Serious Case Review

Elm View Nursing Home

Introduction

The Chair of Calderdale Adults Safeguarding Board made a decision on the 6th December 2011 that a serious case review should be carried out on a nursing home in Calderdale. This was because there were growing concerns over the standard of care given to a number of people receiving care at this nursing home.

The concerns first began to come to light in late 2010 and early 2011 but these escalated in early September 2011. The escalation of these concerns led to a multi-agency safeguarding response which took place in October 2011. This means that all the agencies involved in the care of residents at the nursing home were involved in the safeguarding response.

It was then decided by Calderdale Adults Safeguarding Board that a serious case review was needed, in order to ask some important questions about the multi agency safeguarding response.

About the nursing home and its residents

The nursing home was initially registered for 21 places with nursing care. The registered number of available places was then increased to 27 in April 1996 when the home provided accommodation in 11 single and eight shared rooms. Five of the rooms had en-suite bathroom facilities.

From December 2003 the nursing home provided nursing care only without any additional mental health.

Calderdale Council and NHS Calderdale implemented a joint contract with the nursing home in August 2009. On the 1st October 2010 the nursing home was registered with the Care Quality Commission. The registration was for the following three regulated activities:

- Accommodation for persons who require nursing or personal care;
- Treatment of disease, disorder or injury; and
- Diagnosis and screening procedures.

Most of the nursing home's residents were well over 80 years of age. They had a range of long-term physical conditions, often with multiple co-morbidities and reduced mobility. Many of the residents had a degree of dementia. All of the residents had a high degree of dependency on the nursing home staff for their basic physical needs.

The serious case review

The serious case review was needed to find out whether there were any lessons to be learned from the way the multi-agency response was carried out, if action could have taken place before October 2011, how effective it was and how well the agencies worked together. The safeguarding response was carried out in relation to nine residents at the nursing home.

A number of questions and areas that the serious case review wanted to address are set out below and will explain the line of enquiry that the serious case review followed. With regard to lessons learned, the serious case review sets these out very clearly as a summary and a set of recommendations, which can be found at the end of this report. These recommendations are the lessons learned from this review and are intended to be taken forward and acted upon.

The questions the review asks:

Question one: Why were the serious safeguarding issues in this nursing home not identified before October 2011?

Question two: When concerns arose about the standard of care at the nursing home, did the multi-agency safeguarding response address these effectively and appropriately?

The areas the review looks at:

The areas that the review looks at are specifically about the agencies and other professional people involved and how effectively they worked together to safeguard vulnerable adults. They are:

Area one: How NHS commissioners of care support services; Adults, Health and Social Care Contracts; Care Management Services; Care Quality Commission, and other adult safeguarding professionals interacted.

Area two: How the Care Quality Commission acted as a regulator and inspector; how it makes its decisions; its relationships and communication with local services and how it acted during the multi-agency safeguarding response.

Area three: How the West Yorkshire Police carried out its actions, from its initial intelligence about the nursing home to the criminal investigation and case preparation for the Crown Prosecution Service.

Area four: How primary and community health services supported the nursing home and how concerns were reported and acted upon.

Area five: How the views of the nursing home residents and their relatives were taken into account, particularly in considering that a number of the residents had recently moved from a closed nursing home within Calderdale.

The dates the review covers

The review covered from the 3rd March 2010 until the end of February 2012, when there were no longer any residents living at the nursing home.

The people on the review panel

Independent Chair and Author of the report
Chair of Calderdale Adults Safeguarding Board
Interim Safeguarding Adults Manager from Adults, Health and Social Care, Calderdale MBC
Compliance Manager from the Care Quality Commission
Commissioning and Strategy Manager from Adults, Health and Social Care, Calderdale MBC
DCI Crime Manager from the West Yorkshire Police
Safeguarding Support Worker from the voluntary sector
Safeguarding adults lead from NHS Calderdale Safeguarding
Named nurse for safeguarding from Calderdale and Huddersfield NHS Foundation Trust
Director from the nursing portfolio lead, safeguarding at the South West Yorkshire Foundation Trust

How the review is independent

The review panel was chaired by an independent consultant with experience of serious case reviews and adult safeguarding boards. This independent consultant was commissioned to write this report, and the recommendations have been agreed by Calderdale's Adults Safeguarding Board.

All of the agencies involved completed their own individual management reviews, but these were done by managers who did not have any direct responsibilities for the work with residents of the nursing home.

The police processes at the time of the review

When the review had been completed, police enquiries were still continuing into concerns about the standard of care at the nursing home.

The methodology of the review – its approach

As well as coordinating the review itself, the panel quality-assured the individual management reviews that each agency involved with the residents and/or the nursing home carried out.

The independent chair and report Author analysed and cross-referenced each individual management review which helped identify common themes and areas where practice could be improved to support agencies working together.

Consultation with family members

Family members of the nine residents were contacted by letter from the Adults Safeguarding Board explaining that a serious case review was taking place. The letter asked for their active cooperation to attend a meeting with the independent report author, which some family members did. Some of the concerns and comments made by family members, in the meetings, included:

- The length of time taken to make a decision as to whether a criminal prosecution would take place;
- There were some concerns about the intervention and assessments carried out on the 7th October 2011, particularly in relation to the time of day they were carried out, which was 7.00am. However, some family members felt that under these circumstances the intervention and assessments were carried out as smoothly as was possible;
- Some family members expressed concerns that it was unclear and there was a lack of information about the pathway they should follow if they had concerns or complaints; and
- There were some very complimentary comments about the sensitive and professional approach taken in moving residents from the nursing home.

The background of concerns leading up to the review

Although the timeframe for this serious case review was from March 2010 until the end of February 2012, there had been concerns raised about the standard of care at the nursing home prior to this date. This background information is important in understanding the development of escalating concerns about the nursing home.

Safeguarding alerts not being consistently made

There were instances, at the nursing home, where safeguarding alerts should have been raised, to alert attention to things that were going wrong, but they were not. Here are the instances where safeguarding alerts should have been raised but were not:

- In August 2010, Adults, Health and Social Care were advised by NHS Calderdale that a resident had developed a grade 3/4 pressure ulcer and was not being provided with an appropriate pressure relieving mattress;
- In March 2010, a resident was admitted to hospital with a fractured humerus. There was no satisfactory explanation for this fracture;
- In December 2010, a resident was admitted to hospital with a fractured neck of femur;
- Where there was concern about a resident being dehydrated and unable to stand, there was a decision made by Adults, Health and Social Care not to raise a safeguarding alert due to confusion around safeguarding responsibilities for people who do not ordinarily live in Calderdale. This case was discussed at a monthly monitoring group meeting with NHS Calderdale;
- One resident was admitted to hospital after having left in a bathroom at the nursing home without oxygen, which was an essential requirement for their care; and
- There was a suggestion made by a relative that staff at the nursing home were neglectful in a certain case and had failed to provide a commode for an incontinent resident, and had therefore compromised this person's dignity.

An unannounced inspection in May 2011

The Care Quality Commission received information about a concern over a resident developing a pressure sore. They had also received information at the monthly monitoring meeting, from the local primary care trust about the quality of services at the nursing home, and a family member of a resident had also expressed concerns about care to them. Therefore in May 2011, the commission carried out a review of the nursing home through an unannounced inspection.

The inspection identified minor concerns with two outcomes (04 and 10) and moderate concerns with two outcomes (07 and 17).

- Outcome 04 - People should get safe and appropriate care that meets their needs and supports their rights.
- Outcome 10 - People should be cared for in safe and accessible surroundings that support their health and welfare.
- Outcome 07 - People should be protected from abuse and staff should respect their human rights.
- Outcome 17 - People should have their complaints listened to and acted on properly.

The nursing home had to produce an action plan to explain how it would improve under outcomes 04 and 10, how it would comply with outcomes 07 and 17, and how it would achieve all this by July 2011.

A representative from the Care Quality Commission attended the joint monthly monitoring meeting on 10th May 2011 and shared information about this unannounced inspection with health and social care colleagues.

