

THE CLOSURE OF OXFORD GRANGE CARE HOME

SAFEGUARDING ADULTS: LESSONS LEARNED REPORT

SEPTEMBER 2015

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BACKGROUND AND CONTEXT

1. This document provides a report of the findings of the lessons learned Safeguarding Adults Review established to consider the events surrounding the closure of Oxford Grange Care Home.
2. Oxford Grange Care Home, part of the Northfield Care Homes Ltd group of homes, was subject to an unannounced inspection by the Care Quality Commission on 8, 10 and 12 May 2015. Prior to the inspection the CQC had received concerns about the care and welfare of the people living at the home and insufficient staffing.¹ On 8 May 2015 a safeguarding alert in respect of all 33 residents was made to Kirklees by the home manager as instructed by CQC. The home was subsequently subject to an emergency closure order by CQC on 22 May 2015, and the home was deregistered on 29 May 2015.
3. Under the Care Act 2014 Safeguarding Adults Reviews (SARs) have replaced Serious Case Reviews. Under the previous Department of Health “No Secrets” (2000) guidance, there was no statutory requirement to review cases involving adults at risk, though most authorities were carrying these out as this was regarded as best practice.
4. SARs must be carried out when:
 - An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
 - SAB²s must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.
5. The Care Act statutory guidance also states that “the Safeguarding Adults Board should be primarily concerned with weighing up what type of review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again”³ The purpose of a SAR is not to hold any individual or organisation to account but rather to determine what might have been done differently, so that lessons can be learned and applied to future cases. The principles to be applied to any review process are:
 - A culture of continuous learning and development across organisations
 - A proportionate approach according to the scale and level of complexity of the issues being examined
 - Led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
 - The full involvement of professionals in contributing their perspectives without fear of being blamed for actions taken in good faith; and
 - Invitations for families to contribute to the review

¹ Care Quality Commission: Oxford Grange Care Home Inspection report 30/06/2015

² Safeguarding Adults Boards

³ Department of Health Care and Support Statutory Guidance 2014

6. The guidance is not prescriptive about the form a SAR should take; rather the process should be determined locally according to the specific circumstances of the individual situation.

Decision to undertake a SAR Lessons Learned Review

7. The decision to undertake a lessons learned review in the case of Oxford Grange was taken on 7 July 2015 by the Kirklees Safeguarding Adults Review Sub-group which is a sub-group of the Kirklees Safeguarding Adults Board (KSAB) and includes representation from the Calderdale and Huddersfield NHS Foundation Trust, West Yorkshire Police, and Kirklees Council. The sub-group is responsible for making recommendations to the Independent Chair of the KSAB about commencing reviews, making arrangements for conducting the review and monitoring the effective implementation of recommendations and related action plans arising from the review process. The Chair of the KSAB ratified this decision on 17 July 2015.

Aims and Terms of Reference for the review

8. The aim of the lessons learned review was to enable individuals and agencies to learn lessons about the way in which they work both individually and collectively to safeguard and promote the welfare of adults at risk. As far as possible, the review was to be conducted in such a way that the process was a learning exercise for everyone that had been involved in the case. The Terms of Reference were agreed as follows:-
 1. To consider the extent to which the agencies involved with the home could have foreseen the development of circumstances which led to the emergency closure in May 2015
 2. To consider whether any action could have been taken by any of the agencies involved, including the Care Quality Commission, to assess risk to prevent or mitigate the impact of an emergency closure
 3. To enable the staff involved with supporting the residents and their families to review what went well, what went less well, lessons learned, sharing best practice to inform any future situations, by means of a multi-agency debrief session to share findings, lessons learned and agreed future actions
 4. To enable the families of the residents to contribute to the review, through face to face discussion in a specific debriefing session or to contribute their views in writing. Advocacy will be made available if families wish this.
 5. To offer an alternative opportunity for the residents to contribute to the review, either through their families, advocates, social workers or key workers.
 6. To identify the lessons to be learned from this case in relation to the way in which local professionals and agencies worked together to ensure the safety and quality of the care provided at the home

9. The period covered by the review was 1 December 2014 to 22 May 2015, with agencies required to provide a chronology of their involvement during this period. Agencies were also required to review records prior to this timescale and provide an overview of any additional significant incidents and information from 1 December 2013 to 1 December 2014.

