Bracknell Forest
SAFEGUARDING BOARD

AB Nursing Home

Safeguarding Adult Review

This document contains details of the original Safeguarding Adult Review into the AB Nursing Home commissioned by the then Bracknell Forest Safeguarding Adults Partnership Board. That review was completed in March 2017. At the request of Thames Valley Police, and due to the on-going criminal prosecution, it was not possible to publish the report at that time. When the case finally came to court, it became clear that there was considerable amount of 'new' evidence that required Bracknell Forest Safeguarding Board to commission the original SAR author to facilitate further analysis of this information. The findings and recommendations related to this work are set out in the addendum that can be found at the end of this document.

BRACKNELL FOREST SAFEGUARDING ADULTS PARTNERSHIP BOARD

SAFEGUARDING ADULTS REVIEW REPORT

AB NURSING HOME

Report Author – Margaret Sheather

Date of Report – March 2017

1. Introduction

1.1. This is a report of a Safeguarding Adults Review (SAR) that, while it was triggered by the death of an individual, focussed primarily on the overall functioning of the AB Nursing Home (ABNH) and the relationships with it of the relevant agencies that share responsibility for safeguarding adults. The reasons for this approach are set out in section 2 below.

1.2. It has been a statutory review under Section 44 of the Care Act 2014 and has been carried out in line with the Multi-Agency Safeguarding Adults Policy and Procedures and with Bracknell Safeguarding Adults Partnership Board's (SAPB) SAR protocol. The purpose of any SAR is not to reinvestigate the case or apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately improve the safeguarding and wellbeing of adults in the future.

1.3. As part of its consideration of the report, the SAPB will need to decide how to disseminate the learning points so that all relevant agencies and personnel have the opportunity to improve their practice.

2. The circumstances that led to a Safeguarding Adults Review being undertaken in this case

2.1. The AB Nursing Home has been a cause for concern for a number of years, with its quality of care often verging on inadequate, and its CQC ratings in recent years have been poor. Bracknell Forest Council (BFC) has put a great deal of effort into supporting the home to improve but this has proved to be very difficult for the home to sustain.

2.2. The specific incident that triggered the SAR was that Mrs GF suffered severe scalding on 5th February 2015 from being hoisted into a bath that was too hot. There was a delay in calling the ambulance, which took her first to Frimley Park Hospital from where she was transferred to Chelsea and Westminster Hospital for more specialist care. She died there on 8th February 2015. The reporting of this safeguarding incident by ABNH had also not been in line with requirements.

2.3. The case was referred to the coroner who did not consider it necessary to hold an inquest.

2.4. Another resident of the home had died a few days earlier following the collapse of a ceiling onto her. The Health and Safety Executive investigation found that there was no evidence that this had been a preventable incident, but the two deaths occurring so close to each other focussed attention once again on the difficulties of maintaining adequate standards of care in this home.

2.5. The death of Mrs GF is subject to an ongoing police investigation so the SAR could not address the detailed operational issues relating to the provider's

actions. However, the Bracknell SAPB agreed that it is appropriate to review all the surrounding activities relevant to managing this kind of provider so that as much learning can be gained and implemented as possible at this stage. There may need to be a further stage to the review when the police investigation has been concluded. The situation was felt to meet the criteria that confer on the SAPB the power to commission:

"A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAPB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) the adult had died, and the SAPB knows or suspects that the adult has experienced serious abuse or neglect, or
c) the adult is still alive, and the SAPB knows or suspects that the adult has experienced serious abuse or neglect"[1]

2.6. The decision to commission the SAR was taken on 19th April 2016.

3. Terms of Reference

3.1. The full Terms of Reference for the review can be found at Appendix 1 to this report. It was commissioned by Bracknell Safeguarding Adults Partnership Board with preparatory work done by the SAR sub-group between May and July and the SAR Panel starting its formal work on 24th August 2016, when the Terms of Reference were confirmed. Margaret Sheather was appointed as the independent chair of the review and overview report author.

3.2. The SAR panel members were as shown below

Name	Organisation
Margaret Sheather	SAR Chair and Report Author
Paul Chapman	Care Quality Commission
Stefan McLaughlin	Thames Valley Police
Debbie Hartrick	Clinical Commissioning Group
Abigail Simmons	Bracknell Forest Council (Safeguarding)
Mira Haynes	Bracknell Forest Council (Operations)
Dave Phillips	Safeguarding Board Manager
Elizabeth Britton /	Minutes

[1] Care Act 2014

Louise Neal	

3.3. Individual Management Reviews (IMRs) were provided by the Care Quality Commission, Thames Valley Police, Bracknell Forest Council and the Clinical Commissioning Group in respect of the GP practice. A report was requested from the Health and Safety Executive but its management did not feel it was appropriate to participate because of the ongoing police investigation and the change of regulatory responsibilities for care homes that had taken place since the trigger event for this SAR.

3.4. Each IMR was accompanied by a chronology of the agency's involvement with the AB care home and, where relevant, Mrs GF personally. From these the independent chair created a collated chronology to help to identify how the actions of the various agencies inter-related. The original target date for the completion of the review was the end of January 2017, but the large volume of information that some IMR authors needed to review meant that a longer period was required for the preparation of the reports. The completion date is therefore now expected to be March 2017.

3.5. Because of the ongoing police investigation it was not possible to involve the provider organisation in the review either as a Panel member or in making a formal submission. The Panel has therefore had regard to any guidance issued by national provider organisations where relevant.

3.6. "Learning Together" was selected as the methodology for conducting this SAR because the circumstances of the review mean that it is going to be based on themes to be researched rather than the details of the specific event. The specific areas of enquiry identified for the review were:

- How all professional organisations can "bridge" the related issues of quality and safety in their relationships (commissioning, monitoring, contracts) with providers of care; how providers are commissioned and how this can be a process that promotes safe care.
- What the rights, risks, roles and responsibilities are in this work and to whom they belong, including:
    - those with professional roles associated to the care commissioning and provision
    - the service user and their relatives
    - other individuals or organisations that may have contact with the care provider
- Information sharing and communication

- How people and their families can be well-informed about the quality of care they should expect and supported to raise their concerns/ assert their requirements

All of these themes include consideration of how well current policies and processes support good practice and what changes may be needed.

3.7. In order to be able to see the pattern of activity over a significant timescale, the period to be reviewed was set at 1st December 2012 to 31st December 2015. The research undertaken took two main forms:

- the independent chair reviewed a range of documentation such as previous SARs of care homes, a published study of the conclusions of a large number of SARs undertaken over a ten year period and guidance that was available to care homes from national bodies and charities;
- the commissioning of the IMRs from the relevant agencies

3.8. The approach to the review also anticipated that it would be necessary to follow up the initial provision of the IMRs with conversations with key individuals to clarify or develop any points that emerged from the reports. However, the panel felt that the key learning emerged sufficiently clearly from the reports themselves that this element of the process was not required.

4. Case Summary: the facts

4.1. In line with the particular circumstances of this review as set out in earlier paragraphs, the contents of this section will focus on the functions of the nursing home and agencies' interaction with it rather than the individual case which triggered the review.

4.2. ABNH had a long history of varied and often problematic quality of care. When shortcomings were identified the care might improve for a period, though this often required active intervention and monitoring from the local authority to achieve, but this improvement was rarely sustained in the longer term. This is perhaps best illustrated by way of a "case summary" from the reports of the Care Quality Commission (CQC) and the decisions of Bracknell Forest Council's (BFC) Care Governance Board that fall within the timescale set for the review.

Care Quality Commission

4.3. Following inspections in 2011 and 2012 that had both identified areas for improvement which had subsequently been met, the first inspection by CQC within the SAR timescale was in May 2013 in response to expressed concerns. It assessed how residents' nutritional needs were met, how staff were supported to address these and the quality of the relevant record-keeping.

Shortcomings were identified in all these points but a follow-up inspection in September 2013 found that the necessary improvements had been made.