Contractual concerns

The Adults, Health and Social Care contracts team found out that a nurse at the nursing home had been employed without obtaining the necessary number of references, which was a breach of their contract terms with Calderdale Council. A manager from the team addressed this with the owner of the nursing home.

In July 2011 there was a monthly monitoring group meeting held. Adults, Health and Social Care, NHS Calderdale managers, the Contracts Compliance Team and Care Quality Commission all attended. This meeting considered if the information indicated that “whole service concerns” were appearing at the nursing home, and the outcome of the meeting was that a whole service safeguarding response was not needed at this time.

Anonymous whistle-blowing enquiry

The Care Quality Commission anonymously received ‘whistle-blowing’ information on 22nd July 2011. This information was about poor standards of care at the nursing home, and was shared with Local Authority Adult Health and Social Care, through Gateway to Care, by a fax on the 25th July 2011.

The anonymous allegation suggested that residents at the nursing home were under-stimulated and neglected. That ill health among residents was not being reported or treated properly. And, it was also alleged that some residents were experiencing physical discomfort due to sitting all day (presumably causing pressure sores/ulcers).

The anonymous allegation was looked into by Adult Health and Social Care's contracts team.

The next monthly monitoring group meeting was held in August 2011. There was discussion about a nurse from the nursing home who had been dismissed for "gross negligence…and incompetence", and there was an agreed action by a manager from NHS Calderdale to follow up the nursing home owner's decision not to refer the case to the nursing regulatory body.

There is a note from this same monthly monitoring group meeting to say that the Local Authority fed back from a visit that the contracts team had made to the nursing home to follow up the anonymous allegations. The note reads "the Local Authority contracts team had visited and had closed the investigation as the allegations were unfounded". The Care Quality Commission then closed this whistle-blowing enquiry on 31st August 2011. It might be presumed that they closed the enquiry, in part, because the Local Authority had not been able to find evidence to support the anonymous alerts.

A responsive review in September 2011

The next monthly monitoring group meeting was held on the 27th September 2011. At this meeting serious concerns were discussed and senior managers from Adult Health and Social Care and NHS Calderdale made the decision to suspend placements at the nursing home with immediate effect. It was directly because of these serious concerns, and as a follow up from the unannounced inspection in May 2011, that the Care Quality Commission carried out a responsive review on the 28th September 2011.

The responsive review was an on-site inspection, which identified moderate concerns with two outcomes (01 and 10) and major concerns with seven outcomes (04, 07, 08, 13, 16, 17 and 21).

- Outcome 01 - People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
- Outcome 10 - People should be cared for in safe and accessible surroundings that support their health and welfare.
- Outcome 04 - People should get safe and appropriate care that meets their needs and supports their rights.
- Outcome 07 – People should be protected from abuse and staff should respect their rights.
- Outcome 08 - People should be cared for in a clean environment and protected from the risk of infection.
- Outcome 13 – There should be enough members of staff to keep people safe and meet their health and welfare needs.

- Outcome 16 – The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
- Outcome 17 – People should have their complaints listened to and acted on properly.
- Outcome 21 – People's personal records, including medical records, should be accurate and kept safe and confidential.

Safeguarding issues and police intervention

On the 28th September 2011 a safeguarding alert was raised for a resident of the nursing home. The allegation was that the resident had been at risk because they had not received the right medical attention after a fall. The allegation and safeguarding alert was found to be correct and a protection plan put in place.

A safeguarding strategy meeting was held on the 30th September 2011. Adults, Health and Social Care, a senior manager from NHS Calderdale, a representative from West Yorkshire Police and representatives from the Care Quality Commission all attended. At the meeting, concerns that suggested high levels of neglect at the nursing home were discussed.

It was decided at the meeting that West Yorkshire Police would carry out an investigation and that the Care Quality Commission would seize records relating to three residents of the nursing home.

On the 3rd October 2011 a follow up safeguarding strategy meeting was held. Representatives from West Yorkshire Police, Adults, Health and Social Care, NHS Calderdale, Care Quality Commission, Continuing Health Care, and corporate communications all attended.

At the meeting the following was decided:

- West Yorkshire Police would consider using a warrant to access all records relating to the nursing home;
- Adults, Health and Social Care would take the lead in arranging meetings with the owner of the nursing home;
- Adults, Health and Social Care and NHS Calderdale would draft a joint letter for families of residents at the nursing home, and they would develop contingency plans for those families who wanted to move their relatives out of the nursing home; and
- To hold another strategy meeting on the 19th October 2011.

A further safeguarding strategy meeting was arranged by West Yorkshire Police on the 5th October 2011, for senior managers of the agencies. At this meeting the following was decided:

- The police would obtain a warrant and seize records from the nursing home and the owner's home; and

- Adults, Health and Social Care Managers would arrange a contract meeting with the owner of the nursing home and provide five social workers as part of a team to support family members and safeguard residents.

The intervention at 7.00am on the 7th October 2011

On this day, at this time, West Yorkshire Police officers supported by NHS Calderdale managers and operational staff, Adults, Health and Social Care social work staff and Health and Safety Executive staff entered the nursing home.

The work that took place that day and over the weekend included making contact with families, carrying out mental capacity assessments for those residents it was appropriate for, documenting 'best interests' and carrying out nursing assessments for all residents to ensure any immediate concerns around peoples safety could be addressed.

These were some of the findings of the work undertaken:

- Evidence of residents with pressure sores;
- One resident found to be very poorly and was admitted to hospital;
- Inadequate equipment, for example, beds were not adjustable and mattresses not suitable;
- Some residents did not have the correct dressings on their wounds; and
- Concerns about the cleanliness of the home and the competence of staff.

The Care Quality Commission held a meeting with the owner of the nursing home on the afternoon of the 7th October 2011 to get their assurance that they would accept the plan of NHS Calderdale to organise nursing staff (from the NHS) to provide nursing care for the residents over the coming weekend. The owner agreed and also agreed not to admit any new residents. The owner gave the Care Quality Commission written confirmation of this.

Follow up from the 7th October 2011 intervention

On the 10th October 2011 a follow up safeguarding strategy meeting was held. The key points of the meeting were:

- All but one family of the residents had been seen;
- Families were regularly reporting weight loss of their relatives at the nursing home;
- Families were concerned about their relatives moving and the harmful impact that may have on them;
- It was unclear which agency was leading and coordinating the safeguarding response; and
- The Care Quality Commission considered whether there was enough evidence to cancel the manager of the nursing home's registration, but it was decided that there was not enough evidence at this stage and the situation would continue to be reviewed.

On the 11th October 2011 a further safeguarding strategy meeting was held. Representatives from West Yorkshire Police, Adults, Health and Social Care and NHS Calderdale all attended, and a decision was made that Adults, Health and Social Care would take the lead in coordinating activity and the communication of the activity to all involved agencies.

On the 13th October 2011, senior managers from Adults, Health and Social Care met with the owner of the nursing home. The owner informed them that a consultancy firm would take over the day-to-day running of the nursing home. It was decided that weekly meetings with the consultancy firm would be held to check on progress.

The registered manager of the nursing home attended the police station and was interviewed under caution. The police were also informed by the nursing home owner that the registered manager had been suspended

On the 19th October 2011 a family liaison meeting with all key agencies was held. There was also a meeting between an Adult, Health and Social Care senior manager and the consultancy firm manager to check on progress.

Also on the 19th October 2011, a safeguarding strategy meeting of all the agencies involved took place. It was agreed at this meeting that the situation had now stabilised, and the following key points were:

- A number of protection plans had been completed and put in place;
- It had not been possible to complete all nursing assessments agreed on the 7th October 2011 and this was impacting on safeguarding issues being identified and protection plans being put in place;
- Progress was noted where a consultancy firm was to take over the running of the nursing home, and that they had produced an action plan;
- A contingency plan for those residents who wanted to move was under development;
- The Care Quality Commission was willing to keep the nursing home open, if it was in the interests of the residents, and as long as there was cooperation from the owner and progress was being made;
- Community matrons were now going into the nursing home;
- West Yorkshire Police were working with NHS Calderdale to put together a report for the Crown Prosecution Service; and
- The Health and Safety Executive were considering prosecution.

