



23 March 2018

Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
Richmond House
79 Whitehall
London
SW1A 2NS

Cllr Izzi Seccombe OBE
Chair
LGA Community Wellbeing Board
c/o Warwickshire County Council
Shire Hall
Warwick
CV34 4RL

By email

Dear Mr Hunt and Cllr Seccombe,

Mendip House Safeguarding Adults Review

On 08 February 2018, the Somerset Safeguarding Adults Board published a Safeguarding Adults Review in to the mistreatment and abuse of residents by staff at a care home for people with autism in Somerset run by the National Autistic Society. The Review was written by Dr Margaret Flynn, who also undertook the Serious Case Review of Winterbourne View Hospital in South Gloucestershire.

All the residents at the care home, Mendip House, and the wider Somerset Court campus on which it was situated, were placed by over 30 different Local Authorities and Clinical Commissioning Groups as far away as Aberdeen. None of the people placed at Mendip House were Somerset residents and parallels have been drawn with Winterbourne View by Dr Flynn, albeit without the cameras.

In summary, the findings of the Review are that:

- Somerset Court is a dated, single-site “campus” model of service provision which sources residents with diverse support needs from around the UK.
- The unprofessional and cruel behaviour of a “gang” of male employees at Mendip House home did not suddenly occur, and action could and should have been taken by the National Autistic Society earlier.
- Neither the history of safeguarding referrals nor Care Quality Commission inspections revealed the cruelty of employees or the failures of management oversight.
- People were placed at Mendip House as a result of the detrimental practice “place hunting” by Commissioners. It does not appear that the agencies that commissioned the placements asked searching questions about the benefits of residents being placed there, or received detailed accounts of how fees were being spent on their behalf.

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- Care planning was poor. Decisions about continuing placements by the agencies commissioning the placements at Mendip House were not based on data such as what was being achieved with, and on behalf of, individual residents.
- There can be no confidence that there is sufficient capacity in speech and language, psychology, behaviour support, learning disability nursing and psychiatry services to meet the needs of unknown numbers of adults who are placed by Commissioners outside their own localities.

Seven years after Winterbourne View it is unacceptable that vulnerable people continue to be placed 'out of sight, out of mind' long distances away from their families and communities by Commissioners who then leave them open to abuse as a result of inadequate monitoring of their care. Even where service models take a modern approach to care, it is highly questionable whether placing a vulnerable person sometimes hundreds of miles from their family and community is the right thing to do, yet Local Authorities with Social Services responsibilities and Clinical Commissioning Groups are not able to prevent new developments that do not meet local needs or commissioning intentions; and whose business plans are predicated on 'importing' people from across the UK.

Furthermore, it is unacceptable that service models that would probably be refused registration by the Care Quality Commission today not only continue to operate unchanged, but continue to 'import' people from across the UK without any consideration of the availability or impact on local resources as a result of poor Commissioning practices. Commissioners are responsible for the decisions that they make, yet they remain unregulated and seemingly unaccountable; in Somerset's experience rarely informing the host Local Authority of a prospective placement, something that is a requirement for similar placements for Children, frequently assuming that local services can be called upon should the placement not be able to meet the person's needs. Such poor practice in relation to what are often the most expensive services commissioned by a Local Authority or Clinical Commissioning Group inevitably leads to public money being used to pay for services in which vulnerable people are abused. This should not be happening in light of the learning from Winterbourne View, but it is, and I see no reason that it will stop without action being taken at a national level.

The Review makes important recommendations for changes at a national level that I request that you take forward urgently. The Review has been discussed by the Independent Chairs of Adult Safeguarding Boards within the South West, who have written an accompanying letter in support of the recommendations of this Review. I am also aware that there are other Reviews in progress within the South West that relate to similar circumstances, which are likely to reach similar conclusions and make similar recommendations in the coming months.

The recommendations from the Mendip House Safeguarding Adults Review are:

1. The Department of Health and Social Care, NHS England and the Local Government Association are requested to:
 - prepare consultations to regulate commissioning;

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- include in those consultations the role of 'lead commissioner' who will assume responsibility for coordination when there are multiple commissioning bodies of a single service and assume responsibility for ensuring that individual resident reviews start with principles and make the uniqueness of each person the focus for designing and delivering credible and valued support;
 - include in those consultations the expectation that commissioners must notify the host authority of prospective placements;
 - set out in guidance the remit, powers, structure and enforcement resources of all agencies immersed in the task of achieving better lives for adults with autism;
 - assert a new requirement to discontinue commissioning and registering "campus" models of service provision
 - assert a new requirement for (a) a formal consultation with Local Authorities with Social Services responsibilities and Clinical Commissioning Groups regarding all planning applications for building residential services that would require registration with the Care Quality Commission to operate, and (b) to decline planning permission for types of service provision for which there is no local demand and which fail to "think small" and "think community."
2. The Department of Health and Social Care, NHS England and the Local Government Association be advised of the actions that Somerset County Council intends to take to address the detrimental persistence of "place hunting" by commissioners. That is, to require commissioners to:
 - fund essential monitoring and reviewing processes;
 - fund residents' access to local health services, most particularly community health services;
 - identify a lead commissioner.
 3. Since it is unlikely that the Care Quality Commission would register this model of service now, Somerset Safeguarding Adults' Board should write to the Care Quality Commission requesting that it (a) makes this fact explicit in its inspection reports; (b) undertakes more searching inspections of such services; and (c) does not register "satellite" units which are functionally linked to "campus" models of service provision.
 4. A Memorandum of Understanding is negotiated by Somerset County Council whereby the aggregate-level information concerning grievances, disciplinarys and complaints, for example, gathered by providers is shared with the Care Quality Commission and pooled with that of local authorities' safeguarding referrals, the "soft intelligence" of Clinical Commissioning Groups, the police and prospective commissioners. The "search costs" of information seeking, negotiating access, processing and storing are excessive – this is most particularly the case when Section 42 inquiries are invoked
 5. The Care Provider Alliance, with the support of the Care Quality Commission and Skills for Care, issue its members with guidance on how the role of responsible or nominated individual in supervising the management of the regulated activity should be performed in respect of quality assurance and safeguarding.

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The abuse and mistreatment of the people placed at Mendip House went undetected as a result of poor commissioning practice. It is my view that without change it is highly likely that similar mistreatment and abuse will be uncovered elsewhere in the future, and I look forward to working with you on the implementation of these important recommendations.

Yours sincerely,

A handwritten signature in blue ink that reads "Richard Crompton".

Richard Crompton
Independent Chair
Somerset Safeguarding Adults Board

Encl.

1. Supporting letter from Siân Walker, Chair, Devon Safeguarding Adults Board on behalf of the South-West Region Independent SAB Chairs Network
2. Mendip House Safeguarding Adults Review

CC.

Rt Hon James Heappy MP
Rt Hon Ian Liddell-Grainger MP
Rt Hon Rebecca Pow MP
Rt Hon Marcus Fysh MP
Rt Hon David Warburton MP
Rt Hon Jon Ashworth MP
Ray James CBE, National Learning Disability Director, NHS England
Nick Rudling, Deputy Safeguarding Lead, NHS England South (South West)

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