4.4. The next full inspection was the first to be done under the revised CQC approach that assesses provision against five questions: whether it is safe, effective, caring, responsive and well-led. It took place as a result of Mrs GF's death and found ABNH to be Inadequate against each question and therefore inadequate overall. A number of warning notices were issued and conditions about further admissions imposed by CQC.

4.5. The follow up to this inspection in April 2015 focussed on the specific legal requirements against the safe, caring and well-led themes and found them still to be inadequate so further regulatory actions were considered. At this point CQC made the decision to issue a Notice of Proposal to remove the registration of the provider, and also the registration of the registered manager. However, a further follow-up in August 2015 found sufficient staff available who had been trained and knew how to respond to changing needs and medical emergencies. The next full inspection that took place in November and December 2015 found the home once again to be inadequate overall, and it was placed in "special measures" with ten areas for action being identified.

4.6. By August 2016 there had been insufficient improvement to take ABNH out of "special measures" and by then it only had fifteen residents in a home with more than 80 places. The home closed on 20th December 2016.

Bracknell Forest Council

4.7. BFC, in common with most local authorities now, has arrangements in place to work with providers of social care to ensure continuous improvement. *"The Council's approach to Care Governance[2] is one of working in partnership with care and support providers to ensure the safety and quality of services within the borough and to residents who have been placed in care settings outside the borough, where the Council retains a duty of care for those individuals. The Care Governance processes and procedures … are designed to ensure the safety and well-being of residents who are receiving adult social care support. They cover all aspects from deciding to commission support from providers to taking action when standards are not being met."*

4.8. The main decision making body is the Care Governance Board which makes decisions about the "flag" status of care provision (red, amber or green) which influences what care may be commissioned from the provider. It also decides what action to take to improve the quality of support or to check on the welfare of those receiving support. A detailed account of all decision-making by the Board was provided in the chronology, but the summary below

[2] Bracknell Forest Council: Care Governance Policies and Procedures.

gives an indication both of the almost constant level of concern and of the active commitment of BFC to seek sustained improvement at the home.

4.9. Throughout the period under review ABNH was the subject of monitoring and support through the Care Governance Board and other BFC staff. ABNH had been amber flagged for much of the year preceding the review's focus period, either because of CQC inspection outcomes or locally expressed concerns, and had briefly been red flagged because of a failure of the hot water system. It remained at best amber flagged through to May 2014 because there was not sufficient action in response to concerns raised and between April and September it was red flagged because of a police investigation.

4.10. In May 2014 ABNH was finally green flagged, though with a limit of one new placement a month and a range of monitoring still in place. This only lasted a short time as a safeguarding concern in July put the home back to red for a week and then amber, but with some positive improvements now noted. The green flag was reinstated in December 2014 but this was only two months before the position broke down again with the death of Mrs GF and the outcome of the CQC inspection and all the subsequent activities. These were now mainly managed through the safeguarding team and the same difficulties continued in achieving any sustained improvement so that by November 2015 the council was making plans to move all its funded residents from ABNH.

4.11. Throughout this period BFC was investing substantial staff time, and therefore financial resources, in attempting to work with ABNH to improve and maintain the standards of care. There was also an intensive programme of monitoring visits and several points at which BFC staff carried out full welfare checks on all residents.

4.12. Thames Valley Police had also had a number of contacts with ABNH including reports of a resident going missing, notifications of deaths, allegations of neglect, inappropriate care or understaffing, assault by a resident on a staff member, a referral from the coroner about the death of the resident on whom the bedroom ceiling fell and the scalding incident with Mrs GF and her subsequent death.

4.13. The facts of the case therefore present a care setting which is unable through its own leadership and management to sustain a safe and satisfactory level of care for its residents. Nor was it able to use the substantial external support and monitoring offered to achieve sustained improvement. This is not an uncommon element in any local care system and, while the responsibility for recognition of the problem and its resolution properly rests with the care home owner, much activity and effort in fact transfers to local commissioners, working with the regulator, as

they seek to balance the need for stability in their care market with refusal to tolerate unacceptable quality of care.

5. Analysis

5.1. This section reports the SAR Panel's discussion and analysis of the information it considered and is structured around the Specific Areas of Enquiry identified in the Terms of Reference. It also draws on the wider contextual information identified by the independent chair.

How all professional organisations can "bridge" the related issues of quality and safety in their relationships (commissioning, monitoring, contracts) with providers of care; how providers are commissioned and how this can be a process that promotes safe care.

5.2. It was clear that in the work both of the BFC and the CQC there had been extensive efforts to bridge these issues. The BFC care governance process provides an effective monitoring method and the "flag" system should operate as an effective tool to alert staff to current risk levels, determine placement activity and promote change in the care home. Alongside this, BFC offered substantial direct support in the home in an attempt to improve the quality of care. The Council was in regular liaison with the CQC during the period under review.

5.3. The main improvement that the panel considered necessary was further development of the provider contract to be more explicit about the care governance arrangements, including the "flag" system and the kinds of problems that would lead to amber or red flags. The contract should also be clear about specific shortfalls which, if not resolved, will be regarded as a breach of contract with consequential action by the council. Recommendation 9.6 below refers to this.

5.4. In this case, ABNH had continually challenged their "flag" status, sometimes through legal systems. This approach to contracts will strengthen commissioners' position when faced with a persistently poorly performing home that does not seem to take seriously the need to put the conditions in place for sustained improvement in quality of care. It also recognises explicitly the quality threshold at which the local authority will take action to end its contract independently of the CQC taking action about its registration.

5.5. The Care Governance Board has proved to be a key forum for multi-agency intelligence sharing and decision-making. Its monthly meetings are well attended. The panel identified that the completeness of the information available to the Board would be further improved by strengthening links between TVP and care governance processes. Recommendation 9.7 below picks up this point.

5.6. There was good communication between the CQC and other professionals involved with ABNH throughout the review period on a whole range of issues including safeguarding concerns and quality issues. BFC safeguarding team also proactively contacted CQC when they had identified concerns about the quality of care.

5.7. The relationship between primary care and the ABNH home was rather different as a provider of health care rather than a commissioner. The home purchased from the GP practice a service over and above the required GMS standard, but the panel agreed with the primary care IMR that a formal contract and service specification between the GP practice and ABNH would have provided a more appropriate basis for the relationship. Such a contract could include a clear statement about the GPs responsibilities if they identify any safeguarding concerns.

What the rights, risks, roles and responsibilities are in this work and to whom they belong

5.8. All the agencies involved in this case share legal and professional responsibility for safeguarding adults in the broad sense. Their more specific roles and responsibilities vary but, as in the section above, those of the CQC and the local authority have some overlaps that need to be understood and well-managed.

5.9. Responsibility for ensuring quality and sharing information is shared between commissioners and regulators rather than located primarily with one or the other. The CQC has developed local relationships with Clinical Commissioning Groups (CCGs) who commission services including care homes with nursing, and meet them regularly to share information gathered by both organisations. There are also meetings with LA commissioners for similar purposes. These help CQC to understand the needs in an area and the general quality of available care and also alert commissioners to any concerns that may have been brought direct to CQC and keeps them informed about any regulatory action being taken.

5.10. The CQC also maintains local links through contact with the safeguarding team and board, the Health and Wellbeing Board, the Overview and Scrutiny Commission and Healthwatch. These all assist in shaping their intelligence about commissioning, market shaping, the quality of local services and the way that local commissioners and providers work together.

5.11. There appear to be two areas for improvement arising from work with ABNH in the way that the CQC fulfils its specific responsibilities.

5.12. Firstly, the Panel thought that the CQC could use the regulations relating to the registered manager more assertively to ensure that unjustified gaps in appropriate management don't open up in a service. Regulation 15 of the

registration regulations[3] requires providers to notify the CQC when a registered manager leaves a location and will no longer be responsible for the regulated activity. The Panel has been pleased to note that in January 2017 an updated CQC policy was introduced on the issue of suspected breach of the registered manager condition of registration. If, within 12 weeks of the manager leaving, the CQC has not received an application for a new manager to be registered it will write to the provider and ask for an explanation. It will take prompt action to ensure the registered manager condition is met without delay and failure to do so will impact on the risk profile for any location.