An increase in safeguarding alerts and legal proceedings

On the 19th October 2011 there was a further safeguarding strategy meeting with representatives of all the key agencies. It was noted that two residents of the nursing home had recently died.

The Care Quality Commission issued a ‘warning notice’ on the 21st October 2011 to the owner of the nursing home stating that if they did not achieve compliance, in a short timescale, then they would be issued a ‘Notice of Decision’ to remove their ability to provide nursing care.

On the 26th October 2011 a number of safeguarding alerts were raised, which followed on from the health assessment information. Of nine safeguarding alerts, eight were confirmed. Families of six residents then arranged to move their relatives from the nursing home, which left 15 residents with complex needs who had chosen to continue living at the nursing home.

On the 15th November 2011 the Care Quality Commission went on site at the nursing home to review their compliance and found evidence that improvements had been made but that these needed to continue.

On the 16th November 2011 a further safeguarding strategy meeting took place. The main points of the meeting were:

- A case, in relation to five residents, was being prepared by the police for the consideration of the Crown Prosecution Service;
- There were concerns that improvements could not be maintained in the long term; and
- There were concerns that nursing staff at the nursing home did not have the rights skills to competently carry out their duties.

On the 22nd November 2011 there was a further safeguarding strategy meeting. The main points of the meeting were:

- The Crown Prosecution Service had not yet made a decision about a criminal prosecution, and a prosecution advice file was submitted to them on the 25th November 2011; and
- There were some concerns about progress being maintained at the nursing home and this view was confirmed at the monthly monitoring meeting held on the 22nd November 2011.

On the 7th December 2011, the Interim Director of Adults, Health and Social Care, wrote to family members advising them “in the strongest possible terms” that they should seek alternative accommodation for their relatives. Senior managers in Adults, Health and Social Care had proactively held discussions with other nursing homes in case there was a need to transfer any resident as soon as possible.

During December 2011 it became known that the nursing home was running at a considerable financial loss and that there was an intention to sell the building.

Between the 17th December 2011 and the 10th February 2012 Adult Health and Social Care continued to receive information about safeguarding concerns for people still resident at the home, which included concerns about general quality of concern and the safety of individuals in the home.

On the 23rd January 2012 a senior manager made an unannounced monitoring visit to the nursing home. A safeguarding strategy meeting about this visit was then held on the 25th January 2012. The overall view, expressed at the meeting, was that improvements were unlikely to be maintained in the long term and the remaining residents needed alternative placements. The Director of Adults, Health and Social

Care was advised that “decisive action was required” to safeguard residents at the nursing home.

On the 3rd February 2012 the owner of the nursing home informed that they had had a potential buyer for the nursing home. The potential buyer confirmed, on the 6th February 2012, that they intended taking over the running of the nursing home from the 13th February 2012 on a lease basis.

A joint letter dated the 10th February 2012 from the Director of Adults, Health and Social Care and the Director of Public Health was hand delivered to the relatives and families of residents at the nursing home. The letter informed them that all residents of the nursing home should be moved out and transferred as soon as possible.

On the 14th February 2012 a monthly monitoring group meeting was held and stated at the meeting that all residents would be moved out of the nursing home by the 17th February 2012.

All residents were moved out of the nursing home and the owner said that they would ask for deregistration of the nursing home from the Care Quality Commission.

Between March 2012 and the present time the West Yorkshire Police have undertaken further interviews under caution with the owner and the registered manager of the nursing home.

Following a decision by the Crown Prosecution Service that the owner of the nursing home and the registered manager should face criminal proceedings in relation to the neglect of residents at the nursing home, both were found guilty of “willfully neglecting” 4 residents at the nursing home, and received 12 months prison sentences.

Question one of this review: Why were the serious safeguarding issues in this nursing home not identified before action was taken in October 2011?

To answer this question, this section looks at how all the key agencies involved in providing services, organising contracts for services, regulating activity and monitoring care at the nursing home worked together. It also looks at how those agencies communicated with each other over the actions they took and how the views and wishes of the residents and their relatives were taken into account.

Inconsistent use of the safeguarding procedures

Before October 2011, there were a number of incidents that should have indicated concern about standards of care at the nursing home. Safeguarding alerts should have been raised in response to these incidents. This would have been good practice and what the Adults Safeguarding Board procedures state should happen.

Examples of when it would have been right to raise a safeguarding alert, or enquiry, but it was not, include:

- When a resident suffered a fracture and was transported to hospital in an inappropriate vehicle;
- A resident suffered a fall and fracture in August 2011 that was not raised as a safeguarding alert until late September 2011;
- When it was known by Adults, Health and Social Care (senior manager and contracts team) that there had been issues raised about 'skin integrity' care for different people (between January 2011 – June 2011); and
- When there was an allegation that a resident was "slapped" and "dragged by [the] hair", which was not investigated by the nursing home.

Because these early concerns were not properly identified and addressed, including formal meetings with the owner of the nursing home, opportunities for early intervention and prevention could not happen.

Additionally the individual safeguarding responses were followed up appropriately on an individual basis by individual workers across different teams, which made it difficult to appreciate the significance of how information built up and accumulated about the nursing home.

A particular example stands out when the information given by a relative should have led to a safeguarding response from Adult Health and Social Care. The issue was discussed at the monthly monitoring meeting but due to misunderstanding around safeguarding responsibilities for people who do not ordinarily live in Calderdale, the decision was made to close the safeguarding concern.

By July 2011 queries were being raised at the monthly monitoring meeting about building concerns and the possibility of a pattern of "whole service concern". This was closely followed by the anonymous allegations received by the Care Quality Commission in late July 2011. The allegations were of under-stimulation, poor health treatment and general neglect of residents in the nursing home. Given that there had already been some concerns about the nursing home and this was, potentially a whistle-blowing allegation from someone who was familiar with the inside of the nursing home, the allegation should have resulted in a safeguarding alert.

The safeguarding adults procedures in Calderdale were clear about the actions people should take when they had concerns around the safety and welfare of vulnerable adults.

The evidence seen in this serious case review is that safeguarding alerts are not consistently raised by outside agencies with Adult Health and Social Care where they should be.

This Author believes this suggests that the failing in raising safeguarding alerts is across a number of organizations, it is recommended more work should be undertaken to ensure people understand how and when to raise a safeguarding concern.

The Author believes possible explanations of why alerts are not being raised when they should, might include:

- Workers are unaware of the process for raising safeguarding alerts (or the process is too complex);
- Workers do not agree or do not understand the level of concern for raising safeguarding alerts;
- Workers do not see themselves as having responsibility for raising safeguarding alerts; and
- Managers, as part of the agency network that provides care and services do not 'own' or promote to staff how important safeguarding alerts are.

There were some examples given in the individual management reviews of good practice in raising safeguarding alerts. The Calderdale and Huddersfield NHS Foundation Trust, for example, shows the sound practice of the Tissue Viability nurse, in relation to pressure ulcers.

It was also identified how difficulties in progressing the nursing assessments had an effect on the progress of safeguarding responses. The Author believes this highlights inconsistency in the flow of information from one agency to another, when and what is required.

The unclear role of the monthly monitoring meetings

The monthly monitoring meetings that were held could have been an extremely valuable forum for all agencies involved to get to know what was going on, particularly where there were concerns about safeguarding residents. But, the meetings were unable to develop a full picture of the failing standards of care at the nursing home.

The Adults, Health and Social Care made it clear the groups "terms of reference, formal delegations or escalation procedures" needed to be enhanced in response to the changing nature of this group.

Originally, the monthly monitoring meeting had been to focus on contracts but this had evolved over time, due to the demands and expectations of organisations represented.

