Summary

Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust

January 2007
The Healthcare Commission

The Healthcare Commission’s full name is the Commission for Healthcare Audit and Inspection. It exists to promote improvements in the quality of healthcare and public health in England. We are committed to making a real difference to the provision of healthcare and to promoting continuous improvement for the benefit of patients and the public.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and has taken over some responsibilities from other Commissions. It:

• has replaced the Commission for Health Improvement (CHI), which ceased to exist on March 31st 2004
• has taken over responsibility for the independent healthcare sector from the National Care Standards Commission, which also ceased to exist on March 31st 2004
• carries out the elements of the Audit Commission’s work relating to the efficiency, effectiveness and economy of healthcare

We have a statutory duty to assess the performance of healthcare organisations, award annual ratings of performance for the NHS and coordinate reviews of healthcare with others.

We have created an entirely new approach to assessing and reporting on the performance of healthcare organisations. Our annual health check examines a much broader range of issues than in the past, enabling us to report on what really matters to those who receive and provide healthcare.

Investigating serious failings in healthcare

The Healthcare Commission is empowered by section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003 to conduct investigations into the provision of healthcare by or for an English NHS body.

We will usually investigate when allegations of serious failings are made, particularly if there are concerns about the safety of patients. Our criteria for deciding to conduct an investigation are available on our website at www.healthcarecommission.org.uk

In investigating allegations of serious failings in healthcare we aim to help organisations to improve the quality of care that they provide, to build or restore public confidence in healthcare services, and to seek to ensure that care provided to patients is safe throughout the NHS.

The Healthcare Commission is responsible for this report, and for ensuring that Sutton and Merton Primary Care Trust publish an action plan in response to this investigation. The action plan will be available on the Healthcare Commission’s website. The London Strategic Health Authority and the Healthcare Commission’s regional team for London will be jointly responsible for monitoring the implementation of the actions that have been agreed.
Executive summary

On February 8th 2006, the Healthcare Commission decided to investigate the service provided for people with a learning disability at Sutton and Merton Primary Care Trust (the PCT). The chief executive of the PCT had contacted the Healthcare Commission in January 2006 and requested that an independent investigation be carried out following a number of serious incidents in its learning disability service, including allegations of physical and sexual abuse. The request was supported by the South West London Strategic Health Authority. The aim of the investigation was to establish whether the ways of working at the PCT were adequate to ensure both the safety of people using the service and the quality of the service provided.

The Healthcare Commission examined the quality and safety of care at Orchard Hill Hospital, the community homes in Sutton and Merton, and at Osborne House in Hastings. Orchard Hill Hospital is one of the last hospitals to close where people with learning disabilities have lived for a long time; two judicial reviews delayed closure. The investigation also explored how the PCT worked with people with learning disabilities, their carers and their families, including how they were involved in decisions relating to care and treatment. Governance, management and leadership arrangements were also examined.

The investigation team comprised members of staff from the Healthcare Commission and external advisers, including a person with a learning disability and a representative from the Commission for Social Care Inspection (CSCI). The British Institute for Learning Disabilities (BILD) and the Department of Health’s Valuing People team also provided advice to the investigation team. In addition, the Healthcare Commission set up an external reference group to ensure a broad range of expert advice was received. Evidence was collected from interviews, analysis of documents, relatives and carers, visits and observations and a review by BILD.

Findings about the quality of care

The Healthcare Commission examined the houses that people lived in and the way in which care was delivered to 184 people with learning disabilities at the PCT. This included looking at the model of care provided, relevant national policies, best practice and whether care was based on the needs of individuals. We found that the model of care was largely based on the convenience of the service providers rather than the needs of individuals. For example, during meal times some people’s shoulders were wrapped in a large sheet of blue tissue paper, and they were then fed at a speed that would not allow for any enjoyment of the food.

The overall provision of activities was very low, with some people having only three to four hours of activity a week. The majority of activities were provided at Orchard Hill Hospital and many people came back to the hospital for GP, dental and chiropody services. They did not have the opportunity to gain access to the full range of healthcare in the community.

There were some examples of good practice regarding the quality of care, such as people living in smaller groups at Osborne House and people being taught how to make a cup of tea at the Woodlands Centre. However, most of the houses people lived in were unsuitable, with particular difficulties for people with mobility problems requiring wheelchairs and hoists. The

environmental constraints and the ways of working meant that the privacy and dignity of individuals were sometimes compromised.

