# Autumn Grange Care Home

## Report for Nottingham City Safeguarding Adults Board (NCSAB)

## Safeguarding Adults Review

## Assurance Report

## Executive Summary for publication

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**Independent Reviewer**

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## 1. Introduction

1.1 This report provides a summary of the findings of a review undertaken in 2016 on behalf of the Nottingham City Safeguarding Adults Board into the current arrangements for the safeguarding of adults in the City's care homes who may be at risk of abuse and or neglect.

1.2 The review has been prompted by issues linked to the inadequate and unacceptable standard of care in Autumn Grange, a care home registered to accommodate 52 people over 65 who had needs associated with ageing or dementia, that operated in Nottingham City until its closure in November 2012. It also provided respite care. At the time of closure there were 28 residents.

1.3 The review follows the conviction of Yousaf Khan, Director of Sherwood Rise Limited who ran the Autumn Grange Care Home, on charges of manslaughter by gross negligence at Nottingham Crown Court in February 2016. These charges arose from the death of a former resident of the home, Resident A, in November 2012. Mr Khan pleaded guilty to gross negligence manslaughter and received a custodial sentence of three years and two months. Mohammed Khan, who was employed as the manager at the care home, was sentenced to one year of imprisonment, suspended for two years, for breaches of the Health and Safety at Work Act 1974. Yousaf Khan was disqualified from being a company director for eight years and Mohammed Khan was disqualified for five years. The Company was convicted of corporate manslaughter and was fined £300,000.

1.4 The Statutory Guidance to the Care Act 2014 states in para 14.162:

*Safeguarding Adults Boards must arrange a Safeguarding Adults Review 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.*

And in para 14.164:

*The SAB 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. This may be where a case can provide useful insights in to the way organisations are working together to prevent and reduce abuse and neglect of adults.*

1.5 This legislative requirement came into effect in April 2015. Although the events at Autumn Grange took place before the Care Act came in to force, the Board Chair and lead partner organisations commissioned this Safeguarding Adults Review following the convictions in February 2016 and hence the availability of witness statements. The Terms of Reference for the review

were drawn up with the aim of achieving effective learning and improvement actions to ensure that preventative measures are in place to reduce the possibility of any future deaths or serious harm occurring again in such circumstances.

**2. <u>Background to this Review</u>** – *information in paragraphs 2.1 - 2.11 provided by Nottingham City Council Adult Social Care and the Care Quality Commission*

2.1 Following a number of safeguarding investigations, the contract between Autumn Grange Care Home and Nottingham City Council and Nottingham City Primary Care Trust was suspended on 18th November 2011. A Multi Agency Provider Investigation Procedure (PIP) was initiated in December 2011 as a result of ongoing concerns relating to neglect, omission, inaccurate recording of information and dignity issues.

2.2 During the period of the Provider Investigation, unannounced and announced visits to Autumn Grange took place. These were by the Local Authority Adult Safeguarding Social Workers, and staff from the Quality and Commissioning Team, the Care Quality Commission and the Primary Care Trust. The care home also received significant training input from CityCare.

2.3 The care home remained under a PIP and during this period the contract was reinstated in March 2012 with conditions of controlled admissions. In July 2012 representatives from all agencies agreed to the de-escalation of the PIP as the care home had demonstrated sufficient sustained improvement.

2.4 Planned visits to Autumn Grange took place throughout July, August and September 2012 as part of the various agencies' contract compliance and monitoring. Information about Autumn Grange was also shared at the Multi Agency Quality Information Sharing Meeting (QUIF). The purpose of this regular multi agency meeting was for partner agencies involved in contract monitoring, regulation and safeguarding to meet and to share information in order to risk assess current concerns in relation to care providers and to co-ordinate interventions.

2.5 The QUIF in August 2012 noted that 'Improvements are being seen' in relation to Autumn Grange, the view also of a Primary Care Trust monitoring officer who visited on 2nd October. In October 2012, however, it was shared at the QUIF that 3 safeguarding investigations had been initiated in relation to Autumn Grange. As a result of this information a Safeguarding Strategy meeting was arranged to take place in November 2012. This meeting was then superseded by the chain of events from 28th October 2012.

2.6 On Sunday 28th October 2012 an email was sent to the Adult Social Care Access and Crisis Team and the Care Quality Commission from an anonymous "whistleblower". On the 29th October 2012 an Adult Safeguarding Strategy Meeting was convened and in accordance with the Adult Safeguarding Multi Agency Policy and Procedures the police were alerted due to the potential criminal nature of the allegations of neglectful and unsafe care made. A multi agency response to the

concerns was initiated including an unannounced visit by two social workers on Tuesday 30th October 2012. The findings of the visit corroborated the "whistleblower's" allegations. A further unannounced Social Worker visit took place on Wednesday 31st October 2012 and as a consequence of this immediate suspension of the City Council and NHS Primary Care Trust contract with Autumn Grange was instigated.

2.7 On Thursday 1st November 2012 further visits took place to Autumn Grange and on Friday 2nd November 2012 a Provider Investigation Procedure (PIP) meeting took place to address the escalating concerns in relation to the findings from the visits.

2.8 Due to the information shared at the meeting and gravity of concerns, the meeting agreed Nottingham City Council had no option but to place City Council care staff in the home over the weekend to ensure the safety of residents. This was an unprecedented action but all parties agreed this was a better course of action than the distressing experience of moving residents out on an emergency basis. The Care Quality Commission then also undertook an unannounced inspection which identified similar levels of concern about the standards of care and safety of residents. Also the District Nurse Team made a Safeguarding referral on finding that Resident A had a Grade 4 pressure ulcer.

2.9 Later on Friday 2nd November 2012 a meeting took place with the proprietors of Autumn Grange and despite disagreement for some time, with threats that they would close the care home with immediate effect, they finally agreed to accept Council care staff into the home. However, they subsequently informed agencies that they would be closing the home on Monday 5th November.

2.10 As a result of these events, council and health staff continued to provide care for the residents at Autumn Grange over the weekend; relatives and friends of residents were informed of the situation; the health and social care needs of residents were assessed and all 28 residents were moved to other care homes.

