

**'Six Lives: the provision of public services to people with learning disabilities' - BILD welcomes 'an honest report' but has doubts about how real change will be made to happen for people with a learning disability**

An independent report, 'Six Lives: the provision of public services to people with learning disabilities', was published 24<sup>th</sup> March by the Health Service and Local Government Ombudsmen. Focusing on investigations into the deaths of six individuals, it calls for an urgent review of health and social care for people with learning disabilities. The report revealed:

- Significant and distressing failures in service across health and social care;
- One person died as a consequence of public service failure. It is likely the death of another individual could have been avoided, had the care and treatment provided not fallen so far below the relevant standards.
- People with learning disabilities experienced prolonged suffering and poor care, and some of these failures were for disability related reasons;
- Some public bodies failed to live up to human rights principles, especially those of dignity and equality;
- Many organisations responded inadequately to the complaints made against them which left family members feeling drained and demoralised.

'To improve healthcare for people with a learning disability only requires some simple changes' says Keith Smith, BILD Chief Executive, 'but moving to a situation where all people, whatever their communication needs, are treated with dignity, respect and as equal citizens may take nothing short of a major change in mindset and approach. As the report shows, an underlying culture which values human rights was not in place in the experience of most of the people involved. We question whether all NHS and social care organisations in England have the necessary understanding of positive ways to support people with learning disabilities and their families without significant external support. It appears to be the case that when people can't use words to communicate, our health services struggle'.

'The report calls for those responsible for the regulation of health and social care services to review and assure that health and social care organisations are meeting their statutory and regulatory requirements in relation to the provision of services to people with learning disabilities', said Keith Smith, 'but BILD is concerned that the new Care Quality Commission, starting on 1 April, will not be able to respond effectively as it is still in the process of merging the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission; how is it going to do that?'

The report was a response to complaints brought by Mencap on behalf of the families of six people with learning disabilities who died whilst in NHS or local authority care between 2003 and 2005. The cases of Mark Cannon, 30; Warren Cox, 30; Edward Hughes, 61; Emma Kemp, 26; Martin Ryan, 43 and Tom Wakefield, 20 and were brought to public attention in Mencap's 2007 report *Death by Indifference*. BILD would like to congratulate Mencap and the families for an important campaign that has brought these issues to the fore and should go on to make real change happen.

Speaking about the *Six Lives* report, Ann Abraham, Health Service Ombudsman for England said: "The recurrence of complaints across different agencies leads us to believe that the quality of care in the NHS and social services for people with learning disabilities is at best patchy and at worst an indictment of our society.

As the report makes clear, 'Our investigation illustrates some significant and distressing failures in service across both health and social care, leading to situations in which

people with learning disabilities experienced prolonged suffering and inappropriate care. We also found in some cases that the public bodies concerned had failed to live up to human rights principles, especially those of dignity and equality’.

The report highlights the areas of concern thrown up by its investigation including:

- Communication
- Partnership working and co-ordination
- Relationships with families and carers
- The failure to follow routine procedures
- Quality of management
- Advocacy

The Ombudsmen make three key recommendations:

First, that all NHS and social care organisations in England should review urgently and report accordingly to those responsible for the governance of those organisations within 12 months for:

- the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas; and
- the capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities;

Secondly, that those responsible for the regulation of health and social care services (specifically the Care Quality Commission, Monitor and the Equality and Human Rights Commission) should satisfy themselves, individually and jointly, that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory requirements in relation to the provision of services to people with learning disabilities; and that they should report accordingly to their respective Boards within 12 months of the publication of the Ombudsmen’s report.

Thirdly, that the Department of Health should promote and support the implementation of these recommendations, monitor progress against them and publish a progress report within 18 months of the publication of the Ombudsmen’s report.

*Six Lives: the provision of public services to people with learning disabilities* can be downloaded [here](#).