Staff endeavoured to meet the healthcare needs of people for whom they were responsible but their efforts were compromised by lack of training and lack of specialist contribution from speech and language therapists, psychologists and physiotherapists.

Findings about services for people with behaviour that challenges

In the two houses for people with behaviour that challenges we found that there was a lack of regular staff and that staff had limited expertise. There was also evidence of rigid routines, a deprived environment with a lack of individualised care and insufficient meaningful occupation of time.

In these houses, staff did not report all incidents where the safety of people for whom they were responsible was compromised. There was no policy on the use of restrictive physical interventions and restraint. Although many staff believed that they were not using restraint, our observations and records demonstrated otherwise. Restraint was used inappropriately at times when it should have been used as a last resort. There was no system for monitoring the use of restraint. One woman had experienced a form of restraint for many years, where a splint on her arm was used to prevent movement in order to stop her putting her hand into her mouth. The psychology department did not believe that the continued use of this restrictive intervention was justified. Following a clinical review in February 2006 it was agreed to remove the splint for 30 minutes a day and for staff to observe behaviour. This plan of care has progressed to the splint being used for only three hours a day.

Findings about serious incidents

The investigation team examined 15 serious incidents that occurred in the learning disability service between December 2002 and November 2005. These were incidents of sexual and physical abuse including one incident when a woman with learning disabilities was raped. Many staff reported being shocked and saddened by the incidents. They said that morale had been adversely affected and some staff felt ashamed to say where they worked.

The local authorities of Sutton, Merton and East Sussex each had arrangements for the protection of adults less able to look after themselves and although they differed slightly they were based on the same principles and the policies met the national requirements. The majority of the reviews of serious incidents followed the correct procedures for the protection of adults less able to look after themselves. However, in some cases there were weaknesses in the implementation of the procedures such as poor communication, lack of staff awareness about adult protection, and poor follow-up of actions agreed at meetings.

Findings about short break care for children with learning disabilities

Short break care (also known as respite care) was provided to children and young people with a learning disability in a bungalow in Sutton. We considered this to be unsuitable because the rooms in it were too small. Although the Healthcare Commission had not been made aware of any specific concerns about the short break unit, it was considered important to find out whether the children had been appropriately cared for in what was predominantly an adult service. Prior to November 2005 there was little communication between the PCT’s learning disability service and the PCT’s children’s service about the short break unit. The Sutton team for adults with a learning disability was providing a service to some children in a local school that was not subject to proper contracts or properly funded. However, a comprehensive independent audit had been carried out at the short break unit during January and February 2006 at the request of the head of the children’s service.
and changes were being implemented in response to the findings.

There were inadequate arrangements in place to support staff working in the children’s short break unit until management responsibility was transferred from the learning disability service to the children’s service in November 2005. There were insufficient staff to ensure that children and young people could participate effectively in community activities, the roles of staff were unclear and staff were unable to give sufficient time to caring for and supporting children and young people.

Findings about how people influenced the provision of care

The investigation found that person-centred plans as described in Valuing People only existed for the minority of people. Most people did have some sort of plan for their care, although there was little evidence that these were reviewed regularly.

There was no provision of advocacy in the community houses with the exception of one house in Sutton. Relatives and carers were concerned about the future but said that they were generally satisfied with how the service was being delivered. Relatives wanted people to have more activities, especially in the evenings and at weekends. Few relatives had complained, yet there was little evidence that they were provided with information about how to complain.

Communication with people with learning disabilities was poor. Few staff had effective communication skills and the potential for people to communicate in different ways was not developed. A quote from the records of one person stated: “staff do not require communication training because the client does not speak”. This demonstrates an extremely poor level of understanding and does not acknowledge that those who do not use spoken language may have other ways of communicating.

Findings about arrangements for governance

To promote safe ways of working, the systems of governance of an organisation should ensure that there are sufficient staff in post to support the needs of the individuals to whom they are providing a service. Those staff must have the right training and opportunities for development and the right supervision and appraisals. There should also be good systems for the management of risk.

We found that, historically, staffing levels were low, with a reliance on temporary NHS and agency staff, and there were high rates of sickness and unfilled vacancies. There was poor attendance at mandatory training and insufficient investment in the development of staff. Supervision was not being carried out effectively and many staff had not had an appraisal, a situation which the PCT was not monitoring.