Methodology

10. A range of methods were used to meet the aims of the learning lessons review, including reviewing written records, multiagency agency debriefing, follow up interviews with managers, a relatives meeting plus some individual conversations with relatives, a meeting with the home owner and conversations with ex members of staff.
11. Chronologies were requested and received from:
 1. Kirklees Social Care and Wellbeing for Adults
 2. Kirklees Council Infection Prevention & Control
 3. Kirklees Council Contracting Team
 4. Care Quality Commission

Locala District Nursing also provided information on visits undertaken as part of their general nursing duties.

12. A multi-agency lessons learned workshop was held on 14 August 2015 involving 14 staff from Kirklees Adult Social Care, Kirklees Contract Monitoring Unit, Safeguarding Partnership Team, Care Quality Commission, Locala District Nursing and Greater Huddersfield and North Kirklees Clinical Commissioning Groups.
13. The families of the residents involved were invited to contribute to the review either by individual contact with the independent author or by their participation in a group discussion held on 22 September 2015 with the Independent Author, Safeguarding Board Manager and an independent advocate. In total 7 family members contributed to the review.
14. Given that the residents involved had already experienced major change and upheaval following their move from the home, it was important to ensure that finding out their views did not run the risk of unsettling them further. Relatives were asked how their family members' views could be included. They confirmed that it would not be appropriate to make direct contact, however relatives were happy to contribute any issues they would like to make in respect of their family members. Information was also drawn from the individual care reviews which had been undertaken after people had moved to their new homes.
15. The home owner was interviewed by the independent author and provided his perspective on the events leading to the closure of the home.
16. Staff who previously worked at the home were contacted by letter and telephone and asked for their views or comments they would like to contribute, 5 took up this offer.

OVERVIEW OF AGENCY INFORMATION

17. Oxford Grange was a 43 place registered care home providing residential care for people some of whom may be living with dementia. **In June 2013** following a routine inspection by the Care Quality Commission the home was found to be non-compliant with 4 regulations – maintenance of premises, care and welfare, infection control, safety of equipment. A warning notice was issued for breach of infection control.
18. **In September 2013** Kirklees Council Infection Prevention and Control received a self-assessment audit from the home which was judged to be 93% compliant. However there is some confusion in the records as to the dates when the audit was undertaken and who completed it.
19. **In December 2013**, the home was re-inspected by CQC. It was found that it was now compliant with all regulations. The CQC report referred to the report issued on 19 September 2013 by Kirklees Infection Control with a risk rating score of 95%. However it is not clear from the information recorded whether or not the self-assessment had been validated externally.
20. **In January 2014** concerns were expressed to Kirklees contracting monitoring team by a relative who was visiting the care home as they were looking for a care home place. These concerns were about a lack of dignity and respect by staff to residents and a perception that not enough staff were on duty to meet care needs. The contracts team alerted safeguarding and a safeguarding strategy meeting was held. The conclusion was that there was no evidence of abusive care practices but that staff needed guidance on how to respond to visitors to the Home particularly at weekends when the Home Manager was not available.
21. **In March 2014** a contract monitoring visit was made to check that the care home was meeting the standards set within the Council's contract for care home provision. Care practice was found to be to be satisfactory. No defaults were issued and it was agreed to review in 3 months to see if a further visit was required. By July 2014 no further issues had been raised with the contracts team or discussed at the contract liaison meeting. The home was removed from the priority visit schedule.
22. **In November 2014** Kirklees contracting team was notified that the home manager was leaving and that oversight would be undertaken by the home manager of another home owned by the same company. CQC were also informed and followed this up with the care provider who did not raise any concerns. At the contract liaison meeting in **January 2015** no issues were raised by those attending in relation to the home.
23. **On 11 March 2015** an outbreak of diarrhoea and vomiting at Oxford Grange care home was reported to Kirklees Council Infection and Prevention Control. A visit was made within 24 hours of initial notification, daily contact was maintained and a post outbreak audit was undertaken at the end of the outbreak. The outbreak was reported to CQC on 12 March and the contracting team on 27 March. Contract monitoring scheduled a visit for April 2015. A visit was due as the team aimed to visit all homes at least every 12 -15 months, or more frequently if concerns were raised.
24. **On 14 and 30 April 2015** two contract monitoring visits were undertaken during both of which a number of default notices were issued and the findings shared with

CQC, Safeguarding and Infection Control. Following the second contract visit on 30 April a decision was also made by the Council to cease placements at the home. Social Work Teams, Clinical Commissioning Groups and other Local Authorities were informed.

