SCIE Learning Together

social care
institute for excellence

What gets in the way of care home commissioners and regulators, in Sutton and the surrounding areas, identifying providers who are failing to give safe care, sharing their intelligence and acting together before a point of sudden closure is reached?

Version 4

6th April 2017

Fran Pearson

Section 1: The events under review, and why this case was chosen for a Safeguarding Adults Review

1.1 Why this case was chosen for a Safeguarding Adults Review

1.1.1 Two nursing homes, Grantley Court in Sutton, and Merok Park in the neighbouring local authority of Surrey, belonging to the same owner, and providing accommodation for older people who were frail, mainly with dementia and resulting complex needs, both closed in a short period between 9th and 12th December 2014.

1.1.2 Concerns about four residents who were moved from Grantley Court became the subject of a police investigation. The investigation was closed because there was no evidence that a case of criminal neglect had taken place. However each agency's investigations - police, the local authority, NHS commissioners and the Care Quality Commission - uncovered multiple instances of poor care and a disregard for the dignity for a group of adults who were very much at risk. The rapidity of the closures and the speed of the associated moves of the residents was potentially traumatic.

1.2 Succinct summary of the case

1.2.1 The residents at Grantley Court were not all from Sutton, but from Surrey, Kingston and Merton as well. What they did have in common was that their levels of need were high (many of them had dementia). They were amongst the frailest older people receiving services locally, and the care requirements of some of them were particularly complex. Different organisations from those boroughs funded some of the placements. In recognition of the high and complex health needs, both physical and mental, of these older residents, some were placed there under arrangements for NHS Continuing Healthcare, arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need"; others were funded under s117 aftercare arrangements for people with certain mental health conditions. Some wealthier residents were self-funders, paying for their own placements because they had assets above a nationally-agreed threshold.

1.2.2 In July 2014, a relative raised a safeguarding alert with Sutton about a family member at Grantley Court. The experienced nurse manager of Grantley Court had

recently left and this appeared to have an immediate impact on the standards of care at the home. Safeguarding concerns around the care of multiple residents were uncovered as the Sutton team checked on each resident during August and September 2014. Under an agreed plan, an embargo was placed on any new residents coming in, and the most vulnerable residents were moved out to new placements. In August 2014 a decision was reached in Sutton that the accumulation of individual safeguarding concerns meant that establishment concerns came into consideration - bringing a range of procedures and communications with other boroughs. At Merok Park, unacceptably poor care standards led to the Care Quality Commission taking action to cancel its registration in late 2014.

1.2.3 Professionals from different organisations worked to an agreed plan to try and manage the situation at Grantley Court to secure a little more time to relocate residents. At Merok Park, residents were moved on the last day that the home was open - 9th December. At Grantley Court, despite their attempts to work with the owner to prevent a sudden closure, professionals had two days to move residents after the owner gave notice of closure on December 10th, closing the home on 12th, with the last residents leaving that day.

1.2.4 A police investigation began in December 2014. It centred around three residents from Kingston who had been placed at Grantley Court until 10th December - when they were moved to a resource centre in Kingston. During the admission procedure at the resource centre, staff there saw bruising to the older people from Grantley Court which was not documented in any handover material. They contacted the borough police in Sutton, who began an investigation - later extended to include a fourth former resident of Grantley Court. The Detective Inspector who summarised the investigation in a report said that the home "had clearly suffered following the departure of [the experienced] manager" and quotes the GP for the home as saying the same. To add to leadership problems, the police investigation noted communication from the GP to London Borough of Sutton in August 2014 stating that there had also been a loss of staff nurses at Grantley Court, coupled with "an influx of very needy and highly dependent patients mostly with severe dementia and challenging behaviour". A new manager who arrived in October 2014 identified that the reason care fell below expected standards at Grantley Court was "due to a lack of training for staff. He did not feel that the staff at Grantley Court had any training in the care of people with severe dementia" (quoted in summary of police report).

1.2.5 As far as a third home belonging to the owners, Faygate, providing residential rather than nursing care, and located in Sutton, was concerned, commissioners agreed a plan to try and support it to stay open at least over Christmas. The owner closed the home in January 2015.

1.3 The decision to carry out a Safeguarding Adults' Review

1.3.1 In December 2015, the relevant Sub-group of the Sutton Safeguarding Adults Board concluded that a Safeguarding Adults Review, under section 44 of the Care Act, was the appropriate approach for reviewing events at the nursing home. On 15th December 2015, they wrote to the Independent Chair of the Sutton SAB, recommending this course of action, which the Chair agreed.