2.11 The care home closed its doors on Monday 5th November. CQC subsequently issued an urgent Notice of Decision to prevent admissions to the service on 30 November 2012, which took immediate effect and was not appealed. On 17 December 2012 the CQC also issued a Notice of Proposal under section 17 of the Health and Social Care Act 2008 to cancel the registration of the provider which took effect on 6 March 2013.

2.12 Resident A started living in Autumn Grange Care Home on 18th September 2012 and was moved to alternative provision on 5th November 2012. Resident A died on 22nd November 2012.

2.13 Following the death of Resident A, it was identified at a Home Office Forensic Post Mortem that the cause of her death was:

- Right lower lobe pneumonia
- Debility and low body mass index - weight at post mortem – 25kg
- Dementia

Resident A had acquired, whilst in Autumn Grange Care Home, a stage 4 sacral pressure ulcer across her lower back.

2.14 Nottinghamshire Police undertook a thorough and detailed assessment of all documentation provided by Adult Social Care and the Care Quality Commission relating to Autumn Grange Care Home and the 28 residents who were being cared for until its closure. Areas of concern raised across the current residents were emotional, physical, financial discrimination and acts of neglect and omission.

2.15 154 witnesses were interviewed and a file was submitted to the Crown Prosecution Service (CPS) in April 2013, advising of the criminal culpability of managers/senior staff members at the care home as a result of systematic failures in provision of care to the residents. This led to the convictions in February 2016.

2.16 Following the death of Resident A, local agencies involved in the care of residents at the care home undertook internal and multi-agency reviews of their care arrangements in the light of the concerns that had come to light.

2.17 In April 2014, the then Nottingham City Adult Safeguarding Partnership Board undertook an information gathering exercise to ascertain what steps local agencies had taken to improve their organisational safeguarding arrangements, information sharing and joint working arrangements. The basis of the information gathering was in regard to the involvement of agencies with four individuals, being Resident A and 3 other residents chosen at random who had been resident at the care home prior to its closure in November 2012. This exercise identified that agencies had made considerable improvements in key areas following the closure of Autumn Grange in 2012.

2.18 The Board was unable to further progress its review as it was identified that there were significant gaps in information available from the care staff of Autumn Grange and therefore limited insight into the day-to-day activity within the care home. It was anticipated that the Police through witness statements would have information about the staff culture and care environment within Autumn Grange relevant to the review. This would obviously be advantageous in reaching conclusions about how and why the situation developed. The voice of care staff in Autumn Grange could not be reflected due to the continuing process with the Crown Prosecution Service (CPS). It was identified that the process would be weakened if conclusions were reached before any legal outcomes were finalised. It was agreed that the review would be revisited once the CPS has concluded its process.

2.19 Following the completion of the criminal proceedings, significant additional information arising from the police investigation was made available

to the NCSAB. In considering past processes and the Board's duties and responsibilities under the Care Act 2014, the Chair of the NCSAB agreed with lead agencies that there should be a Safeguarding Adults Review. It was agreed that the focus of the review would be to evidence the current arrangements in the City for the safeguarding of residents of care homes and to identify any remaining actions that could be taken to strengthen this. Given the amount of time that had elapsed and the significant improvements that have taken place locally, it was important that the review should be both relevant and proportionate.

## 3. Terms of Reference for the Review

3.1 The Terms of Reference identified the purpose of the review as follows:

1. *To review evidence that is now available following conclusion of the criminal trial.*
2. *To review available outstanding concerns of former residents and relevant family members.*
3. *To identify questions upon which it is recommended further assurance should be sought and learning identified.*
4. *To complete a 'confirm and challenge' process where agencies provide evidenced assurance in regard to improvements in their systems, practice, policies or procedures since 2012.*
5. *To provide a written report outlining the work undertaken under 1-4 above which provides assurance where appropriate and identifies any local safeguarding practice where the reviewer identifies further assurance and / or learning be sought by the Board and makes any other relevant recommendations to the Board.*

3.2 The NCSAB sought an Independent Reviewer with substantial experience to undertake this work. The reviewer was required to have worked at a senior level in Health and/or adult social care and possess detailed knowledge of both provider and commissioning arrangements across Local Authorities and the NHS.

3.3 The selected reviewer has over 30 years of senior management experience, having worked in both health and adult social care organisations and has in depth knowledge of how large complex organisations operate. In addition she has a strong background of partnership working, working with a wide range of stakeholders, care home providers and the Care Quality Commission. She has experience in working with adults at risk, has a commitment to, and understanding of, the importance of engaging residents, families, treating all with dignity and respect, providing strong leadership / management and always striving to ensure quality safer services are being delivered. She has been a Chair of a Safeguarding Board and worked very closely with a number of Independent Safeguarding Chairs.

3.4 The review has been undertaken in two stages. Firstly, the reviewer identified themes for a 'confirm and challenge' assurance exercise arising from the historical information contained in witness statements and the agency reviews of 2014. She then undertook a process of assurance with agencies in regard to current arrangements. This took the form of written submissions by each agency which provided evidence in regard to a range of indicators. This has enabled her to reach a professional judgement regarding the level of safeguarding assurance that can now be provided to the NCSAB and forms the basis of the conclusions and recommendations of this report.

## 4. Information from witness statements and earlier agency reviews

4.1 The following was among information in the review of witness statements and previous agency actions:

- Witnesses identified examples of what, in their view, was unacceptable and degrading care provided by some care staff and descriptors of the care home management's indifference towards the residents and their relatives.
- There appeared to be very little information indicating that relatives approached the management of the care home directly, with one exception; when a direct approach to the management of the care home was made by a relative expressing his concerns as to the care his father was receiving the response from management was: 'if you don't like it, you can move your relative'. Some care home staff did advise relatives 'there are better places than here' or 'that she should get him out of here as it wasn't a suitable place for him to be'. The reviewer identified that relatives did not complain to the care home management or to care home staff due to a fear of reprisals on their relatives.
- Families were visiting the care home frequently, some as often as several times a week, and reported that over a period of time they saw the deterioration of their relative in terms of their physical, mental and or emotional well-being.
- Witness statements from the care home staff indicate that some of the care home staff did alert the care home managers of their concerns but management were said to have ignored these concerns and or/undermined their employees – some had their employment terminated.
- Witness statements from care home staff provided a distressing and disturbing picture of how residents were being cared for. There were care home staff who did attempt to alert the Care Quality Commission on a number of occasions regarding the quality of care being provided in the care home. These were followed up with improvement action

plans being required from the care home management which were not always delivered on time and did not evidence sustainable continuing improvements. Care home staff commented not only on the physical state of the care home but also on the quality of personalised care that was being delivered by some of their colleagues and that 'inexperienced and cheaper staff' were being employed.

