Department of Health & Social Care

From Helen Whately MP
Minister of State for Care

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Your Ref: 13020/CH
Our Ref: PFD-1198676

Ms Alison Mutch OBE
HM Senior Coroner, Manchester South
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

28th April 2020

Dear Ms Mutch

Thank you for your letter of 17 December 2019 to Matt Hancock about the death of Lewis Mendelson. I am replying as Minister with portfolio responsibility for learning disabilities and I am grateful for the additional time in which to do so.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Mendelson's death. It is important that we take the learning from Mr Mendelson's death to ensure that people with learning disabilities receive the highest quality care that meets their needs.

I am deeply concerned to read in your report that Mr Mendelson was not assigned a social worker and an annual review of his care was not conducted by the Stockport Metropolitan Borough Council. This is the second Prevention of Future Deaths report received by the Department where Manchester South coroners have raised concerns that annual care reviews have not been conducted by Stockport Council as required by law. This is clearly unacceptable and I expect Stockport Council to look into this matter thoroughly.

The Social Care Act 2014[1] is clear that local authorities should carry out regular reviews of care plans. The guidance states that:

> "*without a system of regular reviews, plans could become quickly out of date meaning that people are not obtaining the care and support required to meet their needs. Plans may also identify outcomes that the person wants to achieve which are progressive or time limited, so a periodic review is vital to ensure that the plan remains relevant to their goals and aspirations.*" [2]

Local authorities should establish systems that allow the proportionate monitoring of both care and support plans to ensure that needs continue to be met.

[1] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#Chapter13

There are several different routes to reviewing care and support plans. These include:

- A planned review, the date for which is agreed with the individual during care and support, or support planning, or through general monitoring;

- An unplanned review, that results from a change in needs or circumstance that the local authority becomes aware of, e.g. a fall or hospital admission; and,

- A requested review, where the person with the care and support, or support plan, or their carer, family member, advocate or other interested party makes a request that a review is conducted. This may also be the result of a change in needs or circumstances.

It is the expectation that local authorities should conduct a review of the plan at least once every 12 months, although a light touch review should be considered six to eight weeks after agreement and sign-off of the plan and personal budget, to ensure that the arrangements are accurate and there are no initial issues to be aware of. This light-touch review should also be considered after revision of an existing plan to ensure that the new plan is working as intended.

Councils are accountable to their local populations and that includes accountability for meeting their statutory duties under the Care Act 2014.

If an individual is unhappy with the care arranged by a local authority, they can make a complaint using the local authority complaints process. If they remain dissatisfied, they can seek assistance from the Local Government and Social Care Ombudsman.

In relation to Deprivation of Liberty Safeguard (DoLS), we recognise that the current DoLS system is bureaucratic and inefficient and that it fails to provide vital safeguards to people who lack capacity to consent to their care and treatment arrangements.

As a short-term solution, the managing local authority can use an urgent authorisation while also making a request for a standard authorisation. Looking forward, the Mental Capacity (Amendment) Act (2019)[3] introduced Liberty Protection Safeguards (LPS), that are planned to replace DoLS in October 2020. LPS will provide protections for individuals in a more streamlined and focused way. Each application will take the responsible body less time to process and more people will be provided with safeguards than under DoLS.

We are aware that social worker support is not always as available as it should be for people across our health and care system, leading to health inequalities and poor outcomes for people. Social workers have a professional duty and an accountability not just to tackle these health inequalities but to lead solutions and protect people's rights. That is why the Chief Social Worker for Adults in the Department of Health and Social Care is leading work in Government, with our systems partners, the wider public and crucially, experts by experience, to develop social work and social care practice in this critical area.

[3] http://www.legislation.gov.uk/ukpga/2019/18/enacted

To support local authorities, we are providing councils with access to an additional £1.5billion for adults and children's social care next year. This includes an additional £1billion of grant funding for adults and children's social care, and a proposed 2 per cent precept[4] that will enable councils to access a further £500million for adult social care. This £1.5billion is on top of maintaining the £2.5billion of existing social care grants and will support local authorities to meet rising demand and continue to stabilise the social care system.

