

**Confidential**

**Cornwall and Isles of Scilly Safeguarding  
Adults Board  
Safeguarding Adults Review  
The Morleigh Group**

Final Report

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## 1. Introduction

### 1.1. Overview of the circumstances that led to this review

- 1.1.1 The Morleigh Group owned and managed 5 Nursing Homes across Cornwall, Alexandra House, Clinton House, Collamere, Elmsleigh and St. Theresa's, along with 2 residential homes, The Brake Manor and Tregertha Court.
- 1.1.2 In December 2014 the CQC raised concerns over the poor performance of the of the Morleigh Group as a whole which led to Cornwall Council (supported by NHS Kernow) suspending all placements to home within the group in January 2015.
- 1.1.3 In February 2015 following meetings with the owners of the group an action plan was agreed and the suspension of placement was lifted.
- 1.1.4 In October 2015 a systemic safeguarding alert was raised by Cornwall Council for the Morleigh Group with particular concerns over Clinton House and in November 2015 a multi-agency meeting was raised over the unacceptable levels of care across the group and the sustainability of care delivery.
- 1.1.5 Further concerns were then raised in January 2016 and in November 2016 the Morleigh Group closed Clinton House (Alexandra House had been closed in 2015) and in December 2016 sold the company and remaining homes to the Cornwallis Group.
- 1.1.6 In November 2016 Panorama aired a documentary covering 2 of the care homes in the Morleigh Group (Clinton House and St. Theresa's) which identified unacceptable levels of care and neglect.

## **1.2. Statutory duty to conduct an Adult Safeguarding Review**

- 1.2.1. The Cornwall and Isles of Scilly Safeguarding Adults Board has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:
  - a) An adult with care and support needs has died and the LSAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the LSAB knows or suspects they have experienced serious abuse or neglect, and
  - b) There is reasonable concern about how the Board, its members or others worked together to safeguard the adult(s)
- 1.2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

## **1.3. Cornwall and Isles of Scilly Safeguarding Board's decision to conduct a review**

- 1.3.1. The Cornwall and Isles of Scilly Safeguarding Board decided to commission a Safeguarding Adult Review on the Morleigh Group at their meeting on the 13<sup>th</sup> July 2017.

#### **1.4. Terms of reference for the Review**

- 1.4.1. Following an initial scoping meeting, the focus of the review was defined as being agencies who had been involved and engaged with any of the 7 homes within the Morleigh Group over a 3 year period between Dec 2013 and the date of the sale of the homes to the Cornwallis Group in Dec 2016. The following questions were decided upon by the SAR panel:
- i. Monitoring – What was the interface between commissioning, contract management, quality and safeguarding and how effective was this interface?
  - ii. Improvement – How were agencies working together with the provider to address concerns and instigate sustainable improvement actions and how were these actions monitored? How did the responder rise to the challenge?
  - iii. Practice – What was the effectiveness and sustainability of the Multi-Agency approach in managing the systemic allegations and how were individual allegations brought into the systemic process?
  - iv. Assurance – How was the sustainability of improvement managed and what actions were taken to embed change across the group? Were there ongoing Multi-Agency quality assurance processes in place to support the sustainability of improvement actions?
  - v. Experience – How effective was the process for the families and residents when they raised concerns about their experiences? Were responses to the families and residents managed effectively and what impact did this have on the experience of those living in the care homes?

#### **1.5. Other Investigation**

- 1.5.1. The Police launched operation Juniper as result of allegations that surrounded the Morleigh Group. This investigation is now concluded. The author is not aware of any other investigations by statutory bodies.

## **2. The Review Methodology**

### **2.1 The review model**

The approach recommended by the overview writer and chosen by the review panel was as follows:

- i. Chronologies of involvement from all agencies who provided services and were involved or engaged with any of the 7 homes within the Morleigh Group over the time period above.

- ii. Internal Management Reviews (IMR's) from the same agencies, addressing the questions within the terms of reference and addressing the areas contained within the IMR template used by Cornwall and the Isles of Scilly Safeguarding Board. The purpose of the IMR's was to enable each agency to reflect on their own their own involvement with the Morleigh Group and to identify recommendations for change if necessary.
- iii. The overview writer also set each agency specific questions to answer that arose from their chronologies and this was aimed at clarifying incidents mentioned or seeking further information.
- iv. A press release was put out by Cornwall Council asking for any current or former residents and/or their families to make contact with the local authority if they wished to take part in the review.
- v. All GP's surgeries were also written to asking if they wished to take part in the review.
- vi. The BBC Panorama programme was also written to asking if they wished to take part in the review
- vii. A learning event was held to enable those practitioners and managers who were involved with the Morleigh Group an opportunity to give first hand information, hear the views of others, identify areas that may have been missed by their IMR writers and to help shape and feel part of the recommendations.
- viii. SAR panel meetings were held to discuss progress and assist analysis.

## 2.2 Agencies providing information to the review

### 2.2.1.

Cornwall Council Adult Social Care (ASC) Safeguarding Team	ASC's Safeguarding Team is responsible for deciding whether a safeguarding concern requires a response under the Councils statutory duties and for co-ordinating that response.
Cornwall Council Quality Assurance (QA) Team	The function of the QA team during this review period was to: Complete reviews (audits) of the quality of provision of a service and to follow up on any actions where the review identified any issues. Take specific actions in relation to provider performance feedback forms and where the issues were significant actions could include suspending the service from admissions and moving residents from the service.
Cornwall Council Commissioning Service	The Commissioning service are responsible for the contract management with the care homes. However, they only took on this role in 2016 as previously the commissioning role for the Morleigh Group

	was undertaken by the Cornwall Council QA team manager who had a joint role.
Care Quality Commission (CQC)	The independent regulator for all health and social care services in England.
South West Ambulance Service Trust (SWAST)	Provider of emergency and urgent care services to residents across Cornwall and the Isles of Scilly.
Devon and Cornwall Police	Territorial Police Force responsible for Policing the counties of Devon and Cornwall.
Cornwall Partnership NHS Foundation Trust (CFT)	Provides a range of mental health and physical health services to children across Cornwall and the Isles of Scilly.
NHS Kernow (NHSK) also shown as the Clinical Commissioning Group (KCCG)	NHS Kernow is the clinical commissioning group for Cornwall and the Isles of Scilly.
GP's Practices.	At least 4 GP's practices provided information either through interviews with the Author or the Practitioner Learning Event.

### 2.3. Participation by residents, families and staff

- 2.3.1. A press appeal was put out across Cornwall appealing for any residents, families or staff to contribute to this review. The author spoke to two ex-members of staff and one relative of a former resident.

### 3. The Morleigh Group – A Pen Picture

- 3.1. The Morleigh Group is a private limited company formed in 2003 with one shareholder (the owner). The Morleigh Group is described as a group providing nursing and residential care services for the elderly. Over a period of time and prior to this review period the Morleigh Group acquired the seven homes that form what was known as the Morleigh Group and are the focus of this review. Those homes being; Alexandra House, Clinton House, Collamere, Elmsleigh and St. Theresa's, along with 2 residential homes, The Brake Manor and Tregërtha Court.
- 3.2. The owner of the company played a key role in the running of the Morleigh Group, however there were also other family members that held roles within the group.

### 4. Case Chronology Overview, along with a review of notes from GP's interview and evidence from staff and families.

## 4.1 Alexandra House

- 4.1.1. 3<sup>rd</sup> December 2013 CQC receive Safeguarding alert from Cornwall Council re the ability of Alexandra nursing home to meet the needs of residents with complex needs and medication concerns. Decision made to carry out a responsive inspection on 9<sup>th</sup> December 2013.
- 4.1.2. Inspection carried out by CQC on 9<sup>th</sup> December 2013 as per entry above 4.1.1. Breach of regulation, Management of medicines recorded.
- 4.1.3. CQC first meeting with provider on the 7<sup>th</sup> January 2014, as portfolio had now increased to seven homes. Management structure and staffing levels discussed. CQC wanted to see a consistent service including effective governance across all services.
- 4.1.4. 19<sup>th</sup> March 2014, CQC carry out follow up inspection to look for improvements in relation to administration of medicines. Improvements made, found to be compliant.
- 4.1.5. 4<sup>th</sup> April 2014, further meeting between CQC and provider to discuss the registered manager situation and how the provider plans to grow the service.
- 4.1.6. CQC planned inspection, 26<sup>th</sup> June 2014, compliant in all areas.
- 4.1.7. 30<sup>th</sup> June 2014, resident admitted to RCHT with significant facial injuries, conflicting accounts of how this had happened. Threshold for S42 met, outcome inclusive.
- 4.1.8. 2<sup>nd</sup> September 2014 CQC Management review meeting (MRM) to discuss the Morleigh Group as a whole. There are currently seven locations and four have significant non-compliance (one having two warning notices). One location is rated red by Cornwall Council and five are Amber rated.
- 4.1.9. CQC meeting with provider on the 23<sup>rd</sup> September 2014 following MRM above at 4.1.8. discussed the need for an overall management structure and a Quality Assurance system at provider level. Also, the need for consistent managers at each home. Managers are being recruited and then leave within weeks.
- 4.1.10. 13<sup>th</sup> January 2015 the CQC receive whistleblower concerns from an agency worker that there is only one working bathroom for 25 people, threadbare bedding and a lack of meaningful activities. Decision made to carry out a responsive inspection on the 15<sup>th</sup> January 2015.
- 4.1.11. CQC inspection carried out on the 15<sup>th</sup> January 2015 as per entry above at 4.1.10. Breaches of care and welfare and premises were identified and warning notices issued.
- 4.1.12. The CQC held a meeting with the provider on the 11<sup>th</sup> February 2015 to discuss the current situation whereby all seven homes are in suspension with Cornwall Council and the financial implications of that. Discussed how the group could improve.
- 4.1.13. 12<sup>th</sup> May 2015 the home was voluntarily closed by the provider. Most residents had moved out in the preceding weeks.

## 4.2 Clinton House

- 4.2.1 A multi-agency safeguarding process was already underway in relation to Clinton House at the start of this review period due to systemic failures at the home. There was also a Cornwall Council QA action plan in place at the start of this review period that had been put in place following a Cornwall Council review in October 2013.
- 4.2.2 On the 4<sup>th</sup> December 2013 the CFT referred another safeguarding matter to the local authority safeguarding team. The referral was in relation to the neglect of a resident who had been left for long periods in wet and soiled clothing. Further concerns were also raised in relation to faulty manual handling equipment, ill-fitting slings and handling belt. There was also a complaint regarding the general attitude of staff. The local authority triage forwarded the concerns to be included in the current systemic process. However, the final safeguarding review meeting for the systemic process listed at 4.2.1 was closed with a meeting on the 8<sup>th</sup> January 2014 and this matter was not recorded as being mentioned. Further enquiries revealed that this matter had been closed on Mosaic (local authority recording system)
- 4.2.3 On the 16<sup>th</sup> December 2013 a further alert was raised by the CFT to the local authority safeguarding team regarding a complaint made by a resident at Clinton House, who stated that they had been handled roughly and had received bruising as a result. This matter was also forwarded by the triage team for inclusion in the systemic process underway as at 4.2.1. However as at 4.2.2 this systemic process was closed on the 8<sup>th</sup> January 2014 and this matter not recorded within the minutes of the closure meeting. This matter was identified on the 28<sup>th</sup> February as being closed on Mosaic. In relation to the closure of the systemic safeguarding process recorded at 4.2.1 it was recorded in the minutes of the 8<sup>th</sup> January 2014 that monitoring would continue via the service improvement team. (now the QA team)
- 4.2.4 On the 28<sup>th</sup> December 2013 Anonymous Whistleblower concerns were received by the CQC regarding low staffing levels. This was noted for follow up with the provider on the 7<sup>th</sup> January 2014 when a meeting was planned with them.
- 4.2.5 On the 7<sup>th</sup> January 2014 the CQC held a meeting with the provider as their portfolio had now increased to seven homes. Feedback from recent inspections was discussed along with the management structure of the homes and staffing levels. It was stressed to the provider that the CQC will look at the activity of the provider as a whole and will want to see a consistent service and effective governance across all services.
- 4.2.6 January 2014 Cornwall Council QA action plan review took place
- 4.2.7 On the 23<sup>rd</sup> January 2015 a safeguarding alert was raised to the CQC by a visiting tissue viability nurse, as they suspected it had been caused by incorrect manual handling methods. The home was asked to do its own investigation and it appears that the person was admitted to Clinton House from hospital with the pressure sore.
- 4.2.8 Anonymous concerns were received by the CQC on the 31<sup>st</sup> January 2014 regarding staff shortages and the owner bullying staff. There was no specific mention about harm to people. This was noted for the next inspection.
- 4.2.9 On the 27<sup>th</sup> February 2014 the family of a resident raised concerns to the CQC regarding their family member who was staying at the home for a short period of time. The family felt that the home had not provided good care or support for their relative who had a learning disability. This complaint was escalated to the senior management within the CQC and shared with Adult Services at Cornwall Council. It was also noted for the next inspection.



- 4.2.10 4<sup>th</sup> February 2014, family of a resident who had recently died following admission to hospital, allege neglect prior to hospital admission. Threshold for S42 met, outcome recorded as not substantiated.
- 4.2.11 On the 10<sup>th</sup> March 2014 the CQC received anonymous information regarding staff shortages and a lack of equipment. This was noted for the next inspection.
- 4.2.12 March 2014, Cornwall Council QA action plan review took place.
- 4.2.13 A planned inspection was carried out by the CQC on the 22<sup>nd</sup> April 2014 and a follow up in relation to earlier breaches of respect and involvement and to discuss recent concerns raised as above. The inspection found that the home was compliant in relation to respect and involvement, care and welfare, safeguarding and staffing. They did however find a breach of assessing and monitoring the service. The outcome as agreed between the inspector and manager and the report published on the 10<sup>th</sup> May 2014.
- 4.2.14 April 2014 Cornwall Council QA action plan review took place.
- 4.2.15 24<sup>th</sup> April 2014. The CQC held a planned meeting with the provider and discussed each home in the group and how the provider was going to structure the service as it grows. The registered manager situation was also discussed.
- 4.2.16 May 2014, Cornwall Council QA action plan review meeting but the provider claimed not to have received the dates/times despite evidence to the contrary.
- 4.2.17 July 2014, Cornwall Council QA action plan meeting cancelled by the new manager and cancelled again in October.
- 4.2.18 On the 7<sup>th</sup> August 2014 the CQC received Whistleblower concerns regarding the lack of staff at Clinton House, only one shower for 37 residents and the fact that carers were having to do the cleaning. This was noted for the next inspection.
- 4.2.19 On the 20<sup>th</sup> August 2014 a relative raised concerns to the CQC regarding the home being unable to meet the needs of their relative who was diabetic and on a respite stay at Clinton House. The CQC noted this for their next inspection.
- 4.2.20 On the 2<sup>nd</sup> September 2014 the CQC held a management review meeting to discuss the Morleigh Group as a whole. One location was already rated red by Cornwall Council and five are amber rated. Four of the homes also have CQC non-compliance and one has two warning notices. There was also a concern about the lack of registered managers. It was agreed to keep the registered manager situation under review and maybe consider fixed penalty notices. It was also agreed to hold a meeting with the provider to discuss the concerns.
- 4.2.21 On the 4<sup>th</sup> September 2014 concerns were raised to the CQC (source unknown), regarding the low staffing levels, running out of 'essentials', lack of hot water, lack of training for new staff and that the staff didn't speak English. An email was sent to the home asking for a report on the concerns raised and a report came back which gave assurances all was well.
- 4.2.22 On the 11<sup>th</sup> September 2014 an adult safeguarding referral was reported to the local authority by the CFT. The following was recorded; residents being restricted or denied fluids or access to appropriate toilet facilities. Cold rooms, poor manual handling practice. Care plans and risk assessments not resident centred. Insufficient admissions criteria, poor cultural behaviour and attitude of staff. Physical and psychological abuse of residents by staff.
- 4.2.23 22<sup>nd</sup> September 2014, ASC receive concern regarding resident who was lifted with a sheet instead of a hoist, her personal care was also neglected. Progressed to S42

enquiry, resident died in hospital and concerns were progressed to organisational enquiry.

- 4.2.24 23<sup>rd</sup> September 2014 the CQC hold a meeting with the provider in relation to concerns following their management review meeting on the 2<sup>nd</sup> September 2014 at 4.2.20. It was stated that the CQC would take enforcement action where they found ongoing non-compliance in the group. They discussed the need for an overall management structure and a QA system at provider level and to have consistent managers at each home. Managers are recruited and then leave within weeks.
- 4.2.25 On the 16<sup>th</sup> October 2014 a strategy and conference meeting was held in relation to the concerns raised above at 4.2.22.
- 4.2.26 26<sup>th</sup> November 2014 the Police carried out a death related enquiry, the outcome of the enquiry was no further action by the Police and the death was natural causes, however there were concerns raised by the deceased's family in relation to his care at the home and the Police have recorded that it is up to the family to report these to social services. The police do not appear to have shared this information or considered safeguarding within their enquiries.
- 4.2.27 1<sup>st</sup> December 2015 allegations received by ASC that resident is being served cold food. Progressed to S42 enquiries but outcome was for the concern to be considered as part of the organisational enquiry.
- 4.2.28 On the 16<sup>th</sup> December 2014 the CQC carried out a 1<sup>st</sup> rated inspection and follow up on an outstanding breach of assessing and monitoring from the inspection of the 22<sup>nd</sup> April 2014. It also followed recent concerns but does not appear to have included the ongoing concerns as part of the local authority safeguarding process already underway as at 4.2.22. The rating was recorded as 'requires improvement' as the CQC found a breach for care and welfare as well as a repeated breach for assessing and monitoring.
- 4.2.29 A referral was made to the local authority on the 23<sup>rd</sup> December 2014 by the CFT in relation to allegations of organisational abuse. This was in relation to a resident whose diabetes was not being managed, had pressure sores and also a fractured wrist. There was a strategy discussion on the 27<sup>th</sup> December 2014 and an investigation plan put into place.
- 4.2.30 On the 6<sup>th</sup> January 2015, Concerns were raised to the CQC by a social worker regarding residents at Clinton House with pressure sores due to lack of intervention/care along with call bells and water jugs being placed out of reach. This is recorded as being dealt with on the inspection of the 16<sup>th</sup> December 2014.
- 4.2.31 February 2015 a new Cornwall Council QA action plan was issued although it is not clear when the previous one was closed.
- 4.2.32 On the 6<sup>th</sup> February 2015 an adult safeguarding referral was made by the CFT regarding allegations of organisational neglect and omissions in care leading to pressure sores. The concerns were not dealt with separately but were fed into the LA review process for the systemic abuse at Clinton House which began on the 11<sup>th</sup> September 2014 recorded at 4.2.22
- 4.2.33 On the 11<sup>th</sup> February 2015 the CQC met with the provider at their request to discuss the current situation where all seven homes were in suspension with Cornwall Council and the financial implications of this. No minutes or record of this meeting seen.
- 4.2.34 On the 16<sup>th</sup> February 2015 there was a LA review meeting in relation to the concern raised at 4.2.22, some progress being made but concerns still being evidenced re

- moving and handling, dignity and respect issues, poor standard of care plans, communication and admission concerns.
- 4.2.35 March 2015 review of action plan took place.
- 4.2.36 On the 12<sup>th</sup> May 2015 there was a LA review meeting in relation to the safeguarding process starter at point 4.2.25. the allegations of neglect were substantiated but the safeguarding process was closed with continuing monitoring and support of the local authority service improvement team along with the KCCG.
- 4.2.37 May 2015, Investigation report into referral at point 4.2.29 received and the allegation of neglect had been partially substantiated. It was found that the discharge from RCHT to Clinton House had been poorly managed and communication between EIS teams poor which had contributed to the resident's overall care.
- 4.2.38 The CQC held a management review meeting with their legal team on the 18<sup>th</sup> May 2015 to discuss what action to take regarding four homes within the Morleigh Group one of which was Clinton House. This was in relation to all four homes having no registered manager. Decision note to go ahead with any fixed penalty notices as this would involve interviews under PACE and they felt that the work involved was not proportionate to the outcome. Agreed to meet with the provider to discuss the manager situation.
- 4.2.39 May 15 placements suspended, reason unknown.
- 4.2.40 May 2015 Cornwall Council QA action plan review meeting took place.
- 4.2.41 10<sup>th</sup> June 2015 focused inspection by the CQC to follow up on breaches of care and welfare and repeated breach of assessing and monitoring from the inspection of the 16<sup>th</sup> December 2014. Breaches met but remains as 'requires improvement' as not long enough track record of improvement.
- 4.2.42 15<sup>th</sup> June 2015 the CQC held a meeting with the provider to discuss the manager situation. Deadline extended to 14<sup>th</sup> August 2015.
- 4.2.43 On the 19<sup>th</sup> June 2015 the CQC received information from the SWAST regarding a safeguarding alert made in relation to the delay in calling for medical assistance when a resident suffered a fit. The home was asked to provide details and their account was satisfactory.
- 4.2.44 July 15 action plan review meeting cancelled.
- 4.2.45 August 2015 action plan review meeting did take place, no notes available.
- 4.2.46 August 2015 suspension of placements lifted but no reason given.
- 4.2.47 September 2015 placements suspended again but no clear reason given.
- 4.2.48 One the 1<sup>st</sup> October 2015 the CQC received anonymous concerns about there being insufficient food, the boiler was not working, no soap available, low staffing numbers and people left in wet clothing. The home was asked for a report and they claimed that the allegations were not true. This was noted for the next inspection.
- 4.2.49 On the 6<sup>th</sup> October 2015 the CQC held a management review meeting to discuss issuing a fixed penalty notice to Clinton House along with three other locations; all of whom still had no registered manager. The meeting agreed to send a letter using the decision tree tool for all inspections at each location since there had not been a registered manager to evidence the impact of no registered manager.
- 4.2.50 The CQC received Whistleblower concerns on the 14<sup>th</sup> October 2015 in relation to residents not being washed, poor management of pressure care and the home being dirty as there were not enough cleaning staff. The decision was made to bring forward the next planned inspection to follow up on concerns.

