Blackburn and District Trades Union Council

Response to the NHS England Consultation Document:

"Proposed redesign of learning disability and autism spectrum disorders (ASD) services in the North West"

(Closure of Calderstones specialist NHS service)

This is the response of Blackburn and District Trades Union Council to the NHS England Consultation Document: "Proposed redesign of learning disability and autism spectrum disorders (ASD) services in the North West".

Blackburn and District Trades Union Council is a local body of the Trades Union Congress comprising delegates from Trade Unions with members working or living in the Boroughs of Blackburn with Darwen and the Ribble Valley.

It is our view that the Consultation Document fails to provide a convincing argument for any of the options it outlines. It seems to us, moreover, that it fails in a broader sense to be fit for purpose in that it is largely lacking in any data or analysis on which to base its conclusions and that the range of options it offers are unduly restricted.

It is clear on this last point, for instance, that there are at least three additional options that should have been considered:

Option 3
Would see the retention of medium secure services at the Mersey Care Whalley site and the dispersal of low secure beds across the North West;

Option 4
Would see no or marginal change in the current level of provision on the site; and

Option 5
Would see an expansion of either, or both, low and medium secure services on the Mersey Care Whalley site.

The Consultation Document is confused or confusing when it refers to *"The Mersey Care Whalley site (formally known as Calderstones Partnership NHS Foundation Trust)"*. Calderstones Partnership NHS Foundation Trust incorporated facilities both at the Whalley site and elsewhere – at Scott House and Gisburn Lodge, for instance. It is consequently made unclear what the status of these latter is expected to be in the event of *"the closure of the Mersey Care Whalley site".*

The Consultation Document also appears to us to muddy the waters when it comes to the (brief) narrative given as to the history leading up to its conclusions.

The Mersey Care Whalley site (then known as Calderstones) closed as an in-patient residential hospital for people with learning disabilities in 1999. The residual facility at Whalley did accommodate a small number of people who were thought to demonstrate "challenging behaviours", but its main function became the provision of specialist low and medium secure accommodation for persons referred through the Mental Health Act. It seems to us to be misleading to portray what is now on site as *"England's last old long-stay learning disability hospital"* (how the NHS England website headlines this consultation).

In fact, the very title of the Consultation Document adds to the general atmosphere of misdirection and sleight of hand. What is particularly at stake here is less a *"Proposed redesign of learning disability and autism spectrum disorders (ASD) services in the North West*" than a question of

what medium and low secure facilities should be provided for people with learning disabilities as an alternative to the criminal justice system.

Had the headline accurately been *"NHS specialist unit to close despite recent multi-million pound investments"* it would have undoubtedly raised a greater number of eyebrows and provoked more intense scrutiny by politicians and public. Far from being "old" much of the Whalley site has been purpose built in the C21st:

Maplewood 1 (Low Secure) was built in 2002;

Woodview (Medium Secure) was built in 2007; and

Maplewood 2 and 3 (Low Secure and Personality Disorder) was built in 2013.

The Consultation Document says: *"The proposed model of care has been driven by the joint publication of 'Building the Right Support' with NHS England, the LGA and ADAS".*

It is our view, however, that "Building the Right Support" and its underpinning "Service Model" are not a particularly sound foundation on which to determine the level of capacity required to support that *"majority of the people who use the forensic services* (and who) *come into NHS care after contact with the legal system or prisons and are supported on a care pathway through secure services and on into community settings*"

The "Service Model" underpinning "Building the Right Support" says:

"Admission to ***secure inpatient services*** *should only occur when a patient is assessed as posing a significant risk to others. Often they will be detained under Part III of the Mental Health Act ('patients concerned in criminal proceedings or under sentence') and in contact with the criminal justice system, with or without restrictions from the Ministry of Justice. Some patients, however, may be detained in secure settings under Part II of the Mental Health Act where they pose an equivalent level of risk to others and this risk cannot be managed safely in less secure settings. For example, those who have been diverted away from the criminal justice system as a result of criminal justice agencies not taking the case through the courts, or discontinuing proceedings once it is seen that the person is already in hospital. In line with the Mental Health Code of Practice, only patients who require a combination of enhanced physical, procedural and relational security should be placed in secure services."*

"Building the Right Support" says:

1.8 Implementing this model, and giving people greater power over the services they use, will result in a significantly reduced need for inpatient care. We expect that as a minimum, in three years' time no area will need capacity for more than 10-15 inpatients per million population in clinical commissioning group (CCG) commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low-, medium- or high-secure services).