- What was apparent is that professionals visiting the care home were misled and/or were deceived - as recorded by one of the care staff, 'when soup was being carried to residents it was uncovered but if family or another professional was around it was covered with a bowl', 'crockery was plastic, stained and grubby. When family/officials came china cups would appear for tea'.
- Following the closure of the care home, there was extensive work undertaken by all partners, with the Local Authority leading on several 'lessons learnt' sessions. Participants from all the key agencies attended, examining a range of issues such as current practice, communication between agencies, effectiveness of sharing information, the risk assessments, decision making processes, engaging residents and families. Each organisation was responsible for ensuring their identified improvement plan was fully implemented within agreed time lines. All organisations recognised the importance of effective partnership working which was crucial if cross-disciplinary issues were to be addressed and resolved.

## 5. Agencies participating in this Safeguarding Adults Review

5.1 The review has involved information from ten agencies. These are the eight agencies that had had direct involvement with Autumn Grange Care Home:

- Nottingham City Council's Adult Social Care (ASC - Safeguarding Quality Assurance team and Quality Assurance and Commissioning team)
- NHS Nottingham City Clinical Commissioning Group (CCG - which replaced Nottingham City Primary Care Trust on 1st April 2013)
- Care Quality Commission
- Nottingham City Council's Community Protection, Environmental Health and Safer Housing
- Nottingham CityCare Partnership
- East Midlands Ambulance Service
- A Nottingham GP Practice
- Nottinghamshire Police

5.2 For the purpose of the current assurance for the NCSAB, two additional agencies have also been involved:

- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust.

## 6. Identification of themes for assurance

6.1 The reviewer was initially provided with 198 documents for review. These comprised 169 documents relating to statements from 154 witnesses, and 29 review documents completed by the 8 agencies listed above in 2014. This enabled her to compile a baseline of themes relevant to the safeguarding of residents in care homes in the city in 2016.

6.2 Given the volume and varied contents of information presented it was important to try and streamline the findings into themes relevant to the safeguarding of residents in care homes in the City in 2016. Adopting a thematic approach made it easier for all involved in focusing their responses in a systematic and coordinated way.

6.3 The initial findings were grouped under three themes:

- People and Leadership
- Practice and Systems
- Governance and Accountability

6.4 Having identified relevant themes in her review of the historical information provided, the reviewer used these to identify questions to form the basis of the 'confirm and challenge' assurance exercise to be undertaken on behalf of NCSAB in 2016, which was modified in discussion with agencies at a workshop. An Agency Safeguarding Assurance Return Template was sent to each agency for completion and return. A Schedule of Safeguarding Assurance Indicators was also sent to agencies to assist in completion of the template. The ten completed templates were then forwarded to the reviewer for analysis.

## 7. Assurance process

7.1 The assurance template was developed with the aim of identifying how effective each respective organisation's safeguarding leadership, practice, policies, management governance and partnership working are now and in the immediate future. From the completed documentation, it was anticipated that there would be sufficient evidence-based information provided, which would allow the reviewer to identify the actual positive / proposed changes organisations had made and the impacts these had on service delivery and on the overall safeguarding agenda. Inevitably there would be work in progress

or areas that may need additional attention either per organisation or in partnership with others.

7.2 Each agency was asked to identify what changes had occurred in their organisation since 2012 with regard to each of these themes. This was not just in respect of any changes that may have been made after considering events at Autumn Grange, but comprehensively with respect to safeguarding across their organisation. They were asked to identify what impact these changes had on the three themes and what, in their view, were the areas that still were being worked on or needed further attention. The safeguarding assurance template drilled down into more detail using the indicators of assurance as a guide for respective organisations to consider when responding. This template was devised to outline expectations that each organisation should have when delivering safeguarding services.

7.3 There was a dual purpose in completing the safeguarding assurance template. Primarily, it was to provide evidence-based information for the reviewer but it was also there to help each agency to self-assess on the level of confidence they had in their organisation's ability when dealing with safeguarding issues.

7.4 There has been a robust process of discussion and sign-off. The process, contents and timelines were agreed in advance but as with any complex process these were reviewed and modified to accommodate changing circumstances.

7.5 The reviewer has been mindful of the characteristics of a good service as outlined in recent Care Quality Commission guidance to inspectors and providers of Adult Residential Social Care Services.
http://www.cqc.org.uk/sites/default/files/20160422_Adult Social Care residential_provider_handbook%20April_2016_update.pdf

7.6 The Care Quality Commission identifies five lines of enquiry to be asked of any service. These are:

- **Are they safe?**
- **Are they effective?**
- **Are they caring?**
- **Are they responsive to people's needs?**
- **Are they well-led?**

7.7 These questions have informed the approach taken by the reviewer in identifying questions and themes in her analysis of the documentation provided to her. This in turn has informed the areas of assurance undertaken

on behalf of the NCSAB regarding arrangements for the safeguarding of Nottingham's care home residents in 2016.

7.8 It is possible to identify a range of characteristics that one would expect to be in place to protect adults living in care homes who may be at risk of abuse and or neglect. These characteristics relate to a range of factors in regard to the three themes previously identified.