- 4.2.51 Planned inspection from 4.2.50 carried out on the 20<sup>th</sup> October 2015. This was 2<sup>nd</sup> rated comprehensive inspection following the concerns recorded at 4.2.50. Breaches for premises and equipment, dignity and respect along with governance were recorded. The rating was 'requires improvement'.
- 4.2.52 On the 20<sup>th</sup> October 2015 the CFT made a safeguarding referral in relation to the neglect of a resident at Clinton House who had died on the 19<sup>th</sup> October 2015. This alert was added to three other alerts alleging neglect for residents at Clinton House and a meeting process began on the 1<sup>st</sup> February 2016.
- 4.2.53 On the 21<sup>st</sup> October 2015 a safeguarding alert was made to Cornwall Council from the CQC as a result of finding a resident during the inspection of the 20<sup>th</sup> October who was not receiving appropriate care and had skin damage. Confirmation received from Cornwall Council on the 2<sup>nd</sup> November 2015 that a strategy discussion had taken place.
- 4.2.54 On the 30<sup>th</sup> October 2015 the CFT made safeguarding referrals in relation to 3 residents at Clinton House detailing various evidence of neglect. These were fed into the systemic process that had been started on the 20<sup>th</sup> October 2015 (4.2.52) but the first meeting had been put back until the 2<sup>nd</sup> March 2016 with no reason recorded.
- 4.2.55 13<sup>th</sup> November 2015 meeting arranged by Cornwall Council, CQC and KCCG to discuss concerns about the provider.
- 4.2.56 November 2015 action plan review meeting planned but didn't take place, no details available.
- 4.2.57 3<sup>rd</sup> December 2015, another care home provider reported to the CQC a poor handover when a resident from Clinton was transferred to them.
- 4.2.58 December 2015 action plan review meeting but no record of outcome.
- 4.2.59 January 2016 further action plan review meeting but again no outcome recorded.
- 4.2.60 The CQC held a management review meeting on the 7<sup>th</sup> January 2016 to review the registered manager situation at Clinton House. However, as Clinton House had a registered manager in post who was applying for the job if it was decided not to proceed with any action.
- 4.2.61 On the 14<sup>th</sup> January 2016 the CQC received concern from a CCG healthcare professional regarding poor weight recording for a resident at Clinton House, along with poor staff support for residents at meal time. This was noted for the next inspection.
- 4.2.62 On the 21<sup>st</sup> January 2016 the CQC received a call from the Quality Monitoring Team reporting low staffing levels, poor support for people at meal time and poor weight recording. This appears to be the same call received by the CQC at 4.2.39.
- 4.2.63 1<sup>st</sup> February 2016 LA review conference in relation to concerns raised on the 30<sup>th</sup> October 2015 (4.2.54). No record in minutes as to what had caused delay in arranging meeting. Next meeting arranged for 2<sup>nd</sup> March 2016.
- 4.2.64 On the 2<sup>nd</sup> February 2016 the CQC carried out a focused inspection of Clinton House, following up on the warning notice for safe care and treatment issued at the inspection on the 20<sup>th</sup> October 2015 and following recent concerns. Breaches were found regarding premises and equipment and person-centred care. Warning notices were also given for dignity and respect, safe care and treatment and also governance. The rating given was 'requires improvement'.
- 4.2.65 4<sup>th</sup> February 2016 Whistleblower concerns raised from staff alleging poor care at night, people not toileted during the day, new staff not being trained, poor use of

- equipment, low staffing levels and false recording. These had all been covered at the inspection on the 2<sup>nd</sup> February 2016.
- 4.2.66 6<sup>th</sup> February 2016 anonymous concerns to CQC re staffing. This had been covered at inspection on the 2<sup>nd</sup> February 2016.
- 4.2.67 9<sup>th</sup> February 2016 LA strategy review in relation to concerns raised on the 30<sup>th</sup> October 2015 (4.2.54). Multiple areas of concern recorded in the minutes which identified that many assurances regarding improvements provided at the last conference meeting could not be corroborated. All residents to be reviewed.
- 4.2.68 11<sup>th</sup> February 2016 concerns raised to ASC re neglect of resident. Progressed to S42 enquiry which was cancelled and recommendation made that this alert to be considered as part of the systemic review.
- 4.2.69 On the 25<sup>th</sup> February 2016 the local authority held a review meeting in relation to the concerns raised on the 30<sup>th</sup> October (4.2.54). A whole service review had been carried out by Health and EHSC and identified no immediate risk to residents. The final meeting on the 25<sup>th</sup> April 2016 recorded progress against most actions and a decision was taken to close to Adult Protection and suspension of placements was lifted.
- 4.2.70 29<sup>th</sup> February 2016 anonymous concerns to CQC re staffing. This had been covered at inspection on the 2<sup>nd</sup> February 2016.
- 4.2.71 March 2016 action plan review meeting.
- 4.2.72 March 2016 QA team state that suspension of placements is lifted but no rationale why, they were put back in place at the end of March see 4.2.77
- 4.2.73 On the 17<sup>th</sup> March 2016 the CFT raised a safeguarding alert following allegations of neglect in relation to a resident at Clinton House. Alert raised by the EIS. This appears to have been added to the alert raised on the 30<sup>th</sup> October 2015 at point 4.2.35.
- 4.2.74 18<sup>th</sup> March 2016 the CQC received an anonymous concern relating to staffing, call bells not working, no domestic staff and no cook. The home was asked for an explanation and reasonable explanations were given. It was noted for the next inspection.
- 4.2.75 18<sup>th</sup> March 2016 the CQC received reports from an ex staff member that a nurse may have given 2 residents injections to hasten their deaths. This was reported to the Police who investigated and found no criminal activity.
- 4.2.76 23<sup>rd</sup> March CQC received concerns from an ex member of staff. Long list of concerns given using room numbers. The CQC emailed person for more specific details re names and dates and noted to follow up at the next inspection.
- 4.2.77 23<sup>rd</sup> March 2016 phone call from Cornwall Council to CQC to raise concerns that EIS had raised to them in relation to a person who had sustained skin damage during a respite stay at Clinton House. A call was made by the CQC to Cornwall Council Commissioning to ask them to consider reinstating the suspension of placements. Which was done. Next planned inspection bought forward to 7<sup>th</sup> April 2016.
- 4.2.78 23<sup>rd</sup> March 2016 Police contact with the CQC regarding allegation at 4.2.75. Police not continuing investigation as believed to be malicious.
- 4.2.79 On the 7<sup>th</sup> April 2016 the CQC carried out a focused inspection to follow up on warning notices for dignity and respect, safe care and treatment, and governance issued at the inspection of the 2<sup>nd</sup> February 2016. Also, to look at recent concerns. The warning notices had been met. There were repeated breaches for safe care and treatment and governance and the rating was 'requires improvement'.

- 4.2.80 On the 25<sup>th</sup> April 2016 despite the above findings from the CQC the local authority review meeting from the concerns raised on the 30<sup>th</sup> October 2016 (4.2.54) concluded that there was evidenced progress against most actions and the alert was to be closed to adult protection and the suspension of placements was lifted.
- 4.2.81 On the 22<sup>nd</sup> June 2016 Cornwall Council raised concerns to the CQC after receiving information from a relative about the care of a resident. Long delays in getting help and a lack of respect from staff. The CQC noted this for their next inspection.
- 4.2.82 On the 24<sup>th</sup> June 2016 the CQC received an anonymous call from neighbours of Clinton House saying that they heard people calling for help all day and that the manager is rude to neighbours. This was noted for the next inspection.
- 4.2.83 3<sup>rd</sup> July 2016 anonymous call to CQC reporting no hot water, residents not having breakfast till 11.20 and call bells not working. This was noted for the next inspection.
- 4.2.84 July 2016, Cornwall Council QA action plan reviewed.
- 4.2.85 Your voice matters contacted the CQC on the 27<sup>th</sup> July 2016 requiring further information on the issue raised at 4.2.83. Information requested and assurances sought from Clinton House by phone. CQC were told that home had hot water and the washing machine had been repaired. Staffing levels were fine and meetings and supervision were taking place, this was noted for the next inspection.
- 4.2.86 August 2016 action plan review carried out but no update recorded.
- 4.2.87 Concerns raised to the CQC by a resident's family regarding a lack of hot water, dirty rooms, dirty carpets and people not being well cared for. This was noted for the next inspection of 16<sup>th</sup> December 2016.
- 4.2.88 22<sup>nd</sup> October 2016, Police receive allegation of wilful neglect of a resident from the nephew of a resident following information provided by Panorama.

### 4.3 Collamere

- 4.3.1. A safeguarding alert process was already underway at the start of this review period. It had been started at the beginning of 2013 and had been raised by a local GP's surgery who had concerns over patients being admitted to Collamere with no records. This was raised as an alert as patients were being put at risk, not only was there an absence of records but residents were not being assessed on arrival. Although this alert was before the review process it is considered relevant as the process carried on into 2014. (identified through a visit to a GP surgery and reading their notes, not included in any agency chronology)
- 4.3.2. On the 16<sup>th</sup> December 2013 a letter was written by a local GP to the Cornwall Council Safeguarding Team and copied to the CQC regarding a staff nurse being on duty for 18hrs and the GP deemed it unsafe. This matter is not recorded by ASC; however, the GP did receive an email from the Safeguarding Team saying that they had finally met with the owners of the Morleigh Group and will be writing to the GP. This appears to be in relation to the ongoing safeguarding alert raised at 4.3.1.
- 4.3.3. On the 20<sup>th</sup> December 2013, the CQC have recorded receiving a letter of concern sent to the Cornwall Council Safeguarding Team from a GP who was concerned about the lack of information regarding new admissions to the home. The CQC noted this for their next inspection.
- 4.3.4. There was also a Cornwall Council QA action plan in place at the start of this review period.

- 4.3.5. On the 3<sup>rd</sup> January 2014 the CQC carried out an inspection at Collamere in relation to staffing and record keeping breaches that had been picked up on the previous inspection on the 5<sup>th</sup> August 2013. It is noted that improvements have been made and all outstanding breaches had been met. It does not mention however the concern raised by the GP in 4.3.2 and it doesn't mention the ongoing Safeguarding Alert at 4.3.1.
- 4.3.6. On the 7<sup>th</sup> January 2014 the CQC met with the provider as the provider portfolio had recently increased to seven services. Recent inspection activity was discussed along with the management structure and staffing levels. It was stressed to the provider that the CQC would look at the activity of the provider as a whole and want to see a consistent service including governance across all services.
- 4.3.7. On the 11<sup>th</sup> January 2014 the Police dealt with an incident at Collamere where a nurse slapped one of the residents. The nurse was arrested, charged and found guilty of assault. There is no mention of any involvement of other agencies in relation to this incident.
- 4.3.8. Alert raised on the 17<sup>th</sup> January 2014 regarding repeated medication errors in relation to a resident at Collamere. This was progressed to S42 enquiries and the allegations were fully substantiated but no result is recorded, no evidence of information sharing.
- 4.3.9. At the beginning of January 2014, the local GP surgery wrote to the Safeguarding Team expressing their concern and frustration that nothing was being done in relation to the alerts that they had previously raised (4.3.1). The surgery had taken advice from the BMA/GPC and were suggesting that it was unsafe for them to take patients with no records or assessment and that there had been several near misses. The correspondence was copied to the CQC. The Safeguarding Team replied to the Surgery and the meeting below at 4.3.10 was arranged. The CQC also replied to the surgery and despite listing the very real concerns in their reply then suggested that the surgery implements its own complaints procedure. This appears to be as a result of the suggestion that the surgery may not be able to take any more referrals from the home in question and followed a complaint from the provider.
- 4.3.10. During February 2014 a safeguarding adults review process meeting took place. This was in relation to the previous alert raised in February 2013 and mentioned at point 4.3.1. It appears an action had been set in February 2013 to convene a meeting between Collamere and the local GP surgery to discuss communication issues. This related to Collamere admitting residents frequently with no medical records or assessment. This issue had been going on for nearly two years and notes from the Surgery show this was raised constantly with ASC and the CQC. It is also quite clear from CQC policy that a proper assessment must take place to ensure that the needs of residents can be met. However, the outcome of the meeting was that the GP's surgery and Collamere should work together to resolve the issue, it was even commented on by the chair that 'this will happen or not'. It also appears that the owners of Collamere were now registering patients with another surgery instead of complying with the requirement for an assessment. It was also mentioned at the meeting that the issue was a wider systemic issue that involved the whole county and not just Collamere and other homes were refusing to accept residents who should be in hospital and that the surgery for Collamere should be applauded for its stance, however the situation was not addressed. The Chair summarised by saying that the placing authority had a responsibility to agree to an admission process

which provides basic information, there is an equal onus for homes to have this information before accepting patients. It was clear however that this was not happening and yet it clearly had not been addressed during this process. The information recorded here and at 4.3.9 was obtained from records held at the GP's surgery and has not been mentioned by any of the other agency chronologies. The evidence of this safeguarding process clearly differs from the findings of the CQC inspection of January 2014.

- 4.3.11. On the 9<sup>th</sup> February 2014 the CQC refer to information sharing from the Local Authority Service Improvement Team although the Service Improvement Team do not mention this themselves. There is no record of what this information is.
- 4.3.12. Alert raised on the 24<sup>th</sup> February 2014 regarding a resident who was the subject of neglect at Collamere. Medication errors resulting in his Parkinson's not being managed, left sleeping in wet clothing due to incontinence and not being fed appropriately. This progressed to S42 enquiries and the concerns were substantiated but there is no outcome recorded.
- 4.3.13. March 2014 Cornwall Council QA action plan review meeting.
- 4.3.14. On the 14<sup>th</sup> April 2014 the CQC received reports from a relative re cleanliness, poor staffing levels and the fact that the home was poorly maintained. It was noted for their next inspection.
- 4.3.15. April 2014 Cornwall Council QA action plan review took place.
- 4.3.16. On the 24<sup>th</sup> April 2014 the CQC met with the provider for an update on the current position regarding the whole group. Each home was discussed including the position regarding the registered managers and how the provider plans to structure the service as it grows.
- 4.3.17. An allegation of neglect by Collamere was reported to ASC on the 13<sup>th</sup> May 2014 where it was alleged that a resident had been left in bed for 4 days and that she was not given proper medication. S42 enquiries were carried out and the allegation was partly substantiated but no outcome is recorded.
- 4.3.18. On the 9<sup>th</sup> June 2014 concerns were raised regarding verbal abuse by a carer on a resident. This resulted in the carers employment being terminated. However, there is no record of any further safeguarding measures i.e. is this indicative of practice in the home.
- 4.3.19. On the 12<sup>th</sup> June 2014 concerns were raised about the care of a resident at Collamere. The alert details a number of concerns including the resident being confined to their bed, pressure sores, extensive weight loss and being fed whilst lying flat resulting in a risk of choking. The case progressed to a conference but the outcome is not recorded.
- 4.3.20. On the 10<sup>th</sup> July 2014 the CQC completed a planned inspection to follow up on recent concerns. The inspection is recorded as being compliant in all areas covered which included; consent, care and welfare, safeguarding, staffing and assessing and monitoring.
- 4.3.21. July 2014 full QA team audit took place and the existing action plan was replaced by a new one. There is no outcome of the original action plan recorded.
- 4.3.22. On the 31<sup>st</sup> July 2014 an alert was raised by a worker at Collamere to ASC in relation to the incorrect use of equipment which caused bruising to residents. Residents being left soaked in their own urine and staff that were not trained properly. There is however no record of what was done with this alert or who it was shared with.



- 4.3.23. On the 1<sup>st</sup> August 2014 the CQC received concerns via a Whistleblower about poor practice at Collamere, this included ; a lack of choice about activities, call bells being taken away, poor practice, no DBS checks being carried out on staff, low staffing levels and poor staff training. A decision was taken to carry out a responsive inspection on the 18<sup>th</sup> August 2014.
- 4.3.24. August 2014 full Cornwall Council QA review took place.
- 4.3.25. On the 8<sup>th</sup> August 2014 concerns were raised to the CQC by a new member of staff at Collamere that the equipment in place was poor and that incorrect manual handling techniques were being used. This was noted for the inspection due on the 19<sup>th</sup> August 2014.
- 4.3.26. On the 11<sup>th</sup> August 2014 Social Services referred a matter to Police regarding a resident at Collamere, this involved an allegation of sexual assault, poor care and neglect. The matter was investigated by Police and no further action was taken. What is worthy of note however is that the Police make comment about the general concerns around care at Collamere and note that it was inspected by the CQC and was found to be compliant and that small improvements that needed to be made were being made. It does not appear that the information above was passed to the CQC who were in fact making a further inspection of the home 8 days later due to other concerns that had been made. The above information was also only provided by the Police in their chronology and not by Adult Social Care who appear to have raised the concerns.
- 4.3.27. On the 13<sup>th</sup> August 2014 the CQC received information, via the Department of Health, from a relative of a resident regarding poor standards of care. This was to be followed up in the inspection planned for the 19<sup>th</sup> August 2014.
- 4.3.28. On the 19<sup>th</sup> August 2014 the CQC carried out their planned Inspection following Whistleblower concerns raised on the 1st August 2014. It found that the concerns raised were not substantiated. Collamere was compliant in relation to; respect and involvement, care and welfare, requirements relating to workers and staffing.
- 4.3.29. On the 9<sup>th</sup> September 2014 the CQC held a management review meeting to discuss what actions to take in relation to the Morleigh Group as a whole. There were seven locations and four had significant non-compliance (one had two warning notices). One location was rated red with Cornwall Council and five were amber rated. Each location had been inspected once since 1/4/14 and two locations more than once, with four follow up inspections planned in September and October 2014. Also concerns about the lack of registered managers had been raised. It was agreed to keep the registered manager position under review and maybe consider fines in the future. It was agreed to hold a meeting with the provider to discuss the concerns.
- 4.3.30. On the 23<sup>rd</sup> September 2014 the CQC held a meeting with the Morleigh Group and explained the concerns at 4.3.29. It was explained that enforcement action would take place where ongoing non-compliance was found within the group. The need for an overall management structure and a QA system at provider level was discussed and the need for consistent managers at each home. Managers were being recruited and then leaving within weeks.
- 4.3.31. On the 28<sup>th</sup> October 2014 the CQC received an anonymous concern regarding staffing levels and poor care. This was noted for the next inspection.
- 4.3.32. Allegation of sexual assault investigated by the Police following allegations by a resident that one of the nurses sexually assaulted her whilst undressing her.

Investigation by Police but no further action against suspect(s). All relevant agencies were involved in the safeguarding process.