25. On **28 April 2015** CQC were notified by a relative of concerns regarding care and welfare and inadequate staffing and that the manager had reported that there were not enough staff. Plans were made for an unannounced inspection to take place.
26. On **8, 10 and 12 May** the home was inspected by 5 adult social care inspectors and an expert by experience. A number of breaches in regulations were identified; management was described as disorganised and chaotic, with staff lacking leadership and direction. Due to the concerning nature of some of the observations made by the inspectors, safeguarding alerts in respect of all residents in the home were made to the Council's safeguarding team.
27. Infection Control also carried out a further audit on **12 May 2015** which showed that significant issues in relation to infection control remained and had not been addressed since the audit in March.
28. On **14 May 2015** a multi-agency safeguarding strategy meeting was held attended by Kirklees Council staff, Locala Community Partnerships and CQC, with the home owner's representative and home manager in attendance for part of the meeting. The Home tabled a draft action plan at the meeting which had been required by CQC to address the serious concerns being raised. The meeting was also informed that a consultancy team comprising of staff experienced in turning around failing homes had been brought in by the home owner and had started that day to implement the action plan urgently. It was agreed that reviews of all residents to assess their needs and wellbeing would start immediately; that the home owner would arrange a meeting for relatives to inform them of the situation, and the Council would also attend; and that a further strategy meeting would be arranged for 19/20 May for the purpose of receiving the more detailed action plan to be provided by the home.
29. On **15 May 2015** CQC issued a letter giving notice of potential enforcement action under Section 31 of the Health and Social Care Act 2008. The CQC had been notified by the care home owner that the registered manager had been asked to leave, raising further concerns in addition to the inspection findings.
30. A letter was also sent on this date by the home owner to relatives to update them on the fact that the home was to be sold, that a recent CQC inspection had raised concerns and that the home owner and management consultants were working with CQC and the local authority to make the improvements needed. Relatives were also invited to a meeting on 21st May with the prospective new home owner, with Kirklees Council in attendance. Kirklees Council Social Care and Wellbeing for Adults also wrote separately to relatives inviting them to contact a named senior manager and giving a contact number.
31. A joint staff communication was also sent on behalf of Oxford Grange Care Home and the Council to staff working in the home advising them that concerns had been raised following the CQC inspection, that support would be put in place, and that help was available from the onsite home manager or a named senior manager in

the Council if they had any concerns. The ongoing health and safety of the residents was emphasised as a priority.

32. On **Sunday 17 May** Kirklees Contract Monitoring Unit undertook an unannounced visit at 7.00am and observed some issues of concern in relation to the cold temperature of the conservatory and breakfast service for residents who were already up at that time. This was fed back to the home owner and consultants, CQC and the Council's safeguarding unit.
33. During **week commencing 18 May** reviews of all residents were being undertaken by the Kirklees reviewing team who were based at the home to undertake the reviews and be available for relatives. The purpose of the reviews was to update and confirm the care needs of each resident, to determine the extent to which their needs were being met at Oxford Grange, and to agree changes to care plans if necessary. Also during this week the consultants appointed by the prospective home owner were involved in taking improvement action. A new interim home manager was appointed and commenced work on 20 May 2015.
34. On **21 May 2015 pm** concerns about safety and quality of care of residents, and arrangements for cover over the upcoming Bank Holiday weekend were raised directly with CQC by a whistle blower.
35. The prearranged relatives meeting was also held on **21 May 2015 7.30pm** at Oxford Grange.
36. On **22 May 2015** following a further inspection visit by CQC, urgent enforcement action under Section 31 of the Health and Social Care Act 2008 to close the home by 29 May 2015 was taken.
37. **23 May 2015 – 29 May 2015** the social work team began to work with relatives regarding new placements for residents; by **29 May 2015 all** residents had been placed in alternative care homes and the home was closed.