1.9 These planning assumptions will mean that, at a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed, and 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision. Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community. The change will be even more significant in those areas of the country currently more reliant on inpatient care. In three years we would expect to need hospital care for only 1,300-1,700 people where now we cater for 2,600. This will free up money which can then be reinvested into community services, following upfront investment."

Neither document provides anything to show that these "planning assumptions" are other than wishful thinking. Note also that "Building the Right Support" says that *"the bulk of change in secure care"* is expected to occur in low-secure, rather than medium secure, provision (section 1.9 p.6) – an odd ground on which to justify the idea that the urgent need is to close the *medium secure* facilities at the "Mersey Care Whalley Site" (the Consultation Document is prepared to envisage the continuation of some low secure provision at Whalley but not medium secure provision).

The basic underlying fact is that 95% of the 202 people using "Calderstones Partnership NHS Trust" inpatient services at the end of January 2015 were individuals detained under the Mental Health Act, who were referred not just from the North West but also from Yorkshire (Source: Calderstones Partnership NHS Trust website). If the argument being put forward is not that these people are being incorrectly detained, then nothing in either "Building the Right Support" or in the underpinning service model answers the key question of what *should be* the appropriate level of both medium and low secure service provision.

If we turn, however, to the evidence coming from real experience in the criminal justice system there are grounds to ask whether capacity, even at the current level, is not ***too low***.

The confidence shown by NHS England in its planning assumptions contrasts markedly with the concerns expressed by those looking at how people with learning disabilities interact with the criminal justice system, who find that the whole area is one fraught with difficulty because of a lack of basic data.

In its 2011 Report "Pathways to Unlocking Secure Mental Health Care" (which did not distinguish between secure non-prison facilities for those with mental health and those with learning disabilities) the Centre for Mental Health commented that: "*It is estimated that 30% of the new money that followed the past decade of mental health reform has gone into secure care, and yet the reform strategy of the time (the National Service Framework for Mental Health and the NHS Plan) was largely concerned with reforming community services. **It can be argued that investment in secure care in recent times has not been strategic and not been based on an understanding of need"** (our emphasis). "While the Centre is confident in the findings from this review, these have largely emerged from qualitative data. There is a gap in knowledge that needs to be filled in order for our recommendations to be realised.*

"The Centre recommends that a needs assessment be conducted that provides an understanding of the regional requirements across all tiers of security for all the groups described in the previous section. It is quite possible that much of the data that would inform the needs assessment already exists. The needs assessment should be a concurrent activity with the development of the frame-

work of guidance and quality standards for secure care as each activity will inform the other".

The Report found, meanwhile, that:

"Beyond the general policy statements relating to grave, serious and significant danger, secure services do not have a clear and consistent understanding of the profile of who should be treated in medium secure care. This leads to inconsistent decision making, potential inequity and higher costs. There is no national model of care and the services provided can differ dramatically by locality".

"A number of blocks exist in the system such as how services are commissioned, limited provision, and difficulties in providing adequate community care. This means that medium secure provision can be difficult to access and results in 'blocked beds'". And,

"A striking finding from this review is that the services on offer and the pathways available vary considerably across England. In some areas there appear to be well-developed pathways across all tiers of security and good links with prison in-reach, but in most areas accessing lower secure services can be difficult. It is clear to us that there ought to be informed by guidance and quality of standards and as much as possible equity of access to services across the country".

Government policy, at least as far back as 1990 (Home Office Circular No 66/90 "PROVISION POR MENTALLY DISORDERED OFFENDERS"), has been that *"wherever possible, mentally disordered persons should receive care and treatment from the health and social services"* rather than through the criminal justice system, and this has been taken to cover people with a learning disability. There has, however, been a recurrent concern that people with learning disabilities were being inappropriately kept in prisons, to their detriment and the detriment of the prisons themselves.