This means the purpose and role of the meeting was not clearly understood, and the group had started to review and monitor safeguarding concerns. When there are complex cases involving many agencies who need to share information it is vital that roles and functions of meetings are clear and understood by all parties. The terms of reference for this group should also make clear that reviewing and monitoring safeguarding responses are covered by the multi-agency safeguarding policy and procedure, and should take place under a different process.

Effective responses to safeguarding allegations

The contracts team and the Adults, Health and Social Care safeguarding team did not have clear processes about how to manage allegations made about the nursing home. The safeguarding policy and procedure did not make reference to managing whole service safeguarding concerns.

The anonymous allegations that were made to Adult Health and Social Care in July 2011, did not result in a safeguarding response, but was instead looked into by the contracts team.

The Author believes agencies need to ensure every effort is made to establish the correct information about anonymous allegations, to ensure appropriate actions are taken.

A lack of reviews of residents of the nursing home

The Author could not find evidence to indicate that all residents had received an annual review of their needs by Adults, Health and Social Care. Nursing reviews for individuals whose care was fully funded by health (Continuing Health Care) did take place but the outcome of these reviews was not consistently shared with Adults, Health and Social Care. This made it difficult to effectively identify trends of themes in care that were emerging.

The NHS Calderdale individual management review covering Continuing Health Care said that concerns were identified in June and July 2011. Their concerns were about documentation in the nursing home:

- The poor quality of nursing paperwork;
- The poor quality of information in the nursing home;
- The poor quality of copies of photocopied documents;
- A lack of regular recordings of residents' weight (weight was recorded separately to the main body of care records);
- The chaotic nature of care records and the fact that not all residents had care plans in place;
- That there was an unpleasant odour in the nursing home;
- That the layout and organisation of the home was regulated and unpleasant for the residents; and
- That there was no personal, private space for reviews to be carried out.

The lack of joined-up working

The poor organisational standards at the nursing home, alongside the individual concerns about residents and the whistle-blowing allegations should have helped agencies, to have considered the strong probability that the nursing home was failing in its care of vulnerable residents.

The Adults, Health and Social Care individual management review identified concerns around leadership at the time. This was because of how the Directorate operated at the time with different heads of service for "service provider contractual issues" and "individual service user issues".

There is evidence of inconsistent communication about the nursing home and the concerns about the care there, from one agency to another. This was not helped by the absence of a procedure to define whole service safeguarding and how agencies should work together.

The individual management review that focused on primary medical services (General Practice) says that there were a high number of GP visits to residents at the nursing home, and a high number of telephone consultations. However, these visits and consultations from GPs were of multiple GPs from three different practices. This meant that no one practice held full information about the patient care, or concerns about the residents, and any patterns or themes of concerns about care at the nursing home were therefore difficult to detect.

The South West Yorkshire Partnership Foundation Trust individual management review also says that they were not aware of any safeguarding concerns at the nursing home, and as they provided the mental health service for four residents there, this could have had a negative effect on that care.

Safeguarding policy did not effectively define 'collective care abuse'

Collective care abuse happens when the routines in use in an organisation, in this case in a nursing home, force residents to sacrifice their own needs to the needs of the organisation. Abuse may be carried out by those who have accepted the poor custom and practice of that nursing home.

To understand and recognise collective care abuse, professionals involved need to widen their view from just the individual. For example, if one resident seen has poorly treated pressure ulcers and an inadequate mattress, it could be likely that this also applies to other residents. Where professionals think critically and take in the wider view, safer and better working practices can flourish and risks can be properly assessed.

Until September 2011, professionals tended to see each individual concern about a resident as a single event which meant that there was never a gathering understanding about the standards of care that had become so poor. Developing, an understanding, that the practices and customs, or the 'regime' of the nursing home, had become abusive was made difficult by the fact individual workers from different teams would respond to individual safeguarding concerns

The value of 'professional curiosity' cannot be overestimated when it comes to safeguarding vulnerable adults, which means asking questions about individual areas of concern. If an individual concern is seen as a 'window' to the wider view, and that it might apply to many more residents than just one, then lines of useful enquiry can be made.

It would also need all information gathered to be held in one place and communicated to all involved agencies and this was not consistently happening. All of the individual management reviews said that there were missed opportunities for sharing and analysing information about the nursing home. A further example is when a medication inspection undertaken by community pharmacists in April 2011 found that the nursing home had not implemented recommendations, issued in June 2010, in relation to managing their medicines better. It is recognized by all agencies involved that the use of standalone computer systems that do not readily communicate has a significant impact on the sharing of effective intelligence.

Question two of this review: When concerns arose about the standard of care at the nursing home, did the multi-agency safeguarding response address these effectively and appropriately?

Appropriate meetings

When a series of safeguarding alerts were found to be true, in late September 2011, a strategy meeting was held on the 30th of that month. The meeting was chaired by a manager from Adults, Health and Social Care and attended by Police, Adults Health and Social Care representatives, the safeguarding lead for NHS Calderdale representatives and Care Quality Commission representatives. This was an appropriate meeting to hold considering the seriousness of the concerns and the West Yorkshire Police individual management review says that there was shared opinions that the "level of neglect was serious enough to reach a criminal standard".

In October 2011, two further strategy meetings took place on the 3rd and 5th, again with the representatives from the appropriate agencies, and, it was particularly useful that the Care Quality Commission representative attended these meetings also.

Safeguarding policy at the time did not require the Local Authority to investigate safeguarding concern

Strategy meetings were chaired by different agencies and the individual management reviews say that this meant there were differences about how some decisions were made and how different parts of the safeguarding concerns should be looked at, and how the safeguarding response should be managed. This affected the overall continuity and control.

The Author believes the absence of guidance and procedures on how to manage a whole service response, was likely to mean that agencies would fall back on their own 'business as usual' skills instead of working together with each other and that this may lead to some tensions between them.

The Author believes there were tensions between agencies where there was a need for joint working. These were because of a lack of understanding about each other's roles and responsibilities in respect of safeguarding adults.

The appropriateness of the intervention at 7.00am on the 7th October 2011

The West Yorkshire Police individual management review does say that much discussion took place about the appropriate timing of the intervention. It was decided that it would have the least impact if physical health checks were undertaken early in the morning when residents were being supported with their personal care needs as part of their usual morning routines. This is reasonable and is evidence that there was proper consideration of the dignity and needs of residents.

However, there is potential for a negative public perception of police carrying out 'dawn raids'. One relative, who spoke to the author, considered that the early start of the assessments at 7.00am had had an unsettling effect on the nursing home. Yet another relative praised the efficiency of the operation.

Overall, it can be said that this was an appropriate and effective piece of work under difficult circumstances.

Agencies need to ensure they hold detailed discussions about how the logistics of these types of interventions would work, with regard to timings, personnel and above all, residents' needs and care.

There was evidence in the planning of the 7.00am intervention on the 7th October 2011 that the following elements were discussed and planned for:

- The needs of residents;
- The communication with families – letters were delivered to family members offering meetings that day; and
- Contacting and meeting the owner of the nursing home.

The findings of the intervention were later collated for the Crown Prosecution Service and resulted in a successful criminal prosecutions for the owner and registered manager. This proves that this safeguarding response was completely necessary and was therefore effective and appropriate.

There were many positive aspects that emerged from the intervention, such as:

- The detailed health assessments were essential for ensuring individual health needs were met and also for obtaining evidence of poor standards of care;
- There was a very high level of commitment by all of the agencies involved in the safeguarding response, as evidenced by the dedicated use of extra resources;
- There was very open and healthy communication with relatives of the residents in the immediate aftermath of the intervention; and
- Social work assessments clearly identified people did not have the mental capacity to consent to their care and treatment and the time concerns were raised. Without this it would not have been possible to evidence a crime of "Willful Neglect".

The positive outcomes of the intervention

After the intervention and assessments of residents that took place on the 7th October 2011, there was evidence of continued and frequent communication with relatives of residents. When it became clear that the nursing home was not going to be taken over by new owners, relatives were advised, quite correctly, that transfers to other nursing homes should take place as soon as possible. Needs of residents were taken into account and staff were very aware of the possible negative impact of moving very elderly vulnerable residents.