- 4.3.33. November 2014 NHS Kernow undertake a comprehensive root cause analysis investigation into aspects of care at Collamere findings included; manager with no clinical training or qualification, low staffing levels, lack of leadership and a lack of an holistic overview of residents needs.
- 4.3.34. On the 9<sup>th</sup> December 2014 the CQC received Whistle blower concerns regarding low staffing levels at Collamere. This was noted for the next inspection.
- 4.3.35. In January 2015 it appears that admissions to Collamere and all Morleigh Group homes were suspended, there are no records in any of the Chronologies regarding this and the local GP's surgery for Collamere only found out via a local newspaper.
- 4.3.36. On the 11<sup>th</sup> February 2015 the CQC met with the provider at the providers request to discuss the situation whereby all seven homes within the group were in suspension with Cornwall Council and the financial implications of that. The non-compliance was discussed and suggestions were made as to how the group could improve.
- 4.3.37. On the 24<sup>th</sup> February 2015 concerns were raised to the CQC by a healthcare professional about staff using j-cloths to clean residents. The manager at Collamere was spoken to who assured that staff always have wipes to use. The manager did say that the owner had made a comment in the home this week about staff using too many wipes and this did upset staff. This was noted for the next inspection.
- 4.3.38. On the 2<sup>nd</sup> March 2015 the GP surgery became aware that the homes within the Morleigh Group were taking admissions again, however this information had not come from the local authority.
- 4.3.39. March 2015 Cornwall Council QA action plan review
- 4.3.40. On the 14<sup>th</sup> April 2015 Whistle blower concerns were raised to the CQC and to ASC in relation to the fact that there was just one agency nurse on duty at night for 42 residents. The CQC noted this for there next inspection due on the 29<sup>th</sup> April 2015. The result for ASC is not recorded on their systems.
- 4.3.41. On the same day 14<sup>th</sup> April 2015, a carer at Collamere contacted ASC to inform them that approx. 2 weeks ago whilst working at Collamere she attended a resident during the night to change her pad. The resident was incontinent and her clothes and bed were wet with urine. As she was about to change her pad a nurse entered the room and stopped her saying that the resident was only allowed one pad a night. Resident was left in a wet pad, with wet clothes and on a wet bed. The risk rating came out as high and the service improvement team were informed, however no outcome is recorded.
- 4.3.42. On the 28<sup>th</sup> April 2015 the CQC were contacted regarding poor staffing levels at night, it is unclear who the alert came from. The CQC were due to do a planned inspection the next day 29<sup>th</sup> April 2015.
- 4.3.43. On the 29<sup>th</sup> April 2015 the CQC carried out a planned inspection and to follow up on recent concerns. The inspection rated the home good overall ('well-led requires improvement').
- 4.3.44. On the 6<sup>th</sup> May 2015 Whistle blower concerns were again raised regarding staffing levels to the CQC and the fact that the environment was not being adequately maintained. According to the CQC these issues had been dealt with at the inspection recorded at 4.3.26.
- 4.3.45. May 2015 Cornwall Council QA action plan review

- 4.3.46. On the 18<sup>th</sup> June 2015 the local GP's practice wrote to the Council Head of Safeguarding regarding their ongoing concerns over the lack of information being provided by Collamere when new residents were admitted, this also included other concerns such as the lack of trained nurses. The surgery received a telephone call reply to this letter from the Safeguarding Standards team saying that there were no previous concerns about Collamere, they then stated that they were 'standards' and the CQC were 'operational' and should be informed. It was explained to them that the CQC were fully aware. The Safeguarding Standards team however said that they didn't see what they were able to do.
- 4.3.47. On the 22<sup>nd</sup> June 2015 the CQC received a letter from a local GP regarding the lack of trained nurses working in the home. This was noted for the next inspection.
- 4.3.48. June 2015 Cornwall Council QA action plan review.
- 4.3.49. On the 10<sup>th</sup> July 2015 an Adult Safeguarding Referral was received by the Local Authority from the CFT in relation to allegations of neglect and omissions in care that related specifically to two residents but the practice witnessed could easily lead to harm to others. The outcome appears to be that the Local Authority Service Improvement team were asked to follow up and that they were working with the home. However, this referral has not been mentioned by the Adult Services chronology. There is also no mention of this being passed to the CQC.
- 4.3.50. On the 13<sup>th</sup> July 2015 the SWAS reported concerns to the CQC regarding poor manual handling of residents and an uncaring attitude. This was noted by the CQC for their next inspection.
- 4.3.51. On the 15<sup>th</sup> July 2015 the CQC received concerns from a local GP regarding medication errors. This was noted for the next inspection.
- 4.3.52. On the 23<sup>rd</sup> July 2015 the CFT made two safeguarding referrals in relation to two different patients. These referrals mentioned specifically that the two patients were left for long periods of time sitting in the same position and this had caused pressure sores. The referrals also mentioned poor record keeping. Neither of these matters were triaged into Adult Safeguarding but were referred to the Service Improvement team who were asked to follow up the concerns and work with the home. There is no mention of these concerns being passed to the CQC.
- 4.3.53. On the 5<sup>th</sup> August 2015 the CQC were contacted by Public Health England<sup>1</sup> in relation to the recent outbreak of Norovirus. They were concerned that staffing levels at the home were too low to cope with an outbreak. Information had been passed to the Public Health England Team from the Local Authority. This information was noted by the CQC for the next inspection.
- 4.3.54. On the 13<sup>th</sup> August 2015 an alert was raised by a local GP and who had met two registered general nurses at the home who had expressed concerns about staffing levels. The GP had also received a letter from a relative of a patient at Collamere who had expressed concerns about the lack of very basic care including cleanliness and hygiene. Anonymous concerns were also raised in the same letter from a member of care staff. The alert mentions some detail about the levels of staffing and care witnessed. There is nothing recorded by ASC in relation to what was done regarding this alert.
- 4.3.55. On the 17<sup>th</sup> August 2015 the CQC received concerns raised by a local GP practice re staffing levels at Collamere and the lack of equipment. This appears to be the letter

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<sup>1</sup> Public Health England – Executive agency of the Department of Health and Social Care.

referred to in 4.3.54. This was noted for the next inspection. There is no mention of liaising with other agencies.

- 4.3.56. On the 19<sup>th</sup> August 2015 concerns were raised to ASC regarding the neglect of personal hygiene of a resident, poor environment, neglect of diet and health needs. This progressed to a S42 and the outcome was that it would be dealt with as part of the systemic enquiry. Resident died in hospital the next day and police enquiry stated not suspicious as resident died from cardiac arrest. It appears individual concerns above were not dealt with.
- 4.3.57. 10<sup>th</sup> September 2015 provider confirms voluntary suspension of placement for Collamere due to lack of leadership/manager.
- 4.3.58. On the 2<sup>nd</sup> October 2015 the CQC received Whistleblower concerns re poor staffing levels at Collamere and also the lack of access to the kitchen after the cook goes home so people cannot have snacks. This was noted for the next inspection.
- 4.3.59. 6<sup>th</sup> October 2015 allegation received by ASC that resident had missed their medications. Progressed to S42 enquiries but not substantiated.
- 4.3.60. On the 21<sup>st</sup> October 2015 the CQC carried out a planned 2<sup>nd</sup> rated inspection and to follow up on the breach of regulation 17 (governance) from the inspection of the 29<sup>th</sup> April 2015. There had also been a number of recent concerns raised mentioned above that needed to be investigated. The inspection found breaches of person centred care, premises and equipment and also staffing. A warning notice was given for governance. The home was rated as 'requires improvement'.
- 4.3.61. On the 10<sup>th</sup> November 2015 There was a meeting called to discuss the concerns about the Morleigh Group, the meeting was between the Adult Services, KCCG and CQC.
- 4.3.62. November 2015 Cornwall Council QA action plan review
- 4.3.63. On the 12<sup>th</sup> January 2016 the CQC have recorded that concerns were raised regarding low staffing levels, a lack of quality food and poor equipment at the home. Although it is not recorded where these concerns came from. The CQC asked the home to provide an explanation and a reasonable explanation was given. The concerns were noted for the next inspection.
- 4.3.64. January 2016 Cornwall Council QA action plan review.
- 4.3.65. On the 15<sup>th</sup> January 2016 a focused inspection was carried out by the CQC to follow up on the warning notice regarding governance (4.3.60) and following recent concerns mentioned above at 4.3.58. The breaches found on the 21<sup>st</sup> October (4.3.60) in relation to premises and equipment and staffing had been met. There was however a further breach of person centred care. An outcome of 'requires improvement' was recorded.
- 4.3.66. On the 20<sup>th</sup> January 2016 there was an Adult Protection Conference in relation to Collamere recorded by ASC. The Chair recorded that a lot had happened since the last meeting in October 2015 however there are no records of this previous meeting. At 4.3.61 there is reference to a multi-agency meeting recorded on the 10<sup>th</sup> November 2015 and it could be this meeting that is being referred to. The Chair goes on to say that there has been a huge commitment from the Morleigh Group to address the issues identified and this has been recognised during recent CQC inspections. The homes are committed to taking on board any learning and are ensuring this is cascaded across to other homes within the group. The Chair felt that as significant improvements had been made, there is no need to continue with the

- Adult Protection process. However, the QA team will continue to work with the home until the action plan has been completed. Suspension of placements lifted.
- 4.3.67. On the 7<sup>th</sup> March 2016 a relative contacted the CQC in relation to the home not being clean and carers not wearing appropriate protection equipment. This was noted by the CQC for their next inspection.
- 4.3.68. March 2016 Cornwall Council QA action plan review.
- 4.3.69. On the 13<sup>th</sup> May 2016 concerns were raised to the CQC by the family of a resident in relation to the care of their relative. This was noted for the next inspection.
- 4.3.70. On the 22<sup>nd</sup> June 2016 an alert was raised to the CQC by SWAST in relation to a medicines error. The home were asked for details of the incident and stated that the medicine was delayed due to a manufacturing issue and a substitute was provided the next day. The CQC have noted that they will review the medicines at their next inspection in a few weeks.
- 4.3.71. On the 18<sup>th</sup> July 2016 the local GP's surgery wrote to Collamere expressing their concern about the home not providing adequate patient information before admitting patients and trying to register then with the surgery. This letter was copied to the Council Safeguarding Team but there was no reply from the team or from the home.
- 4.3.72. July 2016 Cornwall Council QA action plan review
- 4.3.73. On the 22<sup>nd</sup> July 2016 an allegation of poor practice was recorded in relation to rough handling of a resident and medication not being administered properly. This was progressed through to a S42 enquiry and the allegations other than the administering incorrect medication were substantiated. However, no outcome is recorded.
- 4.3.74. On the 16<sup>th</sup> August 2016 the CQC carried out a planned 3<sup>rd</sup> rated inspection of Collamere to follow up on the outstanding breach of person centred care from the inspection of the 15<sup>th</sup> January 2016. Also following recent concerns raised (4.3.67, 4.3.69, 4.3.70). They found a repeated breach of standards for person centred care and new breaches for nutrition and hydration, safe care and treatment for medicines, staffing and governance. The outcome was agreed at a management review meeting of the 22<sup>nd</sup> August 2016 and the outcome was 'requires improvement'.
- 4.3.75. On the 16<sup>th</sup> September 2016. Allegations were raised to ASC that staff at Collamere were not following the dietary requirements of a patient, resulting in the risk of choking and constipation. The resident also had pressure sores and the home environment was unclean. It is recorded that a S42 was met and safeguarding actions were taken to address the concerns, however the exact actions or amount of information sharing is not recorded.
- 4.3.76. September 2016 Cornwall Council QA action plan review.
- 4.3.77. On the 28<sup>th</sup> September 2016 the SWAST raised a safeguarding alert to the CQC in relation to concerns about a resident being given the wrong medicines. There were also concerns about a lack of leadership at the home as there was no registered manager and there was no clear information from the provider about how the home was being managed. The CQC decided to bring forward their next inspection to the 10<sup>th</sup> October 2016.
- 4.3.78. The CQC focused inspection was carried out on the 10<sup>th</sup> October 2016 following the concerns raised by SWAST and to follow up on the previous breaches from the

inspection of the 16<sup>th</sup> August 2016 (4.3.74). The Domains of Safe, Effective and well-led were covered.

- 4.3.79. The local GP's surgery wrote again to Collamere regarding admissions assessments and copied in the Safeguarding Team, CQC and MARU. The only reply came from the CQC on the 11<sup>th</sup> November 2016 when they contacted the surgery out of the blue and asked if anyone had responded to their concerns and at this point were very interested in what the surgery had to say.
- 4.3.80. On the 14<sup>th</sup> October 2016 concerns were raised by a relative about the care of their relative residing at Collamere. The CQC have recorded that the concerns were covered in the inspection of the 10<sup>th</sup> October 2016.
- 4.3.81. The CQC held a management review meeting on the 19<sup>th</sup> October to discuss the outcome of the inspection of the 10<sup>th</sup> October 2016. The decision was taken that the Domains of safe and effective will remain as 'requires improvement' and well-led will be inadequate due to the lack of confidence in the management of the home and at provider level. The overall rating did not change as the rating cannot be changed at a focused inspection. The draft report was not issued as the inspection was extended to a comprehensive inspection and a 2<sup>nd</sup> day.
- 4.3.82. On the 24<sup>th</sup> October 2016 the CQC received Whistleblower concerns about the care being provided to four specific residents. With the whistleblowers consent safeguarding alerts were raised for each person.
- 4.3.83. On the 26<sup>th</sup> October 2016 ASC received referrals from the manager at Collamere and an Inspector with the CQC raising concerns of neglect and omission of care and psychological abuse. It was decided by ASC that a whole service referral was appropriate given the ongoing concerns around similar issues within the group.
- 4.3.84. On the 27<sup>th</sup> October 2016 the CQC held a management review meeting to discuss information received from Hardcash productions in relation to other homes in the Morleigh Group (St Theresa's and Clinton House). A focused inspection had taken place on the 10<sup>th</sup> October but a decision was made to extend this to a comprehensive inspection and complete a 2<sup>nd</sup> day on the 4<sup>th</sup> November 2016.
- 4.3.85. An inspection of the centralised recruitment process at the providers head office found that staff at some of the providers other homes (St Theresa's, Clinton House, The Brake Manor and Tregërtha Court had started work before there DBS checks had been completed.
- 4.3.86. The focused inspection of the 10<sup>th</sup> October was extended to the 4<sup>th</sup> comprehensive inspection and a second day was completed on the 4<sup>th</sup> November 2016. This followed the MRM of the 27<sup>th</sup> October to discuss the information from Hardcash productions (4.3.84). Repeated breaches for person centred care, safe care and treatment for medicines, staffing and governance were found. Along with a new breach for premises. The outcome was a rating of inadequate and a notice of proposal to cancel the provider was published. The MRM took place the same day and a decision was taken to cancel the provider.

#### **4.4. Elmsleigh Nursing Home**

- 4.4.1. 7<sup>th</sup> January 2014 CQC first meeting with the provider as they had recently increased their portfolio to seven services. Feedback re recent inspection and discussion about ongoing Safeguarding. Management of each home along with staffing discussed. Stressed to the provider that CQC will look at the activity of the provider as a whole and want to see a consistent service, including effective governance across all services.
- 4.4.2. There was a Cornwall Council QA action plan already in place at the start of the review period. A review was due to take place at the end of January 2014 but it isn't clear if this took place.
- 4.4.3. February 2014 Cornwall Council QA action plan review.
- 4.4.4. 10<sup>th</sup> March 2014, concerns of neglect by nurse at home regarding administration of a drip. Substantiated and nurse faced disciplinary proceedings.
- 4.4.5. 23<sup>rd</sup> April 2014 Whistleblower concerns were received by the CQC regarding; staffing levels, care provided, medicines and cleanliness at the Elmsleigh. Decision taken to bring next inspection forward to 1<sup>st</sup> May 2014.
- 4.4.6. CQC meeting with the provider for an update on the current position. Each home was discussed along with the registered manager position and how the provider plans to structure the service.
- 4.4.7. 28<sup>th</sup> April 2014, Whistleblower concerns about staffing, medication, food levels and nurse competency. Noted for inspection on the 1<sup>st</sup> May.
- 4.4.8. Planned inspection by the CQC on the 1<sup>st</sup> May 2015. Non-compliant in care and welfare, medicines and staffing.
- 4.4.9. 1<sup>st</sup> May 2014, Safeguarding alert raised to Adult Social Care by CFT regarding the care of three residents. Poor care and negligence, particularly around palliative care needs for vulnerable adults, this was shared with the CQC who noted it for their next inspection. No other actions recorded by ASC.
- 4.4.10. 15<sup>th</sup> May 2014, suspensions lifted but it is not clear when this suspension was put in place or why it was lifted.
- 4.4.11. May 2014 Cornwall Council QA action plan review planned but not sure if it took place.
- 4.4.12. 27<sup>th</sup> July 2014 concerns were raised believe to be from health to ASC via the CQC that residents within Elmsleigh were allegedly been subjected to poor practice, neglect and institutional abuse. CQC indicate that Elmsleigh remain non-compliant in relation to Care and Welfare, Medication and Staffing following the previous inspection on the 1<sup>st</sup> May 2014. It is noted that there have also been systemic alerts raised previously regarding similar issues. No actions recorded.
- 4.4.13. 1<sup>st</sup> August 2014, Safeguarding referral from SWAS re resident phoning 999 themselves due to chest pains, staff were unaware of their condition and stated resident did not have capacity, which was disputed by the ambulance crew. CQC noted this for the next inspection.
- 4.4.14. 13<sup>th</sup> August 2014 concerns raised by family about care of their relative. Noted for next inspection. No specific details given.
- 4.4.15. 2<sup>nd</sup> September 2014 CQC hold MRM to discuss all homes due to concerns.
- 4.4.16. 6<sup>th</sup> September 2014 crime recorded by police whereby resident has had cash stolen from a top drawer beside bed over a 6 week period. No evidence of this being reported to other agencies.
- 4.4.17. 15<sup>th</sup> September 2014 the CQC receive anonymous concerns re the state of a resident's room. Noted for next inspection.

- 4.4.18. 23<sup>rd</sup> September 2014 CQC meeting with provider due to concerns about the whole group.
- 4.4.19. 10<sup>th</sup> November 2014 concerns raised to the CQC by another care home provider about the home and how people are treated, physical abuse, restraint and poor nutrition. Inspection taking place in 2 days time.
- 4.4.20. 13<sup>th</sup> November CQC 1<sup>st</sup> rated inspection. Complaint in medicines and staffing but there were breaches for assessing and monitoring and complaints. Rated 'requires improvement'.
- 4.4.21. 14<sup>th</sup> November 2014 complaint to CQC from a relative about the state of the premises. Enforcement action already being taken from the inspection at 4.4.120
- 4.4.22. 21<sup>st</sup> November 2014 concern raised to CQC regarding lack of care for their relative. These were covered at the inspection of the 13<sup>th</sup> November at 4.4.20
- 4.4.23. 30<sup>th</sup> November concerns raised to the CQC by a relative about the lack of communication at the home. This was covered at the inspection of the 13<sup>th</sup> November 2014 at 4.4.20
- 4.4.24. 11<sup>th</sup> December 2014 alert by ASC Safeguarding regarding a number of incidents and reports relating to poor quality of the service provided. There had recently been three safeguarding alerts regarding individuals care, this appears to relate to 4.4.6 although this was back in May. CQC have also recently issued an improvement notice. Three separate relatives have also commented on the poor quality of care. Given this information the home has been put in red which means no new placements will take place, even so the provider accepted a respite request.
- 4.4.25. 30<sup>th</sup> December a carer who wished to remain anonymous raised concerns about the care at Elmsleigh. Residents were left in wet beds and there were no incontinence products available.
- 4.4.26. 5<sup>th</sup> January 2015 the Director of Clinical and Corporate Affairs emailed the contracting manager at Cornwall Council raising concerns and requesting a meeting to discuss alternative methods of working with the home. There is no evidence of any reply despite follow up requests.
- 4.4.27. 15<sup>th</sup> January 2015 concerns raised to CQC by a relative regarding cleanliness of home.
- 4.4.28. 19<sup>th</sup> January 2015 concerns raised to ASC of neglect of resident at home including unexplained bruising. Outcome not recorded but record states it is being considered as part of systemic review.
- 4.4.29. January 2015 KCCG raise concerns that despite almost continuous input from health and council service improvement team there is no improvement at Elmsleigh.
- 4.4.30. January 2015 systemic safeguarding procedures were instigated for both Elmsleigh and Alexandra House. Due to high level of concern regarding Morleigh Group placements were suspended to all homes. No clear rationale or action plan process recorded.
- 4.4.31. 20<sup>th</sup> January 2015 NHS Kernow safeguarding lead and Cornwall Council meet with Morleigh Group owner.
- 4.4.32. 28<sup>th</sup> January 2015 Whistleblower concerns raised to the CQC regarding a lack of funding for basic items. This was covered at the inspection of the 13<sup>th</sup> November 2014, 4.4.15.
- 4.4.33. 4<sup>th</sup> February 2015, full Cornwall Council QA review of Elmsleigh. It appears a new plan was issued but not clear when and if the previous plan was closed as only one review had taken place since December 2013.