For Stockport, this means that the Council is set to receive an additional £4.8million from the new Social Care Grant and the Council could raise up to £3.6million of additional funding specifically for adult social care in 2020/21 following the introduction of the precept[5]. In addition, Stockport Council will receive £11.6million of funding through the maintenance of the existing Adult Social Care grants in 2020/21. Future funding for social care will be set out at the next spending review.

I share your concern that no best interests' meetings were held to consider Mr Mendelson's care in hospital. While a formal best interests meeting is not a duty, under section 4 of the Mental Capacity Act (2005)[6] (MCA) the decision maker must take into account, if it is practicable and appropriate to consult them, the views of anyone named by the person as someone to be consulted, anyone engaged in caring for the person or interested in their welfare, any person with lasting power of attorney or a deputy appointed by a court.

The person at the centre of the authorisation should also be consulted and the Code of Practice recommends that all possible and appropriate means of communication should be tried. A best interests meeting may be required if there is a dispute or a decision is required concerning a long-term move or serious medical treatment. Section 4 (9) of the MCA confirms that if someone makes a decision which they reasonably believe is in the best interests of the person who lacks capacity they will have complied with the best interests' principle set out in the Act.

In relation to an Independent Mental Capacity Advocate (IMCA) for Mr Mendelson, under the MCA an IMCA must be instructed and consulted for people lacking capacity to consent to their care and treatment when an NHS organisation is proposing to provide serious medical treatment. The MCA Code of Practice[7] provides guidance on when an IMCA should be instructed. I am advised that it is currently under review by the Ministry of Justice and consultation is planned. The revised Code will improve protections for the person at the centre of the authorisation and ensure that their wishes and feelings are considered.

Turning to the wider aspects of your report, you may wish to note that in 2015, the Government established the Learning Disabilities Mortality Review (LeDeR) Programme.

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[4] https://www.gov.uk/government/speeches/provisional-local-government-finance-settlement-2020-to-2021-statement

[5] This projection includes a small proportion of base tax rate growth.

[6] http://www.legislation.gov.uk/ukpga/2005/9/section/4

[7] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

The Programme systematically reviews the deaths of all people with a learning disability, aged four years and above, that are notified to it. The Programme enables a detailed picture to be built of key improvements that are needed both locally and at a national level, to reduce the inequality in life expectancy between people with a learning disability, and those without.

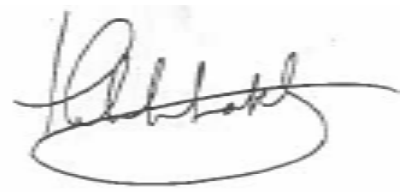
I am advised by NHS England and NHS Improvement that Mr Mendelson's death is currently being reviewed under the LeDeR process and I expect the local NHS to reflect on the findings of the review and take necessary action to address any failings in the care provided locally for people with a learning disability.

One of the commonly reported learning points in local LeDeR reviews is the need for learning disability awareness training for staff in health and social care settings.

On 5 November 2019, we published our response to the consultation on mandatory learning disability and autism training for health and care staff[8]. We are now working with Health Education England and Skills for Care to develop and test, during 2020/2021, a standardised training package, backed by £1.4million investment. Work is already underway to develop the training and testing will take place in a variety of health and social care settings to help shape how it will be rolled out and delivered in future. Our plans to introduce mandatory training will go a long way to ensuring more people receive the safe, compassionate and informed care they have a right to expect.

Finally, I have asked officials to bring your report to the attention of the National Director for Learning Disabilities, Ray James, who is leading work nationally to improve services for people with learning disabilities and/or autism.

I hope this response is helpful. Thank you for bringing these concerns to my attention.



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[8] https://www.gov.uk/government/consultations/learning-disability-and-autism-training-for-health-and-care-staff