Insufficient action had been taken to address and manage risks that had already been identified. There had been an increase in reported incidents but the total number was still low. Policies and procedures were not systematically reviewed or effectively disseminated to staff.

A committee in the learning disability service provided staff with a forum to meet and share issues about the quality of the service, but its effectiveness was limited because issues identified did not always reach the governance committee, or the PCT’s board. Prior to 2006, reports to the board focused on the two judicial reviews previously referred to, and the hospital replacement programme, not the overall quality of the service.

Findings about management and leadership

Our investigation found that home managers did not have time to manage effectively due to historically low staffing levels. There were some examples of good practice by home
managers and modern matrons but neither group was seen to champion services for people with learning disabilities. The roles and responsibilities of modern matrons were not clear to staff.

Other PCTs that commissioned services at the hospital had concerns about the quality of care and the length of time taken to redesign the service. Partnerships were in place with Merton Local Authority and were also being developed with Sutton Local Authority. The strategic health authority’s monitoring of the quality of services provided to people with learning disabilities was not sufficiently robust. There remains a high level of concern about whether new services can be provided for people at Orchard Hill Hospital and at Osborne House by the target dates of 2009 and 2010 respectively, because of the limited management capacity and the insecure financial arrangements.

Conclusions

Institutional abuse occurs when the rituals and routines of a service result in the lifestyles and needs of individuals being sacrificed in favour of the needs of the institution. This abuse was found to be prevalent in most parts of the learning disability service. Most people were unable to go out into the community most of the time. There was an extremely low level of activities on offer and even people who were based in the community did not participate in community life but returned to the hospital for healthcare or day activities. This type of institutional abuse was largely unintentional but it is abuse nevertheless. It was mainly due to lack of awareness, lack of specialist knowledge, lack of training and lack of insight. It was exacerbated by low morale among staff, shortages of staff, inadequate supervision and a lack of leadership. Most environments that people lived in were unsatisfactory with inadequate access for disabled people, poor decoration and furnishings, and insufficient space in bathrooms for hoists.

The way that short break care was provided was unacceptable as individuals requiring short breaks would be placed for a few days or weeks with other people who had lived together in a house for many years. This took up a lot of staff time and meant that the needs of people who had lived there for many years often took second place. For example, one person requiring short breaks had behaviour that challenged, and as a result of that behaviour other people living in that house stayed in their bedrooms for long periods because they were frightened.

There were serious deficiencies in record-keeping. In particular, the requirement for people to have a person-centred care plan based on the principles of Valuing People was not adequately met. The care plans that did exist were often not up to date and there was little evidence of regular reviews of these plans. Some people had plans called health action plans. However, the review by BILD found that, although some of these were comprehensive and detailed, they did not meet the requirements of Valuing People. Instead, the plans were focused on maintaining people’s health rather than focusing on improving people’s lives.

The overall model of care provided by the learning disability service was one that promoted dependency. There was little evidence of clinical effectiveness or up to date practice, based on relevant clinical and social research. The culture was such that staff concentrated on what people could not do rather than on what they might be able to do. Staff were also very apprehensive about trying new ways of working that might represent a risk to the individual. Generally, people with learning disabilities were not supported and encouraged to develop new skills, which can sometimes be achieved by taking therapeutic risks based on an agreed plan of care.

We found that there was inadequate specialist support for people with behaviour that challenges. For three years, the psychologist had repeatedly asked for more resources but had not been supported in this request. Due to
In the absence of a policy about restraint and lack of training, staff were restraining people inappropriately without giving sufficient consideration to alternative approaches. Items such as straps on wheelchairs and splints on limbs were used to restrict movement, and their use was not regularly reviewed to determine whether they were still required.

An analysis of serious incidents showed that people were at risk from each other, and at times from staff. While no one could have anticipated some of the serious incidents that did occur, there were some weaknesses in the action that the learning disability service took after these serious incidents. If more robust action had been taken after each serious incident, this would have sent a clear signal about the PCT’s commitment to the safety of the people using its services. Staff appeared to be unaware of their duty to protect adults less able to look after themselves. Very few staff had attended training about the protection of adults less able to look after themselves and not all staff had access to the relevant policies.

The management of risk was not effective in the learning disability service. Although structures were in place, such as a risk register, this did not result in the necessary action being taken to address the risks that had been identified. Although most accidents were reported, there was evidence that not all incidents which put the safety of people at risk, or near misses, were reported. This meant that an opportunity to learn from incidents, accidents and near misses was limited, and as a result the PCT missed important opportunities to improve the service. At the same time there was a fear of taking therapeutic risks in the approach to care in the learning disability service that to some extent prevented the development of new skills in people with learning disabilities.