5.13. The other area for improvement which the CQC report identified relates to their role in collating and passing on information from care providers and the public and monitoring the quality of that information. The report identified that ABNH could be seen to be an outlier in under-reporting of expected deaths, the poor quality of the information received about them (making that information difficult to interrogate) and the use of incorrect forms for reporting. All these are useful indicators about the quality of the service and the manager's understanding of the regulations they have to meet but these patterns were not brought to the attention of the relevant inspector.

5.14. Further developments would, the panel felt, be helpful in systems of notification to inspectors about indicators of poor quality in the information received from care providers. This then enables the CQC to contact the provider about the quality of the information and provide advice about the requirements if needed. The CQC has recently taken action on this point and Recommendation 9.8 below refers to this.

5.15. BFC practice guidance is clear about professional roles and responsibilities for its staff in safeguarding, care placement and review processes. The role and functions of the Care Governance Board are also clear, but the points made above (paragraphs 5.3 and 5.4) about the use of the contract to clarify expectations are also relevant to clarity of roles and responsibilities.

5.16. The key area of overlap of role and responsibility between the local authority (and other commissioners) and the CQC is in the relationship between registration, regulation, safeguarding and commissioning /de-commissioning. It is possible for a care setting to have fallen below the contracted quality level for commissioners to continue to use it either for current or new residents but still remain registered. This is sometimes the case because due statutory process must be followed by the CQC. Where the CQC has inspected a care home and found areas of inadequacy or the

[3] Care Quality Commission (Registration) Regulations 2009. If a provider is in breach of the registered manager condition, this is an offence of Section 33 of the Health and Social Care Act 2008. This offence can be dealt with by way of a fixed penalty notice or a prosecution.

need for improvement, the starting point (except in extreme cases of failure) is to seek action from the provider. While that is underway, information from CQC is not necessarily in the public domain, which can influence residents' and their families' responses if the commissioner is asking them to consider a move.

5.17. After the death of Mrs GF the local authority felt some frustration that the CQC did not move more actively to remove ABNH's registration, as this would have enabled the remaining residents to be moved more quickly. As it was, because this was a local home that was the residents' and their relatives' choice because it was nearby, there was reluctance from some families to consider a move while the home remained registered.

5.18. This period, when the CQC cannot share information from inspections publicly (until they have followed their inspection process and fulfilled statutory requirements) sometimes has a significant impact on local authority resources where residents, with their families agreement, choose to remain in the provider setting and commissioners continue to carry out their responsibilities to safeguard residents.

5.19. This review could not involve the specific provider directly so has no reflection from them on their role and responsibilities, but it is clear that core responsibilities for the provision of at least safe and adequate care and the management of risks rests with the provider. They have to understand what is expected of them and put the arrangements in place for delivery. Also a provider that is prepared to be open with its staff and residents/relatives about any concerns that are raised and its response to them makes periods of concern or difficulty in the provider's service much easier to manage well.

5.20. From the information available to the review, the events we were considering showed that none of these conditions were in place. The constantly varying "flag" ratings of ABNH indicated the lack of consistent attention by the provider to ensuring safe, adequate and sustainable care standards even with extensive support from the local authority. Normal processes for business continuity were lacking. It was also clear that critical findings of inspections were not shared by the owners with key staff in the home, who were therefore not aware of changes that had been required. This also meant that they gave erroneous/ contradictory information to residents and their relatives when commissioners were seeking to make changes or discuss the need for alternative placements for residents.

5.21. As already noted above, ABNH was purchasing a service in excess of the GMC required standards from the GP practice, so was meeting its responsibilities. The question remains, however, about whether the GMC standards set the right expectations for GPs to be alert to the overall standards in a care setting, beyond the individual they have been called to

attend, and their responsibilities, should there be safeguarding concerns, to raise an alert.

5.22. The main area for improvement identified by the NHS report was to ensure that, where enhanced services are being provided to a care home, these are the subject of robust contractual arrangements. In addition, although the GP had acted appropriately in this case, the specific incident led the practice to identify that more specialist training about burns would be beneficial. It has also continued to strengthen GP knowledge about adult safeguarding, with particular attention to care home situations.

5.23. The role of the police in these cases is clear: to respond to and investigate incidents/ or reports from nursing and care home settings. Crimes should be identified, recorded and investigated. In addition any safeguarding considerations should be paramount and these should be addressed in partnership with other relevant agencies.

5.24. TVP has identified the need for a greater focus on the issues relating to deaths in care home and has therefore put in place a new "Vulnerabilities Steering Group" in recognition that further development of best practice is needed in what can be complex investigations. The Panel welcomed this development. TVP is also revising its Adult at Risk guidance and the panel noted that this needed to be shared through the SAPB to ensure that inter-agency policy and guidance remains consistent across the Board partners.

5.25. The panel also noted a more general issue for professional agencies going into care homes about their role in challenging practice appropriately even where they might assume the qualified staff to be competent to make risk assessments and take responsibility for the work of the care assistants. This is potentially an issue to follow up in inter-agency training, to ensure that all professionals are able to raise any concerns that they have assertively with staff in the home. It also has relevance to the management culture in the individual home, which will determine how staff are likely to respond to questions or comments about observed practice.

5.26. Thinking about the rights, roles and responsibilities of the service user and their relatives, and the risks that might be involved for them requires a different perspective. Their ability to exercise their rights and fulfil their roles and responsibilities depends very largely on the information that is made available to them by all the other parties with a role in the situation. These points are picked up in paragraphs 5.30 and following, where the fourth theme of the review is discussed.

Information sharing and communication

5.27. Shortcomings in inter-agency communication and information sharing are a common feature of Safeguarding Adults Reviews, but this does not appear to have been a significant issue in this case. All the Individual Management

Reviews reported generally good communication and information sharing between professionals, and there is no evidence that issues were missed or actions not taken because of lack of information.

5.28. The reports and discussion identified a number of further improvements that could be made, some of which have been mentioned already. The include:

- The specific internal information management improvements identified in the CQC recommendations
- Finding a way to provide honest information to residents and their relatives about quality and safety problems when the home owner/manager may not be co-operating
- the police recommendation about clarifying terminology in safeguarding contacts to them to ensure that it is clear when a possible crime is being reported

5.29. In terms of communication with the provider, this was extensive and explicit, but seems to have met with constant resistance to taking the actions necessary to achieve sustained improvement. The NHS report notes a strong working relationship between the GP practice and ABNH but what is less clear is whether there were any observations from the GPs about the overall quality of care being provided and what arrangements are in place for any concerns to be passed on.

How people and their families can be well-informed about the quality of care they should expect and supported to raise their concerns/ assert their requirements

5.30. As noted earlier, people and their families can only exercise their rights, roles and responsibilities and understand what the risks might be if they are well-informed in the way this theme of the review picks up. The general information available to them needs to be:

- easily accessible in a variety of formats
- brought to their attention at the right time
- explicit about rights and proper expectations of care providers and commissioners

and needs to be supported by a clear understanding of their own or their relative's care and support needs.

5.31. What emerged from the IMRs and from the panel's discussion was that there is more activity across all agencies to gather residents' and families' reactive views and experiences than there is to ensure easy access to proactive information that is available to them when they make their placement decision and during their residence in a care home. Discussion also identified the more complex issues of how to ensure that there is a

"general public" understanding about what constitutes good care that then provides the starting point for people who have to make a personal decision for themselves or with a relative. Out-dated expectations may lead to acceptance of sub-standard care or environments.

5.32. BFC policy and practice guidance is clear about professional roles and responsibilities but doesn't extend to those of the service user and their relatives, and therefore what information they may need to make good decisions. The council website has useful information, but takes several clicks to get to the relevant page, so a more prominent link would be more helpful. On the specific page, people are appropriately directed to CQC reports and also advised to discuss their needs with a social care practitioner, District Nurse, Health Visitor or GP. All of those professionals therefore need to be equipped to respond well to enquiries and to offer consistent guidance on quality expectations.