KEY FINDINGS AND LESSONS LEARNED

38. The findings, analysis and lessons learned are based on evidence obtained from a range of sources. Written documentation was analysed including chronologies and reports submitted, and individual care reviews of residents. Two debriefing sessions were held, one for staff involved with the closure and one for relatives. Individual interviews, either face to face or by telephone were conducted by the independent author with managers involved with the closure, ex members of staff from Oxford Grange and two relatives who were unable to attend the debriefing meeting. The key areas covered are:

- To what extent could the events which led to the emergency closure in May 2015 have been predicted or foreseen by the agencies involved?
- Could any action have been taken to prevent or mitigate the impact of an emergency closure?
- How well did the agencies work together before, during and after the closure of the home?
- How did relatives perceive the care provided to their family members at the home prior to the events in May 2015; how did they experience the support they received during and after the closure process? How well did their family members settle in their new homes?
- What communications issues arose?
- What worked well/not so well – are there areas of good practice to share?

Could the events that resulted in closure have been predicted or foreseen?

39. Agencies involved were asked to submit chronologies which covered specifically the period from December 2014 to May 2015, but also to review the extent of their involvement in the preceding 12 months, i.e. December 2013 to December 2014. When the Home was inspected in June 2013 there were issues in relation to infection control, care and welfare, maintenance of premises and equipment safety. However on re-inspection in December 2013 it was found that improvements had been made and the home was now compliant. Families and social work staff visiting the home during this period described the staff as caring, albeit as the home was an adapted property rather than purpose built it did not have all modern features.

40. Contract compliance visits made by the Council's Contract Monitoring Unit during 2014 similarly did not reveal any major issues. A multi-agency "Early Indicator Form" has been agreed by the Safeguarding Adults Partnership and is designed for use by professionals when visiting homes in Kirklees. Its purpose is to provide early intelligence to the multi-agency contract liaison meetings of any concerns arising which are below safeguarding thresholds. None of these forms were received in relation to Oxford Grange during the period reviewed. District nurses were involved with 16 residents throughout 2014, visiting on average 2-3 times per week to see individual patients. During that period no safeguarding concerns were identified by district nursing staff. GPs were also asked by North Kirklees CCG whether they had identified any care or safeguarding concerns during the period; they also did not identify any issues.

41. The resignation of the registered manager in November 2014 seems to have triggered the beginning of a period of instability in terms of leadership and management, with a series of interim management appointments and cover being provided by managers from other homes in Northfield Care Homes Ltd. It was also during this period that the home owner had started to experience ill health and was looking to sell Oxford Grange and two other homes in the area. CQC and Kirklees Contracting Unit were informed of the resignation of the manager in November 2014. Contracting decided to schedule a visit in April 2015 unless concerns were raised before that date. Both families and members of staff who contributed to the review commented that the absence of a consistent manager impacted adversely on the running of the home. There was no “captain in charge of the ship”; seven months was a long time without a manager; people “started to cut corners” and staff were “expected to do a lot”.
42. There were nevertheless events during this learning lessons review period which may have indicated that care standards were slipping. The first was the safeguarding referral in January 2014 when a relative was concerned when visiting to enquire about a new placement and reported concerns about a lack of dignity and respect in relation to two residents and their perception of staff shortages. This referral proceeded to a strategy meeting involving representatives from the care provider where it was concluded that abuse had not occurred; however action had been taken by the care provider to confirm the standards expected when greeting visitors and responding to residents. On reading the record of the strategy meeting it is the view of the author that appropriate action was taken in relation to this referral.
43. During the remainder of 2014 a further 6 safeguarding alerts were made in relation to residents at Oxford Grange. Five were reported by care home staff with the sixth reported by a relative. All of these alerts were investigated and it was concluded that the care home had taken appropriate action. The number of alerts made by a care provider to safeguarding is not necessarily an indication of poor quality care; it can also indicate good levels of awareness about safeguarding and the need to refer for investigation. However it is important that effective systems are in place to review any trends in referrals which could be indicator of growing concerns.
44. The March 2015 outbreak of diarrhoea and vomiting was a significant event and was responded to swiftly by specialist infection and prevention control staff. The findings of the infection control staff in March 2015 echoed the previous CQC inspection concerns regarding infection control.
45. In summary it would appear that monitoring systems were in place to flag up care home concerns and that they were being used appropriately. However there may be further scope for ensuring strengthened triangulation of information held in a number of different systems, i.e. inspection compliance, safeguarding, contracting and public health. However the major trigger seems to have been the combined impact of the change of manager, uncertainties created by the proposed sale of the home and the owner’s ill health which together resulted in deterioration in care standards which soon took hold.