> *"Against the draft protocol, we did consider that the criteria for a SAR was met towards the "outer margins" of the remit required, however, determined that it was likely met against:*
>
> ***2.1 (bullet 2) "An adult at risk has not died, but has sustained injury, and/or experienced significant abuse or neglect and there is a concern that partner agencies could have worked more effectively together to protect the adult."***
>
> *We acknowledged that the category in this case would have been neglect as opposed to injury or abuse - [senior police officer] confirmed that subsequent to police investigation, there was no evidence for a case of criminal neglect charges to be brought, however as a group we considered that the evidence required for a criminal case was substantially higher than a SAR would require, and that "neglect" had a long range.*
>
> *As a sub-group we also however considered in any case that the following within the draft protocol applied:*
>
> ***2.2 The SSAB will consider conducting a SAR when the above criteria are not met but when:***
>
> . ***A review into the circumstances of a death or serious abuse or***

neglect can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults who are at risk of, or experiencing, abuse and neglect.

1.4 The period of professional involvement that is under review: why this period was chosen, and the questions that the review set out to answer

1.4.1 Learning Together reviews typically consider the work of professionals with a service user during a period of 6 - 18 months. This differs from some types of review, which cover longer periods of professional involvement. The reasoning behind the shorter timeframe lies in the fact that this is a systems review, which sets out to establish which aspects of a case are still happening in the wider safeguarding practice of local organisations, with a view to promoting good practice, and changing poor practice. Looking back a long way reduces the chance of being able to do this, as organisations will have changed, as will national and local policy.

The Review Team agreed a timeframe of January 2014 to January 2015.

1.4.2 A scoping meeting was held with representatives from Sutton and the independent chair was consulted and also had input. Although the focus of this review is on what happened in Sutton, because the same owners ran Merok Park, in Surrey, events there have been drawn on for the findings in the report. As a consequence, although this review was commissioned and led by Sutton Safeguarding Adults' Board, colleagues from Surrey joined the review process, as did colleagues from one of the authorities that had placed their residents in Grantley Court - Royal Borough of Kingston.

The review set out to answer the following questions:

1. What gets in the way of care home commissioners and regulators in Sutton and the surrounding areas identifying providers who are failing to give safe care, sharing their intelligence and acting together before a point of sudden closure is reached?

2. What can be put in place to reduce the likelihood of such situations occurring in the future?

3. When providers do suddenly close, how can local safeguarding systems best respond to the crisis?

1.5 Learning reviews and the requirement for organisational improvement

1.5.1 The purpose of a review is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. However, one implementation guide (SCIE 2015) acknowledges *... it can be difficult to keep a focus on the learning in the face of terrible abuse or neglect, media and public interest. This is especially so if it appears at first that 'human error' was to blame for the failure to prevent it.*

1.5.2 The SCIE guide suggests four ways to support a focus on learning:

- Clarify how organisational factors can be the cause of incidents.
- Use techniques to avoid hindsight bias in commissioning and quality assuring [review] reports.
- Demonstrate that top management want [reviews] to 'tell it like it is'.
- Be transparent about how SARs fit with disciplinary procedures.

The methodology for this review was chosen to try and achieve all these things.

SECTION 2

The Learning Together Methodology

2.1 What *Learning Together* is

2.1.1 *Learning Together* is a systems approach to understanding multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper underlying issues that are influencing practice more generally. It is these generic patterns that are explored as 'findings' or 'lessons' from the case. The process looks at the safeguarding system through the specific case that triggered the review and which provides a 'window on the system'.

2.1.2 In line with the requirements of the Care Act, the model ensures that the workers involved and their operational managers play a major part in the review, in analysing how and why practice unfolded in the way it did and highlighting the broader

organisational context. Data is gathered from a variety of sources including a review of existing documentation alongside data provided by front line practitioners and their managers. Within this report these professionals are referred to as the Case Group. The review is completed by a team of senior managers who did not have line management responsibility for the case, led by two independent Lead Reviewers, who form the Review Team.

A critical aspect of the review, using this methodology, is the perspective of the service user (where this is possible) and their family and friends.

2.2 The Lead Reviewers and our independence

2.2.1 The Lead Reviewers for this case were Fran Pearson and Sue Bairstow. Both are experienced in carrying out reviews and involving families and service users in the process. Neither reviewer has any connections, professional or personal, with the agencies or the family involved in this review. Fran Pearson wrote the final report.

2.2.2 The Lead Reviewers received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and challenges the reviewers to show the evidence for the findings - hence making those findings more reliable.