5.33. Age UK has published a range of material on this topic including a Care home checklist [4] and the BFC website provides a link to their website and to other materials. While web-based information is clearly a primary source of information now for many people, it is not so for all, and, in any case, there still needs to be "signposting" information in key access points to direct people to more detailed materials, whether on-line or hard copy. Depending on what work has been done previously on communications, commissioners and the SAPB may wish to review what's available and how to enable anyone who needs it to get access to relevant information at the right time.

5.34. Beyond the provision of information needed to support decisions about admission to a care home, the panel discussed how the care contract might be able to be used to reinforce understanding of service user's rights and expectations. If the service user and /or their family were directly involved in establishing the contract that is being entered into on their behalf, this would provide the opportunity to offer proactive information about what good provision looks like and their entitlement to raise concerns where provision falls short.

5.35. A broader discussion at the point of decision-making could also include information about how the Care Governance Board works to monitor care quality and what sorts of problems will lead it to take action. This would all potentially improve service users' and families' confidence to exercise their rights and understanding if the situation reaches a point where a change of placement is being proposed.

[4] "Care home checklist – helping you to choose the right care home"; ageUK April 2016

Whether any particular practice might have changed the outcome

5.36. Each IMR author was asked to consider whether their review identified any particular action or practice that, if done differently, might have changed the outcome.

5.37. The CQC, NHS primary care and the police did not identify any specific action where a different response from the agencies concerned might have changed the outcome. BFC suggested that a local authority might be more stringent on timescales for improvement and that this should be stated in the contractual arrangements (see relevant points about the contract above.) In the case of ABNH BFC's involvement built up from quite soon after the contract began in 2007 to an unprecedented level by the time of the events that are the subject of this review.

5.38. This was an ongoing feature of the relationship with ABNH that was not duplicated in any other home that the LA commissions in the borough. The contract might have been terminated earlier had it not been the home of choice for many local people, which led the LA to give this exceptional support to try and achieve sustained, improved performance.

5.39. The Panel was conscious that once the result of the police enquiry and any subsequent court case is known it may be possible to review the actions of the provider more fully. This in turn may lead to further discussion of whether any particular practice might have changed the outcome in this case.

6. Views and comments from the family

6.1. The Independent Chair met Mrs GF's daughter, Ms CD, to hear her views about her mother's care and the events surrounding her death. She offered some very helpful reflections on the various stages of the process, which are summarised below, and has relevant professional experience herself which informed her views.

6.2. It had felt to the family that there had been little real choice of care home when Mrs GF needed to move from her former sheltered housing, having been in hospital for a period. They were asked if they would like to look at homes but were not provided with a list of care homes in the area so the task felt very difficult to tackle, particularly as they lived some distance away.

6.3. There was pressure to discharge Mrs GF from hospital and ABNH was suggested. The manager at the sheltered housing told Ms CD that the home didn't have a very good reputation and Ms CD also noted the varied performance in the CQC reports. She raised these concerns with the social

worker at the time who agreed that it had not been functioning very well but reassured them that it had now improved.

6.4. The report from BFC confirms that the original placement at ABNH was made to facilitate Mrs GF's discharge from hospital, but was intended as an interim placement to allow time for a longer-term decision to be made. When the position was reviewed, however, it seemed that Mrs GF had settled well at ABNH so the placement was confirmed for the longer term

6.5. Ms CD regretted that was no continuity of social work contact during the time Mrs GF was at ABNH; they were contacted for their views about the home though rarely by the same person, and were invited to reviews but sometimes at too short notice to be able to attend. When they'd been asked for their views they didn't usually get feedback after the social worker had visited the home.

6.6. From Ms CD's perspective, the first 8 months or so the care seemed fine; there was clear evidence of personalisation in Mrs GF's care and good continuity of care and nursing staff. There was then some deterioration, and they really noticed the difference around Christmas 2014 when there seemed to be staff shortages and more turnover of staff.

6.7. The most radical difference was after Mrs GF was moved, with the family's agreement, from the wing she was on which catered mainly for the more active dementia-affected residents, to one for more dependent residents. The whole atmosphere was different in that section, the care and attention was much less personalised, it was difficult to find staff to talk to, there was a lack of welcome and fewer staff. Ms CD also noted in general the varied English language skills of the staff and the impact this had on communication.

6.8. Ms CD felt she would have been more likely to have raised these concerns if there had been consistent contact with a social worker or she had known more about the opportunity to raise concerns with CQC.

6.9. The panel noted this point, and the earlier one about continuity of contact, and the dilemma for the local authority of trying to provide consistency and continuity with very limited resources. One option it suggested is to have a named link person in the council for each care home that family members or others with concerns (or compliments) could contact. This would provide relatives with a consistent link and also develop a repository of knowledge about a particular home.

6.10. Ms CD would have welcomed the approach the panel has discussed (5.34 above), in which service users and their families would be much more fully involved in the contract process and would have more information about care governance and its significance in ensuring their relative's good care. This would have given her more confidence about how to address concerns and what the commissioners would do in response.

6.11. On a broader level, Ms CD also highlighted what it means to a family when a parent has to make the transition from their own home to a care home and the impact on their family of realising that the parent is no longer able to fulfil the role they had always previously held. This emotional issue is a significant part of the context of the decision for family members and is certain to affect the way they engage with the decision-making process.

6.12. Ms CD noted that she did make a formal complaint to BFC that the family had received no message of condolence after their mother's death. She was pleased to have had a very prompt and apologetic response to her complaint which also told her that improvements had been made to systems to avoid this happening in future.

7. Good Practice identified

7.1. As in most reviews of this sort, the individual agencies were able to identify incidents of good practice by their staff, as well as the areas that needed further improvement. These are set out below as reported by each agency.

Thames Valley Police

- Recognising the limited training available to officers in relation to care home investigations, Detective Sergeant 4 arranged for some training for his team from the Independent Chair of a Serious Case Review into another care home (Orchid View 2014).
- The overall review of TVP's activities linked to ABNH demonstrated good joint working on investigations from an early stage and effective contributions from the Domestic Abuse Investigation Unit to safeguarding the residents at ABNH

Primary Care

- Nominated Lead GP who takes ownership of primary care interventions at ABNH
- Person centred care promoted by the GP using individualised Care Planning and regular review.
- Good professional relationship and communication processes with ABNH
- ABNH purchased an enhanced service from the GP surgery which was above the level required by a GMS contract.
- Timely GP follow up visit to ABNH on the day of the bathing incident when unable to contact the home by telephone.

Bracknell Forest Council

- The sustained efforts of BFC since 2008 to the present day of working in partnership with ABNH to support improvements in the quality of care and support they provide.

- BFC placing extra conditions on placements at ABNH for BFC funded people from September 2013 and the extra constraints placed on these in May 2014 and which remained thereafter.
- The staged approach adopted to relocating residents after the incident which brought about the tragic death of Mrs GF. This approach demonstrated a sensitive and sensible reaction to a complex issue. The attention to adhering to the MCA 2005, safeguarding people in their accommodation, maintaining a good working relationship with the provider and also with residents and their families throughout has presented BFC practitioners with a delicate balance to achieve. Overall this has been accomplished.

Care Quality Commission

- Good communication with other professionals. The IMR shows that when concerns were raised the CQC responded appropriately and shared its findings with the relevant people. In addition Care Quality Board meetings provide for discussion of emerging risks and information sharing
- CQC's response to serious concerns and safeguarding people at ABNH, as evidenced in the IMR's detailed account of the CQC inspections over the relevant period and how these were followed up

8. Conclusions

8.1. The majority of commissioners of care services are currently working in a context where the supply of affordable care has reduced and continues to do so because of funding and staffing pressures affecting the care market nationally and the impact of national reductions in local authority budgets. In that context it is not surprising that a local authority will work hard to try and support an established provider to improve their performance so as to maintain continuity of care for their residents and continuity of supply in the local area. There is, however, likely to be a cut-off point where the cost of support can no longer be justified because it is not generating sustained improvement and commissioners need to be prepared to make those decisions when necessary. It was in this context that ABNH and the key agencies were operating during the period that is the subject of this review.