7.9 These protective characteristics include the following:

i. That residents and their families or advocates are actively engaged in shaping their care and that they are empowered to provide feedback on their experience.
ii. That all professionals entering care homes, including those whose immediate remit is not the delivery of health or social care functions, should be able to identify potential safeguarding issues and be skilled and knowledgeable in taking these concerns forward.
iii. That professionals, care staff and advocates are clear as to how to raise concerns and are well advised and supported in doing this.
iv. That systems and processes work to ensure that information is joined up and that professionals work together to ensure that there is a shared holistic view of needs and vulnerabilities.
v. That care home staff are well trained and fully aware of their responsibilities in regard to safeguarding.
vi. That the registered care home manager is qualified to provide support, advice, guidance and supervision for the care staff in line with the service specification in the contract between the care home and the Local Authority/ Clinical Commissioning Group.
vii. That up to date care / End of Life plans are seen as key documents in ensuring resident's needs are fully identified, met and accurately documented in a timely manner.
viii. That information systems in each organisation are 'fit for purpose' when responding to safeguarding referrals and risk assessments.
ix. That agencies work together in a proactive way to share information and act in a coordinated way that promotes early identification of failing providers.
x. That actions agreed and taken are followed through in a robust and timely manner.
xi. That responses to referrals including whistle-blowers and anonymous referrals are robust.
xii. That the skilled workforce is sufficiently resourced to undertake the work.
xiii. That robust governance arrangements are in place within organisations and across the whole system.
xiv. That local arrangements meet the requirements of best practice as defined nationally.

## 8. Summary of findings

8.1 Four years on, this review provides the opportunity to highlight some of the positive changes that have taken place both within respective organisations and across partner agencies – evidencing that the safeguarding agenda is high priority for all organisations. The reviewer found there is a sharper focus on delivering quality safer services and increased management support and scrutiny of practice. The reviewer also identified that stronger collaborative approaches to integrated working are in place with partnerships based on trust and confidence. There are robust governance arrangements in place. The prime driver and motivation for undertaking this exercise commissioned by the NCSAB was and is to ensure that the duty of care to this most vulnerable adult group in our society and their families is fully adhered to. The reviewer, from the evidence examined, believes there is sufficient robust evidence provided by all organisations that a level of assurance can be given to the NCSAB.

8.2 Using the safeguarding assurance template with its specific focus on what each organisation should have in place, there is a stronger management grip and overview on safeguarding activities both at operational and strategic level with clearly defined governance arrangements. There is evidence that partners have an understanding of their interdependency on one another and that partners need to cooperate when operating within a whole system and not work in isolation. This was well documented in the returns – frequent multi-disciplinary meetings held at management levels. Organisations provided the necessary information that supported the view that the safeguarding agenda is given a high priority by management and that systems, processes and governance arrangements were in place and were robustly managed. This contributed to the evidence when making the final professional assurance judgement.

8.3 Inevitably, there will always be areas that need further work as new challenges are identified. Continual improvement is to be expected particularly given the increased focus nationally on the safeguarding adults agenda. Operating within a more robust performance and quality management framework within each organisation is evident as is partnership working. Closer cooperation between agencies strengthens the integrated model of care and again this was evident especially between the Clinical Commissioning Group and Adult Social Care at a strategic level.

8.4 The picture that has emerged is one of confident coordination providing a good level of assurance that partners are all working together to the benefit of the resident when presented and needing to respond to safeguarding issues. This is evidenced in the agencies' returns. The reviewer recognises the high priority this area of work is given by all and the new challenges facing

organisations on a day to day basis. There was evidence at a strategic level that both commissioners and providers are constantly looking to improve the quality of the service delivered to residents by means of the service specification.

8.5 The strong emphasis on joint partnership working across organisations is especially evident between Adult Social Care (ASC) and the Clinical Commissioning Group (CCG) from the perspective of quality and commissioning. In line with the national driver for closer working and integration between health and social care there are already systems and meetings in place that enable this to happen. The single contract for care home owners by the CCG and ASC is welcomed. The CCG and ASC have their own quality assurance teams, both undertaking announced and unannounced care home inspections. These organisations undertake commissioning and quality assurance functions, using their own valuable resources - staff knowledge, skills and having the same or similar area of expertise. The two organisations have already agreed an approach as to how best to monitor the nursing and care home services utilising their resources and skills in the most effective and efficient manner. The CCG leads on quality monitoring care homes with nursing whilst the Local Authority ASC leads on residential care homes.

8.6 All agencies have provided information as to how they monitor their performance through the use of effective data collection and how the analysis is used to identify immediate issues, trends, themes and areas that require further thought and development. The governance arrangements are well documented and are robust with senior managers and boards providing appropriate challenges and at the same time receiving a level of assurance that the safeguarding agenda in their respective organisations is well managed and continues to be given high priority. Information sharing between agencies is evident – it is essential to ensure that all information across the various professions is triangulated before decisions are made ensuring that they are evidence based and that there is a clear rationale for the decision should a challenge be made. Sharing and comparing data is an area that is evolving as a whole system approach is adopted which enables the monitoring of the quality and performance of each of the care homes. Identifying warning indicators in this way ensures that issues can be quickly addressed. Current arrangements are in place which indicate that this part of the assurance process is well managed, giving a level of confidence that timely decisions are made regarding care homes and their performance.

8.7 As organisations change and evolve, there is a need to ensure that all partners are aware and understand each other's roles and responsibility when operating within the safeguarding agenda. The review did highlight that not all organisations have the same level of understanding of each other's role and

remit, so confusion and misunderstanding can occur. The Care Quality Commission (CQC) and the Environmental Health colleagues have held a workshop to address this as have the CCG and ASC and CQC. The Smarter, Safer, Stronger Networking events provide evidence that this is addressed as part of the joint training sessions. The aim is to target front line professionals to understand the different teams' and agencies' roles when working within the safeguarding agenda.

8.8 Working with vulnerable individuals brings challenges and essential support mechanisms are in place for most staff within their own organisations. However, there are occasions when specialist advice, support and guidance would be sought and welcomed from partner agencies. GPs play an important role in promoting and monitoring the health and wellbeing of their patients in residential care homes. Their remit is wide ranging but their exposure and experience when dealing with complex safeguarding cases can be more limited than that of other professionals who are faced with safeguarding situations most days. The established Local Enhanced Service arrangement is welcomed as it provides additional support from GPs for care homes. However, it does mean that GPs are more likely to encounter safeguarding situations. The CCG are reviewing how they can further strengthen the current arrangements which will ensure that GPs are provided with an extra level of support in working with issues of safeguarding. Environmental Health colleagues have also recognised that they would benefit from greater access to colleagues with safeguarding experience and skills when faced with complex safeguarding situations.