Preventing or mitigating the impact of emergency closure

46. Evidence from the literature⁴ demonstrates that:

“The impact of resettlement on the health of frail elderly people is a natural cause for concern”

Moving residents is therefore always something to be avoided if at all possible. The main focus of working with failing providers is to work with them towards improvement so that very vulnerable residents do not have to move unless there are no other alternatives to sustain their health, safety and wellbeing.

- 47.** The CQC inspection took place over three days, 8, 10 and 12 May. The inspectors' findings were of such significant concern that the care home provider was required to make a safeguarding alert to Kirklees in respect of all residents at the home. At the multi-agency safeguarding strategy meeting on 14 May initial plans were tabled by the prospective home owner to bring in additional consultant capacity to make the urgent improvements required. Concurrently reviews or reassessments of all residents were to be undertaken by Kirklees Council's Reviewing Team to assess whether their care needs were being met. It was also agreed that the home owner would arrange a meeting with relatives to inform them of the concerns that had been raised and the plans to improve the home.
- 48.** Between 14 and 21 May 2015 a significant amount of additional resources were provided to the home by both the home owner and the Council. Infection control and contracting staff undertook spot checks on the home; social work staff began review work and senior managers were in close contact with both the consultants brought in to the home and the Care Quality Commission. District Nursing and GPs were contacted to contribute to the individual reviewing process. A letter was sent to relatives on 15 May by the home owner inviting them to a meeting at Oxford Grange on 21 May.
- 49.** However, despite this intensity of activity the evidence suggests that it was proving very challenging to make the changes required in the timescales required. The addition of agency staff to improve staffing levels made consistent care-giving more difficult; the manager who had been in charge of the home left suddenly, and a picture emerges of a lack of a robust turnaround plan with clear leadership roles and accountability assigned.
- 50.** Conversations with some staff who were working during this period revealed that they felt that with more time they could have “brought things up to scratch”. They felt that they were working hard to turn things around during this period, for example being offered additional shifts to help with the work needed. It then came as a major shock when the announcement that the home was closing was made. Staff interviewed said that caring for the residents was their top priority during the period, but that at times the situation was chaotic and pressurised. The additional agency staff brought in to increase staffing levels created additional challenges, as they were unfamiliar with the residents and the routines of the home and required induction and support to work effectively.

⁴ Glasby et al (2011) : Achieving Closure : good practice in supporting older people during residential care closures p34

- 51.** From the relatives perspectives the meeting on the evening of 21 May 2015 did not give them the clarity or assurances they needed. At the meeting they were informed that the care home was working closely with the CQC and the Council to make the improvements required, yet within 24 hours they were notified of the decision to close (it is important to note that if there is an exposure to the risk of harm, CQC have to use its urgent powers in a short timeframe). This presented a picture of very mixed messages and a lack of transparency about the full extent of the concerns and problems. The key messages presented at the meeting were that there were concerns about the home, but that there was a plan in place to work together with the home and the new owner to improve things. Reviews would be undertaken with residents to ensure the care provided met their needs and there would be a follow up meeting a week later.
- 52.** The issues of concern that were relayed to relatives at this meeting were a surprise. They were told that there was inadequate completion of care records, and that there were concerns about managerial administration; lack of training was also reported as a concern. Family members said that they went away from it worried about their relatives, but felt that something was being done about it, and that extra help was being brought into support the home. The family members expressed the view that the information presented by the Local Authority was quite vague and that there seemed a reluctance to share any detail. A draft CQC report was mentioned but not shown, and Local Authority staff gave the impression that they didn't know the full details.
- 53.** A decision had been made at the safeguarding strategy meeting on 14 May that the care provider would host the meeting with relatives, with the Council in attendance and that the CQC would not attend, given that the purpose was to focus on providing assurance to relatives of the work being undertaken to make the improvements so that the home could remain open. However, notwithstanding CQC's regulatory role, and the need to carry out their legislative responsibilities, if all three organisations had been present at the meeting then it may have led to a greater degree of sharing about the full extent of the issues that needed to be addressed to enable the home to stay open.
- 54.** The seven day emergency closure notice was served on 22 May which was the Friday before the Spring Bank Holiday. Council social work staff were brought in to work with relatives all over the weekend to find alternative placements. However the timing inevitably created further pressure, as some families were away for part of the weekend, and there were in effect only three normal working days available before 29 May to make the arrangements.
- 55.** There was a mixed picture from the relatives who contributed to the review about how they found the support available to help find alternative suitable care for their relatives. Some described the support from their social worker as "fantastic" others felt they were given very little time to make major decisions about the future of their family member.
- 56.** The 10 day period between 12 and 22 May was extremely challenging for all concerned. CQC stated that they did want to give the care provider time to demonstrate that they could make the improvements required as this would be preferable to the impacts on people of having to move from their homes, but this had to be balanced with the need to ensure the care and safety of the residents. The care provider brought in significant additional resources to try to turn the