The decision to move residents out of the nursing home was not taken lightly and the time it took for some residents to move could leave a question about possible "drift" This concern is not supported and was due to professional concerns about the impact of transferring vulnerable residents. All of the families consulted by the report

Author praised the sensitivity and efficiency of staff in carrying out the transfers of residents.

All residents had been moved out of the nursing home by the 17th February 2012, but work continued to ensure that all safeguarding plans continued to be in place. This was good practice and contributed towards the continuity of care of the residents.

Overall the intervention that took place on the 7th October 2011 and the management afterwards of the 'case' was very effective in safeguarding residents at the nursing home. There was a good understanding of the need for effective liaison with relatives and protection plans were appropriate.

Area one of this review: How NHS commissioners of care support services; Adults, Health and Social Care Contracts; Care Management Services; Care Quality Commission, and other adult safeguarding professionals interacted.

There were many ways that information and concerns about care at the nursing home were coming in and could have been used to let agencies know what was happening before late September and October 2011, when the safeguarding response occurred.

Issues of information-sharing

Had there been full and consistent sharing of this information between agencies and more decisive decision-making, it is possible that considerable distress could have been avoided.

A number of the individual management reviews say that some of the key processes used by agencies involved, including those who commission services and those who lead adult safeguarding, are not as developed as they need to be. For instance, the function of the monitoring meeting was unclear as was the process for undertaking whole service safeguarding responses

Sharing information across agencies was critical in understanding what was happening at the nursing home. This was not consistently done and did not support agencies to hold an accurate view of the standard of care in the nursing home.

The Author also believes the role of Adults, Health and Social Care in terms of leading safeguarding responses was not well established and was not helped by a lack of challenge from other agencies.

This report makes the point that unless these issues are addressed and clear pathways and processes are put in place for information-sharing between agencies about safeguarding issues then similar problems are likely to occur.

Area two of this review: How the Care Quality Commission acted as a regulator and inspector; how it makes its decisions; its relationships and

communication with local services and how it acted during the multi-agency safeguarding response.

What the Care Quality Commission did

The Care Quality Commission acts and functions according to the terms and requirements of the Health and Social Care Act 2008.

In brief, as already detailed in this report, the Care Quality Commission acted on the concerns about a resident developing a pressure sore and they carried out a responsive review in May 2011. A further review of the nursing home was then carried out in September 2011 and a number of concerns were noted. It was due to these concerns that management review meetings were held between the compliance manager of the Care Quality Commission and the acting manager of the nursing home.

The Care Quality Commission were then involved in the multi-agency meetings following the safeguarding response at the nursing home in October 2011, and a decision was then made on the 11th October 2011 that there was not enough evidence to cancel the registration of the manager at the nursing home.

Mixed messages

However, there appear to have been some mixed messages in communications between the Care Quality Commission, and Adults, Health and Social Care. Following the meeting on the 11th October it was reported by the compliance manager of the Care Quality Commission that the Local Authority had expressed a preference for the Care Quality Commission to take immediate action. The Local Authority confirmed that they had capacity to provide alternative accommodation for the residents of the nursing home.

The Care Quality Commission individual management review then says that following attendance at a multi-agency meeting on the 12th October 2011, "Calderdale contracts department contacted to inform Care Quality Commission …that they did not have capacity within the area to accommodate the service users [residents] if the Care Quality Commission were to proceed with urgent action". This message then seems to have guided the response by Care Quality Commission to review the plan and to issue warning notices.

This action was almost certainly intended as a helpful response, in difficult circumstances and the owner of the nursing home was suggesting plans were starting for selling the home and then bringing in an outside management agency.

However, it had become clear in February 2012 that improvements at the nursing home could not be maintained. The agreement was then made, between agencies including Care Quality Commission, that placements could not continue and relatives were advised that there was a need to move residents. This move took place within a few days of the advice given to relatives.

Addressing whistle-blowing

There were two occasions towards the end of July 2011 when Gateway to Care were made aware by Care Quality Commission of a number of concerns made by an anonymous staff member from the nursing home. On the first occasion the allegations were:

- The manager intimidated and bullied staff;
- Two pregnant care workers had been scheduled on to the same night shifts;
- The home was short staffed;
- Residents were neglected and not interacted with, taken to the toilet or brought their food;
- Resident ill health wasn't being reported;
- A resident had developed a condition in December 2010 which wasn't treated until March 2011; and
- Some residents were suffering 'pains in their behinds due to sitting all day'.

On the second occasion, Gateway to Care received further notice from Care Quality Commission of an anonymous alert relating to problems with resident's food, pressures sores on residents and toileting arrangements. The alert also said that staff felt under threat of losing their jobs and things were getting left or rushed.

On reflection these whistle-blowing allegations about individuals should have led to much more robust action from Care Quality Commission, such as some multi-agency agreement about how the concerns were going to be explored.

The meeting did consider a nursing employment issue which had been brought to its attention by the home. The owner had reported dismissing a registered nurse due to 'gross negligence and incompetence' which he alleged related to pre-signing of medicine sheets and not checking drugs given out during the night.

There was also concern, discussed at a monthly monitoring group meeting of Calderdale Council, Care Quality Commission and NHS Calderdale representatives about the scheduling of two pregnant care workers on the same night shifts and the manager's decision to employ a nurse without seeking two references as required under the terms of the contract.

The outcome from the sharing of information between agencies, on concerns relating to staffing within the nursing home, was that an unannounced compliance monitoring visit would take place in late August 2011 led by the Contracts Compliance Team and supported by the Continuing Health Care Team. This was appropriate given the concerns that had emerged about staffing issues.

There were however also additional concerns about individual residents that had been raised by the whistle-blowing incidents that were not addressed by a specific safeguarding response.

A compliance visit at the nursing home on the 18th August 2011

An unannounced monitoring visit also took place after this compliance visit, on the 25th August 2011. Poor outcomes were identified in the areas of care planning,

accident reporting, and administration of staff files, incident reporting, staffing levels, recruitment processes, training of staff and the state of the environment. Whilst it was noted during both visits that a resident had been admitted to hospital without the proper procedure being followed, which was to notify Gateway to Care of the incident, the seriousness of the circumstances of the resident's admission to hospital was not noted.

The findings from the visits were reported to the monthly monitoring group in August 2011. These were:

- The officer in charge had been unable to find documentation required during the visit;
- Two pregnant staff had been scheduled onto the same shift twice, without a risk assessment taking place;
- Significant gaps had been seen in the care plans;
- The was no staff training matrix available;
- A serious clinical incident had not been reported to Calderdale Council; and
- There had been a gas leak in March/April which had not been reported or documented.

These were important findings that gave a picture of the level of disorganisation at the nursing home and there was ideal opportunity for the main agencies involved, including the Care Quality Commission to address these as well as the concerns about the care of residents; the same concerns that had been given in the whistle-blowing allegations.

The further review of the nursing home that the Care Quality Commission carried out on the 28th September 2011 did, as detailed in this report, identify a number of major concerns. It did not however identify the true level of seriousness in the situation at the nursing home. It was only just over a week later, on the 7th October that the joint investigation team discovered the scale of the poor standard of care. With care being so poor that one resident had to be immediately admitted to hospital.

Working with other agencies

There is good evidence that the Care Quality Commission followed regulations and guidance in the work with other agencies and the nursing home. They were also willing to be flexible and supportive in taking action, once the scale of concerns was known in early October 2011.

The Author believes there is a sense that the individual management review of the Care Quality Commission was not critical enough regarding their response to the whistle-blowing incidents. This could be a significant learning point that should be reconsidered by the Care Quality Commission and other agencies.

There are also issues about the Care Quality Commission, along with other agencies, of failing to use the monthly monitoring meetings effectively so that patterns of abuse could have been identified. The Care Quality Commission should have an important role in raising challenging questions to investigate concerns in this area, particularly at multi-agency meetings such as the monitoring meetings.

Area three of this review: How the West Yorkshire Police carried out its actions, from its initial intelligence about the nursing home to the criminal investigation and case preparation for the Crown Prosecution Service.