2.3 Any limits to the Review Team and Case Group participation?

2.3.1 Because the care homes had closed almost two years before, in the circumstances that they did, practitioners and managers who worked in them were unavailable to contribute. Further time passed between the decision to hold a review, and the start of the process, because it took two to three months to set up an initial scoping meeting - this was due to the difficulties in coordinating the diaries of the range of agency representatives at a time when there was no dedicated administrative resource for the review. An administrator was later made available to provide some support to the review process, and this made a noticeable difference with practical tasks.

2.3.2 Carrying out a review across local authority and organisational boundaries is always challenging. However, as the purpose of the review became better understood, and in part due to clarity by the independent chairs of Sutton, Surrey and Kingston Safeguarding Adults' Boards, about the importance they attached to participation of professionals from each area, the number of professionals contributing to the review began to grow. There were some variations in those who attended, most notably from the local authority and NHS commissioning organisation at Surrey. There were a variety of reasons for this - and as the review progressed, it began to feel as it was intended to when it was scoped out - about shared learning across Sutton, Surrey and Kingston.

2.3.3 The approach for this review perhaps made it slightly more difficult to guard against hindsight bias. Learning Together reviews employ particular techniques to try and reduce the effects of hindsight on the opinions gathered from the managers and practitioners who make up the Review Team and Case Group. Because this review was based around one workshop to gather data and a second to test it out, there was slightly less scope to take participants back to recalling what it felt like at the time they were working with residents at Grantley Court than there is when individual practitioners are interviewed. The reports provided to the review were all written with the benefit of hindsight, which may have influenced some of their content. However, to balance this, some of the reports, especially the long and detailed chronology from London Borough of Sutton captured, in the language professionals used at the time, a vivid picture of Grantley Court in the autumn of 2014 and the unedited comments of professionals, families and residents. In addition, some Case Group members (practitioners) talked with a similar vivid recall when they described their thoughts and actions at the time of the closure of Grantley Court on the workshop day.

The Review Team was made up of the following professionals

Fran Pearson	Lead Reviewer
Sue Bairstow	Lead Reviewer for the workshop day
Deborah Klee	Independent Chair, Sutton Safeguarding Adults Board
Head of Initial Contact, Adult Safeguarding and Service Transformation	London Borough of Sutton - People Directorate

Detective Chief Inspector	Metropolitan Police, Sutton Borough Command
Designated Adult Safeguarding Manager	Sutton Clinical Commissioning Group
Head of Safeguarding	London Borough of Kingston - Adult Social Care
Strategic Head of Safeguarding and Quality Assurance	Surrey County Council - Adult Social Care
Area Director -Service Delivery	Surrey County Council - Adult Social Care
Adult Social Care Head of Adult Social Care Inspection for London	Care Quality Commission
Inspection Manager	Care Quality Commission
Designated Nurse for Safeguarding Vulnerable Adults	Surrey Clinical Commissioning Group

Case Group of practitioners / workshop attendees

	Royal Marsden Community NHS Trust
Team Manager - Adult Mental Health and Substance Misuse	LB Sutton - People Directorate
Social Worker	LB Sutton - People Directorate
Social Worker	LB Sutton - People Directorate
Assessment Officer	LB Sutton - People Directorate
Senior Category Manager	LB Sutton - People Directorate
Head of Mental Health, Transitions, Community and Clinical Health	LB Sutton - People Directorate
Occupational Therapist	LB Sutton - People Directorate
Inspector	Care Quality Commission

2.4 The perspective of families

2.4.1 The Review Team agreed that the voices of family members would inform this review. The relatives of four different residents agreed to be interviewed, although a slightly larger group of relatives were contacted. The Review Team would like to thank them for their time. Some of their views are summarised in this section, but are also woven into later parts of the report. Three residents of Grantley Court were moved to one care setting run by another local authority. The manager of that setting agreed to be interviewed, providing some extra detail and insight about those three vulnerable adults. In addition, the chronology provided by London Borough of Sutton contained verbatim reports of what members of other families told Sutton employees about their relatives at Grantley Court. These gave a picture, not just of the distressing nature of their concerns and the poor practice at Grantley Court, but also captured vividly what some of the personalities and preferences of the residents were. These have been referred to where appropriate.