Our investigation found that the views of people with learning disabilities were seldom heard. They were not regularly sought and therefore could not be taken into consideration when decisions were made. Some staff believed incorrectly that if a person could not talk, he or she could not communicate. Very few staff had any specialist training in ways of communicating with people with learning disabilities and as a result interpersonal techniques became focused on observation and completion of tasks rather than on inclusion and development. Many relatives felt that the staff did the best they could and that they were kind and caring people. However, relatives, carers and advocates were not treated as partners in the process of planning care. In particular relatives were concerned about the future of the service and wanted the PCT to communicate more with them. This has improved in the last six months.

In November 2005, the Sutton Disability Partnership for Children and Young People took over the management of the short break unit for children with learning disabilities. Since this time, it has been well managed. There have been many changes implemented and the move to a much larger bungalow with better access to play facilities will be completed early in 2007. Prior to that date, the unit was not known of by the head of children’s services in the PCT. Also its suitability had not been assessed in any way prior to an audit requested by the head of children’s services.

The interactions between staff and people who lived in the learning disability service were generally kind in nature, but were not in accordance with best practice. For example, people were cared for, rather than supported by staff to be as independent as possible. It was usually staff rather than people with learning disabilities who opened the front door to members of the investigation team and we were always introduced to staff but not always to people who lived in the houses. Some staff spoke about people as if they were not there and some staff spoke to each other at meal times and not to the person whom they were assisting to eat.

There were shortages of staff throughout the learning disability service, together with above average levels of sickness, unfilled vacancies...
and reliance on temporary NHS and agency staff, particularly at the hospital. The PCT increased the staffing budget for the learning disability service in April 2005 and again during our investigation but additional staffing alone will not necessarily make a difference to the lives of people with learning disabilities.

We found that insufficient staff had participated in relevant courses or attended mandatory training on what to do in the event of a fire, or how to move people safely. There was no robust system of supervision and very few staff had had an appraisal or a personal development plan.

There were failures in management and leadership, from home managers to the PCT’s board. Home managers did not have the time or the training to manage effectively. Instead they were working alongside healthcare assistants to support people with all aspects of daily living. The role of modern matrons was unclear and they were drawn into doing the work of the home managers rather than leading change. In addition, there were no clinical champions campaigning for or delivering improvements to the quality of care offered to people with learning disabilities.

The capacity and the effectiveness of the learning disability service management team was limited. There was no robust system for monitoring what was happening in the service and often managers thought something was happening or had been implemented when in fact it had not. Important messages about the learning disability service were not effectively communicated to the PCT’s board.

The PCT’s board received information about the proposed redesign of services from the hospital and Osborne House, and at an earlier time, about the two judicial reviews aimed at preventing the closure of the hospital. However, they did not get robust information that enabled them to monitor the quality of services for people with learning disabilities. These services had always been a small part of the overall responsibilities of the PCT and its predecessor organisations, which meant that it was difficult to compete for resources.

The fact that there had been seven chief executives in the last decade and four different organisations (with three different health authorities), created a lack of continuity and follow-up of management action. The unique combination of circumstances at this PCT, including the frequent changes in management and the two judicial reviews, meant that no one individual was responsible for the poor quality of services for people with learning disabilities.

The current chief executive, with the full support of the PCT’s chair, requested this investigation and, although recognising it will be challenging, all are committed to acting on the findings and implementing the recommendations.

The closure of long-stay hospitals like Orchard Hill should have happened many years ago in line with the Government’s policy, as well as the closure of campus-type accommodation like Osborne House. The hospital is one of the last long-stay hospitals in the country to close and the PCT requires external support to ensure that this happens without unnecessary delay. In the light of our investigation the Healthcare Commission considers that the PCT is unlikely to be able to manage this process effectively without adequate transitional financial arrangements. Without these arrangements and effective change, the provision of services will continue to be provided in completely inadequate environments, making it extremely difficult for the PCT to implement new ways of working that are more in line with Valuing People. The redesign must be managed differently to ensure that new services are developed and provided to meet the needs of people with learning disabilities in these services.
Key recommendations and progress

A number of immediate changes were implemented while the investigation was underway. In particular there has been a significant increase in the number of people with person-centred care plans and progress has been made in ensuring that people have comprehensive healthcare assessments. There has also been an increase in staffing levels and new staff have been appointed to clinical and managerial posts.