Some early police intervention

Involvement by the West Yorkshire Police was limited before their input in late September and early October 2011.

In February 2009 a relative of a resident contacted the police after reading an article in the local newspaper about the poor standards of care at the nursing home. The relative was concerned she had seen bruising when her resident relative had been admitted to hospital from the nursing home. West Yorkshire Police, Safeguarding Unit communicated with Adults, Health and Social Care over this and they were assured that the resident had suffered a fall and caused the bruising. There was no evidence to support continuation of a criminal investigation.

The West Yorkshire Police individual management review says that there was no consideration that the newspaper article might be indicating widespread abuse.

There was also, in 2009 and 2010, occasional police contact with the nursing home to do with the sudden deaths of residents. But no wider concerns were raised about these events and the deaths were established as being due to natural causes.

The start of the police investigation plan

On the 29th September 2011, West Yorkshire Police, Safeguarding Unit were informed by Adults, Health and Social Care about the concerns for three residents at the nursing home. The police then attended a safeguarding strategy meeting the following day. At that meeting the information said, “the level of neglect was serious enough to reach a criminal standard”. A further strategy meeting was then scheduled for the 3rd October 2011.

On 4th October 2011 police put together and started an investigation plan. This involved putting together a team of police officers. The team was a senior investigating officer, a deputy senior investigation officer, three detective sergeants, two family liaison officers and seven police constables. Plans were also made for getting a warrant, communicating with the coroner’s office and developing a media strategy.

Overall, the investigation that was carried out at 7.00am on the 7th October 2011 was a thorough and efficient operation. It has been detailed previously in this report, how tension arose between agencies over the levels of care leading to safeguarding issues.

The findings from the investigation have been detailed in this report and clearly justify, what might be seen as, an intrusive entry into the nursing home. But there was good communication with relatives by all the agencies involved.

However, some relatives were concerned about how effective the systems had been for keeping them informed about where the Crown Prosecution Service were up to with decisions about prosecution.

Overall, there is evidence that the West Yorkshire Police took the concerns about the nursing home very seriously and they gave significant resources to make sure a thorough and effective investigation took place, jointly with the other agencies involved. This looks very positive for their future joint working.

The actions of the police and other partner agencies also resulted in successful criminal prosecutions of the owner and registered manager.

Area four of this review: How primary and community health services supported the nursing home and how concerns were reported and acted upon.

Evidence of good practice

The NHS Calderdale individual management review talks about the support given to the nursing home by GPs and that there was evidence of good practice, which was:

- There was a system for making sure that the wrong repeat prescriptions were not being used;
- Annual assessments of residents with diabetes and dementia were carried out;
- There was evidence that GPs consulted with relatives of the residents;
- There was evidence that there was advice and support for nursing home staff about caring for the residents;
- Flu vaccinations were given to a number of the residents; and
- Referrals were made, when appropriate, to specialists such as dieticians and nutritionists.

Areas where practice could be improved

1. A particular issue, which is talked about in the NHS Calderdale individual management review, was that information was spread between three GP practices and several GPs within each practice. This made it difficult for any practice to develop a full picture of concerns at the nursing home and is likely to present an ongoing challenge as individuals have the right to choose which GP they want to register with.

   Although there were many meetings held, such as the monthly monitoring meetings, between NHS Health and Adults, Health and Social Care, before October 2011 about the standard of care at the nursing home there was not a consistent means of sharing background information with GPs.

2. The Author believes it would be useful for the Adults Safeguarding Board to think about how all agencies, including GPs are aware of the functions of the various safeguarding meetings and the professional responsibilities of those attending those meetings.

   This issue is also highlighted in the NHS Calderdale individual management review: a number of the residents were on dietary supplements and saw dieticians. But the summaries that the dieticians made, which went to the residents' GPs, did not always contain the detailed information about the resident's assessment or, for example, a target weight. This information would have helped to monitor and highlight weight-loss concerns to GPs.

3. It was also talked about in the NHS Calderdale individual management review that prescriptions for dressings for wounds were requested on an ad-hoc basis by nursing staff at the nursing home. These requests were often 'tagged on' to a repeat prescription. But there was evidence, that when health assessments were made on the 7th October 2011, that the dressings were not always appropriate for the wounds they were being used for.

4. From an inspection of the medical records, the NHS Calderdale individual management review identified that there were no completed assessments from the Tissue Viability Service within the GPs' medical records. The NHS Calderdale individual management review says that sharing these assessments would have made the service to residents better.

5. The South West Yorkshire Foundation Trust individual management review talks about details of their involvement with five residents of the nursing home. At various times these residents were seen by the Care Home Liaison Team between January 2012 and 1st March 2012, although the contact between the Care Liaison Team and the nursing home stopped after 17th February 2012, when the nursing home closed. Before this, more than one review, or Care Programme Approach, was carried out at the nursing home with no particular problems identified in relation to any individual resident. In fact there is nothing to say from the records that the South West Yorkshire Foundation Trust was ever made aware about any concerns of poor care at the nursing home.

   Although concerns about the nursing home were becoming clearer in July and August 2011, the South West Yorkshire Foundation Trust were not informed about those concerns or involved in any discussions about general concerns at the nursing home. Had they been aware, the Care Coordinator could have made a more in-depth assessment and helped to put together the wider picture.

Learning points

The Calderdale and Huddersfield NHS Foundation Trust individual management review talks about a number of 'learning points' to be addressed, these include:

- The need for discussion about how the trust fits into the information-sharing process when there are concerns about care homes;
- The need for services (the Tissue Viability nurse in this case) to receive feedback from the Primary Care Trust when they have raised an alert; and
- The role of NHS providers when care homes are not meeting adequate standards.

Area five of this review: How the views of the nursing home residents and their relatives were taken into account, particularly in considering that a number of the residents had recently moved from a closed nursing home within Calderdale.

Residents' moves to the nursing home

Two residents were moved to the nursing home in July 2011, when it was known that the care being provided was rated "adequate". For these two residents however a move was essential as their previous nursing home was not providing adequate standards of care.

There had been a recent Care Quality Commission Inspection in May 2011 that had identified some minor concerns and it was known that there had also been concerns raised previously about pressure ulcers (August 2010 and May 2011), and also that there had been an incident when a resident had suffered a fracture.

It could be said however that in the absence of robust evidence about the quality of care at the nursing home, and also the quite positive Care Quality Commission inspection that had been carried out. The picture view of the care provided in the nursing home was not accurate.

One of the residents who transferred to the nursing home had been reviewed by Continuing Health Care and the Adults, Health and Social Care social worker on 16th June 2011 with a relative present. The relative did not want their elderly resident to be transferred to the nursing home as they were happy with the level of care already being provided in their current care home and did not want to unsettle their routine. However, during July 2011 it became clearer that the resident would need to move to the nursing home as care needs could not be met and a specialist placement was needed.

Although some concerns has been raised by the Continuing Health Care Team that the nursing home may not be able to meet the Mental Health needs of the individual as it was not registered EMI (Elderly Mentally Infirm). The decision was made to taken in conjunction with the family member that this was in the person's best interests.

The previous nursing home of the two residents who transferred closed in August 2011. Due to the unusual circumstances of the move, including that the nursing home did not have an EMI registration it was agreed by the social care team manager that the social worker would conduct a six-week review of the placement to assess how well the resident, who had required a specialist placement, was

adjusting. The resident was reported to have settled in well by July 16th and did not require a specialist EMI placement.

In July 2011, another resident was transferred to the nursing home. This was their fourth care placement. During their stay in the previous nursing home they had experienced significant weight loss. But it was reported in September 2011 that they seemed to have settled in very well and there were signs of improvement. A relative was also reported to be happy with the placement.

Residents' moves were reasonable but there was a lack of information

Given the information known at the time, the residents' moves to the nursing home were reasonable. Communication with relatives was sensitive and professional. But it became clear in a meeting between relatives and the Author of this report that relatives had very little information about the differences (and similarities) between complaints, concerns and abuse allegations.