2.4.2 The relatives had all chosen either Grantley Court or Merok Park for their relatives - sometimes because one of the homes was better than another option based on specific criteria -

> *The home looked a bit tired but it had a 5 star rating for the kitchen. Another one we considered only had a four star.... We talked to a few people before making our decision. Some care homes can look like hotels and seem impersonal. Although it looked a little tired Merok Park felt homely.*

None had complaints about the care their relatives received at either Grantley Court or Merok Park. They experienced the closures in different ways, as did their relatives. This is explored in more detail in the Findings.

2.4.3 Whilst not the view of families directly, one former manager of another care setting, where three of the service users went at short notice, gave her perspective on their wellbeing on arrival. One of those older people had no one obvious by way of family, so asking a professional's view was relevant. The three that came arrived at 8pm. They were in clean clothes, but no outer clothing, just a blanket provided by the ambulance crew. The home manager's immediate impression was that they looked clean but unloved, and scrubbed up for the occasion. They gave the impression of not having been looked after. They were hungry - they consumed two packets of chocolate biscuits between them with their cup of tea.

2.4.4 The manager had been told she and her staff would get the Care Plans for these individuals, but it amounted to one side of A4 paper, with basic information only - Next of Kin, a photo, and the name of their GP, plus their current medication. There was no information about what they liked in order to help look after them. They routinely did body mapping at the home - so did did this assessment fully in the morning. Staff had noticed a bit of bruising the previous night. Two of the three people agreed to be photographed. The whole of one side of one person's face and neck were bruised plus a large part of their back. This person had numerous other bruises, which care staff mapped, but there was no explanation for them from the previous home. So the manager asked a local GP to come in, and contacted the local police and social care team. She has worked with older people for years, and never seen anything like this.

Section 3: The Findings

3.1 Outline of this section

3.1.1 This section contains five priority findings that have emerged from the Review. The findings explore how effective professional practice was in protecting very vulnerable older people in this case. Each finding also lays out the evidence identified by the Review Team, to illustrate that these are not one-off issues. For each finding, evidence is provided to show the issue in the finding creates risks to other adults in the future, and that the issue is a problem in the local system which undermines the reliability with which professionals can do their jobs.

3.1.2 This section begins with an appraisal of the professional practice in the events leading up to the care home closures. The Review Team worked together to analyse data gathered from practitioners at a workshop, the views of relatives, and written documents. Collectively the Review Team formed judgments about the effectiveness of professionals' practice in working with the situation of care provider failure that developed during 2014. In order to minimise the degree to which hindsight can affect the way we judge practice, the appraisal of professionals' practice is based on what was known and was knowable at the time, not on what we have the advantage of knowing now. As set out in the 'limitations' section above though, the material and approach for this review made it particularly difficult to guard against hindsight bias.

3.2 Key dates in the review period

January 2014	Care Quality Commission inspects Grantley Court Nursing Home in Sutton. Care and welfare standards met, but fails in back office duties including administration
January 2014	London Borough of Sutton agree structured programme of improvements with home owner
June 2014	CQC inspect Faygate House, a residential care home in Sutton, belonging to the same owners. Several areas of concern, none major
29 July 2014	Members of one family report concerns about their relative, from Surrey, and placed at Grantley Court - followed up by LB Sutton
June 2014	Experienced manager of Merok Park leaves
July 2014	Experienced manager of Grantley Court leaves
5 August 2014	Strategy meeting takes place for the man referred by his relative
5 August 2014	A Sutton welfare visit to Grantley Court finds standards of care and welfare to residents has dropped to an unacceptable level. Immediately notify CQC, stop the home from taking on any more residents and begin a phased programme of removing residents
6 August 2014	Safeguarding raised with Sutton for another Grantley Court resident - strategy discussion same day
7 August 2014	Third resident at Grantley Court is subject of safeguarding. Sutton contact Surrey, where the individual is from, and referral made for advocate for him
11 August 2014	Welfare visit to this third resident by Sutton practitioner
14 August 2014	Strategy meeting about third resident
18 August 2014	Case conference
21 August 2014	Embargo put in place on new admissions to Grantley Court
22 August 2014	Contract & Financial review meeting
27 August 2014	A fourth safeguarding raised - for another Grantley Court resident
28 August 2014	GP for Grantley Court writes to the LB Sutton 'Over the last two months, I have had some increasing concern about the