The following key recommendations by the Healthcare Commission aim to bring the PCT into line with best practice and national guidelines. (The complete list of recommendations, and further detail about the PCT’s progress to date, can be found at the end of this report.) The PCT is required to publish an action plan with timescales for action within nine weeks of the publication of this report.

- It is of fundamental importance that services for people with learning disabilities are based on individual person-centred care plans and health action plans that meet the requirements of Valuing People, to promote social inclusion and improve health. Such plans should be developed for all people using the learning disability services by the end of October 2007.

- Social, recreational and educational activities must be provided to enhance the quality of life of individuals. These should take place in people’s homes and in the community.

- The PCT must develop and implement a policy about working with restrictive physical interventions and staff should receive training where relevant in how to restrain a person. The use of restrictive physical interventions such as straps and splints should be reviewed and they should only be used as a last resort.

- The PCT must, after consultation with the Valuing People support team, engage the support of an external clinical team to provide mentoring and coaching for the home managers. They should help to develop skills in leadership and encourage staff in the homes to embrace new ways of working, based on an inclusive model of care.

- The PCT must take the necessary steps to assure itself that the workforce has the appropriate mix of skills, experience and training. Also that they attend mandatory training, that attendance is effectively monitored and if staff are found not to be attending, that action is taken.

- The provision of advocacy services should be reviewed to ensure that people with learning disabilities are able to articulate their own opinions and choices wherever this is possible.

- The board must satisfy itself that an effective mechanism for assuring quality is in place to monitor the quality of care, and the safety of people with learning disabilities. This must include information given to the board about the quality of care provided by the learning disability service.

- The strategic health authority must ensure that external support is provided to the PCT so that new services can be developed without further delay, and that the closure of Orchard Hill Hospital can be achieved by the agreed target date of April 2009 and Osborne House by the target date required by the White Paper Our Health, Our Care, Our Say of 2010.

- The strategic health authority must ensure that, from the board down, the PCT’s responsibility as a provider of services is clearly separated from its responsibility as a commissioner of services, and that the latter holds the former to account for delivery.
Wider lessons

This is the second investigation into services provided for people with learning disabilities that the Healthcare Commission has completed. In July 2006 we published the report of a joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust. There are some unique factors in this investigation which set it apart from the Cornwall investigation, such as the two judicial reviews and the large number of people still living in a hospital setting. However, there are also some similarities in the findings, which may have relevance for other organisations providing services to people with learning disabilities:

- institutional abuse was occurring but staff were often unaware that what they were doing in fact constituted abuse
- people, their relatives and their advocates were not involved sufficiently in the planning of care and there were low levels of activities
- services for children with learning disabilities were provided in isolation from other children’s services
- the arrangements for governance did not allow for effective monitoring of the quality of the services
- the PCTs failed to commission safe services of good quality and the strategic health authorities failed to discharge their responsibilities to effectively manage the performance of the learning disabilities service

The Healthcare Commission intends to build on these wider lessons by carrying out a comprehensive audit of learning disability services both in the NHS and the independent sector throughout England. This will improve the understanding of the key issues affecting people who are using learning disability services, and also provide information about what improvements can be made by organisations which are providing learning disability services. It is anticipated that the results of this audit will be published in 2007.
Recommendations

The Healthcare Commission expects the PCT to consider all aspects of this report. Here, we highlight areas where action is particularly important.

**Quality of care**

1. It is of fundamental importance that services for people with learning disabilities are based upon individual person-centred care plans and health action plans that meet the requirements of *Valuing People*, to promote social inclusion and improve health. Such plans should be developed for all people living in the learning disabilities services by the end of October 2007.

2. The PCT must ensure that medical, nursing and therapeutic care is provided in accordance with best practice throughout its learning disability service.

3. Social, recreational and educational activities must be provided to enhance the quality of life of individuals. These should take place both in people’s homes and in the community and should include developing links with relevant groups on work, training and education. Many of these should be in place and be provided by March 2007.

4. The PCT must immediately implement the new policy about working with restrictive physical interventions. Staff should receive training where relevant in how to restrain a person. The use of restrictive physical interventions such as straps and splints should be reviewed and should only be used as a last resort.