- 4.4.34. 11<sup>th</sup> February 2015 meeting with the provider to discuss the current situation whereby all seven homes were in suspension with Cornwall Council and the financial implications.
- 4.4.35. 23<sup>rd</sup> February 2015 focused CQC inspection to follow up on previous warning notice from 13<sup>th</sup> November 2014. Compliant with warning notice and both breaches. Rating remains as 'requires improvement' as not long enough track record of improvement.
- 4.4.36. 3<sup>rd</sup> March 2015 concerns raised to CQC by a visiting professional about the care for one person who has lost weight. Care records did not provide clear information for staff to follow, especially given that it was reported that there appears to be a high use of agency staff. Noted for next inspection.
- 4.4.37. March 2015 Cornwall Council QA action plan review took place.
- 4.4.38. April 2015 QA action plan review was cancelled, not clear by whom.
- 4.4.39. 18<sup>th</sup> May 2015 CQC meeting with legal to discuss what action to take re 4 locations including Elmsleigh. See 4.2.38.
- 4.4.40. CQC met with the provider on the 15<sup>th</sup> June 2015 to discuss the registered manager situation. Deadline of 15<sup>th</sup> July 2015 to have a registered manager application in process for four locations including Elmsleigh. Deadline extended to 14<sup>th</sup> August 2015 but not achieved at three locations including Elmsleigh because all the managers left.
- 4.4.41. 2<sup>nd</sup> July 2015 concern raised CQC by relative that handrails were not cleaned after faeces were smeared on them. CQC spoke to manager at home who said that the rails would have been cleaned.
- 4.4.42. July 2015 QA action plan review took place with Cornwall Council QA team and KCCG safeguarding nurse.
- 4.4.43. July 2015 action plan for Elmsleigh completed and recommendation to open it again to placements which took place.
- 4.4.44. August 2015 Cornwall Council QA action plan review took place. This was however more of a meeting to support the manager rather than a review meeting. Manager subsequently left the role.
- 4.4.45. 8<sup>th</sup> September 2015 planned 2<sup>nd</sup> rated inspection by the CQC to look at recent concerns. Breach of premises and equipment recorded. No registered manager in post. Rated 'requires improvement'.
- 4.4.46. September 2015 QA team and KCCG action plan visit.
- 4.4.47. CQC MRM to discuss fixed penalty notice for three locations including Elmsleigh see 4.2.31.
- 4.4.48. October 2015, unannounced visit to Elmsleigh by the Cornwall Council QA team and placements suspended 2 days later, rationale not seen.
- 4.4.49. 10<sup>th</sup> November 2015 Joint meeting arranged between Cornwall Council, KCCG and CQC to discuss concerns about the provider across all the homes.
- 4.4.50. 23<sup>rd</sup> November 2015 concerns raised to CQC by a relative about the state of the care home, the service has just had an inspection and another one is due in September 16. Copy of complaint sent to Local Authority as person has asked for their relative to be moved to a new home.
- 4.4.51. November 2015 QA team action plan review meeting but cancelled as there was no manager in place.
- 4.4.52. 4<sup>th</sup> December 2015, concerns raised to the CQC by a relative re the cleanliness and smells in the bungalow unit of the home. CQC spoke to provider who advised that

- there had been a problem with the drains. This has been resolved and a new carpet will be fitted. Noted for next inspection (due Sept 2016).
- 4.4.53. 8<sup>th</sup> December 2015 Police deal with an assault on staff by an agitated resident who did not have capacity. Incident was dealt with however Police note that residents room was soiled and smelt but window could not be opened. It does not appear that safeguarding issues/cleanliness etc were raised with local authority.
- 4.4.54. 29<sup>th</sup> December 2015 joint KCCG and local authority letter to Elmsleigh informing them of the lifting of suspension of placements. However, restricted to 2 per week. No rationale given and no evidence of who was monitoring situation.
- 4.4.55. January 2016 Cornwall Council QA action plan review meeting.
- 4.4.56. 7<sup>th</sup> January 2016 MRM by CQC to discuss the registered manager situation at three homes in group including Elmsleigh. Reasonable excuse letter sent out to Elmsleigh and gave the provider one month to take relevant action.
- 4.4.57. 2<sup>nd</sup> February 2016 Police deal with an allegation of assault on resident by carer. Reported by Deputy Manager. No further action taken. Not recorded if this was passed to other agencies.
- 4.4.58. 12<sup>th</sup> February 2016 phone call to provider by CQC who advised that an existing manager had applied to be the registered manager for Elmsleigh. CQC decide not to proceed with any action.
- 4.4.59. 21<sup>st</sup> March 2016 Police report re missing person, concerns re resident who stated home do not look after her. Passed to Maru, Cornwall.
- 4.4.60. 26<sup>th</sup> March 2016 call to Police from resident above at 4.4.38 saying she had bruises on her wrists from where someone tried to stop her calling Police she then hung up. Called back and spoke to a member of staff who stated that this related to an incident a few days ago, staff say they have this in hand and have removed the night worker that she has been threatening. No Police attendance.
- 4.4.61. 12<sup>th</sup> April 2016 concerns raised to CQC from unknown source re lack of heating and hot water and poor staffing levels. CQC spoke to provider who assured us that problems with the boiler had been resolved. Noted for next inspection in June.
- 4.4.62. 21<sup>st</sup> April 2016 concern raised by relative to CQC about the lack of care given to a person with dementia in the home for respite. Poor standards of hygiene, help not given to eat and tablets found in their pocket. Plan to follow up at next inspection in June 2016.
- 4.4.63. April 2016 Cornwall Council QA action plan review meeting.
- 4.4.64. 10<sup>th</sup> May 2016 report to CQC by SWAS re self-harm of one person. Environment reported as strong factor by Ambulance crew. CQC to follow up at planned inspection in June 2016.
- 4.4.65. 14<sup>th</sup> June 2016 planned 3<sup>rd</sup> rated comprehensive inspection by CQC. Repeated breaches of premises and equipment. Still no registered manager. Warning notice re safe care and treatment. Rated 'requires improvement'.
- 4.4.66. 28<sup>th</sup> June 2016 information sharing from CC to the CQC re a Safeguarding alert raised by the District Nurses re the care of one person. It is recorded by the CQC that this matter was dealt with at the inspection of the 16<sup>th</sup> June 2016.
- 4.4.67. 30<sup>th</sup> June 2016 Police receive a referral from the MARU via an Advanced Nurse Practitioner in relation to an adult resident possibly experiencing physical abuse by his carers. Police reviewed the information and did not start an investigation as there was no information to support this. The concerns were fed into the systemic process that was ongoing.

- 4.4.68. July 2016 Cornwall Council QA action plan review meeting.
- 4.4.69. 12<sup>th</sup> September 2016 concerns raised to the CQC from a visiting relative re the security of the building, staffing levels and meeting peoples needs. Decision taken to bring forward the next inspection to look at concerns.
- 4.4.70. 20<sup>th</sup> October 2016 concerns raised to the CQC by a family about the care of their relative and the environment. This was marked up for follow up at the next planned inspection of 25<sup>th</sup> October 2016.
- 4.4.71. 25<sup>th</sup> October 2016, CQC 4<sup>th</sup> rated comprehensive inspection. Breaches for person-centred care, dignity and respect, consent, safe care and treatment, premises, governance and staffing. Rated inadequate. Notice to remove the location issued on the 17<sup>th</sup> November 2016.
- 4.4.72. 26<sup>th</sup> October 2016, CQC safeguarding alert raised re two residents found to be at risk from the inspection of the 25<sup>th</sup> October 2016.
- 4.4.73. September 2016 Cornwall Council QA action plan review meeting
- 4.4.74. 2<sup>nd</sup> November 2016 inspection by CQC or Morleigh Groups centralised recruitment process identified staff working at Elmsleigh without a cleared DBS check.
- 4.4.75. 14<sup>th</sup> November 2016 concerns raised by ASC in respect of staff DBS checks, poor record keeping, staff not wearing uniforms and the home not having heating.
- 4.4.76. 29<sup>th</sup> November 2016 alert raised by NHS Kernow CCG following concerns raised by an agency worker, raising concerns about the poor handovers of care, especially in emergency situations. Also concerns about the management and administration of drugs.
- 4.4.77. 30<sup>th</sup> November 2016 concerns raised to the CQC by an agency worker as the heating at the home had broken. Call to the service who assured the CQC that there had been a problem with the boiler and that this had been repaired.
- 4.4.78. 19<sup>th</sup> December 2016 new provider takes over.

#### **4.5. St Theresa's**

- 4.5.1. 4<sup>th</sup> December 2013, anonymous letter received by ASC on behalf of staff and residents at St. Theresa's. Allegations that residents are subjected to unsatisfactory practice, neglect and institutional abuse. Concerns re staffing levels especially at night. No action recorded.
- 4.5.2. December 2013 joint KCCG and QA team visit was undertaken and an action plan set.
- 4.5.3. 19<sup>th</sup> December 2013 CQC receive anonymous concerns re staffing and possible poor care (possibly same as above), noted for next inspection.
- 4.5.4. 7<sup>th</sup> January 2014 CQC first meeting with provider as portfolio recently increased to seven services. Stressed to the provider that CQC will look at the activity of the provider as a whole and want to see a consistent service, including effective governance across the service.
- 4.5.5. February 2014 Cornwall Council QA action plan review meeting planned but cancelled by the provider.
- 4.5.6. 14<sup>th</sup> February 2014 copy of letter received by CQC from Cornwall Council about the care of people at the home and the environment. Noted for next inspection.

- 4.5.7. 18<sup>th</sup> March 2014 Safeguarding concern raised to Police by staff at Hospital following concerns re injuries to a resident. No evidence of criminal actions following investigation and matter closed.
- 4.5.8. 6<sup>th</sup> April 2014 concerns raised via webform to CQC regarding lack of staffing levels and lack of stimulation for people. Noted for next inspection.
- 4.5.9. 24<sup>th</sup> April 2014, CQC meeting with provider to discuss registered manager situation and how provider plans to structure service.
- 4.5.10. April 2014 Cornwall Council QA action plan meeting took place.
- 4.5.11. 6<sup>th</sup> May 2014 concerns raised to CQC via webform regarding staffing leaving including the manager and deputy. Noted for next inspection.
- 4.5.12. 6<sup>th</sup> May 2014 whistleblower concerns raised to CQC re staffing levels as per 4.5.8. noted for next inspection
- 4.5.13. 8<sup>th</sup> May 2014 web form report to CQC as per 4.5.8 noted for next inspection.
- 4.5.14. 16<sup>th</sup> May 2014 web form report to CQC as above, noted for next inspection.
- 4.5.15. 22<sup>nd</sup> May 2014 anonymous report to CQC as above, noted for next inspection.
- 4.5.16. May 2014 Cornwall Council QA action plan review, new manager in place.
- 4.5.17. 3<sup>rd</sup> June 2014, CQC inspection carried out, breaches re staffing and assessing and monitoring. Breaches from previous inspection 28/11/13 met.
- 4.5.18. 11<sup>th</sup> June 2014 CQC receive letter from member of public re poor care at home, noted for next inspection.
- 4.5.19. 14<sup>th</sup> July 2014 CQC receive concerns from a relative re staffing levels, especially trained nurses. Compliance action re staffing already set at last inspection.
- 4.5.20. 14<sup>th</sup> July 2014 Safeguarding enquiry by the Police following concern raised by Social Services that medication wasn't being administered appropriately to a resident. As resident had capacity matter was dealt with via service improvement and closed by the Police.
- 4.5.21. July 2014 Cornwall Council QA action plan review meeting cancelled by new manager.
- 4.5.22. 2<sup>nd</sup> September 2014 CQC management meeting to discuss what actions to take about the group as a whole. Agreed to keep the registered manager situation under review and hold a meeting with the provider.
- 4.5.23. 9<sup>th</sup> Septembers 2014, CQC follow up inspection. Breach re staffing had been met, however repeated breach for assessing and monitoring.
- 4.5.24. 8<sup>th</sup> October 2014 CFT report allegation of inadequate intervention and pain control, assessment deemed allegations were not substantiated.
- 4.5.25. October 2014 Cornwall Council QA action plan review meeting cancelled, not clear by who.
- 4.5.26. 3<sup>rd</sup> November 2014 concerns raised to CQC by family about the care of their relative. Noted for next inspection.
- 4.5.27. January 2015 Cornwall Council QA action plan review did take place.
- 4.5.28. 3<sup>rd</sup> February 2015, CQC inspection. Breach of supporting workers and repeated breach for assessing and monitoring.
- 4.5.29. 11<sup>th</sup> February 2015 CQC meeting with the provider at their request to discuss the current situation where all seven homes are in suspension and the financial implications of that.
- 4.5.30. 15<sup>th</sup> February 2015, anonymous information raised to CQC re staffing levels and management of the home. These areas were covered at the last inspection.
- 4.5.31. March 15 Cornwall Council QA action plan review took place.

- 4.5.32. 13<sup>th</sup> April 2015, concerns raised to CQC re registered managers attitude. Noted for next inspection.
- 4.5.33. 24<sup>th</sup> April 2015, whistleblower concerns raised to CQC re the boiler not working, no water or heating. Decision to carry out focused inspection on the 27<sup>th</sup> April and visit home on Saturday 25<sup>th</sup> April to check if boiler is working and people are safe.
- 4.5.34. 27<sup>th</sup> April 2015, focused inspection by CQC as above. Breach for supporting workers had been met. New breaches for person centred care, premises and equipment. Warning notice for safe care and treatment and good governance. This was the 4<sup>th</sup> inspection where assessing and monitoring/good governance were non-compliant.
- 4.5.35. 18<sup>th</sup> May 2015 CQC meeting with legal to discuss what action to take re four locations including St. Theresa's that do not have a registered manager. Decision not to take any further action due to work involved, which would include interviews under PACE and this was not considered proportionate. Decision to arrange a meeting with the provider to discuss manager situation.
- 4.5.36. 2<sup>nd</sup> June 2015, ASC safeguarding alert raised regarding the warning notice issued by CQC.
- 4.5.37. 15<sup>th</sup> June 2015, CQC hold provider meeting to discuss registered manager position. Deadline set of 15<sup>th</sup> July 2015 to have registered manager application process underway. Deadline extended to 14<sup>th</sup> August 2015 because managers at 3 locations including St. Theresa's had left.
- 4.5.38. 22<sup>nd</sup> June 2015, whistleblower concerns raised to CQC regarding staffing levels and lack of equipment such as pressure mattresses. Noted for next inspection.
- 4.5.39. 24<sup>th</sup> June 2015, whistleblower concerns re shortage of equipment. Noted for next inspection.
- 4.5.40. July 2015 Cornwall Council QA action plan review meeting cancelled.
- 4.5.41. 27<sup>th</sup> July 2015 CQC receive concerns from a relative re rain coming in from the ceiling in the lounge area. Believe risk of ceiling coming down. CQC phoned manager re leak but are told this has been ongoing and is due to be repaired. No immediate risk of ceiling coming down. Noted for next inspection.
- 4.5.42. 6<sup>th</sup> August 2015, CQC inspection. Warning notices and breaches met, new breach for consent and fit and proper persons employed.
- 4.5.43. 13<sup>th</sup> August 2015 whistleblower concerns to CQC that during recent CQC inspection some staff were told to hide as they were not eligible to work in the UK. Immigration notified who paid a visit to location. Four non EU nationals working at home and paperwork was in order although overall recruitment paperwork did not satisfy immigration requirements.
- 4.5.44. 21<sup>st</sup> August 2015 Whistleblower concerns re resident with pressure sores. Claims that shortage of equipment has contributed to issue. Decision to carry out inspection on 15<sup>th</sup> September.
- 4.5.45. August 2015 action plan review meeting took place.
- 4.5.46. 27<sup>th</sup> August 2015, following referral from CQC as at 4.5.44 Safeguarding alert forwarded by ASC to CFT. Resident involved admitted to hospital and subsequently died on the 20<sup>th</sup> October 2015. Systemic organisation abuse adult protection level 4 process had already commenced and this was to be considered alongside this.
- 4.5.47. 2<sup>nd</sup> September 2015 concerns raised to CQC by relatives of resident regarding the residents care. Noted for next inspection.
- 4.5.48. 7<sup>th</sup> September 2015 whistleblower concerns made via CQC to ASC re an ex resident whose family were concerned about her treatment re skin problems. Family claim

home lied to them and equipment was taken away after home said that they couldn't afford the rental on them. Complaint also made by family about attitude of manager. Family happy to be contacted for more information. This appears to have been linked in to the ongoing systemic process in place (see 4.5.46), initial conference held 17<sup>th</sup> November 2015 and process closed 14<sup>th</sup> March 2016 but no outcome seen.

- 4.5.49. 8<sup>th</sup> September 2015 concerns raised to CQC by a visiting district nurse re lack of staffing levels and competency and general lack of confidence in management. Noted for next inspection.
- 4.5.50. 15<sup>th</sup> September 2015, CQC inspection. Breaches from previous inspections not covered. Serious concerns about the nursing care provided. Breaches of safe care and treatment, safeguarding and governance. Still no registered manager. Notice of proposal to cease nursing care issued 28<sup>th</sup> September 2015. Rated inadequate.
- 4.5.51. 18<sup>th</sup> September 2015 safeguarding alert raised by CQC re 7 residents found to be at risk during inspection at 4.5.50.
- 4.5.52. 30<sup>th</sup> September 2015 whistleblower concerns to CQC from agency worker re lack of drinks available and high level of urine infection. Whistleblower spoken to and was happy for their details to go to the CC safeguarding team.
- 4.5.53. 6<sup>th</sup> October 2015 CQC management review meeting to discuss fixed penalty notice for 3 locations including St. Theresa's re no registered managers. Advice from legal to either conduct PACE interview or send a letter to give provider the opportunity to explain. Agreed to send letters.
- 4.5.54. 11<sup>th</sup> October 2015, joint meeting with CQC, KCCG and CC to discuss concerns about the provider across all homes.
- 4.5.55. 21<sup>st</sup> October 2015 CQC receive representation from provider appealing against the notice of proposal to cease nursing care at home.
- 4.5.56. November 2015 Cornwall Council QA action plan review meeting took place but as there was a new manager in place it was used to familiarise the manager with the action plan and not used as a review.
- 4.5.57. 22<sup>nd</sup> December 2015, concerns raised by family about the care of their relative, noted for next inspection.
- 4.5.58. December 2015 Cornwall Council QA action plan review took place
- 4.5.59. 4<sup>th</sup> January 2016 CQC management review to discuss the delay in the review of the notice of proposal to cease nursing care (due to a delay in the allocation of a reviewer). Provider had made several telephone calls stating that if the home was not opened to admissions soon then the business would collapse. Decision taken to carry out inspection to check if improvement had been made, before the providers representations were reviewed.
- 4.5.60. 7<sup>th</sup> January 2016 CQC management meeting to review the registered manager position at 3 homes including St. Theresa's, two of homes including St. Theresa's had manager in post who were applying for permanent role therefore decision taken to not take any further action against these homes.
- 4.5.61. 18<sup>th</sup> January 2016 CQC receive call from relative regarding concerns that home is not caring for her father properly. Father is currently in hospital and daughter is waiting for meeting to discuss his care before he returns. Daughter thinks that fluid records were falsified and he has not been given drinks. Noted for next inspection.
- 4.5.62. 21<sup>st</sup> January 2016 information from CC service improvement team to CQC.

- 4.5.63. 25<sup>th</sup> January 2016, CQC inspection. Nursing care found to be safe and planned in a way that met each persons individual needs. Notice of proposal to withdraw nursing care withdrawn. Reported breach for recruitment. All other breaches met. Rated 'requires improvement'.
- 4.5.64. January 2016 Cornwall Council QA action plan review meeting took place.
- 4.5.65. 4<sup>th</sup> February 2016 CQC withdraw St Theresa's notice of proposal to cancel their nursing registration as there is a process in place to appoint a new manager. Also recommend suspension of placements to be lifted. However, the CQC published their inspection report in February 2016 with two Amber indicators one being is the service well led.
- 4.5.66. March 2016 Cornwall Council QA action plan review took place.
- 4.5.67. July 2016 Desktop QA action plan review by the Cornwall Council QA team.
- 4.5.68. August 2016 QA action plan review took place.
- 4.5.69. 26<sup>th</sup> October 2016 alert raised to ASC and CQC by Hardcash productions re their intention to air programme and their findings. Information provided by Hardcash outlined serious concerns about the practice at St.Theresa's
- 4.5.70. 1<sup>st</sup> November 2016 CQC inspection carried out following multi agency safeguarding meeting to discuss information at 4.5.69. Still no registered manager ;breaches for person-centred care, dignity and respect, safe care and treatment, premises, governance and repeated breach for fit and proper persons employed. Rated inadequate.
- 4.5.71. November 2016 Cornwall Council QA action plan review planned for early November but cancelled due to CQC inspection. QA action plan had been in place for 3yrs with 15 planned visits during this time but only 10 taking place.

#### **4.6. The Brake Manor**

- 4.6.1. 9<sup>th</sup> December 2013 safeguarding referral reported to LA by CFT in relation to the neglect of a resident, which eventually led to concerns for 2 other residents.
- 4.6.2. 7<sup>th</sup> January 2014 CQC meeting with provider to discuss their plans, including management structure and governance across all homes.
- 4.6.3. 17<sup>th</sup> January 2014, whistleblower concerns raised to CQC re poor staffing levels, poor care and lack of food. Decision to carry out inspection.
- 4.6.4. 22<sup>nd</sup> January 2014 whistleblower concerns to CQC re poor staffing levels and poor care. Noted for next inspection.
- 4.6.5. 27<sup>th</sup> January 2014 CQC raise alert to ASC from a whistleblower regarding incorrect use of and poor manual handling techniques.
- 4.6.6. 27<sup>th</sup> January 2014 Local Authority ASC manager forwards concerns to CFT re systemic and care concerns for multiple residents at The Brake. No formal strategy, investigation or action plan. No outcome or conference notes on file.
- 4.6.7. 27<sup>th</sup> January 2014, CQC inspection. Breaches of consent, care and welfare and staffing.
- 4.6.8. 24<sup>th</sup> April 2014, CQC meeting with provider to discuss each home and registered manager position.
- 4.6.9. 17<sup>th</sup> June 2014 CQC planned inspection. New breach re assessing and monitoring, repeated breach re consent. Warning notices re care and welfare.
- 4.6.10. July 2014 placements were suspended but it is not clear why this was.

- 4.6.11. 2<sup>nd</sup> September 2014, CQC management meeting to discuss what actions to take against the group as a whole. One location is rated red, five are amber. Agree to hold meeting with provider.
- 4.6.12. 12<sup>th</sup> September 2014 whistleblower concerns to CQC re staffing levels and training. Also lack of lifting equipment, noted for next inspection.
- 4.6.13. 16<sup>th</sup> September 2014, CQC inspection Warning notice re staffing met, new warning notice for care and welfare.
- 4.6.14. 23<sup>rd</sup> September 2014, CQC meeting with provider discussed need for overall management structure and warned that CQC will take action where they find ongoing non-compliance in the group.
- 4.6.15. October 2014 suspension of placement lifted although it is not clear why.
- 4.6.16. 3<sup>rd</sup> November 2014, CQC inspection. Warning notice for care and welfare and breach re assessing and monitoring met. New manager in place, no new breaches. Overall rating of good.
- 4.6.17. 6<sup>th</sup> January 2015, CFT referral to local authority following allegation from residents daughter that her mother was being neglected. Resident had unexplained injuries and home unable to account for them. Resident died 11<sup>th</sup> February 2015. No further information received from Local Authority re outcome of referral.
- 4.6.18. 11<sup>th</sup> February 2015, CQC meeting with provider at their request as all seven homes are in suspension. Discussed how group could improve.
- 4.6.19. 9<sup>th</sup> March 2015, whistleblower concerns to CQC re night care. Worker was disciplined for not following procedure so appears malicious. Noted for next inspection.
- 4.6.20. 10<sup>th</sup> November 2015, CQC meeting with CC and KCCG to discuss concerns about the provider across all homes.
- 4.6.21. 7<sup>th</sup> December 2015 safeguarding alert made to LA by CFT re resident at home. Resident admitted to hospital following fall at home. Resident had previously made allegations of neglect against home. Triaged as level 3, despite acknowledgement that others may be at risk. No further information recorded re concerns.
- 4.6.22. 12<sup>th</sup> January 2016, CQC receive whistleblower concerns re lack of snacks and no hot water in building. Decision to carry out inspection in March 2016, this was decided because the impact on people appeared to be low and there was a high level of inspection being carried out at the other Morleigh Homes in January and February.
- 4.6.23. 8<sup>th</sup> March 2016, entry to say that resident had been found at the bottom of the stairs and there was a concern as to how this had happened. Nothing else recorded.
- 4.6.24. 16<sup>th</sup> March 2016, CQC inspection. No breaches found. Rated good.
- 4.6.25. 13<sup>th</sup> July 2016 allegation of neglect following a residents fall, S42 threshold met but outcome not recorded. Concerns appear not to have been substantiated.
- 4.6.26. 24<sup>th</sup> November 2016, CQC inspection. Rated inadequate
- 4.6.27. 29<sup>th</sup> November 2016 notice of proposal to cancel provider issues by CQC

#### **4.7. Tregertha Court.**

- 4.7.1. 7<sup>th</sup> January 2014, CQC first meeting with provider re all seven homes and how they were going to run them.
- 4.7.2. 1<sup>st</sup> April 2014 whistleblower concerns raised to CQC about the cleanliness of the home, cleaning staff hours reduced. Decision to carry out inspection.