	running of and care provided [there] - with details of individuals
29 August 2014	Sutton host a case conference - with the situation being such that it falls into the category of institutional safeguarding
September 2014	Second CQC inspection of Grantley Court
September 2014	January 2014 CQC report is published late due to a system error
12 September 2014	Internal meeting at the CQC: team for Grantley Court share information with the inspector for Merok Park so they consider the possible impact on those services.
8 - 30 September 2014	Care Quality Commission inspection of Grantley Court - the home now failing in significant areas
October 2014	CQC serves notice of proposal to cancel the provider's registration at Grantley Court
27 October 2014	A new manager, with relevant experience, begins at Grantley Court
11 November 2014	Unannounced visit by Surrey safeguarding team to Merok Park due to disinterest expressed by owner to a financial abuse case involving one of the care staff
14 November 2014	Sutton staff carry out welfare visit to Merok Park - evidence that action being taken to address repairs, but find poor record keeping
25 November 2014	District Nurses covering Faygate Residential Home, send notification to LB Sutton of concerns about lack of heating and hot water, as well as pressure care
November 2014	Sutton's investigation of Faygate begins, including visits from Contracts team - feedback that heating and water problems being resolved and that pressure care being managed more effectively
28 November 2014	Care Quality Commission team for Surrey begin inspection of Merok Park
4 December 2014	Strategy Meeting held in Surrey under Surrey County Council's provider closure/failure protocol. Surrey County Council notified London Borough of Sutton that CQC was going to issue suspension of all registered activity notice at Merok Park on 9th December 2014

4 December 2014	Surrey CC begin search and negotiations for new placements for Merok Park residents
5 December 2014	Manager at Grantley Court announces resignation
5 December 2104	Care Quality Commission notify LB of Sutton of the decision at the previous day's meeting in relation to Merok Park
8 December 2014	LB Sutton starts looking for placements
9 December 2014	Notice to cancel all regulated activities served with immediate effect by CQC in relation to Merok Park
10 December 2014	Some relatives learn of the closure of Merok Park via a Daily Mail story
10 December 2014	Owner issues notice that he is closing Grantley Court two days later
10 December 2014	Sutton send letter to relatives of those in Grantley Court notifying them of the need to move - not received till after moves have taken place
12 December 2014	Owner closes Grantley Court
12 December 2014	(added by someone at workshop: family read in D Mail re Grantley)
12 December 2014	Kingston alerted of Grantley closure and move clients that evening
12 December 2014	Staff at resource centre in Kingston raise safeguarding alerts - two in relation to bruising, and one in relation to poor care including pressure care when residents from Grantley are admitted there
12 December 2014	CQC inspect Faygate
13 December 2014	CQC issue notice of decision confirming cancellation of the provider's registration for Grantley Court
15 December 2014	Resource centre staff make a report to their local police - Kingston Borough Command
15 December 2014	Safeguarding Conference in relation to Faygate Residential Home - District Nurses and LB Sutton Contracts Team, agreed safeguarding concerns being managed. Care Quality Commission give feedback to the conference that they will not be issuing any form of closure notice but will take enforcement action

15 December 2014	Decision made in Sutton with a Head of Service to work with Faygate so it did not collapse over Christmas - Faygate comply with this plan.
15 December 2014	Body maps and photos of residents who moved to the resource centre in Kingston are sent to LB Sutton who in turn notify police - Sutton Borough Command
16 December 2014	2nd and concluding day of CQC inspection of Faygate. Inspectors rate it inadequate and serve three warning notices
January 2015	CQC issues notice of proposal to cancel the owner's registration as Manager of Faygate
13 January 2015	Owner gives one month's notice on placements at Faygate
29 January 2015	Alternative placements found for all Faygate residents

3.3 Appraisal of professional practice January 2014 to January 2015

3.3.1 For an issue to be systemic and form the basis of a *Learning Together* finding, it needs to be something that happens repeatedly in the local safeguarding system. At the start of the period under review - January 2014 - the Care Quality Commission inspected Grantley Court Nursing Home and then due to organisational change the inspection report did not get published within one to two months, as would be usual practice. This left relatives and professionals without an important source of data about the nursing home. The CQC undertook an internal review of their role in events around the closure of the two nursing homes and the residential home that are at the centre of this review. This confirmed that the failure to publish the January 2014 inspection report was due to staff changes and internal reorganisation within the CQC and in January 2015, the CQC published an apology on its website for this. This practice by the CQC, despite its shortcomings, was a one-off and therefore is not part of the findings about the safeguarding system.