8.2. Nor is this the only recent review that has needed to address the relationships between the public, commissioners, providers of care and regulators. The Orchid View Serious Case Review[5] followed inquests that found very serious failings of care that had contributed to the deaths of five residents. Its analysis was shaped around four questions, which overlap with the issues covered in this SAR:

[5] *Orchid View Serious Case Review*; West Sussex Adults Safeguarding Board, June 2014

- *How can the public be confident that:*
    - *the organisations they entrust their care to, or that of their loved ones, are properly managed, with good governance and financial security?*
    - *they provide the good quality of care that they advertise and receive payment for from private individuals and the public purse?*
- *How can people be confident that they or their relative will be safe and well cared for?*
- *What support is available to residents and their relatives, how do they know about it and how to use it if there are concerns about the service?*
- *How can organisations and individual professionals be held accountable for the safety, quality and practice in their services?*

8.3. So this review has been looking at current issues that are shared across many areas and it may be that some of its recommendations can be best implemented through shared learning with and from other local authorities.

8.4. Managing the inter-relationship between regulator, commissioner and provider where a care home is failing to maintain safe and adequate care or is facing de-commissioning or de-registration requires strong foundations in general and close attention to any specific event. The specific events reviewed clearly did receive close and collaborative attention and thorough follow-up. There is less certainty about how the related responsibilities of the regulator and commissioner interlock to ensure timely action based on transparent information when providers fall below either contractual or registration standards.

8.5. The contract arrangements between the commissioner and the care provider will be stronger if they are more explicit about the circumstances that constitute a breach of contract and the action that will be taken. Similarly, residents and their families will be better able to exercise their rights and responsibilities if they are more closely involved in the contract discussions and are aware of the way in which commissioners monitor quality and respond to shortcomings.

8.6. There does not appear to be a strong system in place for providing service users and their families with the information they need to make well-informed decisions about care placements.

9. Recommendations to the Bracknell Safeguarding Adults Partnership Board

Training and Development

9.1. Ensure that all safeguarding adults training continues:

- to raise awareness of the need for all professional staff to be alert, when in contact with care homes, not only to issues about their specific visit, but also to key indications of the quality and safety of the care, for

example about the general environment, interactions between staff and residents and responses from managers when questions or concerns are raised with them

- to emphasise the need for these concerns to be communicated to the local authority and the CQC so that a complete picture of overall performance can be built up to support any necessary action

9.2. Ask Bracknell Forest Council to consider allocating a named contact point for each care home to which concerns (or compliments) can be addressed.

9.3. Continue to develop shared expertise in responding to incidents in care homes; in particular consider inter-agency training based on that recently undertaken by TVP.

9.4. Endorse the CCG recognition of the need for further specialist training for GPs in relation to safeguarding in care homes and the potential for peer group supervision/support for GPs working regularly with care homes.

Care Governance and Decision-Making

9.5. Ask the Association of Directors of Adult Social Services, the CQC and NHS England to work together to clarify between the CQC and commissioners (most commonly local authorities) how their roles and responsibilities interact to respond in a timely manner to a consistently failing care provider.

9.6. Propose to BFC that standard contractual arrangements between commissioners and care providers must state clearly what standards are expected, outline the "flag" system used by Care Governance and therefore what constitutes a breach of contract on which action will be taken.

9.7. Improve links between TVP and Care Governance meetings so that TVP is aware of homes that are a cause for concern through:

- clear reporting path from TVP to BFC and CQC
- provision of intelligence reports from TVP to Care Governance

9.8. Endorse the recent action taken by CQC to improve the quality of information provided in statutory notifications to it by care providers and ask for feedback as part of the SAR Action Plan once implemented

9.9. Endorse the changed arrangements recently introduced in the CQC's response to changes and absences of registered managers and ask for a report on its impact after a year.

Service User and Family Involvement and Information Provision

9.10. Propose that BFC considers introducing an individual service user contract that explains the contractual position and care governance arrangements as described in 5.3 and 5.4 above and therefore assists discussions if/when the Council needs to change an individual's care arrangement

9.11. Consider the experiences described by Mrs GF's family and how these need to be applied to improve communication and involvement in the future.

9.12. Review the information available to service users and their families about safe, good quality care to ensure that it:

- is easily available in a range of formats and signposted from all appropriated locations
- supports their decision-making with clear information about the quality they are entitled to expect and how to assess whether places they are considering meet these standards
- is clear about their right to raise concerns, to whom to take them and how the service user will be protected from any adverse consequences of a complaint

9.13. Support the involvement of service users and carers in the process commissioners use to decide which providers to contract with.

Policy and process issues

9.14. Review recent developments in individual agency safeguarding guidance to ensure continued consistency of inter-agency policies and procedures.

9.15. The issue of responsibility for general welfare checks out of hours still needs resolution[6] as it is not part of the Emergency Duty Service contract but nor is it usually an appropriate use of police resources unless specifically requested in relation to a safeguarding matter.

10.Recommendations of Individual Agencies

The recommendations made by the individual agencies in their IMRs are shown in full at Appendix 2.

[6] Also an issue in a recent Domestic Homicide Review in Slough

APPENDIX 1

Bracknell Forest SAPB Safeguarding Adults Review: BGNH
Terms of Reference

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.9 of the Multi- Agency Safeguarding Adults Policy and Procedures. All Bracknell Forest SAPB members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation, and will reflect the current realities of practice ("tell it like it is").

Legislation

Section 44 of the Care Act 2014 places a statutory requirement on Bracknell Forest SAPB to commission and learn from SARs in specific circumstances, as laid out below, and confers on Bracknell Forest SAPB the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAPB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) the adult had died, and the SAPB knows or suspects that the adult has experienced serious abuse or neglect, or
c) the adult is still alive, and the SAPB knows or suspects that the adult has experienced serious abuse or neglect.

Each member of the SAPB must co-operate in and contribute to the carrying out of a review under this section with a view to:

a) identifying the lessons to be learnt from the adult's care, and
b) applying those lessons to future cases

Governance and accountability

This SAR will be conducted in accordance with the requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014)
- Safeguarding Adults Reviews under the Care Act: implementation

support (SCIE 2015)
- Multi-Agency Safeguarding Adults Policy and Procedures; and
- Bracknell Forest SAR protocol (2016)

As the accountable body responsible for its commissioning, Bracknell Forest SAPB will receive updates on the progress of this SAR at Board meetings, or via offline written briefings as required.

Brief summary of the concerns that triggered this SAR

This Nursing Home has been a cause for concern for a number of years, with its quality of care often verging on inadequate, and its CQC ratings in recent years have been poor. Bracknell Forest Council (BFC) has put a great deal of effort into supporting the home to improve but this has proved to be very difficult to achieve.

The specific incident that triggered the SAR was that Mrs GF suffered severe scalding on 5th February 2015 from being hoisted into a bath that was too hot. There was a delay in calling the ambulance, which took her first to Frimley Park Hospital from where she was transferred to Chelsea and Westminster Hospital for more specialist care. She died there on 8th February. The reporting of this safeguarding incident had also not been in line with requirements.

The case was referred to the coroner who did not consider it necessary to hold an inquest.

Another resident of the home had died a few days earlier following the collapse of a ceiling onto her. The Health and Safety Executive investigation found that there was no evidence that this had been a preventable incident, but the two deaths occurring so close to each other focussed attention once again on the difficulties of maintaining adequate standards of care in this home.