situation around, but there were changes of management even during this short period, leading to further uncertainties about how the care home could be sustained. Council staff were brought in to begin the reviewing process, but by the end of the period this had changed to an emergency closure plan. Finally, as the picture was changing daily, consistent communication with relatives and front line staff was very difficult to achieve.

57. The speed at which the events unfolded following the inspection left little room for planning which, even if it may not have prevented the eventual home closure, might have resulted in less pressure for relatives, residents and staff and better communication, and the potential to carry out a planned rather than an emergency closure. The timing of the closure notice at the start of a Bank Holiday weekend added further pressure to an already fraught situation.

Partnership Working

58. Staff who attended the multiagency debrief session were generally positive about the ways in which the agencies involved worked together during the week preceding the homes closure. They felt there was a willingness and commitment from all involved to support the residents and their families during a very distressing period. However due to the speed under which everyone was working inevitably some issues arose. The reviewing team who were responsible for ensuring that appropriate alternative places were identified for residents felt less in control than they would have wanted in what was required to support residents and staff. They needed up to date information on the needs of the residents, vacancies, together with knowledge and input into how communication was being managed. They would have liked more direct health input from health colleagues, particularly District Nursing and GPs in assessing people's needs.
59. It was only possible for the author of this report to make contact with a small number of staff who had worked at Oxford Grange. However two of the staff members contacted who had worked at the home for many years felt that the Council staff helped as much as possible to support them and the residents and that they all worked together to ensure that people were cared for right up to the home's closure.
60. Overall the evidence from the chronologies and debriefing sessions was that agencies were attempting to work in partnership with each other, with the consultants brought in to improve the home and with residents, relatives and staff, but that the pressure of the situation in the last two weeks of the home's operation made this very difficult. The terms "chaotic" "manic" "swarming with people", "too many cooks" were used by a number of different stakeholders to describe what was happening at the time, indicating a desire to put things right but without the resources being deployed through a clear implementation plan.

Communications

61. SCIE's resource material on short notice care home closures⁵ describes communication as the key to:

⁵ SCIE: Short Notice Care Home Closures: Communication (2011)

- avoiding misunderstandings and establishing trust with residents and their families
- enabling residents and families to exercise choice and control with regard to making alternative arrangements
- allaying fears and maintaining confidence in care arrangements
- protecting organisational reputation and demonstrating transparency.

- 62.** From the evidence obtained from a range of review contributors, overall communications did not go as well as expected. Although communication briefings were in place, relatives and care home staff felt particularly strongly about the inconsistent messages they were hearing, notwithstanding the fact that commissioners and regulators were also reassessing the situation on an ongoing basis as additional information came to light. The reality was that the changing picture in relation to the improvements required did result in changes of perspective on how sustainable the home had become.
- 63.** The reviewing team were not represented at the relatives meeting on the 21 May; they felt that by being at the meeting to provide information and support, it may have made the situation easier when working with families over the weekend after the closure was announced.
- 64.** Care home staff who spoke to the author were understandably very concerned about the negative press coverage that took place. They felt that they were doing their best to provide care to the best of their ability but that “we didn’t know what we were doing wrong and not told how to rectify it”. Relatives were also upset on behalf of the care staff, who they felt were generally not at fault.
- 65.** At the time of the negative press coverage in late May and June, the CQC had not yet published their inspection report and therefore the full extent of the regulator’s concerns was not yet in the public domain. It is the case that all CQC reports are subject to checking for factual accuracy by the care provider before they become public, and that time for this to take place is built into the process. However if it had been possible for the care home provider, in consultation with CQC and the Council to share information more fully with relatives and staff immediately following the inspection it may have been easier for them to understand the seriousness of the situation.