8.9 Each organisation is experiencing pressure on their budgets. The review has highlighted some innovative projects that are either jointly funded or by one partner agency; one example is the early intervention and prevention scheme. This is a relatively new initiative and will be evaluated within agreed time lines but with next year's budget 2017/8 yet to be set, it is possible that there may be a reduction in services which could have an impact on the safeguarding agenda. Current new money provided by the Government is time limited and an exit strategy has to be in place if the schemes are not to be picked up by mainstream funding. Significant progress and improvement has been evidenced and needs to be maintained and continually improved upon. Assessed risks should be identified by each organisation and how these will be mitigated should the level of resources be reduced. The NCSAB operates a risk register which is and will continue to be updated as organisations move into the financial budget discussions for 2017/18. An assurance has been provided to the reviewer that this risk register is a live document with this being a standing item on the NCSAB agenda.

8.10 From the written documentation provided the quality of care provided by any care home is dependent on the quality of the care staff employed and the

management and leadership of the home. The service specification within the contract between the care home owner and the CCG and Local Authority should be explicit in terms of the standard of training required for all care home staff with a specific focus on safeguarding. The care home owner and the registered manager should demonstrate that there is a safeguarding and whistle blowing policy which all employees are fully aware of. Mandatory/ refresher and up to date training programmes alongside supervision should be evident and strongly emphasised ensuring that residents' needs are being met by all care home staff and management. This should be monitored via the contract compliance officer and the quality assurance team. The CQC provide a further layer of assurance with their inspection methodology utilising the 5 lines of enquiry.

8.11 The current contract with service specification that ASC and CCG jointly hold in respect to residential care homes and care homes with nursing is explicit in its requirements. The role of the contract compliance officer is a key role in so far as this role has responsibility for observing and inspecting the care home using their own skills and knowledge and also conducting conversations with a range of stakeholders including talking to residents and families or advocates and other professional colleagues when assessing the care home's contract compliance. Undertaking unannounced and announced visits is part of the process especially when dealing with difficult or deceitful and misleading homeowners. A single contract now held jointly with the CCG and ASC has made contract monitoring simpler. The intelligence that is collected is shared at regular monitoring meetings, including the CQC who also share their information on care homes that they have recently inspected. This approach triangulates all the information across the system enabling the sharing of concerns and making decision-making more robust.

8.12 It should be noted that this review does not attempt to compare the written evidence submitted by organisations in testing it against what staff and management are experiencing and how they operate on a daily basis. The sign off of the assurance template by senior management across all ten organisations provides the additional level of assurance that the written evidence provided is accurate and confirms the current safeguarding arrangements within each organisation.

8.13 There is no evidence to suggest that there would be a different view taken on what has been presented as to what is occurring daily, but this has not been tested by the reviewer as it was not part of the Terms of Reference. The NCSAB may wish to consider whether further more detailed assurance is required.

## 9. Recommendations

9.1 Given all the information and evidence presented to the reviewer, the reviewer has identified a number of areas that she wishes to bring to the NCSAB's attention. Recommendations are offered for the NCSAB to consider.

9.2 That residents and their families or advocates are actively engaged in shaping their care and that they are empowered to provide feedback on their experience. This in the reviewer's opinion is an area that still requires further consideration by the NCSAB.

**Recommendation 1**
That the NCSAB seeks assurance that information and opportunities are provided to care homes' residents who have capacity, residents' families and care staff which ensures they are fully included in planning their care and which enables them to raise any concerns they may have about the care provided, including in confidence to external organisations.

9.3 That care home staff are well trained and fully aware of their responsibilities in regard to the key components of care for residents including safeguarding, care planning, medicines management and record keeping. It is the reviewer's opinion that this area requires assurance as to the current position on the part of the NCSAB.

**Recommendation 2**
That the NCSAB is assured that the service specification of the standard care home contract reflects requirements in regard to safeguarding training, with particular emphasis placed on whistle blowing and making anonymous referrals. All care home staff and registered manager to be fully compliant with this. Contract compliance and other inspection regimes audit these activities.

**Recommendation 3**
The NCSAB seeks assurance that, as part of the quality assurance and service specification of the contract between the care home owners and ASC/CCG, mandatory refresher and relevant/specialist training is provided covering areas of care planning, medicines management, record keeping. That Registered Managers provide appropriate levels of support and supervision to all care staff in the home. That contract compliance and other inspection regimes audit these activities.

9.4 That professionals, care staff and advocates are clear as to how to raise concerns and are well advised and supported in doing this.

**Recommendation 4**
That the NCSAB is assured that via Inspection and contract compliance work as well as information and training, there is rigorous reinforcement of the scrutiny of the guidance that is given to care home staff in regard to taking forward any concerns they may have regarding the care and treatment of care home residents.

9.5 That the registered care home manager is qualified to provide support, advice, guidance and supervision for the care staff.

**Recommendation 5.**
It is recommended that the NCSAB should consider seeking further assurance as to the current local arrangements for ensuring that Registered Managers are fully competent and whether there are any identified issues.

9.6 That up to date care and 'End of Life' plans are seen as key documents in ensuring that a resident's needs are fully identified and met as well as being accurately documented in a timely manner. It is the reviewer's opinion that this is an issue that requires further assurance on the part of the NCSAB.

**Recommendation 6**
That the NCSAB seeks assurance that the statutory requirements for reviews, as laid out in the Care Act 2014, are met in regard to each resident living in a care home.

That the NCSAB assure itself regarding the current arrangements for end of life plans for care home residents.

9.7 That agencies work together in a proactive way to share information and act in a coordinated way that promotes early identification of failing providers. It is the reviewer's opinion that this area requires further consideration by the NCSAB.

**Recommendation 7**
That the NCSAB is assured that when decisions are made regarding the suspension of placements to the care home consideration is given as the financial impact this might have on the quality of care delivered to the current residents. Any decision taken must give the highest priority to securing the safety and protecting the health and wellbeing of the residents.

9.8 That the skilled workforce is sufficiently resourced to undertake the safeguarding work.

**Recommendation 8**
That the NCSAB review its risk register to ensure that it addresses the risk that possible reductions in funding may have on the arrangements in place to safeguard residents of care homes in the city.

9.9 That robust governance arrangements are in place within organisations and across the whole system.

**Recommendation 9**
That NCSAB should review whether the Board's existing assurance processes could be enhanced to ensure that continued robust partnership approaches to safeguarding care home residents are in place.