3.3.2 During August and September 2014 a range of professionals from different agencies assessed the care of residents at Grantley Court. Some of this had an individual safeguarding focus, for example a social worker from LB Sutton responded to safeguarding concerns that began to be raised by relatives. Other work had a broader remit to review issues relating to the home and standards there. For example on 2nd September, two nurse assessors on behalf of Sutton NHS Clinical

Commissioning Group visited "to check staffing levels, bedrooms, equipment, general living environment of the residents and other areas of concern". This issue of different professionals with different powers - some focused on individuals and their care, others considering standards at the establishment as a whole, was to test out the ability of the local safeguarding system to connect the two nursing homes with the same owner throughout the remainder of the period under review, and **Finding Two** explores this in relation to risk in the safeguarding system. Although some relatives did raise safeguarding concerns from August 2014, those who contributed to the review did not have concerns about the quality of care their family members were receiving, and **Finding One** explores why it is that a safe local system is one that operates without making assumptions about relatives' ability to raise concerns.

3.3.3 At the time the nurse assessors visited, they reported that Grantley Court had 20 clients and 5 empty beds. Two days later, London Borough of Sutton staff received a "full list" of current residents there, and these totalled 18. **Finding Three** explores the question of how the provider failure protocols and checklists that are increasingly well-developed by the local authorities provide increasing assurance, but that some groups of adults remain at risk of falling through the net, even though local processes are becoming more robust.

3.3.4 Throughout September 2014, a Sutton local authority social worker was assigned to check on residents, begin speaking to relatives where appropriate about possibly moving them, and to carry out unannounced visits at different times of the day. Towards the end of August a new employee had arrived to fill the requirement for a registered nurse at the home, and the social worker's diligent practice highlighted this new employee's lack of managerial experience and the failing standards at the nursing home. On 19th September, she "informed us that she has worked at Grantley Court for the past 4 weeks having come to England [from another country] 4 weeks ago... She has been thrown in at the deep end with no knowledge of a nursing home environment". [She] went on to say she is very unhappy with the way the home is run. She said [the owner] has not been near the home for approx 10 days but is aware of the recent safeguarding alert which LB Sutton are investigating. "

3.3.5 The reported conversation continued "[she] said she had pleaded with [the owner] to purchase equipment to help with transferring residents. There were residents staying in bed all day she said because of the lack of equipment. [the owner] has

purchased the equipment but is this right without OT assessments and training for the staff?". On 27th October a new manager started who was a qualified nurse with experience of nursing homes. In recognition of the scale of problems at Grantley Court, an appropriate shift took place from individual safeguarding to a process led by aHead of service at the council and involving a wider range of local authority colleagues, principally those from the contracts and commissioning sections of the council.

3.3.6 Local authority safeguarding leads at Sutton and Surrey kept each other informed of developments at Grantley Court and Merok Park during the rest of the process that led to closure. Sutton made a decision to move the most vulnerable first. Although these professionals subsequently reflected on this decision and questioned whether it was the right one, there was a rationale for it, which still makes sense. Residents at Grantley Court fell into two distinct groups. One cohort had moved there some years ago when large mental health hospitals closed - they were generally mobile and in good health. These were the individuals for whom the plan was to remain longer. A very different group of residents had moved in during more recent times - frail, almost all with dementia and multiple health needs, with several being unable to advocate for themselves. It was these older people who were to be found new placements first.

3.3.7 The Care Quality Commission became involved, realised they had an unpublished report, which was made public in September 2014, and carried out a reinspection in September 2014 as well. The CQC inspectors covering Sutton (from the London team) decided to share their concerns about Grantley Court with the inspector for Merok Park (from the CQC Surrey team) in their management review meeting on 12 September 2014. When the Surrey team from the CQC inspected Merok Park, starting on 28th November, they found standards to be so concerning that the decision was made to use their powers to urgently close the service, and this happened in early December 2014. Whilst CQC did not serve a letter of intent to close the service under its urgent powers the provider was aware of CQC's actions and all agencies were advised of the decision to close Merok Park at a multi-agency meeting'

3.3.8 A small group of professionals at London Borough of Sutton worked consistently, and with an attention to detail that put residents at the centre of their practice, throughout August, September and October 2014 to assess risk to individuals at Grantley Court. The Review Team recognised this practice, but at the same time

could see the fragility of a system that relies so heavily on such a small number of professionals. **Finding Four** follows this up by exploring what some of those stresses may be related to.

3.3.9 Guidance on what can be said to relatives was missing in December 2014 as Grantley Court closed in a few short days. This was compounded by events beyond the control of those at Sutton Council who were leading the response. A letter drafted to relatives did not reach them in time, as the home closed so suddenly. Practitioners began discussions with some relatives but felt anxious about what they could or could not reveal in relation to the future of the provision, and this is explored in **Finding Five**. The Review Team noted more recent practice in surrounding authorities, where the uncertain future of large providers has seen Best Interests discussions used as a way to start a dialogue with relatives. **Finding One** explores this.