What good practice points can be learned?

- 66.** Notwithstanding the challenges and pressures in the last two weeks of May, overall it is the view of the author that agencies generally worked together. The chronologies showed evidence of information being shared to manage a rapidly changing situation.
- 67.** Some relatives who contributed to the review spoke positively about the professionalism of the social work staff who were supporting them in finding new homes.
- 68.** An analysis by the author of the individual care reviews following the closure of Oxford Grange showed that considerable care was taken to ensure that residents’ needs were being met in their new homes, that relatives were involved in this process and that care plans were brought up to date. There is evidence of residents

being supported to be involved in their reviews and attention was given to best interests' assessments for people who lacked capacity to make decisions in relation to their situation. Overall the picture was that residents had settled well in their new homes, although a small number of people had experienced an unsettled period immediately following the move. A number of positive comments were made by both resident and relatives of improvements in people's wellbeing and challenging behaviour which had taken place since the move.

69. Some negative comments and concerns about the speed and reasons for the closure of Oxford Grange were recorded in a small number of reviews; however a few months further on relatives were happy with how their family member had settled.

CONCLUSIONS

70. The emergency closure of Oxford Grange was a difficult and distressing experience for all concerned. This Lessons Learned Review concludes that there were some indications during 2014 of the potential for care quality to be affected, notably the resignation of the registered manager, delays in finding a permanent replacement, and unsuccessful attempts to conclude the sale of the home as an ongoing business. However no major issues were raised by relatives, Oxford Grange staff or external professionals visiting the home.
71. From early 2015 onwards the ongoing impact of lack of consistent leadership began to take its toll, culminating in the significant concerns found in the CQC inspection in May 2015. Given the scale and extent of the problems, the task of turning around the home proved too much for the consultants brought in by the prospective home owner. Enforcement action by the Care Quality Commission then became inevitable.
72. The speed of the closure, and the issuing of the closure notice at the start of a Bank Holiday period created significant pressure for residents, relatives, Oxford Grange staff and Kirklees Council officers to ensure that residents who were frail and with a range of dementia related conditions could be settled in new homes. It is a credit to those involved that generally, with a small number of exceptions, the moves took place satisfactorily.
73. The difficulties in ensuring clear, consistent and timely communication proved a major challenge; it resulted in people experiencing mixed messages and severely compromised the ability to plan effectively. This was particularly evident at the relatives meeting on 21 May when they were told that the home was working closely with CQC and the Council to make the improvements required to enable the home to stay open, yet 24 hours later the closure notice was issued.
74. Had it been possible to allow a longer period for the closure to take place, even if only a for a relatively small number of additional days or weeks, although there would still have been major disruption for the residents, relatives and staff it would have enabled better practice in implementing care home closures to have been carried out. SCIE points out:

“If a home closure is unavoidable, the care home managers, local authority and health commissioners must try to manage the pace of the closure in order to reduce the risk to the wellbeing of residents”⁶

75. The ongoing relationship between the Care Quality Commission and local health and social care commissioners is crucial in this respect. In conducting this learning lessons review everyone involved recognised the negative impact the emergency closure had on residents, relatives, care staff, and all agencies involved in managing the situation. By developing strong working relationships, recognising the respective roles of commissioners and regulators, short notice closures should only be necessary when all other avenues have failed.

RECOMMENDATIONS

76. The following recommendations to the Safeguarding Adults Board and its partners are based on the work undertaken in the debriefing sessions for both staff and relatives, and in the light of the analysis of lessons learned. Although short in number it is intended that they will help to inform the SAB review of multiagency procedures in relation to large scale safeguarding investigations which is currently underway and to support residents, relatives and staff should a home closure, whether planned or short notice, arise in the future.