In 2007 the Prison Reform Trust published its "No One Knows" Report which concluded that:

- There was a vast hidden problem of high numbers of men, women and children with learning difficulties and learning disabilities trapped within the criminal justice system;

- 20-30% of offenders had learning difficulties or learning disabilities that interfered with their ability to cope within the criminal justice system; and

- these people were at risk of re-offending because of unidentified needs and consequent lack of support and services, were are unlikely to benefit from conventional programmes designed to address offending behaviour and were targeted by other prisoners when in custody.

Subsequently, the 2009 "Bradley Report" found that a new approach to dealing with mentally ill offenders and those with learning disabilities could prevent these vulnerable groups being caught in the revolving door of the criminal justice system. It could cut crime, improve health, reduce police and court workloads and free up prison places for serious and violent offenders.

The "Bradley Report" recommended, in particular, that;

- There should be better mental health screening on arrival at prison and urgent consideration given to including learning disabilities in the screening process. (pg 102); and

- The Department of Health should introduce a 14 day maximum wait to transfer prisoners with acute, severe mental illnesses to an appropriate health setting. A 2005 Department of Health audit had found that at any one time in the prison estate there are on average 282 prisoners waiting initial psychiatric assessment. The "Bradley Report" found the absence of timely assessments and a lack of specialist beds accounted for two-thirds of the delays. (pg 106).

For the current Consultation Document to be fit for purpose one would have expected it to demonstrate that sufficient progress had been made since "No One Knows" and the "Bradley Report" to justify a policy of closing low and medium secure alternatives to prison for people with learning disabilities. This could be done by showing both that people were being (or would be) diverted into appropriate alternatives and that the problems identified no longer manifest themselves within the criminal justice system.

Unfortunately, the Consultation Document does not do this. And the reason it does not do this may be that there is not an argument to be made for this case.

In respect of potentially appropriate alternatives, the Consultation Document offers vague plans rather than any specific developments.

The Consultation Document says on p9 that *"The Transforming Care Partnerships have agreed and are implementing plans which will be delivered over three years"*. On p10 it says: *"Central to the process proposed by the plan is that over the next three years there will be new, high quality, community based services for those with a learning disability and/or ASD. The plan envisages that, as these services are put in place, the requirement for low secure inpatient beds will reduce and some units may close altogether"*. On p12 it says *"The proposed model of care in low secure services has been discussed with commissioners and national leaders and has gained wide traction and acceptance as innovative, affordable and above all, centred on service users. More locally, over the last 18 months, there has been wide engagement with people who use services, families, carers and staff at sessions to help shape the detail of the proposal".*

If one looks, however, at what, for instance, the "Pan Lancashire Right Track Transforming Care Partnership" Plan *"Transforming Care in Lancashire For individuals with Learning Disability and Autism 2015"* actually says, the future is a lot less specific. The Plan provides a good detailed breakdown of the level of dependence on the Whalley site and a lengthy exposition of what, in theory, would replace it. As yet, however, it does not specify how many people discharged from the Whalley site will require some form of residential support or where and how this will be delivered. *"There should be exploration"* it says on p42 *"to consider alternative accommodation options and development of suitable housing solutions. Opportunity for Capital investments and optimising use of current property investments will need to be undertaken and continue to develop to meet demand"* – which is really just stating the obvious. On p34 the Plan says: *"Each authority needs to ensure that it has a range of appropriate accommodation options available to meet local needs and to make best use of the opportunities provided by personalisation to build flexible individualised models of support"*, which is a fine definition of principle – but it does not tell us anything about the extent to which such accommodation is either already in place, in the planning stage or just an appropriate thing to be on the ideal wish-list. The plan adds: *"There may be par-*

ticular complexities associated with the provision of appropriate local accommodation in relation to.......Supported living from forensic settings" – which again, is not something one would disagree with. The question is one of what precisely going to be put in place.

Though we have not looked at the Greater Manchester Plan in as much detail a quick reading suggests that it is even less specific. To a greater extent than Lancashire, Greater Manchester flag concerns that *"The availability of finance has a significant bearing on the pace of change, including the funding of dowries, whether recurrent or non-recurrent and the level they would be set at"* p49.

In respect of the actual ongoing experience that people with a learning disability have within the criminal justice system, the current reality is also less than encouraging.