Additional information could have been made available had agencies been aware of the wider picture of concern at the nursing home. Certainly by late July and early August 2011 there should have been a more robust approach to investigating the care being provided at the nursing home.

Service developments since the multi-agency safeguarding response

There have been a number of important service developments, as detailed in the individual management reviews that have been introduced because of lessons learned from this case. These include:

- Updated policy procedures for health agencies on adult safeguarding;
- Attachment of dedicated community nursing teams to specific care homes to facilitate continuity of care;
- The introduction of new training on safeguarding investigations and preservation of evidence (for health staff);
- A raised awareness of how low-level concerns can escalate and the need for a zero tolerance approach;
- Key discussions between social care and the police about how joint investigations into safeguarding concerns by the two agencies should be managed;
- Raised awareness in Health and Social Care about safeguarding processes and a revision of safeguarding procedures being undertaken;
- Increased training packages for GPs on safeguarding;
- A strengthening of the NHS Safeguarding Commissioning Policy (for both Adults and Children);
- Considerations by all agencies about the transferability of learning from the Munro Review of Child Protection; and
- A review of the functioning of the monthly monitoring meeting and its relationship to safeguarding processes.

It is clear that this case has had a profound impact on both practitioners and managers and that issues relating to safeguarding now have a very high profile.

Individual agency initiatives to address safeguarding are to be praised. However this progress needs to be built on, particularly in relation to multi-agency work and the need to have agreement about joint working protocols and working.

Summary and recommendations

This is a complex case of 'collective care' or institutional abuse. The number of residents, their diverse and multiple needs, the number of agencies and professional involved have all added to this complexity.

This report raised a number of questions about the multi-agency safeguarding systems that were in place at the time. There are concerns about the consistent understanding and use the safeguarding alert mechanisms across all agencies.

There is some evidence from this case that there is not a shared understanding between all internal and external agencies of what constitutes abuse, of when safeguarding procedures should be used in individual or collective care cases and what the response should be to safeguarding concerns.

There was also a lack of understanding and recognition of 'collective abuse'. This resulted in agencies missing the opportunity to provide a whole service safeguarding responses earlier in the process. . It is unlikely, without significant changes to safeguarding procedures and processes, that future responses to safeguarding incidents will be more effective.

There are joint commissioning and joint working arrangements that are not adequately coordinated to provide good quality shared information or services. A particular example of this is that there are two separate reviewing systems in Continuing Health Care and Adults, Health and Social Care. Sharing of information would compliment both services and offer greater safeguards for vulnerable service users.

Some of the difficulties encountered by agencies in joint working were due to the absence of clear protocols for multi-agency work when undertaking whole service safeguarding response and the fact no one team had oversight of the whole picture. Joint work needs to be undertaken on updating protocols on the commissioning and monitoring of placements with explicit consideration to the management of risk and the process for resolution between agencies when disputes arise. Similarly, protocols need to be developed on assessment of capacity and establishing best interest decisions. The introduction of new arrangements, under the Health and Social Care Act 2012, for accountability and an assurance framework for safeguarding may help in setting out a new framework for partnership working.
This updating of procedures should also cover family communication and support, raising standards, performance monitoring, contract management and escalation with the provider where there are concerns about standards of care. The process for ending a placement agreement and relocating residents also need reconsideration.

There are places where information-sharing between agencies could be enhanced to develop an understanding of collective concerns earlier in the process. An example of this is three GP practices, with multiple GPs, providing services to 25 residents and being able to share information about any safeguarding concerns, highlights problems in both information-sharing and how services are planned. It is acknowledged that this issue is out of the control of agencies as patients are able to exercise significant choice over which GP they choose to see.

The Safeguarding Adults Policy and Procedure does not adequately address 'whole service safeguarding concerns". Whilst this is common to many adults safeguarding boards, this needs to be addressed in line with reviewing safeguarding policies and procedures. High-level inter-agency discussions are also needed in order to ensure that there is a much more strategic approach to safeguarding.

The existing lack of a shared understanding between agencies of thresholds and mechanisms for protective actions is an issue that needs to be addressed.

Although concerns have been identified in the recognition of 'whole service safeguarding responses", when it became clearer, at the end of September 2011, about the nature and level of concerns, action was decisive, speedy and for the most part appropriate. This demonstrated the value of key agencies meeting and planning their joint interventions.

Strategic planning meetings between the police, health managers and Adults, Health and Social Care managers meant that effective interventions took place with the focus being firmly on ensuring that the residents of the nursing home were safe and their needs were being met. The outcome of this safeguarding response does however confirm that intervention could have taken place earlier if the abuse had been identified by better information-sharing and joint planning.

There were some tensions between agencies (mostly about role) in the aftermath of the safeguarding response and it was encouraging to see that those potential difficulties were put to one side in the interests of the residents. There will however need to be full and open talks about these issues if they are to be resolved.

It is extremely important that all agencies take the lessons from this serious case review in order to improve their existing safeguarding practices. There are specific lessons for the better management of 'collective abuse' safeguarding responses that will in the future need to be in day-to-day practice.

Recommendation 1

Calderdale Adults Safeguarding Board should develop and implement a model for early intervention in care home settings.

This recommendation is designed to provide a consistent preventative approach in care settings, to identify any safeguarding issues at an early stage and to improve the quality of care in establishments.

Recommendation 2

Calderdale Adults Safeguarding Board should put in place measures to assure the effectiveness of the safeguarding alert mechanism.

This recommendation is aimed at ensuring that all agencies, including service providers and the wider general public are aware of and use mechanisms for raising concerns about safeguarding issues. Measures that may be required include auditing of cases, accurate management information, and joint training.

Recommendation 3

The existing monthly monitoring meetings should cease and a new properly constituted safeguarding monitoring meeting should be introduced.

This recommendation is intended to provide a formal framework for the multi-agency monitoring of safeguarding concerns in collective care settings and in complex cases. The forum should have representation at a level of seniority that allows operational decision-making.

Recommendation 4

Calderdale Adults Safeguarding Board should introduce a systems- based approach, in line with the Munro Review recommendations, for reviewing, auditing and analysing case material.

This recommendation is intended to establish a more effective framework for the future understanding of and learning from cases. In particular it is intended to help identify strengths and weaknesses within safeguarding systems.

Recommendation 5

Calderdale Adults Safeguarding Board should review and update procedures to ensure that the management of allegations of abuse in collective care settings is explicit.

This recommendation is aimed at ensuring that guidance for practitioners is clear that that there is multi-agency agreement for joint interventions in collective care settings.
A protocol should be put in place between Adults, Health and Social Care and West Yorkshire Police clarifying their respective responsibilities under the multi-agency safeguarding procedures. There should be explicit reference to the responsibilities of all agencies under the Mental Capacity Act to assume capacity. Procedures should

also provide clarity about the threshold for triggering a collective care setting safeguarding response.

Recommendation 6

Calderdale Adults Safeguarding Board should ensure that their policy on whistle-blowing is being adhered to and that all whistle-blowing allegations are properly investigated. This includes notifications of whistle-blowing from external sources.

This recommendation is aimed at ensuring that allegations/expressions of concern from all sources, including whistle-blowing are taken seriously and investigated fully.

Recommendation 7

Calderdale Adults Safeguarding Board should ensure that accurate and up to date information about what to do when there are safeguarding concerns is made available for service users, their relatives and the general public.

This recommendation is aimed at promoting information about safeguarding and encouraging vulnerable service users, their relatives and the wider community to have better access to safeguarding services.

Recommendation 8

Calderdale Adults Safeguarding Board should request Health and Social Care agencies (Continuing Care, and Adults, Health and Social Care) to consider developing an integrated reviewing system.

This recommendation is aimed at encouraging more integrated assessment and reviewing systems and improving the sharing of information.

Recommendation 9

Protocols should be reviewed between all of the key agencies clarifying their respective roles and responsibilities in relation to commissioning, assessment and review of care placements arranged in older people's care and nursing homes.