- 4.7.3. 8<sup>th</sup> April 2014, CQC inspection. No breaches.
- 4.7.4. 24<sup>th</sup> April 2014 CQC meeting with provider to discuss each home and registered manager position.
- 4.7.5. 4<sup>th</sup> July 2014, concerns raised to CQC by 3 different relatives that staff hours had been cut, food is poor and call bell doesn't work. Decision to carry out inspection.
- 4.7.6. 9<sup>th</sup> July 2014, CQC inspection. No breaches.
- 4.7.7. 29<sup>th</sup> August 2014, ASC receive alert from GP who had been called to home. Concerned re staff numbers being cut.
- 4.7.8. 2<sup>nd</sup> September 2014, CQC management meeting to discuss what action to take re group as a whole. Agreed to hold a meeting with provider.
- 4.7.9. 15<sup>th</sup> October 2014, systemic safeguarding alert raised to ASC following individual alert re neglect of one resident. Allegations were individual and general for all residents. Process closed for individual but conference was held for systemic concerns including, staffing, DOLs, broken lift, reporting accidents and incidents.
- 4.7.10. 13<sup>th</sup> January 2015, safeguarding alert raised when resident found in her room on floor with injuries and food around her. Night staff had shown in book that she was dressed and in day room. Police involved but did not meet threshold for criminal investigation.
- 4.7.11. 15<sup>th</sup> January 2015 information via webform received by CQC re concerns over lack of staffing levels.
- 4.7.12. 19<sup>th</sup> January 2015, CQC received ambulance service concerns re lack of staff knowledge about residents. Noted for next inspection.
- 4.7.13. 5<sup>th</sup> February, CQC receive further concerns via webform re lack of staffing and lack of activities. Noted for next inspection.
- 4.7.14. 11<sup>th</sup> February 2015, meeting with provider re providers concerns that all homes are in suspension.
- 4.7.15. 3<sup>rd</sup> March 2015, CQC inspection. Breach re staffing and care and welfare.
- 4.7.16. 23<sup>rd</sup> March 2015, CQC receive webform concerns re staffing levels and care of people with diabetes. Issues had been covered at previous inspection.
- 4.7.17. 10<sup>th</sup> April 2015, CQC receive whistleblower concerns re staffing levels. Covered at inspection of 3/3/15.
- 4.7.18. 18<sup>th</sup> May 2015, CQC management meeting to decide what action to take re four locations who don't have a registered manager one of which is Treggertha Court. Decide to meet with provider.
- 4.7.19. 15<sup>th</sup> June 2015, CQC meeting with provider re registered manager situation. Treggertha Court however has a manager at this point.
- 4.7.20. 12<sup>th</sup> August 2015, CQC receive whistleblower concerns re staffing levels, lack of induction for new staff. Noted for next inspection.
- 4.7.21. 10<sup>th</sup> November 2015, joint meeting with CQC, CC and KCCG re concerns about the provider across all homes.
- 4.7.22. 10<sup>th</sup> February 2016, CQC receive whistleblower concerns re staff levels at night. Home phoned and CQC told that a member of night staff has recently been disciplined and they aren't short staffed at night. Noted for next inspection.
- 4.7.23. 15<sup>th</sup> March 2016, CQC receive concerns from a relative re lack of staff. Noted for next inspection.
- 4.7.24. 6<sup>th</sup> April 2016, CQC inspection. Outstanding breaches met, new breach for safe care and treatment, recruitment, premises and equipment. Rated 'requires improvement'.

- 4.7.25. 18<sup>th</sup> April 2016, meeting with provider re inspection at 4.7.24, decided not to issue warning notices as assurance given about the environment and recruitment systems. Meeting discussed if warning notices were issued this would most likely result in Cornwall Council suspending placements which would then impact on the providers financial ability to resource the necessary improvements to the environment.
- 4.7.26. 17<sup>th</sup> May 2016, CQC receive a concern from the ambulance service re delays in calling 999 after a resident died.
- 4.7.27. 15<sup>th</sup> September 2016, CQC receive concerns that lift is not working and that residents cannot come downstairs. Dates are 13<sup>th</sup> and 15<sup>th</sup> September. Home had notified CQC that lift had broken and that it had been repaired on the 1<sup>st</sup> September.

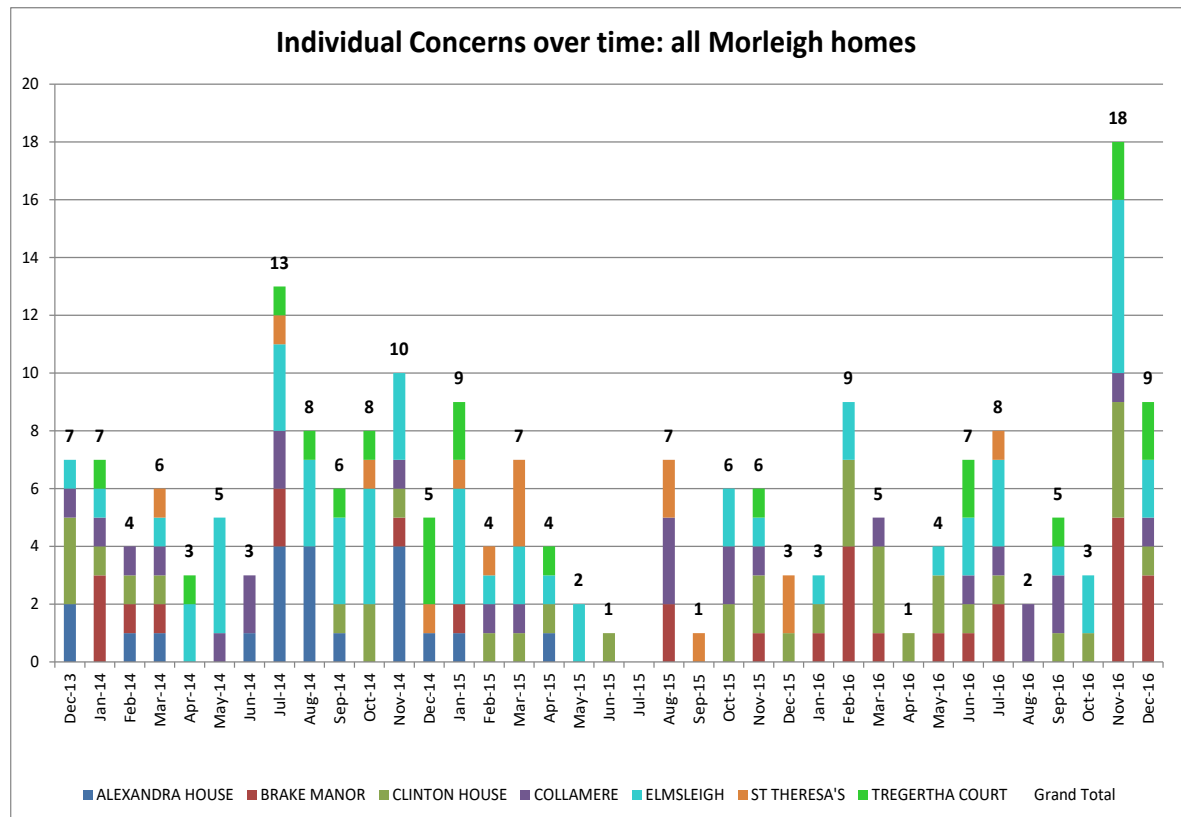
#### **4.8. Summary of chronology information and action plans in place across all homes, identifying main opportunities for intervention.**

The chronologies are lengthy and contain a lot of information gathered over the three year period in relation to each home. It is important to list this as each home was run independently as well as being part of the overall group. Below however is a summary of the main information from the chronologies, along with the various actions plans and interventions that took place, as it relates to the group as a whole. It identifies the key opportunities for intervention and action and feeds into the IMR analysis.

- 4.8.1. At the start of this review period in December 2013 there were already concerns, action plans and alert processes in place for 5 of the 7 Morleigh Group homes, with the exception of The Brake Manor and Tregërtha Court.
- 4.8.2. On the 7<sup>th</sup> January 2014 the CQC had a first meeting with the provider, as the portfolio had now increased to seven homes. The management and staffing levels were discussed. The CQC wanted to see a consistent service including effective governance across all services.
- 4.8.3. On the 24<sup>th</sup> April 2014 there was a further meeting between the CQC and the provider to discuss the registered manager situation and how the provider plans to grow the service.
- 4.8.4. May 2014 Placements to Elmsleigh were suspended.
- 4.8.5. July 14 placement to The Brake Manor were suspended but it is not clear why.
- 4.8.6. On the 7<sup>th</sup> September 2014 the CQC held an internal management review meeting to discuss the Morleigh Group as a whole. There are currently seven locations and four have significant non-compliance (one having two warning notices). One location is rated red by Cornwall Council and five are Amber rated. There had also been a suspension of placements to two of the homes within the group (The Brake Manor and Elmsleigh) during this time. This led to a meeting with the provider to discuss the need for an overall management structure and a QA system at provider level. It was also stated that there was a need for consistent managers at each home. By this stage the action plans and processes mentioned at 4.8.1 had been ongoing for almost 12 months.
- 4.8.7. November 2014 NHS Kernow undertake a comprehensive root cause analysis investigation into aspects of care at Collamere including a manager with no clinical training or qualification.

- 4.8.8. November 2014 NHS Kernow and Cornwall Council suspend placements to Elmsleigh.
- 4.8.9. December 2014 Cornwall Council facilitate a meeting with the Continuing Health Care and provider to discuss the identified concerns. There are no minutes of this available.
- 4.8.10. 15<sup>th</sup> January 2015, placements were suspended to all homes across the group by the local authority supported by NHS Kernow. At this time at least three of the homes (Clinton, Collamere and St Theresa's were on local authority action plans).
- 4.8.11. January 15<sup>th</sup> 2015 NHS Kernow safeguarding adult lead instigated a Morleigh Group serious incident report and requested Cornwall Council to collaborate which they declined.
- 4.8.12. 5<sup>th</sup> March 2015 the Cornwall Council Safeguarding Case Manager contacted NHS Kernow and recommended lifting the suspension of placements and replace with 'place with caution'. This appears to have been agreed but there were still concerns about Elmsleigh and Alexandra which remained in suspension. Concerns were raised by the NHS Kernow Safeguarding lead that the Morleigh Group case was being managed on an ad hoc basis. Systemic alerts being managed by commissioning but individual concerns through the Safeguarding Adults process.
- 4.8.13. 9<sup>th</sup> April 2015 the final safeguarding report for the Morleigh Group was completed and approved by NHS Kernow serious incident assurance group. The summary says that NHS Kernow are not currently assured that the care they are funding is safe, effective or providing residents with a positive experience. Improvements to practice following previous concerns are not sustained.
- 4.8.14. On the 18<sup>th</sup> May 2015 the CQC held a management review meeting to discuss what action to take regarding four homes within the group who had no registered manager in place. The decision was made not to go ahead with any fixed penalty notices as this would involve interviews under pace and they felt that the work involved was not proportionate to the outcome. They agreed to meet with the provider to discuss the manager situation.
- 4.8.15. 9<sup>th</sup> June 2015 the provider gives an update on the action plan and there is an agreement for NHS Kernow safeguarding lead and the local authority service improvement team to facilitate improved working with the Morleigh Group, there is however no record of this or what it entailed.
- 4.8.16. 15<sup>th</sup> June 2015 the CQC held a meeting with the provider to discuss the manager situation and they decided to extend the deadline to the 14<sup>th</sup> August 2015.
- 4.8.17. July 15 Elmsleigh re-opened after all actions completed by provider.
- 4.8.18. July 2015 concerns raised re Collamere as there was no manager in place.
- 4.8.19. 10<sup>th</sup> Sept 2015 provider announces voluntary suspension for Collamere as no manager in place.
- 4.8.20. 10<sup>th</sup> September 2015 the CQC inform the local authority and NHS Kernow of their proposal to withdraw nursing registration for St.Theresa's. This however did not take place.
- 4.8.21. 6<sup>th</sup> October 2015 the CQC held an internal management review meeting to again discuss issuing a fixed penalty notice to the four homes who were still without a registered manager. The meeting decided to send a letter using the decision tree tool for all inspections at each location since there had not been a registered manager to evidence the impact of no registered manager.

- 4.8.22. October 2015 following an unannounced visit to Elmsleigh by the local authority QA team placements were suspended.
- 4.8.23. November 2015, following a CQC inspection and a meeting between the CQC, Cornwall Council and KCCG placements were suspended to Collamere. This meeting also discussed the wider concerns about the provider but no other action plan or outcome is recorded.
- 4.8.24. December 2015 placement to Elmsleigh resume but no reason provided.
- 4.8.25. January 2016 suspension to Collamere lifted but no clear reason why.
- 4.8.26. 7<sup>th</sup> January 2016 CQC management review meeting to discuss the three locations who still did not have a registered manager (Clinton had someone applying for the job so they were not included). The provider was given one month to remedy the situation.
- 4.8.27. February 2016 CQC withdraw St. Theresa's notice of proposal to cancel their nursing registration as there was a registered manager process underway. However, on the 23<sup>rd</sup> February the CQC released a report for St. Theresa's with 2 Amber indicators which were 'is the service well led' and 'is the service safe'.
- 4.8.28. March 2016 the local authority QA team report that the placements at Clinton House were lifted although it is not clear when this was put in place. However, before the end of the month the suspension was back in place for Clinton House. This was a joint decision by NHS Kernow and the local authority due to allegations of severe neglect and abuse towards multiple residents.
- 4.8.29. July 2016, CQC warning notice issued re Elmsleigh and discussed between local authority and KCCG.
- 4.8.30. August 2016 it appears suspension of placements to Clinton House were removed but no rationale given.
- 4.8.31. September 2016 CQC report for Collamere released, 4 Amber indicators.
- 4.8.32. 26<sup>th</sup> October 2016 alert raised to ACS and CQC by Hardcash productions re their intention to air their programme and their findings. Information provided by the production company outlined serious concerns about the practice at four of the Morleigh Group Homes.
- 4.8.33. 29<sup>th</sup> November 2016 following airing of Panorama programme highlighting concerns around four Morleigh Group Homes and a multi-agency meeting to discuss the concerns, the CQC carried out a number of inspections on the Morleigh Group and a notice of proposal to cancel the provider was issued by the CQC.
- 4.8.34. One of the best ways to show the timeline is in the graph below produced by the ASC Safeguarding IMR. It identifies the consistency of concerns raised throughout the period of the review and that the concerns were as strong if not stronger in late 2014 early 2015 than when the Panorama programme was aired in late 2016.



## 5. Themed Analysis.

This section brings together the content of the IMR's, the Practitioner Learning Event and other available information, along with the report author's own analysis, to address the 5 key questions that were central to the terms of reference for the review.

### 5.1. (Monitoring). What was the interface between commissioning, contract management, quality and safeguarding and how effective was this interface?

- 5.1.1. It has been made clear by the Local Authority that a lack of detailed records for the period of this review has hampered the analysis that can be provided. There have been a number of changes within the Local Authority over this time both in structure, policy and personnel.
- 5.1.2. In 2012 the first commissioning strategy was developed for adult social care following the creation of the commissioning team. However, it appears that the commissioning intentions were the responsibility of the Senior Manager for Quality Assurance who held a joint role up until August 2016 when the post holder left. At this time the Commissioning role went to a Senior Manager for Commissioning. Therefore, it appears that the Commissioning and QA teams were one of the same during the period of this review
- 5.1.3. The ACS Commissioning IMR states that between 2013 and August 2016 the responsibility for the care homes commissioning, contracts and quality was with the Senior Manager, Quality Assurance. Commissioning between these dates was

at a micro commissioning level via tripartite individual placement contracts between the Council, the service user and the Provider. The placements were made by the operational social work staff subject to agreement of the funding via the scheme of delegation. Operational staff were responsible for agreeing the fee with the care home. The only review that would have taken place at that time would be when the individual was reviewed by the allocated assessor. There was however no mechanism for collating the information from the individual assessments to identify if the homes were meeting the outcomes of all the individuals residing there.

- 5.1.4. During the period of the review it is not always clear what policies were being followed or if there was policy in place. The individual placement contract had been in place for approximately 20yrs. This contract included a copy of the support plan for the individual residents.
- 5.1.5. The Care Act of 2014 obviously meant that new policy had to be drawn up and in response to this the Local Authority amalgamated its Adult and Childrens Safeguarding Unit. The CFT IMR states that The Safeguarding Adult Board (SAB) produced its interim Safeguarding Policy and Standards in April 2015 with the accompanying SAB Decision Making Standards effective from May 2015. However, it was felt that this did not effectively encompass a response to managing organisational abuse and systemic concerns. Due to concerns raised by health professionals, they were asked to draft an interim policy entitled Organisational Abuse/Failure to Safeguard. This eventually led to the SAB Organisational Abuse Policy being ratified in July 2016.
- 5.1.6. The Senior Manager, Quality Assurance worked with Health counterparts at the Clinical Commissioning Group, the Care Quality Commission and the Safeguarding Team. While there were some meetings with the representatives from the market in relation to fees and workforce issues there were no individual provider contract meetings.
- 5.1.7. ACS Commissioning state in their IMR that during this time there was no policy in place in terms of how long the council and NHS Kernow would work with a provider if they continued to fail to deliver a service at an acceptable standard or failed to sustain improvement. This was clearly one of the reasons why events went on for so long before the were cancelled as a provider. There was no framework to follow or refer to.
- 5.1.8. The Senior Manager, Quality Assurance was responsible for making recommendations regarding suspensions to residential homes. Recommendations for nursing homes suspensions were made jointly with the Senior Manager QA and their counterpart in NHS Kernow. The recommendations would be agreed by Heads of Service and Directors. Where appropriate the notification to the provider would be issued jointly. These decisions were based on intelligence from Quality Assurance; including but not limited to service visits, Provider Performance Monitoring Forms, Compliments and Complaints, safeguarding alerts and information from the Care Quality Commission and Health.
- 5.1.9. In relation to the CQC's role in Monitoring their IMR states that they made safeguarding alerts and shared concerns as appropriate to the local authority. Regular Care Quality Monitoring meetings were well established which the local inspection manager attended and shared concerns about the provider and

individual services. It was stated however at the practitioner learning event that it was a small group of people from each agency that regularly attended meetings and seemed to be the ones dealing with the issues relating to the Morleigh Group. It was suggested that this should have been a larger group and certainly some more senior managers involved. They felt that it was the individuals that were working together without clear and robust processes underpinning this, this was a risk as if an individual left there was no process or system to ensure that things continued.

- 5.1.10. It is quite clear that during the period of the review various homes within the group were placed in suspension as various times; sometimes the homes were placed in Amber which was defined as place with caution, this rating no longer exists. It is not clear however how organisational safeguarding concerns contributed to any suspension decisions. It seems as though providers could have a QA action plan, Safeguarding action plan and CQC action plan in place at the same time. At times the decisions made did not seem to reflect what was happening in their own or other agencies action plans. A good example of this is at 4.3.66 where an Adult Protection Conference for Collamere concluded that due to the commitment and efforts of the Morleigh Group there was no need to continue with the Adult Protection Process. However only 5 days before this meeting the CQC had carried out an inspection and rated the home 'requires improvement'. There was no consistency of working together and no joint message. It must have been a really confusing picture for the provider.
- 5.1.11. The QA team IMR states that it was not clear how effective the interface was between the various teams. QA officers involved have identified that they continued to raise concerns to the QA manager at the time who in turn raised them to the Senior Commissioning Manager however it is not clear what action was then taken. It also appears that the shared learning did not routinely take place in the team. The QA team IMR also states that despite evidence of visits with safeguarding staff there did appear to be a lack of joint working between quality and safeguarding teams during this review period.
- 5.1.12. It was mentioned a number of times within the Practitioner Learning Event that Communication within the partnership was often very poor. Those outside of the immediate teams such as GP's would raise concerns and never receive any feedback or be part of any discussion regarding the alert. An example of this has been confirmed in more detail by health colleagues at 5.3.8.
- 5.1.13. As can be seen at 4.8.1 there were already concerns, action plans and alert processes in place for 5 of the 7 Morleigh Group Homes at the beginning of this review period, it is not clear who were responsible for each of these plans or what they entailed, however the CQC recognised in January 2014 (4.8.2) that there was a need to ensure effective governance across all seven homes and this was relayed to the provider in a meeting. The CQC identified management and staffing as key areas for the provider now it had taken on the whole group.
- 5.1.14. In April 2014 there was a further meeting between the provider and CQC to discuss the registered manager situation and how the provider planned to grow the service. This was an important step by the CQC who appeared to have identified at an early stage that the Group should be seen as a whole and not individual homes. It appears however that what didn't happen at this stage was any recognition from the local authority or senior figures in health that this was

the case. There doesn't appear to have been any involvement from other agencies in the initial meetings between the CQC and the provider, nor were the ongoing actions plans and alerts taken into consideration. There is no evidence at any stage of the QA team or Local Authority Safeguarding Team considering the group as a whole and safeguarding alerts were always registered against individual residents or against individual homes in the case of systemic alerts.

