership NHS Foundation Trust provided a joint statement to the independent reviewer. They are now able to say with confidence that things are different and all correspondence between their organisations about safeguarding concerns is logged appropriately by each of the three organisations.

8.3 Professionals, from the Clinical Commissioning Group and the local authority, did not witness wrongdoing at Long Leys Court. Those from the Clinical Commissioning Group were however at the time unfamiliar with the Safeguarding Board framework for professionals to escalate concerns using the step-by-step multi-agency process that has been in existence since 2014.

Key Area 5

Families, service users and Making Safeguarding Personal

9.1 Agencies reflected on their practice to 'make safeguarding personal' during the period under review and it makes for an uncomfortable read, as the concept was not a new one in 2011 to 2015. Learning disability services even prior to the publication of Valuing People in 2011, had been told by service users, families, and by government that higher value had to be placed on the views and wishes of adults with learning disabilities. If there was any doubt about this in Lincolnshire, then the context of 2011 onwards following Winterbourne View, was a mandate to the whole local safeguarding system to shine a light on Long Leys Court and ask how the views and wishes of patients and families were being valued.

Conclusions – What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe residential setting, free from abuse and ensuring they received good care and treatment?

10.1 That the abuse and neglect at Long Leys Court occurred in the years immediately following the national outcry over another assessment and treatment unit, Winterbourne View, is one of the most striking aspects of this case. Lincolnshire Safeguarding Adults Board's senior leaders' group was timely in asking questions about what the county response was in the light of Winterbourne View. Even more strikingly, they were given assurances about adults at risk with learning disabilities and complex mental health needs that included as part of the data, anonymised references to the twelve individuals who are the subject of this review. These assurances were given in 2013. By 2015 it was apparent

that a culture of abuse and neglect had existed at Long Leys Court while these 2013 assurances were being given.

10.2 Checks in each part of the wider adult safeguarding system in Lincolnshire that should have monitored and protected the adults at Long Leys Court between 2011 and 2015, did not work. Given that the majority of those adults admitted to the unit for assessment and treatment were all from Lincolnshire, the governance task for Lincolnshire SAB and all the other bodies listed above was arguably more straightforward than for parts of the country where the vast majority of residents were from outside the area. This makes the shortcomings in the system even more striking. The multi-agency governance was placed in a joint learning disability board that did not have the ability to hold the relevant organisations to account. Meanwhile the local oversight body, the Clinical Commissioning Group, was not carrying out its responsibilities. Some local perceptions about how best to involve the national regulator, the Care Quality Commission, may have added to this picture of governance that was falling short of what it should have been.

Recommendation 1

Lincolnshire Safeguarding Adults Board to use its "Dashboard" as a tool to identify any gaps in reporting of safeguarding concerns by the organisations involved in this review in relation to adults with learning disabilities, autism and mental health diagnoses.

12.2 By the end of 2020/2021: the LSAB should use its revised dashboard and audit process to probe safeguarding concerns data for the above cohort of adults. Numbers reported by Lincolnshire Partnership NHS Foundation Trust, the NHS Clinical Commissioning Group, and the local authority should match up. This would confirm the three organisations' assessments that they now have robust systems to identify risk and to accurately log shared safeguarding information for adults with learning disabilities, autism and mental health diagnoses. This action could then be closed down.

12.3 For 2021/2022 onwards: the LSAB to make sure there are clear processes for monitoring this information and putting it on the board's assurance programme.

Recommendation 2

Lincolnshire Safeguarding Adults Board will test out how organisations hear, and act upon, the voices of adults with learning disabilities, autism and mental health diagnoses, and the voices of their family carers.

12.4 In 2020/2021 LSAB to: implement its planned updates to the Making Safeguarding Personal Programme, which will include inviting a family member involved in one of the Boards' Safeguarding Adults Reviews onto the group that oversees this work.

12.5 For 2021/2022: Twelve months after the publication of this report, LSAB to conclude the actions for this recommendation by carrying out an audit on its Making Safeguarding Personal Programme and reporting the findings.

Recommendation 3

In order to embed work on Parity of Esteem between physical and mental health, Lincolnshire Safeguarding Adults Board should use the regular reports that come to the board on the local Learning Disability Mortality Review process to drive improvements in physical health care for adults with learning disabilities, autism, mental health diagnoses and complex needs.

12.6 In 2020/2021 LSAB to take a report from the Clinical Commissioning Group - first of all comparing local findings with those outlined in the Annual Report of the national Learning Disability Mortality Review Programme, and secondly, including recommendations on how relevant information from these sad cases where adults have died, can be applied to improve the health of others in this group through preventative work.

Recommendation 4

Commissioners of all the relevant services should provide Lincolnshire Safeguarding Adults Board with assurance that contracts, policies, and the Terms of Reference for relevant governance boards, are all fit for purpose in relation to adults with learning disabilities, autism, mental health diagnoses and complex needs.

12.7 In 2020/2021 the Chair of the Mental Health, Learning Disabilities and Autism Partnership Board is to attend the LSAB and present a report confirming how the recently updated Terms of Reference for that partnership board address the governance issues identified in this review, such as what goes through to LSAB from the partnership. The report should also include assurance on relevant policies and contracts so LSAB members can know that these explain the governance role of the Mental Health, Learning Disabilities and Autism Partnership Board. Once the report has provided the assurance, this action will be complete.

Recommendation 5

The Lincolnshire Safeguarding Adults Board to assure itself annually on the functioning of the multi-disciplinary team that supports adults with learning disabilities, autism, mental health diagnoses and complex needs living both inside and outside Lincolnshire.

12.8 In 2020/2021 this assurance to take the form of a report from the Mental Health, Learning Disabilities and Autism Partnership Board - to come to LSAB at the same time as, and linked to, the report referred to in Recommendation 4. The report should provide a commissioner-led assessment of how the system is working inside and outside the county; and of the quality of work between professionals from the local authority learning disabilities team and the Clinical Commissioning Group. It should include an assessment of how these teams make sure members of LSAB are sighted on the adequacy of protections for the group of adults that this review has been about.

12.9 For 2021/2022 onwards, this assurance could take the form of an annual report from the Mental Health, Learning Disabilities and Autism Partnership Board to LSAB and also be integrated into the LSAB annual audit programme.