The death of Mrs GF is subject to an ongoing police investigation so this SAR will not be addressing operational issues relating to the provider's actions. However, the Bracknell SAPB has agreed that it is appropriate to review all the surrounding activities relevant to managing this kind of provider so that as much learning can be gained and implemented as possible at this stage. There may need to be a further stage to the review when the police investigation has been concluded.

SAR methodology

Learning Together has been selected as the methodology for conducting this SAR. This methodology has been selected because the circumstances of the review mean that it is going to be based on themes to be researched rather than the details of the specific event. Details of the methodology are outlined in the Bracknell SAPB SAR protocol and can also be found in Safeguarding Adults Reviews under the Care Act: implementation support . The Panel will adapt the method to suit the case.

Specific areas of enquiry
The SAR panel (and by extension all contributors) will consider and reflect on the following:

1. How all professional organisations can "bridge" the related issues of quality and safety in their relationships (commissioning, monitoring, contracts) with providers of care; how providers are commissioned and how this can be a process that promotes safe care.
2. What the rights, risks, roles and responsibilities are in this work and to whom they belong, including:
    - those with professional roles associated to the care commissioning and provision
    - the service user and their relatives
    - other individuals or organisations that may have contact with the care provider
3. Information sharing and communication
4. How people and their families can be well-informed about the quality of care they should expect and supported to raise their concerns/ assert their requirements

All of these themes will include consideration of how well current policies and processes support good practice and what changes may be needed.

The SAR will cover a maximum time period from 01/12/2012 to 31/12/2015 but it is recognised that some agencies' reports/input will cover a shorter time to reflect their involvement with BGNH.

Approach
The review will incorporate Individual Management Review (IMR) reports where appropriate, but will also review any documents that have already been produced by the participating organisations. The panel will then:

- review and discuss all the information gathered
- identify follow up conversations that are needed to clarify or develop any points that emerge
- hold one to one discussions with the relevant individuals to gain this clarification
- formulate outcomes

The intention is that this gives the opportunity to speak to more front line staff and hear their suggestions, in the spirit of the 'Learning Together' methodology.

Timescales for completion

This SAR will commence on 14/06/2016 and should be complete by the end of January 2017. As noted above, these Terms of Reference have been developed to reflect the ongoing police investigations, but everyone involved in the SAR process must nevertheless be mindful of not jeopardising that investigation. It is possible that the outcome of the investigation may require the review process to be suspended.

Chair and membership of the SAR panel

The chair and panel membership for this SAR have been determined as follows:

Name	Organisation	
Margaret Sheather	SAR Chair and Report Author	
Paul Chapman	Care Quality Commission	
Stefan McLaughlin	Thames Valley Police	
Debbie Hartrick	Clinical Commissioning Group and GP Practice	
Abigail Simmons	Bracknell Forest Council (Safeguarding)	
Mira Haynes	Bracknell Forest Council (Operations)	
Dave Phillips	Safeguarding Board Manager	
Elizabeth Britton	*(Minutes)*	

NB Because of the ongoing police investigation it is not possible to involve the Provider organisation in the review either as a Panel member or in making a formal submission. The Panel will therefore draw on any guidance issued by national provider organisations in order to identify a benchmark for appropriate quality of care.

The skills, knowledge, and experience required of the SAR chair are set out in section 5 of the Bracknell Forest SAPB SAR protocol. The independence of the chair from the case under review can be evidenced by her having had no contact with the case previously nor having been previously employed for any purpose by the Bracknell SAPB .

Administrative and professional support
David Phillips will coordinate panel meetings and, where possible, circulate all documents at least five working days in advance of each meeting. Minutes will be taken by a nominated representative from Bracknell Forest Council's Safeguarding team.

Evidence and submissions to the SAR
It has been agreed that the following organisations are to submit evidence to the SAR:

Organisation	Nature of the evidence to be submitted	Deadline
Care Quality Commission	IMR and other relevant documentation	21st October 2016
Thames Valley Police	IMR	
Health and Safety Executive	(non-IMR) Report	
Bracknell Forest Council	IMR and other relevant documentation	
GP practice	IMR	

SAR report and publication
Margaret Sheather has been appointed to author the SAR report, the content of which is to be in line with section 9 of Bracknell Forest SAPB SAR protocol and the Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of full SAR report or the executive summary will be published on http://bfsapb.org.uk unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to Bracknell Forest SAPB how to publish the report, setting out clear reasons for the recommendation.

Timings for publication may be affected by any criminal proceedings and court cases, and the SAR report may be held for publication until such time as the proceedings / case(s) has concluded. In the meanwhile, any lessons learned can be taken forward immediately.

Involving and supporting the adult and family / friends / carers (*redact before publishing)*
The review will seek to involve the family of GF in this SAR, via the liaison of the SAR chair with the TVP family liaison officer.

Name	Connection to the adult	Nature/timing of the involvement	Support agreed
Mrs CD	Daughter	Interview by Independent Chair February 2017	

Involving and supporting key staff and volunteers
The review will seek to hear the perspectives of all key staff and volunteers, within the constraints of the review Terms of Reference. One route to this is set out in the Approach outlined above.

The SAR panel member from each agency is responsible for identifying and notifying relevant staff and volunteers of this SAR and giving them the opportunity to share their views on the case.

The SAR panel member from each agency is responsible for ensuring relevant staff and volunteers are provided with a safe environment to discuss their feelings and offered emotional support where needed, including counselling or other therapeutic support.

Disclosure and confidentiality
Confidentiality should be maintained by all SAPB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.9 of the Multi-Agency Safeguarding Adults Policy and Procedures, and section 6 of the Bracknell Forest SAPB SAR protocol.

All SAPB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, Bracknell Forest SAPB may use its powers under Section 45 of the Care Act to obtain the relevant information. The Chair of Bracknell Forest SAPB and/ or the SAR chair may wish to review an organisation's case records and internal reports personally,

request additional records and relevant policies/ guidance, or meet with review participants.

Criminal proceedings may be running in parallel to this SCR, and in such cases all material received by the SAR panel must be disclosed to the police if and as requested.

Individuals will be granted anonymity within the SAR report.

Communications and media strategy

Communications advice will be provided and the communications approach managed by Bracknell Forest Council communications department. All media queries will be referred to Bracknell Forest Council, unless criminal proceedings are ensuing in which case all media queries will be referred to Thames Valley Police.

Legal advice

Legal advice will be sought by the SAR chair as required from Bracknell Forest Council legal services to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and coroner

There is the following police investigation ongoing linked to this case:

- investigation of the death of Mrs GF

The SAR chair has agreed the following arrangements to link the review and ongoing investigations:

- as set out in the earlier sections of these Terms of Reference

The SAR chair will be responsible for ensuring appropriate ongoing liaison with the Crown Prosecution Service, Coroner and the Police as required.

Links to parallel reviews

The SAR panel has identified that this review links to no other ongoing statutory reviews.

Funding and resourcing

It has been agreed that the funding of this SAR will be provided by .

Review of Terms of Reference

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of Bracknell Forest SAPB.

APPENDIX 2

Recommendations from the Individual Management Reviews

Thames Valley Police

1. Thames Valley Police to review current training arrangements in relation to Adults at Risk for the Domestic Abuse Investigation Unit and Force CID. This should include the changes brought about by the Care Act 2014 and investigating crimes against adults at risk and neglect/deaths in healthcare and care home settings

2. Thames Valley Police to complete the work already underway in relation to producing Adults at Risk operational guidance. The focus of this has been creating an Adult at Risk strategy. It is proposed that this will include a new policy, action plan and operational guidance.

3. Thames Valley Police to circulate the NPCC Homicide Working Group's 'An SIO's Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings 2015' document to all Detective Inspectors.

4. Thames Valley Police to publish and promote their revised Standard Operating Procedure for Unusual, Unexplained or suspicious deaths (version 01/02/15) ASAP. This should include reminding investigating officers of the benefit of early liaison between a Major Crime SIO, the DAIU and the Crown Prosecution Service in relation to suspicious deaths of adults in healthcare/care home settings.