- 5.1.15. In September 2014 the CQC held an internal Management Review Meeting to discuss the fact that they had major concerns about the Morleigh Group as a whole. At this time one of the homes was rated red which appears to be The Brake Manor and 5 Amber by Cornwall Council. The CQC also noted the need for consistent managers at each home. There is however a lack of information to confirm the red and amber ratings by Cornwall Council or what was being done around this. Clinton House clearly had a Cornwall Council QA action plan in place but over the course of 2014 a number of review meetings were cancelled by the provider (4.2.16 and 4.2.17). There were also QA action plans in place for Elmsleigh, St. Theresa's, The Brake Manor, Tregërtha Court and Collamere. There had also been numerous alerts raised by professionals, relatives and staff along with anonymous whistleblowers. There is no evidence up to this point that agencies other than the CQC were viewing the group as a whole.
- 5.1.16. There is mention that up until September 2014 there were a number of systemic and individual safeguarding alerts raised, although it is not clear how these fed into any of the QA processes/action plans. There is also evidence (4.2.3) that there was confusion with individual alerts being placed into systemic processes but then not considered. Health professionals voiced their concerns about this a number of times within their chronologies/IMR's.
- 5.1.17. The first real recognition of issues within the group as a whole appear to have come at the end of 2014 and early 2015. In November 2014 NHS Kernow suspended placements to Elmsleigh and also undertook a root cause analysis investigation into care at Collamere. In December 2014 Cornwall Council facilitated a meeting with the continuing Health Care and the provider to discuss identified concerns. This led to the local authority supported by NHS Kernow suspending placements across the Morleigh Group. What then happened appears very unclear and does not show multi-agency or individual agencies working in a positive light.
- 5.1.18. This was an ideal opportunity for all agencies to come together and set out clear plans for how they would support and monitor the Morleigh Group. At this point the CQC already had concerns about the leadership of the homes individually and as a whole. Six of the homes had Cornwall Council QA action plans in place, Health had strong concerns at least about Collamere and Elmsleigh and Adult Safeguarding had received numerous safeguarding alerts/concerns as had other agencies including the CQC.
- 5.1.19. Following the suspension of placements in January 2015 the NHS Kernow safeguarding lead instigated a Morleigh Serious Incident report and requested Cornwall Council to collaborate, however they declined.
- 5.1.20. On the 5<sup>th</sup> March 2015 the Cornwall Council Safeguarding Case Manager contacted NHS Kernow and recommended lifting the suspension of placements and replacing them with 'place with caution'. This appears to be a deviation from the policy at 5.1.8 as the request did not come from the Senior



Commissioning/QA manager or any of their team. The request seems to have been agreed by NHS Kernow with the exception of Elmsleigh and Alexandra who remained in suspension. Concerns were actually raised by the NHS Kernow Safeguarding lead that the Morleigh Group was being managed on an ad hoc basis and this certainly seems the case from the evidence presented. However, there is no mention of this concern being escalated within NHS Kernow or the multi-agency partnership.

- 5.1.21. An email from the NHS Kernow safeguarding lead sent to the local authority Safeguarding team at the end of March 2015 summed up the concerns that Health had. The email states that it was agreed that a Safeguarding Adult alert would be made for the entire group by the council, however, this action had been delayed significantly and was eventually made some weeks later. The process however did not proceed through the safeguarding route but instead was being managed by commissioning. While the author accepted that commissioning would play a role in relation to continuation of funding, a safeguarding process should have been followed to deal with the issues raised in the safeguarding alert. The reason why the alert was not dealt with under a safeguarding process may well have been due to the fact that there was no organisational safeguarding process to follow. The summary of the email identified the main points as.
- i. The decision was made not to proceed via the safeguarding process outside of any discussion with partners
  - ii. Minutes have not been received from any meetings
  - iii. Managing this process under commissioning is possibly putting residents at risk if corrective measures are not put in place.
  - iv. Conversations have been had with the safeguarding adults independent chair, however information regarding decisions made following this meeting have not been shared.
  - v. The whole Morleigh Group issue was being managed on an ad hoc basis.
- 5.1.22. On the 9<sup>th</sup> April 2015 the final Safeguarding report for the Morleigh Group was completed and approved by NHS Kernow. However, the summary of this report states that NHS Kernow are not currently assured that the care they are funding is safe, effective or providing residents with a positive experience. Improvements to practice following previous concerns are not sustained.
- 5.1.23. On the 18<sup>th</sup> May 2015 the CQC held an internal management meeting to discuss the registered manager position. Whilst all of the above was happening four of the homes within the group still had no registered manager in place and this had been the position for some time, a previous meeting had been held by the CQC with the provider 12 months earlier to discuss this. There is no mention of this position with the process that had been started by the local authority in December 2015 at 5.1.18. There is also no mention of the recent whole group suspensions and Local Authority/Health processes that had taken place in relation to this, within the CQC discussions around the registered manager positions. The CQC had made it a priority right at the start of this review period that the Group had effective governance across all services. This clearly hadn't been and still wasn't the case.
- 5.1.24. The CQC internal meeting of the 18<sup>th</sup> May to discuss the manager position decided not to go ahead with any fixed penalty notices as this would involve

interviews under PACE and it was felt that this was not proportionate. They agreed to meet with the provider to discuss the situation.

- 5.1.25. It appears that agencies continued to work in isolation throughout 2015. The CQC held a meeting with the provider in June and decided to extend the deadline for managers to be in place within all homes to August 2015. The local authority QA team continued to carry out QA action plan reviews through 2015 at Elmsleigh, Clinton House, St. Theresa's, Collamere and Tregërtha Court. The author however has not seen these action plans or how they relate to the concerns and suspensions of placements that occurred at the start of 2015 (5.1.18).
- 5.1.26. In October 2015 the CQC again held an internal management meeting to discuss issuing a fixed penalty notice to the four homes without a manager. It was decided however to send a letter using the decision tree tool for all inspections at each location.
- 5.1.27. In October 2015 following an unannounced QA team visit to Elmsleigh placements were suspended although there are no details recorded of exactly why or when the visit was planned as it wasn't a QA action plan review.
- 5.1.28. On the 15<sup>th</sup> October 2015 there appears to have been a meeting between the local authority QA manager, the charging manager and the Morleigh Group Finance Officer, the exact purpose of the meeting is unknown and there are no notes recorded. However, there was then a meeting held on the 10<sup>th</sup> November 2015 at the NHS Kernow offices attended by the local authority senior commissioning manager, the CQC inspection manager, the KCCG Safeguarding Nurse and the QA team officer. It is stated that the meeting was an opportunity to discuss concerns and answer questions in relation to the nursing homes and the financial sustainability of the homes. It was clarified that the meeting was not to discuss the CQC appeal re the St. Theresa's proposal to remove the nursing registration (4.8.20) or safeguarding. It is not clear what if any outcomes were achieved by this meeting. There doesn't appear to have been any structure or policy being followed at this stage and this is probably because they didn't exist. It was clear however that agencies and departments were still working in isolation as during this period the following occurred;
- 5.1.29. At the end of November 2015, the QA team undertook their seventh action plan review of Elmsleigh who were currently in suspension from taking any placements. This action plan had been ongoing since the beginning of the year (there had also been an action plan in place in 2014 with no clear outcome), during 2015 there had been two suspensions of placements. However, this action plan review did not actually take place as there was no manager in place. Despite this the suspension of placements was actually lifted at the end of December although no rationale has been seen for this.
- 5.1.30. At the same time as the above, the CQC had two internal management meetings in 2015, the last being in October to discuss the four homes without a registered manager, one of these being Elmsleigh. They had threatened sanctions but these had not been carried through. There does appear to have been some joint working in November 2015 when following a CQC inspection and a meeting between the CQC, Cornwall Council and the KCCG placements were suspended to Collamere (provider had suspended placements themselves between September and October due to having no registered manager). This meeting also apparently discussed the wider concerns about the group but no action plan or outcome is

recorded. However, the Cornwall Council QA were still reviewing Collamere on a regular basis due to the action plan that they were on but there is no detail as to how this fed into the lifting of suspensions in January 2016. The action plan was still in place when the group was finally taken over.

- 5.1.31. There was a similar pattern through 2016 in relation to the Morleigh Group still being managed on an 'ad-hoc' basis with agencies working in silo's. The CQC had a further internal meeting in January 2016 to discuss the three homes (Clinton had some applying for the job so was no longer considered) without a manager and again extended the deadline by a month for the provider to remedy the situation. They also withdrew St Theresa's notice of proposal to cancel their nursing registration in February as a registered manager process was underway, despite equally releasing a report in the same month with 2 Amber indicators one being 'is the service well led'.
- 5.1.32. On March 2016 the local authority QA team reported that placements to Clinton House were lifted although it was not clear when they had been put into place. They were however back in place later that month due to allegations of severe neglect and abuse towards multiple residents. Despite this however there is no record of what was done regarding this, this suspension was lifted in April 16 again with no clear rationale, this was despite a CQC inspection on the 7<sup>th</sup> April 2016 that rated Clinton House as 'requires improvement'.
- 5.1.33. There is a meeting recorded on the 7<sup>th</sup> July with the local authorities Senior Commissioning Manager, QA Manager and the Morleigh Group. There is no mention of health or the CQC being involved in this. There was a discussion about the delay in completing actions plans and managerial changes in the homes. There is no record of any minutes of this meeting or outcomes. What is very clear from this however is that the focus of this meeting was on the action plans that in most cases had been ongoing from the beginning of this review period and the leadership of the homes. This is something that the CQC had laid out quite rightly as a priority at the beginning of this period but had failed to deal with and yet as key partners in this they do not appear to have been invited to this meeting.
- 5.1.34. There is evidence that a desktop review of the local authorities QA actions plans took place on the 8<sup>th</sup> July a day after the above meeting, why this wasn't done prior to the meeting is not clear and there is no evidence of any involvement from other agencies or outcome to this review.
- 5.1.35. There is no further significant joint working up until the letter from Hardcash productions in October 2016 which resulted in a number of multi-agency meetings that led to the transfer of the Morleigh Group to the Cornwallis Group. What is significant at this time however is that prior to the Cornwallis Group taking over the Morleigh Group the Local Authority Commissioning Team looked at potential options in terms of continued service delivery for the individual residents in the homes. Although there is no copy of these options it is significant that they were considered at this stage and that options were available but there is no mention of them being considered previously.

5.2. **(Improvement)**. How were agencies working together with the provider to address concerns and instigate sustainable improvement actions and how were these actions monitored? How did the provider respond to the challenge?

- 5.2.1. What is very clear from this review is the tremendous support provided by individuals and individual agencies to support the residents within the Morleigh Group Homes throughout this review period. What is not so clear however is how agencies worked together to address concerns and how or if the provider rose to this challenge.
- 5.2.2. The QA team IMR states that from the information provided it is clear that agencies had been working together but it was not clear how effective this joint working was. Concerns were identified and improvements noted and monitored, however it is likely that the underpinning issues (such as culture and leadership impacting on safety and quality of care) were not truly visible and were therefore not acted on in a co-ordinated and structured way by the agencies involved. This point obviously has to be challenged as the CQC identified the leadership issue right from the start of this period and set to the Morleigh Group that effective governance across the whole group was key.
- 5.2.3. The QA team IMR also identified that there appears to have been a less than robust escalation within agencies as well as a lack of true engagement from the provider. The practitioner learning event felt very strongly that the owners of the Morleigh Group would make improvements and say the right thing when the focus was on them but the minute agencies looked away the previous failings crept back in, this is evidenced within the fact that CQC inspections would often find the same issues or if one area had been improved another one then failed the inspection. QA team action plans also ran for many years with no clear outcomes being achieved.
- 5.2.4. The provider did not appear to have its own internal QA process and even if it did it would be difficult to see how it could have operated as it seldom had registered managers in the majority of its homes.
- 5.2.5. The ASC Safeguarding IMR has identified a number of concerns about the attitude of the owner of the Morleigh Group and the author feels that there could be an element of disguised compliance by the provider whereby they attended meetings and on the whole offer positive contributions but then fail to back this up with actions.
- 5.2.6. NHS Kernow staff regularly raised serious concerns regarding poor care delivery in all of the homes across the Morleigh Group. In January 2015 NHS Kernows adult safeguarding lead raised serious concerns regarding the low level of care delivery in all of the Morleigh Group Homes. The concern noted the apparent lack of improvement within the homes where operational abuse and individual adult safeguarding procedures were consistently being raised. Concerns were also raised regarding the effectiveness of the local authority service improvement team who were actively supporting the homes. The Director of Clinical and Corporate Affairs emailed the Contracting Manager at Cornwall Council asking to meet, to discuss whether there were alternative ways of working with the provider. There is however no evidence of any response to this request despite follow up requests.
- 5.2.7. Professionals from Cornwall Partnership NHS Foundation Trust (CFT) and Peninsula Community Health Services<sup>2</sup> worked proactively with the Multi-Agency

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<sup>2</sup> PCHT – Peninsular Community Health Services – provider of healthcare services in Cornwall

and provider when invited to do so by Adult Social Care. They would provide appropriate services and disciplines to help support the patients and the provider. This enabled the provision of a health focused analysis of concerns and enabled input at safeguarding conferences and review meetings. Continuity in this respect was crucial as was the effective monitoring of concerns reported as this facilitated the recognition of reoccurring systemic concerns and themes across the Morleigh Group.

- 5.2.8. The CFT identified concerns within their IMR of the considerable variances in Multi-Agency safeguarding coordinating management and standards of investigation. It was apparent that the provider was not always subject to the same level of robust challenge and monitoring and this did not improve the care outcomes for residents. In addition, the provider was astute and able to exploit the situation to their own ends. There is evidence that Safeguarding Conference meetings for Clinton House and Collamere having to be terminated because the provider reported that they had not provided a response to the safeguarding concerns and despite evidence to the contrary they had not received any written correspondence from the co-ordinating manager detailing the allegations.
- 5.2.9. Some effective inter-agency collaborative working by health helped support the provider and improve quality of care for patients, when their skills and expertise were utilised to try and upskill Morleigh Group nursing and care staff. In response to the alert raised at 4.2.32 extensive support was provided by a St Austell Community Nurse and TV specialist nursing teams to facilitate the upskilling of staff at Clinton House and improve service delivery.
- 5.2.10. Health professionals were often concerned about the closing of safeguarding processes as they did not feel that sufficient time had been given to enable change to be embedded.
- 5.2.11. The Police obviously play an important role in the safeguarding of vulnerable residents/patients within a care home setting, however investigations can often be difficult due to the capacity of the individuals concerned. During the review period the Police received 130 reports. There were 57 reports of sudden death which would be expected and were dealt with in line with the forces policy. The remaining reports covered areas such as missing persons, theft of property etc. However, there were 19 incidents relating to concerns regarding staff, one of which has resulted in a prosecution for assault. This would seem a low rate of prosecution but it has to be seen in light of the evidential difficulties that often existed. As with any agency it is important that the resident/patient is placed at the heart of any investigation and treated in the same way that you would treat any individual. The Police investigations into reports of suspected abuse in the main were thorough and conducted by specially trained officers. However, there were some occasions where practice may need to be reviewed. Following the report of injuries to a resident at 4.5.7 it is recorded that statements were taken from staff by the manager at the home and presented to Police and which decisions were then based upon. We have discussed in other areas where staff have been reluctant or even scared to speak out and statements should be taken by someone not directly involved in the home.
- 5.2.12. A further Police matter recorded at 4.5.20, involved concerns that medicines were not be administered correctly. It was noted that as the resident had capacity then section 44 of the Mental Capacity Act could not be used. Other

offences such as assault however do not seem to have been considered and the enquiry was deemed better be dealt with under service improvement. It is not clear however how this was taken forward or even if it was shared with other agencies. This is again an example of not making Safeguarding personal and placing the resident/patient at the heart of the enquiry.

- 5.2.13. When Police are unable to prosecute, it is vital that they still share information in the correct way, following a Police enquiry on the 26<sup>th</sup> November 2014 (4.2.26) into the death of a resident they concluded that it had been the result of natural causes. The family have however raised concerns about the deceased's care and the Police have said that it is up to them to report this to Social Services. This should have been raised by way of a safeguarding alert by the Police.
- 5.2.14. Even before this review period started due to concerns about the quality of care in the homes the Cornwall Foundation Trust supported by the Kernow Clinical Commissioning Group had put in place two nurse practitioners to work with the homes in a concerted effort to improve long term conditions for the residents. Their work included putting together a management tool kit which was shared with the Morleigh Group.
- 5.2.15. The author has also spoken to two GP's who went above and beyond their required role to visit the homes out of hours and provide support to residents/patients. Community nurses were often used to support patient interventions despite the Morleigh Group being funded to provide the nursing care themselves.
- 5.2.16. There are also lots of examples within the alerts raised in the chronologies that identified the efforts health staff went to supporting residents who were at risk. One such example being at 4.2.2. What this also highlighted however was how agencies were not working together to improve standards. This particular alert that came in at the beginning of the review period and is similar to a number raised throughout was a safeguarding alert raised by health (CFT) in relation to the neglect of a resident who had been left for long periods in wet and soiled clothing. The alert also raised concerns about faulty equipment. The local authority triage forwarded the concerns for inclusion in the current systemic process for the home in question. This process however was then closed in January 2014 with no mention of this alert or the actions to keep the resident safe. The issue was not mentioned in the minutes of any review meeting. Health obviously provided help and support to the resident and health managers did provide information and instruction to the community nursing team and specialist nurses to be vigilant for any other cases of neglect. There was not however any multi-agency response to the alert raised and there are lots of similar examples throughout the review period.
- 5.2.17. What must also not be overlooked is the efforts of the Morleigh Group Staff working within the homes. This is mentioned a number of times by professionals who worked with the homes during this period and also by a direct interview by the author with a former member of staff. Despite sometimes working in poor conditions, understaffed and sometimes without the required skills the vast majority of staff employed within the homes were dedicated to the care of the residents.
- 5.2.18. There are also numerous examples of whistleblowing that appear to come from staff, to the CQC and this often appears as a 'cry for help' as they seek to get

improvements made, examples of this are recorded at 4.2.4, 4.2.7 and 4.2.10. It should be noted how brave staff were to try and raise these issues, especially as one of these concerns (4.2.8) specifically mentions staff being bullied by the owner. These whistleblower concerns however appear to have been dealt with in isolation by the CQC, there is no evidence of these being shared with other agencies and in the vast majority of cases the result of the information received is shown as 'noted for next inspection'. Staff occasionally raised concerns directly such as at 4.3.18 when a member of staff at Collamere raised concerns to the local authority in relation to the incorrect use of equipment and neglect of residents. There is however no mention of what happened to this information or who it was shared with.

- 5.2.19. Relatives also raised concerns throughout this review period and quite rightly should have been encouraged to do so. However, they were treated in a similar way to those concerns raised by professionals. At 4.2.19 a relative raised a concern to the CQC that related directly to the care of their diabetic family member. However, this is not shown as being shared with any other agency and is 'noted for next inspection' which was four months away.
- 5.2.20. There does not appear to have been any clear process for dealing with concerns raised outside of the safeguarding alert process, whether they were raised by professionals, residents, families or staff. It appears that the majority of whistleblower concerns were raised to the CQC although as mentioned above most of these are shown as 'as noted for next inspection' and not shared with other agencies. This meant that apart from the actual concern not being dealt with itself, it wasn't possible for the bigger picture to be built up that included all of the agencies information. An example of this being the concern raised to the local authority at 4.3.22 regarding neglect of residents at Collamere which was not shared with other agencies, followed by a whistleblower concern to the CQC regarding Collamere the next day at 4.3.23 regarding poor practice and staff not having undergone DBS checks. This information should have been shared and a joint approach taken rather than the agencies acting in silo's.
- 5.2.21. What is of more concern is the whistleblower concerns raised that directly identified residents at risk that were not dealt with at the time. One of a number of examples of this being at 4.5.38 where concerns were raised to the CQC regarding a lack of pressure mattresses, the treatment of pressure sores is something that featured strongly in safeguarding alerts and yet this information was 'noted for next inspection'
- 5.2.22. Homes often had both CQC and Cornwall Council QA action plans in place which on their own were aimed at being supportive but these often seemed open ended, especially in the case of the QA plans with most running over the whole course of this review. The message being given out to the homes and Morleigh Group as a whole must also have seemed extremely confusing at times. As mentioned at 5.1.33 when in March 2016 placements to Clinton House were lifted, suspended again later in the month, lifted again in April but the CQC inspected the homes on the 7<sup>th</sup> April and rated it 'requires improvement'.
- 5.2.23. This confusion and lack of joint working between the agencies played into the hands of the Morleigh Group and they became obstructive to the help that was provided and the ongoing processes in a number of ways.