This recommendation is designed to develop updated and comprehensive protocols that offer a framework for effective joint working between agencies.

Recommendation 10

Calderdale Adults Safeguarding Board should ensure that there is the opportunity for staff from all agencies, which are likely to be involved in collective care investigations to reflect on the lessons learned from this case. This should be facilitated through a systematic training programme.

This is intended to optimise the learning from the collective care investigation and this serious case review.

Individual agency recommendations

West Yorkshire Police

1. The role of the Care Quality Commission and their powers to regulate and enforce required better understanding. Safeguarding staff should be given training in the roles and responsibilities of the Care Quality Commission.

2. An investigation of this scale should involve a thorough review of resources and be staffed sufficiently to enable the investigation to progress in a timely manner. Full consideration should be given to enabling dedicated resources to be deployed.

Adults, Health and Social Care

3. The monthly monitoring group should be placed onto a formally constituted basis and brought under the leadership of the safeguarding manager.

4. The capacity of the safeguarding unit and the contracts team should be reviewed to assess if resources allocated to both functions are appropriate to match workload demands.

5. A contract screens module should be built onto the client information system to bring all compliance and safeguarding information together into a single place and to provide access to managers across Adults Health and Social Care the collated intelligence on care settings in relation to:

    i. Number of placements;
    ii. Commercial value of the relationship between the Council and provider;
    iii. Complaints received;
    iv. Compliance concerns;
    v. Monitoring visit outcomes;
    vi. Individual resident care quality reviews;
    vii. Inspection outcomes; and
    viii. Safeguarding alerts and outcomes from safeguarding investigations.

6. The Vision for Adult Social Care should explicitly state that the key driver is the care and well-being of vulnerable adults. How well individual assessed care needs are being met is paramount and the basis from which social care leadership decisions, in relation to safeguarding in collective care settings, should be responded to.

7. Adults, Health and Social Care should consider the need to ensure that safeguarding, commissioning, contract compliance and complaints are

coordinated appropriately with a view to reconnecting the decision-making and leadership of all aspects of care commissioned by the Council on behalf of vulnerable adults. Any new structure should explicitly recognise the mutual dependencies between the functions of assessment of need for care and support, with facilitation and development of the care and support market.

8. Personal and professional support for key decision-makers at leadership level within the Directorate must be put onto a basis that meets the expectations of the Council. That staff will be provided with access to an individual, face-to-face meeting with their Head of Service to discuss their key areas of work on a minimum of a monthly basis.

9. Training should be provided for staff in Gateway to Care, contracts and the safeguarding unit to determine and seek consensus across Adults, Health and Social Care on the thresholds for triggering a safeguarding alert in collective care settings. The response should be coordinated under the leadership of the safeguarding unit.

10. All safeguarding concerns should be channeled through Gateway to Care for a safeguarding alert to be raised and then passed directly into the safeguarding unit so that an appropriate professional social work judgment can be applied to whether or not the concern is serious enough to trigger a referral and whether further coordination action is required by the safeguarding unit. The Safeguarding Adults Team should lead coordination of engagement of operations, contracts and partner agencies in responding to emerging safeguarding concerns in collective care settings.

11. The leadership arrangements within Adults, Health and Social Care for monitoring care quality, judging the significance of quality concerns and identifying appropriateness and proportionality of response where there is evidence of a safeguarding in collective care settings issue should be coordinated into a single leadership approach encompassing:

    i. Complaints alerted through the corporate complaints unit;
    ii. Care quality concerns identified during individual resident care quality reviews;
    iii. Compliance and quality concerns alerted through monitoring visits and/or partner information-sharing agreements;
    iv. Safeguarding alerts notified through Gateway to Care; and
    v. Other statutory notifications to be made to the Care Quality Commission.

12. Social workers should be provided with training to enable them to exercise with confidence their role within the multi-agency safeguarding procedures in terms of coordinating the safeguarding work. In particular training should focus beyond the mechanics of the procedures on equipping social workers with the skills they need to operate within a multi-agency context providing scrutiny and challenge to partner agencies behaviors and decision-making.

13. Adults, Health and Social Care Safeguarding Unit should coordinate the delivery of a programme of training across agencies on safeguarding in collective care settings to seek consensus over thresholds, clarify roles and responsibilities under the procedures and the significance of the Mental Capacity Act (2005).

14. Social worker led, ongoing, proactive weekly reviews should take place for up to the first month following transfer of care for a vulnerable person who is relocated due to a whole service failure. A subsequent further period of review, including with family members, should be arranged in proportion to the continued assessed risk.

NHS Calderdale – Continuing Care, and the Quality and Safety Team

18. NHS Calderdale's process for reviewing nurses to report and respond to concerns is tested to ensure it has been implemented.

19. There is better signposting and access to information for carers and service users on the standards of care they can expect to receive within nursing homes.

20. NHS Calderdale will have appropriate systems, processes and resources in place to work to ensure quality and safety is maintained and improved during the transition.

21. The terms of reference for the monthly monitoring group are reviewed, updated and agreed by partners. This will include clarity on membership, purpose and governance.

22. A review of the multi-agency policies and procedures is undertaken to ensure a clear mechanism to manage both individuals' safeguarding concerns and safeguarding concerns relating to institution issues.

23. There is a process in place and embedded, through contract compliance, to check basic nursing home equipment is provided.

24. A policy and procedure for community pharmacies to report nursing home medication incidents and/or safeguarding concerns including the escalation process is developed and implemented.

NHS Calderdale - Primary Care Services

25. Provide GP practices with information regarding the serious case review process.

26. Scope the risk associated with multiple GP practices providing health care to a nursing home.

27. An agreed process for sharing assessments and outcomes of dieticians' involvement with GPs. This should include a policy for dietary supplements.

28. To scope whether all GP practices prescribe dressings on an ad-hoc basis when there is an identified need recorded in records.

29. An agreed process for sharing assessments and outcomes of Tissue Viability Service's involvement with GPs.

30. To clarify the roles and responsibilities of community matrons in respect of long-term condition and needs of nursing home residents.

Care Quality Commission

31. The Commission needs to ensure that it documents clearly its decision- making processes when agreeing to jointly work with other agencies.

32. For the Commission to provide training or education to other agencies on its enforcement framework and the scope of its legal framework and how this impacts on its decision-making processes.

Calderdale and Huddersfield NHS Foundation Trust

33. Community nursing staff's accountability when working with nursing homes (including the provision of funded nursing reports) should be clarified and communicated to staff within health and social care.

34. The discharge procedure when transferring patients back to nursing/residential homes and transfers of care between healthcare professionals outside acute settings should be reviewed so that all relevant information which contributes to meeting individual need is shared.

35. An agreed process for sharing internally gathered concerns regarding care homes with partner organisations plus follow-up and feedback arrangements should be considered (this would include clarifying processes for awareness raising and gathering concerns).

36. Calderdale and Huddersfield NHS Foundation Trust should work with commissioners to clarify the respective roles and management responsibilities of continuing care lead nurses and community matrons in respect of the long-term condition needs of nursing home residents.

South West Yorkshire Foundation Trust

37. There is no evidence to suggest that staff are not aware of their responsibilities with regard to reporting suspected abuse or substandard care; however communication reminding staff of their responsibilities and processes should be issued.

38. The standards of the Care Programme Approach should be revisited and a brief review undertaken to ascertain whether the lack of attendance at the

review was limited to this case or is endemic in practice. The Care Programme Approach supports our ability to provide proactive safeguarding.

39. Staff should be reminded to ensure that any behavioural issues could be indicative of potential abuse. To this end, to also check on training figures for Calderdale and ensure robust uptake of training.

40. General:

    a. A systematic process for alerting partners to safeguarding concerns in an organisation should be put in place. Some authorities issue regular embargoes or alerts.

    b. The partnership should issue a reminder that communication across care pathways is vital; the consideration of potential safeguarding concerns is an essential part of the care package.

    c. The process for alerting the authority to low-level concerns should be strengthened and built into contracting.