In their Summer 2016 "Bromley Briefing", for example, the Prison Reform Trust reported that:

- *71% of transfers from prison to secure hospitals under the Mental Health Act between April to September 2015 took more than 14 days, the Department of Health's expectation"* (Source: House of Commons written question 18773). And:

- *"Prisoners with learning disabilities or difficulties are more likely than other prisoners to have broken a prison rule; they are five times as likely to have been subject to control and restraint, and around three times as likely to report having spent time in segregation"* (Source: Talbot, J. (2008) "Prisoners' Voices: Experiences of the criminal justice system by prisoners with learning disabilities and difficulties" - London: Prison Reform Trust).

In March 2015 HM Inspectorate of Probation and HM Inspectorate of Prisons produced the Report "A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system – phase two in custody and the community".

This Report did not specifically look at the issue of whether or not prisoners were being adequately or correctly identified as being more appropriate for low or medium secure clinical care. What it did reveal was a situation in which whether or not such issues would be addressed could be quite haphazard because systems were rarely in place to identify people with a learning disability in the first place:

"In the prisons we visited we were alarmed that there were extremely poor systems for identifying prisoners with learning disabilities; in one prison we were even told that they could not identify a single prisoner who had a learning disability. This lack of identification is unacceptable. Even where a learning disability was identified, it was not always sufficiently taken into account in prison processes such as behaviour management and anti-bullying measures; not surprisingly therefore, some prisoners with a learning disability told us about getting into trouble with staff or being bullied because of their learning disability. We are also concerned that little thought was given to the need to adapt regimes to meet the needs of prisoners with learning disabilities who may find understanding and following prison routines very difficult. As a result, prisoners with learning disabilities are at risk of having a much more difficult time in prison than those who do not".

Offenders with learning disabilities thus seem to be facing a double jeopardy. On the one hand, they may be inappropriately retained in prison because there has been no proper assessment of whether or not they should be referred to low or medium secure accommodation outside the criminal justice system. On the other, there is little account taken of their disability within the prison regime and they can consequently have an even tougher time than normal whilst in prison: *"Almost half of the prisoners in our sample said they had felt unsafe and a similar proportion had been on ACCT. Some prisoners described a sense of isolation as a consequence of feeling unable to manage the processes inherent to prison life, as well as the informal yet necessary reliance they had to place in both staff and prisoners to assist them. Some prisoners' poor experiences in making complaints and lack of advocacy during adjudication procedures was of particular concern following the changes to legal aid introduced by the Legal Aid, Sentencing and Sentencing of Offenders Act 2012. A large proportion of prisoners in our sample told us they had been subject to use of force or disciplinary procedures whilst in prison. The poor identification of prisoners with a learning disability meant that the use of such procedures was not subject to any degree of scrutiny".*

Unfortunately, the website "britainsnurses.co.uk" seems no longer to be in operation. It did, however, contain a moving report of a speech to the Florence Nightingale Foundation Conference by Learning Disability Nurse Lynsey Brown, about a project undertaken in three prisons. The reporter commented: *"my overwhelming feeling throughout the speech was embarrassment and disquiet. I described it to Lynsey afterwards as 'listening to someone talk about another country, that was completely failing the most vulnerable people and thinking how luck we are to live in the UK – and then realising she was talking about us'. Lynsey and her colleagues had spent six months on a pilot project, identifying and supporting individuals with learning disabilities. What they found was fundamentally shocking and highlighted little progress over the years, despite Lord Bradley's recommendations and the work done by Jenny Talbot and the Prison Reform Trust".*

Whilst such a situation prevails it surely cannot be right for NHS England to commit unilaterally to service closures of the sort proposed by the Consultation Document. We need to see an assessment of the need for low and medium secure facilities for people with learning disabilities that is part of a multi-agency review looking at all stages of the process of potential interaction with the criminal justice system and the Mental Health Act. Such a review should encompass clarification of the circumstances under which care and treatment from health and social care services should take the place of criminal justice system action, how an effective assessment system for people with learning disabilities could be established, what sort of support can be provided for people for whom prison remains the preferred option and how easy it is for people to access and to move between low and medium secure care as and when required. In the absence of such a review, and of any empirical content of equivalent status, the Consultation Document clearly fails to sustain the weight of the policy decisions it seeks to promote.

The Consultation Document seems to us to be flawed in its general argument. It also seems to us to be tendentious on points of detail.