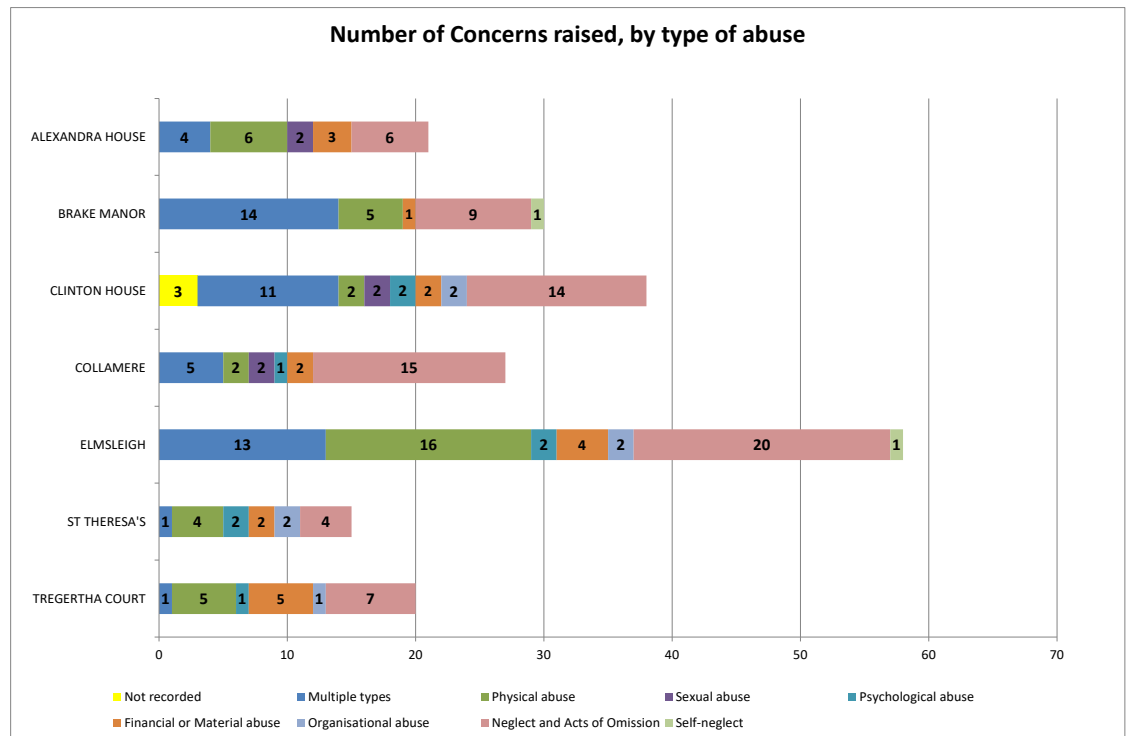
- 5.2.24. They were initially receptive to the suggestion of holding a monthly clinic by the nurse practitioners at their homes, however the planned dates for these clinics were repeatedly postponed before being finally declined. Action plan review meetings were often cancelled as they claimed not to have received notice of these or they couldn't take place as there was a manager in place. During the Clinton House organisational review in March 2016 the owner of the Morleigh Group commented that she was surprised the meeting was being brought forward due to concerns as the CQC inspector has been 'quite happy and noted there had been improvements. This did not tally however with the information provided by the CQC. There was concern voiced that the issues raised were often minimised by the Morleigh Group owner.
- 5.2.25. There is also evidence of the Morleigh Group deliberately turning agencies on each other. When a local GP surgery raised the issue of the lack of assessments taking place for new patients and threatening to stop taking on patients because their voice wasn't being heard, the Morleigh Group complained to the CQC who then asked the GP surgery to invoke their own internal discipline process for refusing to take on new patients.
- 5.3. **(Practice)** – What was the effectiveness and sustainability of the Multi-Agency approach in managing the systemic allegations and how were the individual allegations brought into the systemic process?
- 5.3.1. The Practitioner Learning event made it clear that the reporting system was ineffective and that the system was unable to link reports and identify that it may be the 2<sup>nd</sup>, 3<sup>rd</sup> or 4<sup>th</sup> report for that individual home, there was also evidence of information being recorded on different systems. The CCG had their own system and the local authority had theirs, this happened because health staff did not have access to the local authority recording system (Mosaic). Individual features of the recording system also made it difficult to identify concerns regarding provider as alerts were recorded under the individuals name and not by care home.
- 5.3.2. The CQC IMR states that although the CQC passed safeguarding concerns to the local authority as required and inspectors attended safeguarding meetings to share information, there was a lack of a co-ordinated approach of the actions to bring about the improvements required. This point would have to be challenged however, as quite often the CQC would not pass on safeguarding alerts raised to them by whistleblowers. Contrasting examples of this are at 4.2.9 where concerns raised by a family whose family member was staying at one of the homes for a short period, were passed to Cornwall Council, however concerns raised 4.2.19 which were very similar were not shared with the local authority. Each agency worked in isolation with no clear coordinated plan of action to address issues with the provider.
- 5.3.3. At the beginning of this review the author put together a timeline of all the chronologies, the second entry on the 4<sup>th</sup> December 2013 was a safeguarding alert made by the CFT regarding a resident at Clinton House who was suffering neglect and a failure to respect their dignity which was causing psychological distress. There were also concerns raised re other residents due to the failure of key equipment. These were serious allegations and quite rightly raised as a



safeguarding alert. There was already an ongoing multi-agency systemic safeguarding process ongoing in relation to Clinton House. The local authority triaged the alert for inclusion and consideration as part of the current systemic process. There was no further or separate meeting for this alert but there was a meeting on the 8<sup>th</sup> January for the ongoing systemic alert whereby the outcome was recorded as closed. This recent alert was not mentioned. Furthermore, this alert did not appear in any of the local authorities' chronologies or IMR's. This process occurred numerous times throughout this review period. This issue is further illustrated in the table below provided by the ASC Safeguarding IMR, it shows how few individual alerts over the review period went through to a safeguarding conference.

	No Strategy Discussion/Meeting	Meeting/Discussion but no conference	Discussion and conference held
Tregertha Ct.	3	9	8
St Theresa's	6	5	4
Elmsleigh	33	25	
Collamere	8	17	1
Clinton House	15	22	1
Brake Manor	10	19	
Alexandra Hse	12	7	2
Total	87	104	16

- 5.3.4. One of the issues in dealing with alerts in this way is the delays that occurred in the process. When individual alerts fed into an ongoing systemic process they were often not discussed until the next meeting around the systemic process. An example of this being at 4.2.49 when serious alerts were raised about the treatment of three residents at Clinton House on the 30<sup>th</sup> October 2015 were not discussed until an initial local authority review conference for the systemic concerns at Clinton House was held on the 1<sup>st</sup> February 2016. Clearly this goes against the making safeguarding personal emphasis that should be at the heart of all decision making when alerts are raised.
- 5.3.5. The below chart from the ASC Safeguarding IMR also identifies that the vast majority of concerns raised were in fact Neglect, acts of omission and physical abuse. The concerns of organisational abuse are small, although added together it indicates that there was an issue with the overall care being provided it does seem to point to the fact that the concerns should have been dealt with as individual concerns as well as the relevant management information then being fed into the systemic processes.



- 5.3.6. Health regularly made their voice heard in relation to their concerns regarding the way that the safeguarding alerts were being dealt with. One such example recorded at 4.4.9 (one of the three referrals mentioned) identifies an alert raised by the CFT in relation to a resident at Elmsleigh who was receiving poor care and neglect. The alert was first raised on the 12<sup>th</sup> April 2014 (resident dies on the 14<sup>th</sup> April 2014) and the concerns included the following; no trained staff to commence fluid infusion, no pressure relieving mattresses, staff on duty were from an agency and had a mental health background and did not appear competent to be in charge of such poorly patients, there was also a glove placed over the smoke detector. Health staff took all necessary immediate actions to support the resident and the matter was triaged into Adult Safeguarding on the 17<sup>th</sup> April 2014. There was no direct contact received by health despite follow ups and the offer of assistance. On the 14<sup>th</sup> May 2014 the CFT received an investigation plan from the local authority. No specific actions were identified for PCH<sup>3</sup> but a social worker was identified to liaise with the community team but this did not happen. No individual conference was held but the referrals for the resident were discussed at the Elmsleigh systemic initial safeguarding meeting and the outcome for the resident was shown as unsubstantiated. It was clear that the correct people had not been involved and the concerns around the resident clearly not investigated properly. The CFT safeguarding lead asked for it to be recorded in the minutes that the safeguarding process had failed. They also raised the issue to the KCCG safeguarding leads but there is no evidence that any further action was taken by senior health managers from the KCCG.
- 5.3.7. It is difficult to avoid the role of the conference chair when looking at how concerns were managed and dealt with. They had a key role to play in how alerts were managed, what actions were considered and the outcomes achieved. It seems however that there was a lot of unease, especially from Health in relation

<sup>3</sup> PCH – Pensinsula Community Health Services – provider of health services in Cornwall.

to how conferences were run, often feeling that they were closed down too early with no clear rationale as to why and without any clear outcomes being achieved.

- 5.3.8. One of the issues identified within the IMR's is the lack of access to information that hampered the management of safeguarding alerts. This was identified within the CFT IMR whose author identified that they did not have access to the local authority Mosaic system until mid-2015. This meant much time was taken up trying to find out information from others and they were unable to track cases and effectively monitor risk.

**5.4. (Assurance)** – How was the sustainability of improvement managed and what actions were taken to embed change across the group? Were there ongoing Multi-Agency quality assurance processes in place to support the sustainability of improvement actions.

- 5.4.1. Within the QA team IMR it is noted that they are unable to answer this question as the Quality assurance team data does not provide any of this information. This identified the poor recording keeping that occurred during the time of this review by the local authority. We can see that five homes had action plans at the beginning and throughout this process, however there do not appear to have been any records kept of these. There were QA processes in place and reviews are shown to have taken place but these processes were never ending with no result and no penalties. The record keeping could well have played a big part in this.
- 5.4.2. The ASC Safeguarding IMR has recorded that it is clear from the data and analysis that improvements were not sustained with several homes being subject to organisational safeguarding processes year after year. There doesn't appear to be reference to previous safeguarding processes when current processes are in place. None of the organisational processes considered the other homes in the group in any depth, the homes were dealt with in isolation. When a timeline is pulled together it is clear that patterns and trends did exist but the information did not seem to fall into place. Different social work managers led safeguarding processes with each home and there was not a co-ordinated or county wide approach.
- 5.4.3. The NHS Kernow IMR records that it seems that the management and homes had little will to sustain improvements once the NHS Kernow and Local Authority Staff withdrew.
- 5.4.4. The CQC noted in their IMR that they had a role to play in improvement through their regulatory inspections, the actions that they take and the publishing of reports. These reports are intended to support the provider to improve. The lack of sustainable improvement over the period of time demonstrates that there was a failure to support improvement in the services.
- 5.4.5. Due to their concerns the CQC arranged a meeting with the CCG and information shared in addition to the ongoing safeguarding and discussions at CQC monitoring meetings. This was to make sure that the seriousness of the issues were understood by the CCG. However, the CQC themselves still failed to take any action over the registered manager position despite threatening to do so a number of times.
- 5.4.6. The CFT IMR records that the community based teams and specialist practitioners made concerted efforts to share learning and best evidence based nursing care

practice with the Morleigh Group based on individual adult need. This help was consistent across the review period. Multiple safeguarding referrals were reported during the review period as per the safeguarding policy. Health professionals reported their concerns and often voiced their frustrations that the Morleigh Group were often less than receptive to the assistance and support that health professionals were offering them in an attempt to improve the quality of their care standards. The restructuring of Education, Health, Social Care and Safeguarding management appeared to impact on the overall service improvement response to systemic concerns. The approach was not always effectively conjoined and the fragmented approach plus length of time that the safeguarding process took to commence was of serious concern as this left patients at risk of harm, abuse and subject to poor quality care for long periods.

- 5.4.7. The CFT go on to say that interagency working was often disorganised and inconsistent in its approach and methodology and there did not appear to be a quality assurance process in place to monitor or challenge this. Systemic concerns were viewed as individually pertaining to a specific care home rather than the whole group until 2016.
- 5.4.8. Health professionals from the CFT and Peninsula Community Health were sufficiently concerned about the quality of care in Morleigh Group Care Homes that they were vigilant when present in the facilities. Health professionals were used to sharing intelligence across the health and social care community and worked proactively to support the provider when individual and systemic concerns were identified. It is clearly recognised that by improving the quality of care delivery this improves patients outcomes and up skilling the providers to deliver the nursing skills and interventions they were commissioned to deliver made economic sense.
- 5.4.9. It has been mentioned at 5.2 the efforts made by agencies to support the Morleigh Group residents throughout the period of this review. More examples of this include the following from the CFT.
  - i. The clinical and long term management toolkit documents introduced by the nurse practitioners for care homes
  - ii. Skin bundles, pressure relieving risk assessment tool and wound guidance from the specialist tissue viability service
  - iii. The multi factorial falls risk assessment tool and guidance from the specialist falls team
  - iv. Bladder, bowel and continence assessment tools and guidance from the specialist bladder and bowel management service
  - v. Specialist palliative care support and syringe driver management training
  - vi. Plus, support from a range of specialist community services – community nursing; dementia liaison; Parkinsons disease; diabetes management; stroke services; gastrostomy and feeding training and support; community psychiatric nurses, rehabilitation etc.
- 5.4.10. This support however was not embedded and the Practitioner Learning Event felt that one of the primary reasons for this was the constant lack of or changing of managers, this meant that change was not embedded and new managers often knew nothing of the actions plans that had been set and the history of problems.

- 5.5. **(Experience)** – How effective was the process for families and residents when they raised concerns about their experiences? Were response to the families and residents managed effectively and what impact did this have on the experiences of those living in the care home.
- 5.5.1. It is vital that the voice of those who are vulnerable and users of the service are heard and considered at every stage. This can be done in a variety of ways. Direct contact with the residents or their relatives, information from staff and other visiting professionals, observations from those present at any given time.
  - 5.5.2. It is not just direct information that is important, it is also vital to identify indicators of things that may be happening that may have an adverse affect on those who are vulnerable.
  - 5.5.3. In order to collate information, there must be clear identified processes for those wanting to raise concerns, they must feel safe that they will be protected when they do so and those professionals who receive the information must ensure that it is acted upon. It must also be recognised that it can be extremely difficult for residents, families and staff to raise their concerns and therefore when they do this must be taken very seriously.
  - 5.5.4. The CQC stated at the practitioner learning event that they always looked to speak to residents and/or relatives if they were available when they carried out inspections. They also sought the views of staff but commented that they were often scared to come forward.
  - 5.5.5. The author is not aware of there being a clear whistleblowing policy that was operated by the multi-agency in relation to care homes and especially the Morleigh Group. It appears that the CQC received the majority of whistleblowing concerns and there are numerous examples of these recorded within their chronology. Whistleblowing is however often a cry for help and a last resort for those either working or residing in the homes. This information therefore has to be risk assessed and acted upon appropriately on every occasion. Unfortunately, on most occasions the CQC responded to reports by noting them for the next inspection or monthly meetings with partners. Many of these concerns were in relation to risk that needed dealing with straight away, such as a lack of vital equipment, call bells being removed and a lack of trained staff. The CQC should have had a clear and robust process for acting on these concerns and there should have been a clear process within the multi-agency for receiving and dealing with these concerns and it not being left to a single agency.
  - 5.5.6. The CQC have also acknowledged within their IMR that the experiences of families should have been given more weight when making judgements about the quality of services. They have also acknowledged that the negative information received over a long period of time should have featured more prominently in their inspection reports and should have influenced the judgement and ratings.
  - 5.5.7. The local authority QA team have acknowledged that the team had limited involvement with families and residents in part due to how the audit they conduct is structured as it focuses on documentation rather than interaction and observation. This is clearly a failing and is not in line with making safeguarding personal. There should be far more focus on the experience for the residents.

This would be easier however if all the concerns raised to partner agencies were available to the QA and shared across the multi-agency.

- 5.5.8. NHS Kernow have recorded in their IMR that they had a robust complaints process in place during the time span of this review and although there are no examples provided the author has no doubt that this was the case. What is not clear however is how these complaints were fed into the multi-agency arena and shared with others. This management information as we have mentioned above is vital to build the pictures across the board in relation to how care homes are performing and treating their residents.
- 5.5.9. There is little, if any information contained with the chronologies or IMR's in relation to residents or their families being involved in safeguarding conferences/meetings. This has been confirmed by the CFT IMR where it is noted that it was rare that patients themselves or their relatives were participant in safeguarding meetings. One of the main reasons for this may be because a lot of the individual concerns were placed into systemic processes that did not have the individual at the centre of the process. The ASC Safeguarding IMR has also made reference to this situation and the fact that Making Safeguarding Personal is about keeping the person central to the process.
- 5.5.10. The purpose of Section 42 Care Act enquiries is to decide what action is needed to help and protect the adult. The aims are to establish the facts, ascertain the adult's views and wishes on what they want as an outcome and establish if any other person is at risk of harm. All too often it seems the emphasis was on paperwork, the providers response or the professionals response. It was not often that observations with the residents or their relatives were mentioned.
- 5.5.11. Some cases were also closed prematurely when the immediate risk to the person had ceased i.e., they had moved to another home or even died but the transferable risk had not been dealt with and the risk to others hadn't been taken into account. An example of this is the matter recorded at 5.3.6.
- 5.5.12. One of the best ways of identifying if residents concerns are being dealt with is by looking at the number of repeat referrals that are made. Over the course of this review period 43 people within the Morleigh Group Homes were subject to repeat safeguarding concerns. The table below provided by the ASC Safeguarding IMR author provides the full data available in relation to repeat referrals.

	Concerns						
Home	1	2	3	4	5	Total	
Tregertha	6	3	1		1	11	
St Theresa's	6	3	1			10	
Elmsleigh	25	9	2	1	1	38	
Collamere	17	5				22	
Clinton House	23	6	1	1		30	
Brake Manor	16	5		1		22	
Alexandra House	15	3				18	
Total	108	34	5	2	2	151	

5.5.13. A general appeal was put out through the press for any residents or families that were affected by the Morleigh Group to contribute to this review. The author did speak to a number of people both ex staff and relatives who came forward. Their contributions were extremely useful and supported the findings of this review. It is also quite clear and mentioned above that many relatives and staff tried to raise concerns throughout this period of time via whistleblowing made to the CQC. It was pointed out at the Practitioner Learning Event that many relatives would not have wanted the homes to close as they were close to where they lived and wanted their family members close. Staff also relied on the homes for work. The concerns raised therefore should be seen in this context and treated far more seriously than they were.

## 6. Conclusions

- 6.1.1. In any safeguarding adult review, it is important to try and answer ‘why?’ questions and to reflect on whether the particular features of the case as they have become to be understood reflected wider systemic issues locally and/or nationally.
- 6.1.2. The biggest ‘Why?’ question in relation to this SAR is why did it take a short BBC television programme to bring about the change in the lives of the residents of the Morleigh Group? What was it that brought about such significant change following the Panorama programme that all those professionals working within the multi-agency had failed to achieve over the previous three years, despite the wealth of evidence that is clearly evident within this report and the chronologies and IMR’s prepared before it? There is no evidence to suggest that things were any worse at the end of 2016 than they were at the end of 2013. Some of the key findings are as follows:
- All but Alexandra House had Quality Assurance action plans running throughout the review period, with no clear outcomes.
  - Individual homes and sometimes the whole group were in suspension numerous times.
  - Over 100 residents had concerns raised for them more than once.
  - Over 200 safeguarding alerts were made for individuals but only 16 went through to an individual safeguarding adult conference.
  - Over 80 whistleblower or similar reports were made, concerning a variety of issues many of which put residents at risk.
  - The CQC carried out 44 Inspections across the Morleigh Group during this review period, the vast majority identifying breaches of the requirements laid down for the effective running of the service.
  - There was a period of at least 12 months when four of the homes had no registered manager in place. Despite this being identified as a key area for compliance by the CQC at the start of this review period.

### 6.2. Making Safeguarding Personal

- 6.2.1. This should be at the heart of everything that is done to keep vulnerable adults safe. Professionals within each agency on an individual basis, clearly focused on

this and much work was done, sometimes over and above their roles, to provide the best care for the residents/patients in the Morleigh Group Homes. However, Making Safeguarding Personal does not appear to be sufficiently embedded in practice across the multi-agency. Safeguarding alerts were not looked at from the individuals point of view but were too often lost within a systemic process that had no clear outcomes for individuals. Anonymous concerns raised, predominantly to the CQC, were not shared with other agencies so that the issue raised could be dealt with. Although it was mentioned at the Practitioner Learning Event that residents and families were included in reviews, I have seen little or no evidence of this. The QA team specifically mentioned that their reviews did not concentrate on this as they were mainly focused on paperwork. A number of enforcement opportunities presented themselves to enable the environments to be a better and safer place but these were not taken. There were no processes in place to bring together all the indicators that were presenting themselves to provide a holistic picture of life in a Morleigh Group Home.

### **6.3. Record Keeping**

- 6.3.1. One of the features of this review has been the recognition from the local authority that record keeping was not as it should have been. This is surprising given the seriousness of some of the issues that were dealt with and discussed. There do not appear to be records of Quality Assurance Action plans, individual and systemic case conferences or decisions around the suspension of placements in homes within the Morleigh Group. This has made it difficult to understand some of the reasoning for decisions made at the time. The author has seen a number of complains raised by Health that they were not sent minutes of key meetings, however there is no evidence of this being raised to a higher level.