## 10. Conclusions

10.1 This report highlights the work that has been undertaken jointly by the key stakeholders, the Interim Manager for the NCSAB and the independent reviewer. Examples of positive changes have been identified both within respective organisations and in partnership working across the system. This has to be applauded and welcomed. It is a credit to all staff that they have risen to the challenges. The quality of life for individuals has been improved and is also made safer.

10.2 This review engaged ten different organisations, all operating within their own parameters in terms of remit, statutory frameworks and governance. Safeguarding is one of their key priorities but not the sole one and therefore there are always competing demands on scarce resources and staff. The review covered a period of four years from 2012 - 2016.

10.3 The methodology, utilising the safeguarding assurance template, has attempted to cover the key areas that would provide the reviewer with sufficient evidence to make a professional judgement based on the analysis of agency returns.

10.4 It is well documented that organisations can have in place excellent systems, processes, policies and training programmes but what really makes a difference is the quality of leadership, the organisational culture, quality workforce, clear organisational expectations, solid management support and working with positive strong partners. Effective governance arrangements

and accountability contribute to the whole process in securing the knowledge that safer services are being delivered on a daily basis.

10.5 In order to provide the NCSAB with a level of safeguarding assurance a professional judgement has to be made based on all the reviewed written submissions provided by key stakeholders covering the period from 2012 to 2016. This complex multi-dimensional and multi-disciplinary Safeguarding Adults Review has to be put into context of what had been the expectations, knowledge base and the national profile of safeguarding adults up until 2012.

10.6 Since then the national profile relating to delivering safeguarding adults services has seen major developments including the publication of 'Making Safeguarding Personal', and the introduction of the Care Act 2014, which raises the profile of safeguarding adults with the establishment of the Safeguarding Adults Board - a statutory body with legislative responsibilities. Safeguarding adults is now more in the public eye following the high profile national inquiries such as those of Stafford Hospital and Winterbourne View. Organisations now view safeguarding adults as a priority which is reflected in their strategic business plans and organisational structures, and governance arrangements reflect this, despite the increased financial and work load pressures. There is now a greater vigilance and public awareness of the adult safeguarding agenda. Given this landscape, the independent reviewer has been mindful of the major impacts these national changes/ drivers have had on current local partnerships and delivery of safeguarding services. Leadership, practice, policies and partnership working have moved on significantly and this needs to be highlighted and acknowledged.

10.7 Over the last four years it is apparent to the reviewer that significant progress has been evidenced both in the progress made in individual organisations and in partnership working. This is a real achievement which should not be underestimated given the challenges each organisation has faced and continues to face. Senior management from each of the organisations have expressed their confidence not only in their own managers, but their organisation's ability to address and respond to the safeguarding adults agenda. They believe that through their leadership with support from colleagues, coupled with their strong commitment to partnership working, the safeguarding agenda will remain one of their highest priorities.

10.8 However there is never room for complacency. A stronger management grip on the safeguarding adults agenda is evident but the momentum must be maintained to ensure there is no slippage and all organisations continue to be vigilant. Any action plan developed as a result of recommendations in this report will need to be monitored by the NCSAB with identified and agreed time lines and leads to ensure it complies with current and future performance and quality assurance frameworks. This will provide an additional level of

safeguarding assurance both to the respective organisations as well as the NCSAB.

10.9 Each organisation has evidenced that there is a heightened awareness of the safeguarding adults agenda throughout their respective organisation and therefore the quote 'safeguarding is everybody's business' is a reality – evidenced by the way professionals operate and interact with one another. A performance and quality assurance framework now operates within all organisations and this will further promote the shared agenda that the NCSAB has tasked them with. A more pragmatic view is now adopted by all and it will continue to contribute to the overall safeguarding adults agenda.

10.10 All comments, observations and the reviewer's final judgement have been based purely on the written evidence. The commissioned assignment did not include the opportunity to test the written statements against what actually happens in day to day practice.

10.11 The reviewer having reflected on all the evidence provided by the organisations has concluded, in her professional opinion, that a stronger level of assurance can be given to the NCSAB. It is the independent reviewer's judgement that agencies, supported by their specialist teams, will intervene differently and more effectively should cause for concern be identified, than was the case regarding Autumn Grange Care Home. Interagency working is well embedded with all committed to delivering a more effective, efficient and safer service. There is a stronger management grip on monitoring performance, quality assurance via robust auditing and reporting mechanisms all with a strong safeguarding focus.

10.12 The true test will be whether organisations are fulfilling their statutory duty of care to one of the most vulnerable groups in our society by having all our care homes operating in a safer caring environment, offering the highest standard of care and treating all individuals with dignity and respect. There cannot be a repeat of the very serious events that led to the death of a resident nor the unacceptable care provided to other residents at Autumn Grange Care Home.

10.13 This report was accepted by the NCSAB on 7th December 2016 subject to some minor revisions which have been signed off by the Independent Chair of the NCSAB in agreement with the Independent Author.

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**Postscript** - *written by Malcolm Dillon, Independent Chair, and Louisa Butt, Business Manager, Nottingham City Safeguarding Adults Board*

## 11. Outcomes of the 'Resident A' Inquest

11.1 An inquest concerning Resident A was held in October 2016 in Nottingham.

11.2 The Coroner concluded that Resident A died as a result of Unlawful Killing, as concluded by the earlier criminal proceedings, where it had been established by a Home Office Forensic Pathologist that there were clear and direct causal links between lack of appropriate care for her at Autumn Grange - which led to a grade 4 pressure ulcer, malnourishment, physical decline and pneumonia - and her death. The Coroner stated that care, support and welfare were the responsibility of Autumn Grange, and everyone else had a secondary role.