3.3 In what ways does this case provide a useful window on our systems?

In the Learning Together methodology, findings are categorised using a six-part typology. This enables boards to see what sort of underlying issues cause the most difficulty in their local system. The six categories are:

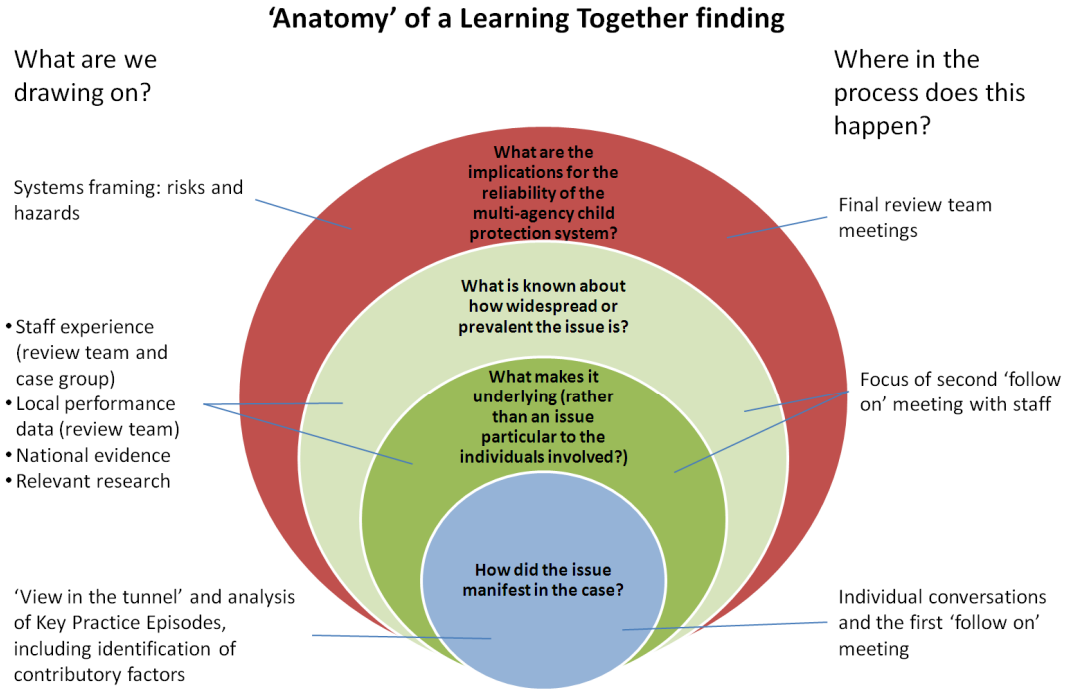
- Tools
- Professionals' interactions with service users, carer(s) and family members
- Management systems
- Response to incidents / crises
- Longer-term work
- Innate human biases (cognitive and emotional biases)

Learning Together Findings are constructed to start with an example of how an issue appeared in the case or cases that triggered the safeguarding review. Analysis then moves away from the case in question to provide, on the basis of information from the Case Group and Review Team members, confirmation that the issue is not just limited to the case, but happens elsewhere in the local safeguarding system. Further analysis considers how widespread and prevalent the issue is in the board's geographical 'patch', or drawing on national data to make an estimate of how much the issue occurs locally. The risks to the local safeguarding system are then elaborated. Each finding ends with a summary of the issues and some questions and considerations for the board. The aim is to move away from action plans that are based on single agencies

making smaller changes to practice, and instead to equip safeguarding boards to exercise their leadership role in tackling difficult partnership issues.

	Finding	Type of Finding
One	For complex reasons, not all families in Sutton, Surrey and Kingston are well-placed to provide professionals with early warning of worsening standards in care homes, with the consequence that local systems need to operate without making assumptions about relatives' ability to do this, and to compensate for it.	The way professionals work with family members
Two	Different professionals with different powers go into residential and nursing homes to review either individual care, or the running of the establishment, with the consequence that, despite bringing this intelligence together, where providers have multiple care homes, risks across those homes are not certain to be picked up, and adults are left at potential risk.	Management systems
Three	Sutton, Surrey and Kingston use increasingly well-developed Provider Failure protocols, but at the point when failure occurs, there is no mechanism for making sure that sufficient messages are getting passed back - with implications for adults most at risk of falling through the net of checklists, who may be left too long and moved too late.	Management systems
Four	In Sutton, coordination of multi-agency networks at time of care home closure could be further developed, because current reliance on a small group of	Response to incidents

	committed practitioners has the consequence that future closures might not be so well supported	
Five	There is a lack of clarity about what can be communicated to relatives and residents at a time of enforced care home closure with the consequence that a very stressful time is made more so, unnecessarily, and options insufficiently discussed	Response to incidents