5. Thames Valley Police to investigate whether there is a culture of officers not fulfilling their crime recording responsibilities on the basis of their perception of the outcome for that crime. The results if this investigation will be presented to the Head of Public Protection to decide of any action.

Primary Care

1. Further exploration of this case to identify potential opportunities for learning through the use of the "Significant Event" process used by GP Practices.
2. GP Training update on the assessment and management of patients with burns
3. GP practices that provide enhanced services to care homes should ensure that there is a robust contractual agreement with the care provider.
4. There should be a focus on safeguarding adult training for GPs in 2016/17.
5. Each GP surgery to identify a Lead GP for safeguarding adults.
6. Consider developing safeguarding clinical supervision for GPs who are responsible for care homes as group supervision and individual when necessary.

7. Develop and implement a Safeguarding Adults policy for GP practices.

Care Quality Commission

1. NCSC (CQC Call Centre) – Expected death Notifications

Notifications about expected deaths should provide sufficient information to enable CQC staff understand the circumstances for the expected death.

2. ASC inspection teams

To ensure that all adult social care inspectors monitor the number of notifications and the quality of information included in them, we must take the following steps:

- Inspection managers will speak with inspectors in their teams and highlight the need to look at expected death notifications. This is already part of the CQC's intelligent monitoring.
- Inspectors will look at the information supplied in each notification and check that the appropriate information has been supplied. This must enable them to fully understand the circumstances of the person's death. Where insufficient information has been supplied the inspector will contact the provider for further information.
- Inspectors will use expected death notifications as part of their risk analysis for locations.

Bracknell Forest Council

1. Contractual arrangements

There is a need for BFC to review their contractual arrangements in order that when an organisation demands the intense level of monitoring and local authority attention as that of BGNH there is a clear threshold that identifies when it is appropriate and proportionate to take decisive action to end the contract and no longer place people with that service.

2. Roles and Responsibilities

There should be absolute clarity about the rights, risks, roles and responsibilities involved for all parties involved in a contract that is arranged between the local authority and a care organisation. This means that not only the are the organisation and the local authority clear about their rights, risks, roles and responsibilities but also that the person in receipt of the care, and anyone who is involved in their welfare should be empowered to understand these as well and to become active participants in the care arrangements. Promoting an empowering approach to the person at the centre of the contractual arrangements and to the people involved in their welfare would be beneficial in reducing what seems to be a 'passive' role in an important agreement about a person's lifestyle.

3. Management of Serious Concerns in a home

The method of managing the situation at BGNH after the tragic incident occurred for GF allowed a gradual withdrawal of BFC residents from this accommodation. Two lead operational professionals were identified to work with all the BFC residents and the self funding people and this ensured that the home was not swamped with professionals and that people had consistent support from the same staff throughout. At the same time a strategic lead from the BFC safeguarding team was closely involved in monitoring and meeting with the home management on a regular basis. This individual was also responsible for collating all of the information gathered from the two lead professionals, from other commissioners and from their own work with the home and enabled the presentation of detailed and consistent updates on a monthly basis to senior managers and other agencies throughout.

4. Management of Information

There has been a need for the mass of information related to BGNH subsequent to the tragic incident affecting GF to be collated in a comprehensive and methodical way. The role of the strategic lead from the BFC safeguarding team was to ensure that this was achieved so that all information relating to all of the events was held in one place within the local authority. This has ensured that the information is readily available to refer to and is easily accessible for purposes such as the police investigation, the Safeguarding Adult review and for future learning and practice in similar situations.

5. Relationships and Trust

The allocation of two lead operational professionals and a strategic lead from the BFC safeguarding team ensured that relationships and trust were built with all staff, residents and relatives involved with the home during what was a very difficult and extended period of uncertainty for all concerned. The investment of BFC in this process and in this particular way undoubtedly aided accommodation moves to take place smoothly and ensured that courteous and well-mannered relationships were maintained whilst working with a home that was failing.

Bracknell Forest
SAFEGUARDING BOARD

ADDENDUM TO SAFEGUARDING ADULTS REVIEW REPORT ON AB NURSING HOME

Report Author – Margaret Sheather

Date of Addendum – 20th June 2022

2. Introduction

2.1. The report of the Safeguarding Adults Review (SAR) that followed the death of Mrs GF after suffering a scalding injury at AB Nursing Home in 2015 was completed in March 2017. At the time the review had focused primarily on the overall functioning of the Nursing Home and the relationships with it of the relevant agencies that share responsibility for safeguarding adults rather than on the specific circumstances of Mrs GF's injury and subsequent death. The report's outcomes and recommendations were therefore also limited in the same way.

2.2. The reasons for this approach were set out in the original report as follows:

"The death of Mrs GF is subject to an ongoing police investigation so the SAR could not address the detailed operational issues relating to the provider's actions. However, the Bracknell SAPB[1] agreed that it is appropriate to review all the surrounding activities relevant to managing this kind of provider so that as much learning can be gained and implemented as possible at this stage.
There may need to be a further stage to the review when the police investigation has been concluded. The situation was felt to meet the criteria that confer on the SAPB the power to commission [a review}.

2.3. The police investigation and subsequent prosecution of the care-home owners, Aster Healthcare Ltd, the registered manager at the time of the injury to Mrs GF, who was also a registered nurse, and the senior carer on duty were not completed until the case came to court in October 2021. This was a sentencing hearing as guilty pleas had been made. For the offence of corporate manslaughter Aster Healthcare was fined £1.04m, having been shown both to have failed to maintain a safe hot water system as required and to have provided false information about this on a number of occasions.

2.4. The former registered manager and the senior carer were both given suspended prison sentences.

3. Multi-agency Reflective Discussion

3.1. The completion of the court case made it possible for the further stage of review, mentioned above, to take place. A multi-agency reflective discussion was held on 28th March 2022 including representatives of the NHS, Bracknell Forest Council safeguarding, social work and commissioning functions, Bracknell Forest Safeguarding Board, the Care Quality Commission and Berkshire Care Association. The list of those attending, some of whom had been involved in the original review, is at Appendix 1 and the session was chaired by Margaret Sheather, the Independent Chair of the original review.

3.2. It was very helpful on this occasion to have the Berkshire Care Association represented, as it had not been possible to include care providers in the original SAR work.

3.3. The purpose of this further session was to:

i. Check the impact of the learning identified in the original SAR

ii. Identify any further learning in the light of the information now available

iii. Agree additional actions therefore required to improve local practice and systems

iv. Consider the current national context for care homes and any opportunities to pass

[1] SAPB became the Bracknell Forest Safeguarding Board (BFSB) in 2019

on our learning at national level

v. Identify any impact of the learning on the methodology of future SARs.

3.4. The session started with the impact statement that Mrs GF's daughter had made to the court hearing, in order to put the family's experience into our work right at the start. This was followed by a summary of the court's findings which provided many of the participants with their first knowledge of the very serious shortcomings that had emerged in the course of the prosecution, as these details had not been available to the original review.

3.5. The main work of the session then focused on the points set out above. This report does not cover all the details of the discussions but aims to draw out the key points that emerged for learning and action.

4. Responses to impact statement and court transcript

Impact Statement

4.1. There were two elements to Mrs GF's daughter's impact statement to the court. One element covered broadly the same issues about the care home placement process and ongoing involvement of and communication with family members of residents that she had raised with the SAR. Actions to address these issues were therefore already identified and the extent of progress needs to be addressed in the Action Plan Review referred to in paragraph 8.1.

4.2. The other element dealt with what had been, for the family, an agonising wait for the prosecution to be concluded and the difficulties of living through the ups and downs of that time. It also highlighted the publicity and communications aspects of the process. The family's main desire throughout was for those responsible to be held accountable for the outcomes of their action.