11.3 The Coroner, in her concluding remarks, commented on the involvement of different organisations.

- She determined that none of the identified failings were causative or made a material contribution to Resident A's death.
- She commended the extensive efforts through training provided by the Primary Care Trust (that then existed) in what she described as trying to turn around a very troubled care home.
- She was satisfied that the Local Authority, in its safeguarding role, acted on matters of concern noted by themselves or other professionals who visited Resident A, took all proper steps, and properly and promptly investigated. When the whistle blower reported on 28th October 2012, the Local Authority undertook prompt and entirely appropriate actions. She was also satisfied that Autumn Grange was properly monitored, with periods of suspension, by the Local Authority in its contractual role.
- She described the GP as an experienced practitioner who did not pick up any concerns about the state of affairs at Autumn Grange and was of the belief that matters were hidden from him and he only saw what was presented to him.
- The Coroner found that Autumn Grange had been 'on CQC's radar since April 2011'. Some matters of concern may have 'slipped through the net', such as an action plan not received. CQC inspections in February and April 2012 revealed causes for concern at the home which were acted upon, including the issuing of a warning notice that was followed up. She found that Autumn Grange was 'bumping along' and 'yo-yoing in and out of compliance'. She commended CQC for accepting that their inspection in September 2012 should have been more rigorous, and the Coroner said that after this, there were a series of missed opportunities on the part of CQC to proactively inspect and determine the true state of affairs at Autumn Grange, which appeared to be accepted. CQC were actively involved and worked closely with the Local Authority in the multi-agency procedure from November 1st 2012.

- The Coroner said it was heartening to see that CQC had made changes to its inspection methodology and procedure; she was reassured that CQC is now in a position to robustly inspect and actively take steps where homes are failing and where measures to support them are not successful. She was assured that matters had moved on dramatically since 2012. She was reassured by evidence from the Local Authority and CQC that relationships between them are good at staff level and senior level.
- She said the case showed that experienced and well meaning professionals can sometimes be misled.

11.4 She also decided to make a Regulation 28 Notice to Prevent Future Deaths report to the CQC, Department of Health and Secretary of State for Justice as she was concerned that there is no systematic mechanism and/or statutory provision to check whether the Nominated Individual for a care home is of good character, such as through a DBS check. At Autumn Grange, the Nominated Individual had previous convictions but CQC does not routinely or systematically request a DBS check for the Nominated Individual.

## 12. Nottingham City Safeguarding Adults Board's development of the reviewer's Recommendations

12.1 Nottingham City Safeguarding Adults Board accepted the recommendations of the independent reviewer at an Extra-ordinary Board meeting in September 2016. The independent reviewer based her recommendations on the evidence that was provided to her by the relevant partner agencies as part of the Safeguarding Adults Review process.

12.2 In accepting the recommendations, the Board decided that it should take into account some information that the independent reviewer had not had the opportunity to consider and to develop the recommendations accordingly.

12.3 The Board also took into account themes that had emerged during the subsequent Inquest into the death of Resident A, which indicated the need for further assurance in some areas.

12.4 The development of the independent reviewer's recommendations into those taken forward by Nottingham City Safeguarding Adults Board is outlined below. The Independent Reviewer's recommendations have been grouped together by theme so do not appear in numerical order, and for clarity the Independent Reviewer's recommendations are labelled 1-9, and the Board's developed recommendations are labelled a-g, and have been placed in grey boxes.

12.5 Raising Concerns

**Recommendation 1**

That the NCSAB seeks assurance that information and opportunities are provided to care homes residents who have capacity, residents' families, and care staff which ensures they are fully included in planning their care and which enables them to raise any concerns they may have about the care provided, including in confidence to external organisations.

12.6 This recommendation was split out to separate i) opportunities for residents to be involved in care planning, and ii) opportunities to raise concerns. The Board are satisfied that the NHS Standard Contract, the local residential Service Specification and the Quality Monitoring Framework for care homes provide adequate assurance that requirements are in place for residents and their families to be involved in care planning and that compliance is monitored. These documents did not form part of the evidence shared with the independent reviewer.

12.7 The updated recommendation therefore concerns only ii) opportunities to raise concerns, and becomes

**Recommendation a)**

The NCSAB should be assured that residents, their family members, members of the local community and care staff have information available to them to enable them to raise any concerns about the care provided, including which external organisations they can share concerns with in confidence, what action can be expected and how to escalate concerns. This should include assurance that residents and families have information about and access to advocacy services.

Workforce

12.8 The level of deception demonstrated by the managers / owners at Autumn Grange was not understood at the time of learning-based debriefs immediately after the event. The scale of deception only emerged during the criminal proceedings and was referred to by the Coroner in the subsequent inquest concerning Resident A. Safeguarding issues in residential homes usually relate to poor leadership, skills deficit or incompetence, but thankfully rarely relate to callousness and intention to deceive.

12.9 Key learning for practitioners and commissioners is the need to ensure people are skilled in remaining alert to the possibility of deception and dishonesty.

12.10 In children's safeguarding this is a clearly understood skill, the need for which has been identified over the years in Serious Case Reviews. Consequently, the need for practitioners to ensure they do not enter into a collusive relationship with parents is highlighted in training. Phrases such as "respectful disbelief" and "disguised compliance" are well understood.

12.11 However, in safeguarding adults, this skill may be more rarely necessary and utilised. But the potential for misrepresentation, abuse of power in relationships or dishonesty should always be considered.

12.12 This issue was not raised by agencies as a key theme during the review; however it was felt by the Board that this is an area requiring further assurance, so the Board decided upon an additional recommendation to this end.

**Recommendation b)**

The adult health and social care workforce including commissioners and practitioners must develop awareness of how to work with deception, avoid confirmatory bias and use professional curiosity to corroborate evidence in safeguarding work. This should be promoted through training, awareness raising and reflective supervision.

12.13 Agency Coordination

**Recommendation 5**
It is recommended that the NCSAB should consider seeking further assurance as to the current local arrangements for ensuring that Registered Managers are fully competent and whether there are any identified issues.

**Recommendation 7**

That the NCSAB is assured that when decisions are made regarding the suspension of placements to the care home consideration is given as to the financial impact this might have on the quality of care delivered to the current residents. Any decision taken must give the highest priority to securing the safety and protecting the health and wellbeing of the residents.

12.14 Recommendations 5 and 7 both relate to agency co-ordination and information sharing where concerns arise about the safety of residents in care homes. Following the inquest into the death of Resident A, which took place after the Independent Reviewer had made her recommendations, the Board decided to further develop these recommendations. They have been broadened to include further areas for assurance which emerged during the Inquest, including the Regulation 28 Notice issued by the Coroner.