We have already mentioned the inaccuracy of presenting the Mersey Care Whalley site as an "*old long-stay learning disability hospital",* when it is mainly a modern site that has received considerable C21st investment. The last tranche of £7m went on Maplewood 2 and 3, which opened in 2013. This was nominated for a BREEAM sustainable building award for its ultra-low energy us-

age. It was built and is run according to the most up to date NHS and Ministry of Justice guidelines and is 100% compliant with the latest specification for low secure accommodation set by the North West Secure Commissioners of learning disability services.

The consultation document states that the Mersey Care Whalley site is *"an institutionalised setting which is geographically isolated"*. It is quite willing, however, to see services delivered by the Alderley Unit - *"a new purpose built building"*. Our understanding is that the Alderley Unit was, in fact, opened before the Mersey Care Whalley site Maplewood 2 and 3 (in 2011) and that it is rather more open to the charge of "geographical isolation". It is also a residual part of an older site.

The Whalley site is easily accessible by public transport, with close rail and bus links to major population centres in the North West, and road connections to the motorway network. The Alderley Unit, on the other hand, is more difficult to access using public transport.

The flaws in the overall argument put forward by the Consultation Document, especially its failure to place the issues under consideration in the proper context of what is best required to support people with learning disabilities should they come into contact with the criminal justice system, and these parts of the package that seem, frankly, misleading serve to give cause for concern that there is an element distorting the whole process of policy formation that is not being fully disclosed. Surely it cannot be seen as acceptable management of public funds that a specialised unit should face closure when millions of pounds have been invested in it over the last two decades and when the social and clinical issues that it seeks to address appear to be very much still a matter of live concern (and may, indeed, be getting worse rather than better in light of the ongoing crisis within the prison system).

If there is a "hidden planet" distorting what we are allowed to see then we would not expect to be able to expose it with our limited resources and level of access. One finger of suspicion does, nevertheless, point at the investment decisions taken by the former Mersey Care NHS Trust regarding the movement of medium secure services from Scott Clinic to Maghull. The Consultation Document says on p11 that: *"A consultation has already been undertaken by Mersey Care in relation to its provision of medium secure mental health services".* The Consultation Document regarding the Maghull development is no longer available on the Mersey Care NHS Foundation Trust website, but what information does still reside appears to significantly weaken any implications that may be drawn from the quotation just cited.

Mersey Care's "consultation", it appears, was opened on 12th January 2015 – that is *after* a decision had already been made by the Trust to commit to the capital expenditure at Maghull. The "consultation" was a local affair, involving *"representatives from key partners and network groups. The initial events invited a wide range of key stakeholder organisations, local politicians, universities, hospital trust partners, clinical commissioners, legal and advocacy services, health interest groups, and members of the public".* It is difficult to imagine that it took on board the wider strategic and policy issues raised by the current consultation.

The development at Maghull is to be sited next to Ashworth High Security Unit and HMP Kennet. It is hard to enter into the aesthetic imagination of anyone who would condemn the leafy Mersey Care Whalley site as an "*institutionalised setting*" by comparison. Be that as it may, the critical point would appear to be that Mersey Care NHS Trust committed to this development without

having the future "business" to back it up. At the Mersey Care NHS Trust "Performance and Investment Committee" held on 17th December 2013 (minutes received by Trust Board on 27.03.2014), for instance, it was reported under Item A4 a) that: *"Mr Walker confirmed that he and Mr Smith had recently met with regional commissioners who were content with the movement of medium secure services from Scott Clinic to Maghull* ***but could not commit to the proposed increase in bed numbers"*** (our emphasis).

Whilst this was going on the Calderstones Partnership NHS Trust was serenely confident of its own future as a specialist provider and was being given a Financial Risk Rating of 4, the best available, by NHS England. Within the course of a couple of years it was to be recast as a financial and clinical disaster area.

Was that all down to Mersey Care NHS Trust going out on a limb on the hunch that because it was responsible for Ashworth NHS England would ultimately be forced into policy positions that would rescue it?

At the end of the day it should not matter who manages the Whalley site. There are grounds for feeling that both the "extra" beds at Maghull and all the existing provision at the Whalley site will be needed. We can only hope that when the issues raised by this consultation are examined a solution emerges that protects all the specialist services on offer until such a time as they can genuinely be regarded as surplus to requirements.

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