5. The PCT should make sure it has firm links to the adult protection coordinator in the local authority. The PCT should also ensure that training is provided about the protection of adults less able to look after themselves so that staff recognise abuse and know how to report it.

6. The model for the provision of short break care must be reviewed to ensure that it does not disrupt the lives of people already living in community homes.

7. The PCT must ensure that services provided for children with a learning disability are fully integrated with other children’s services.

8. Improved working arrangements are needed between children’s and adult services, to ensure that there is a smooth and effective transition for people with learning disabilities.

9. The PCT must implement all the objectives identified in the learning disability service business plan by March 2007 (the full 2006/2007 business plan can be found at appendix F). This includes progressing work on appraisals and supervision of staff as well as ensuring access to specialist healthcare such as that provided by psychologists and speech and language therapists.

**Staff development and training**

10. The PCT must, after consultation with the *Valuing People* support team, engage the support of an external clinical team to provide mentoring and coaching for the home managers, and to help develop skills in leadership to encourage staff in the homes to embrace new ways of working, based on an inclusive model of care.

11. The PCT must take the necessary steps to ensure that the workforce has the appropriate mix of skills, experience and training, that they attend mandatory training, and that this is effectively monitored and action taken if staff are not attending.

12. Training that embraces the principles of *Valuing People* must be provided to all staff. Staff should be encouraged to visit other
services and learn from best practice in other parts of the country.

13. A dedicated programme of education and development is needed to improve the communication skills of staff.

14. The PCT must ensure that there is a robust system for reviewing and updating all policies and procedures, that these are made available to staff and that their implementation is monitored.

Empowering people who use services

15. The PCT should develop policies and procedures that encourage and enable people who use its services to exercise choice and control over their own care.

16. The provision of advocacy services should be reviewed to ensure that people with learning disabilities are supported to articulate their own opinions and choices wherever this is possible.

17. The PCT must develop an easy read version of the process for raising concerns or making complaints, and ensure that people with learning disabilities, their relatives, carers and advocates are informed about the process for making complaints.

Governance and strategic arrangements

18. The board must ensure that services for people with learning disabilities are included in the local delivery plan.

19. The board must satisfy itself that an effective mechanism for assuring quality is in place to monitor and provide assurance on the quality of care and the safety of people with learning disabilities. This must include information to the board about the quality of care provided by the learning disability service.

20. The strategic health authority should work with the PCT to ensure that learning from the independent review of the Cornwall Partnership NHS Trust’s board, arising from the Healthcare Commission’s investigation, is considered and acted upon, where relevant.

Redesigning services

21. The PCT must work with the local authority to ensure that the redesign of services is based on assessments of the needs of individuals, is sufficiently resourced, incorporates quality standards which are based on best practice, is understood by staff and is effectively monitored.

22. The strategic health authority must ensure that the PCT develops new services without further delay, and that the closure of Orchard Hill Hospital can be achieved by the agreed target date of April 2009 and Osborne House by the target date in Our Health, Our Care, Our Say of 2010.

23. In line with the target in Our Health, Our Care, Our Say, the PCT must review its current model of community home provision and improve its community services to enable it to move away from the model of campus accommodation by 2010.

National recommendations

24. In light of the learning from this investigation and the Healthcare Commission’s previous investigation into Cornwall Partnership NHS Trust, clarification from the Department of Health on what a modern learning disability service should look like would help PCTs to commission services for people with learning disabilities. The results of the Healthcare Commission audit of learning disability services should feed into this guidance.

25. The strategic health authority must ensure that, from the board down, the PCT’s responsibility as a provider of services is clearly separated from its responsibility as a commissioner of services, and that those responsible for the latter, hold the former to account for delivery.
What happens next?
The PCT is required to prepare an action plan within nine weeks of publication of this report, to address the recommendations of this investigation. It is expected that this will be prepared in partnership with people who live in the service, their relatives, carers and advocates, as well as representatives from relevant local organisations such as the local authorities. The London Strategic Health Authority and the Healthcare Commission will monitor the implementation of the action plan and the outcomes on a regular basis and there will be a review of progress after 12 months.

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- past and present staff interviewed during the investigation and those who assisted with the organisation of the investigation, particularly Hilary Scott
This information is available in other formats and languages on request. Please telephone 0845 601 3012.

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TURKISH

Kişisel verilerinizi vermeniz kabul ettikten sonra, verilerinizi saklıyoruz ve güvenli bir şekilde saklıyorum.