**Recommendation c)**

The NCSAB should seek assurance that there are robust processes in place for effective information sharing between agencies, including regulatory bodies, in respect of adults in care homes.

**Recommendation d)**

NCSAB should seek assurance that there is effective co-ordination of enforcement action and that processes for holding care home providers to account are robust. This should include the consideration of the financial impact on quality of care where contracts are suspended.

**Recommendation e)**

NCSAB should seek assurance that concerns regarding the competence of Registered Managers and Nominated Individuals are escalated, and should seek assurance from the regulatory body of the arrangements in place for acting when concerns are raised.

**Recommendation f)**

The NCSAB should seek assurance of the clinical oversight of the Local Enhanced Service Contracts and that there are effective mechanisms in place for information sharing between frontline professionals including GPs who are in direct contact with care home residents.

12.15 Contract Compliance

**Recommendation 2**

That the NCSAB is assured that the service specification of the standard care home contract reflects requirements in regard to safeguarding training, with particular emphasis placed on whistle blowing and making anonymous referrals. All care home staff and registered manager to be fully compliant with this. Contract compliance and other inspection regimes audit these activities.

**Recommendation 3**

The NCSAB seeks assurance that, as part of the quality assurance and service specification of the contract between the care home owners and ASC/CCG, mandatory refresher and relevant/ specialist training is provided covering areas of care planning, medicine management, record keeping. That Registered managers provide appropriate levels of support and supervision to all care staff in the home. That contract compliance and other inspection regimes audit these activities.

**Recommendation 4**

That the NCSAB is assured that via Inspection and contract compliance work as well as information and training, there is rigorous reinforcement of the scrutiny of the guidance that is given to care home staff in regard to taking any concerns they may have regarding the care and treatment of care home residents

12.16 The Board are satisfied that the NHS Standard Contract, the Residential Service Specification and the Quality Monitoring Framework for care homes provide adequate assurance that requirements are in place in respect of the issues raised in the Independent Reviewer's recommendations 2, 3 and 4 and that contract compliance is monitored. These documents were not provided to or required by the independent reviewer during her review. The Board do not propose any further action in respect of these recommendations.

12.17 Reviews

**Recommendation 6**

That the NCSAB seeks assurance that the statutory requirements for reviews, as laid out in the Care Act 2014, are met in regard to each resident living in a care home.

That the NCSAB assure itself regarding the current arrangements for end of life plans for care home residents

12.18 The Board decided to separate this recommendation to i) assurance around the statutory requirements for reviews under the Care Act and ii) arrangements for the review which care home providers must have for each resident. The NCSAB is assured that the service specification and Quality Monitoring framework includes the requirement for providers to have in place person centred care plans, including arrangements for the end of people's lives, and that compliance is monitored.

12.19 In respect of the first part regarding the statutory requirements for reviews, the board has taken forward this recommendation, but included reference to the impact of budget reductions on the Local Authority's approach to its duty to keep under review generally care and support plans, and how it is working with partner agencies to ensure residents in care homes are safe.

**Recommendation g)**

The board seeks assurance from the Local Authority that in a time of budget reductions where it has significantly reduced reviewing capacity, the duty to keep under review generally care and support plans (which creates safeguards for citizens) is undertaken effectively, with partner agencies, to mitigate the risk of harm.

12.20 Risk register

**Recommendation 8**

That the NCSAB review its risk register to ensure that it addresses the risk of possible reductions in funding may have on the arrangements in place to safeguard residents of care homes in the city.

12.21 The Board has considered this recommendation and considers that this issue is covered on the risk register by the following identified risks.

- Impact of austerity and increasing demands on partners' ability to meet core requirements

- Failure of Private, Voluntary & Independent Sector Care Home and Home Care providers leading to inadequate capacity in the market

- Concerns about the quality of service provision in the Private, Voluntary and Independent Sector which could impact on their ability to safeguard adults

12.22 The Board therefore decided that further action in respect of this recommendation is not required. The independent reviewer did not have sight of the Board's risk register when making her recommendations.

12.23 Assurance

**Recommendation 9**

That NCSAB should review whether the Board's existing assurance processes could be enhanced to ensure that continued robust partnership approaches to safeguarding care home residents are in place.

12.24 Recommendation 9 remains largely the same but has been slightly reworded in order to assist with the development of the action plan.

**Recommendation h)**

That NCSAB seeks assurance that continued robust partnership approaches to safeguarding care home residents are in place.

12.25 The Board has therefore agreed to take forward the following recommendations:

**Recommendation a)** The NCSAB should be assured that residents, their family members, members of the local community and care staff have information available to them to enable them to raise any concerns about the care provided, including which external organisations they can share concerns with in confidence, what action can be expected and how to escalate concerns. This should include assurance that residents and families have information about and access to advocacy services.

**Recommendation b)** The adult health and social care workforce including commissioners and practitioners must develop awareness of how to work with

deception, avoid confirmatory bias and use professional curiosity to corroborate evidence in safeguarding work. This should be promoted through training, awareness raising and reflective supervision.

**Recommendation c)** The NCSAB should seek assurance that there are robust processes in place for effective information sharing between agencies, including regulatory bodies, in respect of adults in care homes.

**Recommendation d)** NCSAB should seek assurance that there is effective co-ordination of enforcement action and that processes for holding care home providers to account are robust. This should include the consideration of the financial impact on quality of care where contracts are suspended.

**Recommendation e)** NCSAB should seek assurance that concerns regarding the competence of Registered Managers and Nominated Individuals are escalated, and should seek assurance from the regulatory body of the arrangements in place for acting when concerns are raised.

**Recommendation f)** The NCSAB should seek assurance of the clinical oversight of the Local Enhanced Service Contracts and that there are effective mechanisms in place for information sharing between frontline professionals including GPs who are in direct contact with care home residents.

**Recommendation g)** The board seeks assurance from the Local Authority that in a time of budget reductions where it has significantly reduced reviewing capacity, the duty to keep under review generally care and support plans (which creates safeguards for citizens) is undertaken effectively, with partner agencies, to mitigate the risk of harm.

**Recommendation h)** That NCSAB seeks assurance that continued robust partnership approaches to safeguarding care home residents are in place.