Department of Health & Social Care

From Helen Whately MP
Minister of State for Care

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Your Ref: 9341/RD
Our Ref: PFD-1199776

Chris Morris
HM Area Coroner, Manchester South
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

28th April 2020

Dear Mr Morris

Thank you for your letter of 3 January 2020 to Matt Hancock about the death of James Wheeler. 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 Wheeler's death and I offer my most heartfelt condolences to his family. It is important that we take the learnings from Mr Wheeler's death to ensure that people with learning disabilities continue to receive the highest quality care that meets their needs.

I am deeply concerned that the inquest into Mr Wheeler's death found that annual reviews of his care were not conducted as required by the Social Care Act 2014[1]. I am equally concerned at the suggestion in your report that Stockport Metropolitan Borough Council social services may not be carrying out annual reviews of care apart from under exceptional circumstances. I expect Stockport Council to look into this matter thoroughly.

The Social Care Act 2014[2] 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 "*without a system of regular reviews, plans could become quickly out of date meaning that people are not obtaining the care and support required to meet their needs.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.*" [3]

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

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

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

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

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.

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.

[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.

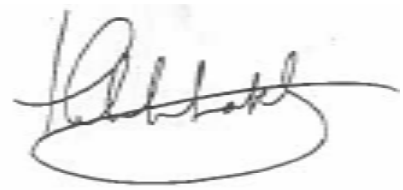
Reflecting on the wider aspects of your report, you may be aware that in 2015, the Government established the Learning Disabilities Mortality Review (LeDeR) Programme. The Programme systematically reviews the deaths of all people with a learning disability, aged four years and above, that are notified 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 a LeDeR review is currently being conducted into the circumstances of Mr Wheeler's death. I am clear that the local NHS must reflect on the findings of the review and take necessary action to improve services locally for people with a learning disability. I have also asked officials to bring your report to the attention of the National Director for Learning Disabilities, [redacted], who is leading work nationally to improve services for people with learning disabilities and/or autism.

Finally, I am advised that following notification of Mr Wheeler's death, the Care Quality Commission (CQC) brought forward a planned comprehensive inspection of Cheddle Lodge, Stockport. The inspection looked at the safety of equipment and processes. The report of the inspection undertaken in March 2018 is available on the CQC website[6].

The CQC identified four breaches of Regulations and the facility was rated Requires Improvement overall. I am advised that Cheddle Lodge was re-inspected in October 2019 and the CQC found the facility to be compliant with the Regulations and received a rating of Good overall.

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



HELEN WHATELY

[6] https://www.cqc.org.uk/location/1-113087594/reports