1. Local Authority, Health Commissioners and the Care Quality Commission to jointly review their approach to the management of quality in the care provider market so that the best possible standards are maintained, and early preventative action can be taken.
2. Health and Social Care Commissioners, community nursing, social work teams, Care Quality Commission and other relevant partners to review the role and operation of the multi-agency contract liaison meeting to ensure that its effectiveness is maximised through systematic information sharing, identifying concerns about care quality and acting upon them as early as possible.
3. Local Authority to ensure information about care provider quality is shared internally on a systematic basis between safeguarding, contracting, public health and social work teams who may pick up concerns or early warning signs of difficulties.
4. Safeguarding Adults Board partners to increase awareness of the Early Indicators of Concern Form with all professionals who may be in contact with care providers. Use of the form to be monitored via the contract liaison meeting.
5. Local authority and local NHS organisations to quantify the resources and expertise available to give regular and ongoing support to homes across Kirklees to improve.
6. The relevant organisations should also draw up joint working arrangements on how the resources available may be used to maintain the appropriate range and quality of care home provision, including how it can be accessed and coordinated in situations where urgent action is required to prevent home closure.

⁶ SCIE: Short Notice Care Home Closures: Continuity of Care – Reducing Risks for all Residents (2011)

7. Kirklees Reviewing Team to consider reviewing residents on a home by home basis. This would enable similar issues being identified for individual residents in a home to be highlighted more easily. It could also enable a more in-depth understanding of individual homes by reviewing social workers and strengthen working relationships.
8. In the event of a potential home closure the Local Authority and the Care Quality Commission should work together to ensure a joint approach at both strategic and operational levels. This should include shared information and intelligence gathering, clarity on decision making protocols, implementation planning, and arrangements for escalating decision making to CQC Head of Inspection and Director level in both organisations if required.
9. Agencies involved with a home closure should ensure that communication with all stakeholders is high priority and that a jointly agreed communication plan for both internal and external communications is formulated. Dedicated resources should be identified to work alongside all parties including the care provider to ensure residents, relative and staff receive timely, consistent and clear messages during the closure period.
10. Assessment and Care Management Teams to ensure written information is available to individual families for example a checklist of 'what to look for' when choosing a care home.
11. The use of advocacy should be offered to residents or relatives in helping them to make the best possible choices in the circumstances. Advocacy should also be offered in meetings regarding the closure and any subsequent debriefing or lessons learned events.
12. Safeguarding Adults Board to commission multi-agency training on achieving best practice in care home closures using SCIE⁷ material.

⁷ Social Care Institute for Excellence

GLOSSARY OF TERMS

Enforcement Action	A range of actions that can be taken by the Care Quality Commission where legal requirements under the Health and Social Care Act 2008 are not met. These powers include issuing a warning notice; restricting or suspending services that can be provided; cancelling a providers registration or prosecuting a manager or provider
Warning Notice	A formal notice issued by the Care Quality Commission under the Health and Social Care Act 2008 requiring the care provider to meet essential standards of quality or safety by a specific date.
Default Notice	A formal notice issued by the Local Authority where a service provider is in breach of contractual conditions
Safeguarding strategy meeting	A multi-agency meeting held under the Safeguarding Adults Board policies and procedures where there is concern that abuse or neglect has occurred and decisions need to be made to protect the adult at risk of or who has been harmed.
Best interests assessments	A professional assessment carried out under the Mental Capacity Act 2005 to determine what course of action is in the best interests of a person who does not have capacity to make decisions.

REFERENCES AND RESOURCES

Kirklees Safeguarding Adults Board: Guidance on Safeguarding Adults Reviews (2015)

Kirklees Safeguarding Adults Board: Managing large scale investigations, 2011 (currently being updated)

West Yorkshire and North Yorkshire: Multi- Agency Safeguarding Adults Policy and Procedures 2015

Kirklees Council: Procedure for Unplanned Closure of Independent Care Homes 2012

Department of Health: Care Act 2014: Care and Support Statutory Guidance, October 2014

Care Quality Commission: Inspection reports Oxford Grange Care Home: - 20 June 2013; 11 and 13 December 2013; 8 10 and 12 May 2014

Glasby, J, Robinson, S and Allen, K (2011). 'Achieving closure: good practice in supporting older people during residential care closures. 'Health Services Management Centre, University of Birmingham and the Association of Directors of Social Services, in association with the Social Care Institute of Excellence.

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