### **6.4. Sharing of Information**

- 6.4.1. Effective safeguarding depends on the flow of information and is often a feature in safeguarding reviews. One feature of this review is there does not appear to have been any reluctance or resistance to share information and in some cases, it did take place, for example the CQC inspection reports were shared across the multi-agency, however it just doesn't seem to have happened in the vast majority of cases. The policies and processes simply weren't in place for the effective sharing of information. Practitioners stated at the learning event that when referrals were made there was often no feedback. Health have mentioned a number of times that minutes of meetings were not provided. There was no gathering of information to form an overall picture (see analysis). Whistleblower concerns were often not shared with all agencies. There were instances of the suspension of placements being lifted but there were still QA team or CQC actions plans in place that identified risk.

### **6.5. Contingencies**



- 6.5.1. The question was posed at the initial SAR meeting ‘was this group too big to fail’ and was this a concern or even fear that held agencies back from taking action at an earlier point. The Care Act 2014 section 48 is quite clear that local authorities must step in if a business fails and there should have been a clear and robust contingency plan in place for this to happen if need be. If this had been the case agencies would have been able to act more freely and enforce non compliance safe in the knowledge that there was a contingency plan available. There is no evidence however that this was ever the case or was an option open to those who were dealing with the suspension of placements. In November 2015 there appeared to have been a meeting between the local authority QA manager, the charging manager and the Morleigh Group Finance Officer but it was not clear what this meeting was about. There is no other mention of any contingency planning around the Morleigh Group until the end of 2016 shortly before it was taken over. In order to deal with concerns of this type those managing the situation must have all available options open to them.

## **6.6. Enforcement**

- 6.6.1. The aim of all agencies working with the Morleigh Group was to work with and support the owners to improve the quality of life, wellbeing and safety of those that they cared for. This was evident throughout this review and at times the Cornwall Council QA reviews turned into support sessions for new managers (4.4.44 and 4.5.56), the CQC gave the owners of the Morleigh Group ample opportunity to recruit new managers to homes and we have seen the work done by the CFT to provide support at 5.4.10. However, when all this fails not only should enforcement action be threatened but it must also be carried out. The CQC on a number of occasions discussed fixed penalty notices or the withdrawal of the nursing care licence (St Theresa’s), however this was not carried through, the reasons given for not issuing fixed penalty notices for the lack of registered managers was that it would require interviews under PACE, this may have been an obstacle to overcome but when the focus should have been on the individual and the risk of harm then this should not have been a reason for not taking enforcement action to remedy the situation. The local authority and the KCCG also had powers to suspend placements to the homes and in fact they did do this on numerous occasions. However there didn’t seem any coherent strategy behind this and it almost happened too much to have any effect. On occasions when placements were re-instated there was a limit as to how many residents could be admitted per week but there did not seem to be any monitoring or control over this. The Police took enforcement action whenever possible although when this is/was not an option it is still vitally important that information sharing takes place so that other safeguarding process can be applied.

## **6.7. Analysis of information**

- 6.7.1. It was discussed at the Practitioner event how powerful graphs such as that at 4.8.34 (and others) are. At a glance it shows the number of concerns per home and as information is built up it can be compared against previous years and

other such locations. In compiling this review 1000's of pieces of information were available from all agencies, that when brought together produce a compelling picture. However, this information has to be understood and analysed to make meaningful management information. When this is done properly it gives a powerful case for change and supports any escalation process if change is not seen to be taking place. In this review the information has come from separate agencies, when compiling a merged chronology of all the information there was rarely any cross over of information. Individual agencies held their own information and it was never brought together in one place. Individual alerts, whistleblower concerns, repeat concerns, types of abuse, concerns by perpetrator, by age, by gender, police involvement, conferences held (or not) is all information that should be collected across the multi-agency for all locations not just those involved in this review. When viewed and compared this will provide an excellent picture of what is happening at each location and will be a measure of how safe the residents are and an indicator of their quality of life and wellbeing. The question has to be asked, if all of this information had been available in a sufficient format during the period of this review would action have been taken prior to the airing of the Panorama programme?

#### **6.8. Structure of Service**

- 6.8.1. Organisations are constantly going through periods of change for various reasons, however it is important that the basic structure of safeguarding services remain in tact to ensure that service delivery is not affected. During the majority of this review period the Commissioning for the Morleigh Group and QA teams were essentially one and the same and led by the same manager. This has now changed and the Commissioning team is not directly involved with the residents. The QA teams should be an independent function that is not influenced by any other department, so that they are free to challenge not only the providers but also other departments if their recommendations are not being acted upon.

#### **6.9. Audits/Reviews/Action Plans.**

- 6.9.1. All of the homes within the Morleigh Group were subject to CQC inspections or QA team reviews on a regular basis but why did this make no difference? Nearly all of the Cornwall Council QA action plans were in place for too long with no meaningful or clear outcomes. Although the management changes and provider engagement played a part in this, this in itself should have raised concerns. There is no evidence of any escalation of the fact that the action plans went on for so long. There is also evidence within the data that the audit tool may not have been fit for purpose and had no ability to measure and monitor culture and leadership. However, the CQC inspections did have a focus on leadership and they have identified this from a very early stage in the review period. The concerns however carried on and despite the issue constantly being discussed internally and with the provider the situation didn't improve throughout the period of review.

#### **6.10. Escalation**

6.10.1. It could be argued that the reason the Panorama programme achieved the result it did was because the concerns aired reached the very top of each of the agencies working within the partnership. This shouldn't however have to wait for a programme such as this to have this effect. Each agency and the partnership as a whole should have escalation policies in place. They are quite simple and straightforward but have not been mentioned throughout this review by any agency so we can only assume that they did not exist. Although policies themselves are quite straightforward there does need to be some detail at each level to identify each role holders responsibility when the process is used. Although there is no mention of a process in place there was occasionally evidence of concerns being raised to a higher level (5.3.8) but no evidence of what was expected or indeed what actually happened when the concerns were raised. The use of and outcomes of the escalation process should also be captured within the data referred to at 6.7.

### **6.11. Referral process**

6.11.1. The local authority operate a triage process for referrals but it is noted within the QA team IMR that approx. 10-20% of referrals completed by health and social care professionals go directly to the Quality Assurance Team without going to the safeguarding triage process. This is likely to have been the case throughout this review period and was confirmed at the Practitioner event. This is likely to lead to a degree of overlap in roles between the QA team and Safeguarding team and this has been reflected within the QA team IMR. It is also vitally important in safeguarding vulnerable people that professionals remain vigilant to all indicators, even those that may not be direct safeguarding concerns in the first instance. It is vital then that all referrals are recorded and signposted to ensure that there is no duplication and that all information is gathered and fed into any system as described at 6.7.1. All referrals need to be properly assessed and fed into the appropriate process. It is vital that concerns about individuals are treated as such and once a person centred outcome has been achieved that deals with all the risk identified, then that outcome can be fed into organisational processes.

### **6.12. Contract Management**

6.12.1. We have seen at point how the 5.1.3. commissioning process was out of date and not fit for purpose in relation to being able to hold providers of care services to account. There were no real review processes, timescales for change or penalties built into the contracts. This meant that when issues were identified there was no real process to fall back on or refer to. Action plans went on for years and there seemed almost to be a blockage to any enforcement action taking place. There is only reference to one meeting with the Morleigh Group Finance officer (5.1.28) during the course of this review period although the exact purpose of this meeting is not known.

### **6.13. Whistleblower/Complaints processes**

6.13.1. There is no multi-agency whistleblower policy identified but it appears that most whistleblower concerns were made to the CQC. They had their own process in place but they are a monitoring and inspection service and not reactive to dealing with individual Safeguarding alerts made by whistleblowers. There was no whistleblowing process in place within the multi-agency for processing these reports and this still appears to be the case. There was and still is confusion as to who deals with concerns raised whether they be via whistleblowers or other avenues. The author when speaking to a GP's surgery saw evidence of a number of concerns being raised to the Cornwall Council QA team by the surgery, only to be told by the QA team 'we don't deal with individual concerns we only deal with systemic concerns'. There was no signposting as to the correct team to refer the issue to or understanding that these may have fed into systemic processes. This process requires ownership, clear signposting and a robust risk assessment process so that concerns raised to any agency can be fed into a central point, assessed and the appropriate action taken to safeguard individuals.

#### **6.14. Suspension of placements**

6.14.1. This happened a lot but there doesn't seem to have been any clear process that was followed. Unfortunately there are no records of why decisions were made or rationale for opening services again. There were often conflicting processes underway when suspensions were lifted that did not always indicate services were safe to resume. It was not always clear that all agencies were consulted when decisions were made in relation to suspensions.

#### **6.15. Identifying good practice**

6.15.1. The primary aim of all agencies involved in this review is to support the provider to ensure that they provide a safe and well led-service. Although there are lots of examples of individuals doing this there are no examples of any organised multi-agency support to improve provider services, there is no mention of any workshops or training support for managers or of arranging any mentoring process with other providers who were coming out as good within audits and inspections.

#### **6.16. Conference management**

6.16.1. Conference chairs have extremely important roles, all too often however throughout this process decisions made at conferences appeared weak, without clear rationale and did not deal with the risk identified in the alert. One of the roles of the chair is to challenge those involved if progress has not been made and outcomes not achieved. The example provided at 4.3.10 shows a process that has been allowed to drift with no clear guidance from the conference chair and no clear outcomes. The issue being dealt with in this example had already been going on for some considerable time and it was even mentioned by the chair that it was a wider systemic issue that involved the whole county. The outcome however had no resemblance to the issue raised. The outcome was dealt with as an issue of communication between the surgery and the home

when in fact it was a clear case of non-compliance by the provider. However this issue was never resolved and still carried on until the Morleigh Group was removed as a provider. The chair was even recorded in the minutes of the conference stating that the agreed outcome will 'either happen or not'

## 7. Recommendations.

- 7.1.1. A review of the findings and conclusions at the learning event resulted in a shared view that the Morleigh Group case was not a unique case. It reflected practice across the multi-agency and there were systemic systems and patterns that if unchecked could affect other cases. The recommendations that follow are designed to strengthen how agencies work together in similar cases in the future.
- 7.1.2. As would be expected due to the seriousness and publicity surrounding the issues relating to the Morleigh Group some individual agencies have already indicated within their IMR's that change has already taken place. Depending where some of these processes are at, they should be included in any future action plan/monitoring. The change already underway, wherever possible is reflected below.

### 7.2. On contract management (Recommendation 1)

- 7.2.1. Contracts for the provision of care services must include a link to safeguarding compliance and the review and inspection processes that underpin these. Clear guidance around compliance with these processes, timeliness of compliance and penalties must be included. They must also ensure that their aim is to support the provider in supplying a service that promotes the individual well-being of those it is intended for. Contracts must have regular review periods built in.
  - 7.2.1.1. According to the Commissioning IMR work is already underway to change the commissioning contracts to include a measure of the risk in relation to those services that require improvement or are inadequate and/or have open action plans with the Quality Assurance Teams. This must be reviewed in line with the recommendation above.
- 7.2.2. Those working in commissioning must ensure that they are sufficiently trained and have an understanding of Safeguarding up to the highest levels of management, they must also work closely with the QA team, Safeguarding teams, CQC and any other inspection and review teams. Training should be refreshed on a regular basis and be a requirement for postholders.
- 7.2.3. **The Cornwall Council Commissioning team along with the KCCG are asked to reflect on this recommendation and take appropriate steps to ensure the recommendations are embedded into future contract management**

### 7.3. On Whistleblower/Complaints procedures (Recommendation 2)

- 7.3.1. There should be a clear whistleblowing/complaints policy that is signposted for all staff, residents, families and other professionals to follow. It is inevitable however that whistleblower concerns will end up outside of any recognised process such as those going to the CQC. What must happen however is agencies

must know where to send these concerns to so that they can be properly risk assessed and acted upon as necessary. The data must then be collected and fed into management information.

7.3.1.1. There is mention within the QA team IMR that relatives complaints often get sent to the QA team, however the QA team do not perform a complaint investigation function and it is therefore highly probable that this situation has not yet been addressed.

**7.3.2. All agencies are asked to reflect on their own and whistleblowing policies and how these come together to ensure information is shared appropriately with all agencies and appropriate action taken to deal with concerns.**

#### **7.4. On Management information (Recommendation 3)**

7.4.1. Each agency should ensure that it has the ability to collect management information on provider performance and that it can be presented in such a way that informs the risk that is present. This information should be collected across the partnership and analysed by the multi-agency to ensure that a complete picture is presented. This information should then be viewed on a regular basis by a multi-agency group of senior managers.

7.4.1.1. The CQC have already mentioned in their IMR that they have developed sector specific 'dashboards' which enables staff to have a day to day view of providers and the degree of presented or predicted risk.

7.4.1.2. The ASC Safeguarding team within their IMR have already produced a number of graphs and performance charts (some of which have been used in this review) that would form the basis of the management information referred to at 7.4.1.

7.4.1.3. The Police already have dedicated safeguarding researchers who complete the research at the referral stage to provide a greater chance of identifying 'systemic abuse cases' this however now needs to feed into management information and be part of the wider multi-agency research and analysis.

**7.4.2. All agencies are asked to reflect on this recommendation and ensure that they have the ability to collect and analyse Management information appropriately to ensure that safeguarding issues are identified and risks appropriately managed.**

#### **7.5. On Contingency planning (Recommendation 4)**

7.5.1. The multi-agency must have robust contingency plans in place to ensure that a seamless provision of care can be provided should they have to invoke their duties under sec 48 of the Care Act (temporary duty on local authority to provide care). These plans must be constantly reviewed and funding provision made available. The fact that the contingencies are in place must be known by those working in the audit and inspection teams so that they are able to follow through with any enforcement, knowing that the contingencies are there.

**7.5.2. All agencies are asked to reflect on their role within any contingency plans but Cornwall Council should take the lead in ensuring they, along with partners, are ready and capable of implementing section 48 of the Care Act in scenarios similar to the Morleigh Group.**

## 7.6. On Escalation Policies (Recommendation 5)

- 7.6.1. Each agency must have its own internal escalation policy to ensure that effective challenge can be made when professionals do not agree that the correct procedures are being followed, or they disagree with actions taken (or not). There must also be an overarching escalation policy for the multi-agency to ensure that inter-agency disagreements can be resolved in a structured way and clear outcomes achieved. It is important that role holders at every level understand the requirements of their role within the policy. It is suggested that the escalation policy is overseen by the Adult Safeguarding Board.
- 7.6.2. All agencies are asked to reflect on and review their Escalation policies and ensure that they are clearly signposted for all staff. The Adult Safeguarding Board should oversee that a multi-agency policy is in place.**

## 7.7. On enforcement (Recommendation 6)

- 7.7.1. Each agency that has powers to enforce compliance must have the ability to carry this out and capture the evidence where required. Each safeguarding alert must be properly documented and evidence captured through the taking of statements and other evidence capture, as this may be required at a later date.
- 7.7.1.1. The CQC have already begun to recruit investigators/interviewers to ensure that PACE interviews can be conducted in future and that this is not a blockage to enforcement.
- 7.7.2. The CQC and Cornwall Council are asked to reflect on this recommendation and ensure that they have the ability, resources and processes to enforce action where breaches of regulations or the law are identified.**

## 7.8. On Audit, report and action plans (Recommendation 7)

- 7.8.1. The Quality Assurance Audit tool must have a focus on 'Making Safeguarding Personal'. It must include observation, discussion with residents, relatives, staff and other professionals. It must also include any whistleblower concerns and make reference to management information regarding the setting and compare this to similar locations. Action plans must also have clear timescales embedded and the penalty for non-compliance. There should then be a clear process for dealing with non-compliance and enforcement action as necessary. Action plans should also clearly make reference to any other ongoing process such as CQC inspection reports and there should not be duplication of actions within each audit/inspection. Where necessary action plans should be discussed and co-ordinated between agencies.
- 7.8.1.1. The Cornwall Council Quality Assurance team already have a review process underway for their QA audit tool. This should be completed as a matter of urgency and ensure that the above recommendations are covered within it.
- 7.8.2. The Cornwall Council Quality Assurance team are asked to reflect on this recommendation and ensure that the review process already underway captures the learning from this review.**

## 7.9. On Suspension of placements processes (Recommendation 8)

- 7.9.1. Cornwall Council Quality Assurance Team have already developed a new process in 2017 to ensure that requests for suspension of placements to be put in place or lifted is clearly documented. Whilst the documentation for requesting and lifting suspensions is in place the procedural document has not yet been updated. This should be completed as a matter of urgency. However, the new documentation for requesting and lifting placements is missing two key sections, that were key findings from this review.
- i. There should be a section for recording all other relevant agencies views when proposing to lift suspensions.
  - ii. There should be a section to note any current action plan processes that might still be running when suspension is due to be lifted.
- 7.9.2. The Cornwall Council QA team is asked to reflect on this recommendation and consider adding the above recommendations into the new process for requesting or lifting suspensions.**

## 7.10. On Mentoring (Recommendation 9)

- 7.10.1. The role of all agencies is to support providers to ensure that excellent, person centred care is provided. The multi-agency should consider putting in place a structured mentoring programme so that where good practise is identified in care homes this can be shared with those that are struggling to achieve the required standards. Participation in this programme could be included in commission contracts and/or quality assurance action plans.
- 7.10.2. All agencies should reflect on this recommendation and identify how they can support a structured mentoring programme. It should be for the Adult Safeguarding Board to decide who to lead the programme but all agencies including the CQC should support the programme by identifying good practice and those homes that would benefit from the scheme.**

## 7.11. On reporting allegations/alerts (Recommendation 10)

- 7.11.1. There should be a single 'front door' for all alerts and then these should be signposted accordingly. This single point of reference for all allegations should include individual and organisational alerts, this is to ensure that there is no confusion over who should deal with the concern and what it involves.
- 7.11.2. There should be clear pathways of communication set up to ensure that those reporting concerns are notified of who is dealing with the report and the outcome should also be communicated back to the person making the original report.
- 7.11.3. The Cornwall Council Safeguarding team and QA teams should reflect on this recommendation and how it fits with current provision. Health should also ensure that any concern where this is a safeguarding element is appropriately referred through the 'single front door'. The CQC should also ensure that any concerns raised to them, especially those through the whistleblower process are referred into the Cornwall Council Adult Safeguarding in a timely manner.**



### 7.12. On dealing with allegations/alerts (Recommendation 11)

- 7.12.1. Individual safeguarding alerts/concerns must be reviewed and completed in their own right with a focus on the desired outcome for the individual concerned and a focus on their wellbeing. Individual concerns should not be closed and incorporated into an organisational process. The outcomes of alerts/concerns should be monitored and fed into the management information at 7.4 to ensure that this policy is monitored.
- 7.12.2. The findings of individual concerns should be fed into any organisational processes that are ongoing.
- 7.12.3. The Cornwall Council Safeguarding team should reflect on this recommendation and ensure that all alerts/concerns are focused on the wellbeing of those subject to the alert/concern raised and that all recommendations arising are recorded and dealt with appropriately.**

### 7.13. On Training (Recommendation 12)

- 7.13.1. Little has been mentioned within this SAR and the IMR's that preceded it around training, there is therefore little evidence base to support any recommendation around this area. There is however a clear need to ensure conference chairs are sufficiently trained to enable them to carry out their role and there is a need to ensure that senior managers are able to identify risk and act upon it accordingly. In relation to training therefore the author would recommend the following.
  - i. There are a number of new policies and processes coming out of the review into the Morleigh Group, there should be a robust and documented round of training to all those affected to ensure that they are aware of the requirements of their role. There should be a strong focus on senior management.
  - ii. There should be an ongoing programme of training developed for conference chairs that includes case studies, learning from reviews and training on new policies and procedures.
- 7.13.2. All agencies should reflect on their current training programmes and ensure that any learning and/or new policies and procedures that come out of this SAR are included in any future training.**
- 7.13.3. Cornwall Council should reflect on the recommendation in relation to conference chairs and ensure that the training and selection of conference chairs is reviewed and that there is an ongoing training and supervision programme in place to ensure the learning of this review is taken forward.**

### 7.14. On Making Safeguarding Personal (Recommendation 13)

- 7.14.1. Conduct a multi-agency audit and/or other quality assurance mechanism to evaluate how far 'Making Safeguarding Personal' has been understood and embedded in practice.
- 7.14.2. All agencies should review their policies and procedures and ensure that they are all 'person centred' and focused on the needs of the individual.**

### 7.15. On Communication (Recommendation 14)

7.15.1. The safeguarding policies and procedures must be clearly communicated across the multi-agency and easily accessible via the web-site. There should be a clear description of everyone's roles and position and the escalation policy mentioned at 7.6 should be able to be accessed through the website. This is to ensure that those working outside of the immediate safeguarding teams i.e. GP's have access to this information and processes.

**7.15.2. The Cornwall and Isles of Scilly Safeguarding Board should reflect on this recommendation and ensure that all Safeguarding Policies and Procedures are accessible to everyone working with vulnerable adults.**

**7.16. On SAR impact (Recommendation 15)**

7.16.1. Reconvene a learning event after 12 months to evaluate with managers and practitioners across the agencies involved what has changed as a result of learning from this SAR.

**7.16.2. The Cornwall and Isles of Scilly Safeguarding Board should reflect on this recommendation and consider ways to evaluate progress from all agencies against the recommendations above within 12 months**

**Appendix 1. Acronyms used in this report**

PCHT – Peninsular Community Health Services

RCHT – Royal Cornwall Hospital Trust

CCG – Clinical Commissioning Group (NHS Kernow)

NHS Kernow – National Health Service Kernow (also known as the CCG)

LA – Local Authority

CC – Cornwall Council

QA – Quality Assurance

ASC – Adult Social Care

CQC – Care Quality Commission

CFT – Cornwall Partnership NHS Foundation Trust – provider of Health services

GP – General Practitioner

MRM – Management review meeting.