4.3. The main learning points arising from this were:

i. The paramount importance of good communication and sensitive management of the relationship with family members throughout all processes from the first consideration of a placement.

ii. The impact on the family of feeling under pressure to find/agree a placement relatively quickly. This continues to be a difficult point to resolve as pressure on the NHS and funding and staffing difficulties in the care home sector have, if anything, increased in the period since the original review.

iii. The points made by Mrs GF's daughter in her victim impact statement should be checked against the original review report and any not already covered should be included in the review of the action plan and relevant actions identified.

The Court Transcript

4.4. The group received a presentation that summarised the detailed information uncovered during the police investigation about the general management of AB in the years running up to Mrs GF's injury and death and the home's response to her injury. While all of those present were aware of the history of indifferent performance by AB as set out in the original report, for many of the group it was the first time they were aware of the shocking level of inaction, deceit and falsified recording that had occurred, particularly in relation to what the court called "a calamitous history of problems" with the hot water

system.

4.5. The detailed account of Mrs GF's injury and the home's response to it was also very disturbing in its account of a very poor standard of care that led to the injury itself, the sluggish and inappropriate response and the failure to recognise and report an obvious safeguarding incident promptly.

4.6. The main learning points identified in discussion of this additional information were:

i. The very serious consequences that can result from not abiding by the legal and regulatory framework. Rigorous and detailed approaches by regulators and commissioners are therefore needed to ensure standards are being met and proportionate action taken on poor performance.

ii. These approaches need somehow to allow for the possibility of deceit and falsification of records.

iii. The original SAR had made recommendations about the functioning of the Care Governance Board and this needs to be further reviewed including consideration of how to increase the transparency to care providers of the way the "flag" system works.

iv. Further consideration needs to be given to whether to make placements in a home that is frequently amber flagged and also to whether the flag system is sufficiently robust to share with the public. If that route is not taken then other arrangements to ensure that families have a realistic understanding of the care home proposed for their relative must be made.

v. Care providers all expect to share responsibility for ensuring poor providers are not tolerated and to work on systems to implement this.

vi. The lack of care home representation on the Care Governance Board prevents suggestions coming from the sector about improvement to practice and dissemination of learning. Further discussion is needed about how to improve these links, particularly if membership of the CGB is not considered appropriate.

5. Impact of learning from the original SAR, other additional learning and proposed improvements

General commissioning/provider/regulator issues

5.1. Shortly after the original review the CQC introduced a revised inspection system and intelligence-gathering arrangements that all present agreed were significant improvements. However, it was also felt that practical spot-checks needed to be included in inspection visits (e.g. of water temperature) not just the review of policies.

5.2. The importance of concentrating on the culture of the environment was also agreed. CQC's approach now recognises this more fully, not being simply process driven, but <u>all</u> agencies that visit a care home need to have this in mind. This needs to be addressed in training and supervision.

5.3. The Care Governance Board has improved its relationships with care homes as well as its monitoring activities and is generally more in control of its work. (But see comments above about formal Care Provider input to the governance process.)

5.4. Providers find the contract monitoring process over-bureaucratic and would like to see a better-balanced use of time from the statutory service towards care reviews, which are

often difficult to arrange. This requires joint consideration between the two relevant council teams.

5.5. Care providers need to ensure, possibly via their association, that all staff are aware of the potential personal consequences of falsifying records or giving false information. This in turn raises the question about whistle-blowing processes in the sector and how these can be effective.

5.6. In relation to care home placements, social workers are now having more detailed discussions with families about the pros and cons of proposed placements. However, the impact of families' own preferences should not be under-estimated. For example, in this case when the local authority started to move residents out of the home because of its failures a number of families were reluctant to take this step.

The response to the injury

5.7. As a result of the SAR, all GPs locally were given additional burns training and advice.

5.8. Some present at this discussion were not clear why, considering the seriousness of Mrs GF's injury, an ambulance was not called immediately by the care home, nor why the GP did not advise this course of action as soon as they were contacted. It was confirmed that this was investigated at the time of the review, which revealed that the GP was not given the full story of the incident at the time of the call and therefore not able to assess the need for emergency care. The GP was not told of the length of the submersion or that the burns were likely to be more than a scalding. Clear guidance needs to be given to all relevant personnel about what urgent steps to take or advise in the case of serious injury.

5.9. This is particularly necessary at the current time when public messaging is urging people to seek appropriate care and to provide clear information about where to go in different circumstances.

5.10. Some concern was expressed at the meeting about how easy or otherwise it is to get a District Nurse or GP to visit a care home now. Information provided by the NHS representative has confirmed that GPs are visiting care homes and conducting more ward rounds as part of their new contracts, which has increased in frequency since this SAR. This includes conducting visits for individuals where indicated. It is true that the use of technology means more virtual appointments and telephone consultations which helps the practitioner to assess whether a face-to-face visit is required, and this is working well in many areas.

6. The national context now and opportunities to pass on learning nationally

6.1. Financing of adult social care continues to be the dominant issue, along with the related point about cross-subsidy by privately funded residents of publicly funded placements. Care Providers are clear that there is a mismatch between money available in the system and the actual cost of delivering care. There is no immediate prospect of this position changing.

6.2. Price inflation is now also having an impact and will add to the pressures on care providers.

6.3. However, the kind of poor care and negligent and deceitful behaviour under scrutiny in this case is not dependent on the level of funding. Basic good care standards such as

water temperature control, attention to the resident's reactions and honesty in responses can be achieved within the current system.

6.4. Registered managers are in a key position in the care system, carrying a large responsibility, and they pay a heavy price for failure. However, they need the support of the care home provider, which was clearly not available in this case, rather the opposite – with pressure on the manager to contain costs and collude with the owner's approach.

6.5. Notwithstanding the manager's professional responsibility to have resisted the expectations put on them, the discussion was concerned at the inequity that allows the owner to continue to operate, having paid a fine, while the manager's career is ended. It may be reasonable to consider representation to the appropriate authorities about this imbalance.

6.6. As already mentioned, effective whistle-blowing processes are vital and need to continue to be promoted nationally by all agencies. There should also be national awareness-raising about the issues and outcomes in this review to remind both owners and managers about their responsibilities.

6.7. Beyond the financial context, recruitment is the biggest single challenge care homes face and all affected organisations need to keep the workforce issues in the government and public eye.

7. Any impact on future SARs

7.1. It was noted that the system for collating SARs is now similar to that of children – with an SAR library in place. Once this addendum is completed the whole AB SAR can be published and its findings will be added to that library. This provides a resource for learning and development.

7.2. This additional session reinforced the importance of involving families in a SAR in whatever way is manageable for them. They bring a different perspective to the issues under consideration and can help keep a complex process focused on the people at the heart of it. Implementing this will require a clear understanding of the balance of learning and allocation of responsibility in the process.

7.3. Consideration should be given to a role for the chair of the review in following up the implementation of actions proposed by the review. For example: 'The Chair to be provided with an update after x months,' so that priority continues to be given to the implementation of any Action Plan.

8. Next steps

8.1. The Action Plan from the original SAR must be fully reviewed and updated to reflect all the additional learning points noted in the preceding sections, with clear ownership of each aspect stated and target dates for review and completion set.

8.2. The Safeguarding Board did share learning and communication locally following the original review, but this did not include all the relevant organisations. Part of the Action Plan implementation needs to be the preparation of a comprehensive learning brief for wide sharing across all the relevant organisations.

8.3. These two key steps need to be taken jointly across all the sectors involved.

Appendix 1

Review session attendance

Margaret Sheather	Independent reviewer for original review
Brian Boxall	BFSB Independent Chair & Scrutineer
Abigail Simmons	Head of Safeguarding & Practice Development, Adult Social Care
Amy Todd	Principal Adults' Social worker
Ben Sladden	Strategic commissioning manager
Debbie Hartrick	Director of Safeguarding, Frimley CCG
David Tanner	Representative from Berkshire Care Association
Fidelma Tinneny	Representative from Berkshire Care Association
Kay Puddle	CQC Inspection manager for Bracknell (at time of original review)
Paul Chapman	CQC inspection manager
Jonathan Picken	BFSB business unit manager
Julie Sheppard	BFSB business unit support officer