3.3 The Findings

<u>Predicting provider failure and keeping adults at risk safe</u>

Finding 1

For complex reasons, not all families in Sutton, Surrey and Kingston are well-placed to provide professionals with early warning of worsening standards in care homes, with the consequence that local systems need to operate without making assumptions about relatives' ability to do this, and to compensate for it.

How did the issue appear in this case?

Four relatives agreed to be interviewed for the review, and the former manager of the resource centre in Kingston where three residents moved, gave an account of their support networks. Although the agreed care was not being delivered at the nursing homes, the relatives did not have concerns and accepted the care that was on offer. One older person moved three times in a year. More than one person was discharged to the nursing homes in this case from hospital, so relatives had to move quickly to find a placement, and based decisions on what was acceptable on indicators such as the lack of a smell of urine

Why is it underlying and not only present in this case?

Review Team members said that relatives of care home residents across Sutton, Kingston and Surrey can, in their experience, continue to feel that even with declining standards, their family members are content with their placements. One reason for this in the opinion of the Review Team, is that relatives form relationships with care staff and see them doing the best they can. Relatives such as the one quoted earlier in this report, are, in the wider experience of Review Team, under pressure to find placements for their family members and 'all they hear is '"find a place"', which can lead to a period of relief once they do this, which in turn may mean it is a little while before they begin to consider the surroundings and care at the placement. The principal issue though that Review Team members see in their work with relatives, is that they do not know what good care looks like. The Mental Capacity Act means that as part of the process, professionals need to contact relatives for a discussion about any part of a resident's care that might be restrictive. In 90% of cases across the area, the Relevant Person's Representative for older care home residents, is one of their relatives, in line with the Mental Capacity Act. Having these conversations has added to the data about what relatives expect. The Review Team were able to reference growing quantities of this data for all care homes they work with - especially for Sutton where the policy is to see each individual care home resident face-to-face despite national guidance that a desktop review of a the situation is acceptable.

How widespread and prevalent is the issue?

The issue is known to be widespread. For example the Surrey Safeguarding Adults' Board has produced a leaflet called "Are you being provided with good care at home that keeps you safe?" - although it is for home care users rather than those in residential care, it was drawn up to respond to what is accepted to be a national concern: that both older people and their relatives are reluctant to complain about the quality of care.

Glasby, Robinson and Allen (2011) interviewed the most senior local authority managers across the country, who had had the greatest exposure to managing care home closures. They noted the particular effect that an enforced closure has on relatives, as opposed to carefully planned programmes to change local care offers. A director of adult services told them:

> *We were considering an enforced closure of a ...home. Their [relatives, residents and care staff] perception was that there was nothing wrong with the care and it didn't need to close, but CQC saw clear cases of neglect and thought it did need to close. Also in many cases family will not accept that care was deficient - I think this is partly about guilt and how it reflects on them. So you get different perceptions from clients / families / council /regulators.*

But this needs to be balanced against the relatives in Sutton and Surrey who raised concerns about their family members, triggering the multi-agency response that led to an embargo on placements at Grantley Court and the Care Quality Commission action to close Merok Park. Nationally the Relatives and Residents Association also cautions against judgement of relatives whose family members are in care

> *The vast majority of people who get in touch with us are desperately worried about the standards of care their elderly relative is receiving at home, in care homes or in hospital.*

Why does it matter?

The proportion of older people who fund their own placements and who rely on their relatives to identify a nursing or residential placement for them, or identify that placement themselves, is reported by commissioners to be higher in Sutton, Kingston and Surrey than the national average. In Sutton, commissioners estimate the proportion of self-funders to be 65% compared with Institute of Public Care figures that place the national average of self-funding residents at 44.9%. For Kingston, the proportion of adults who fund their own care is reflected in plans for the future:

Royal Borough of Kingston Adult Social Care Market Position Statement 2016-2017 (Royal Borough of Kingston 2016):

"The impact of self-funders (p18)

The services directly funded by the Council only represent a percentage of the overall care market across Kingston. Self-funders are the majority consumers of local care and support and potentially have a very significant impact on what the local market provides by way of services... A self-funder is someone who "pays for all their social care or support from their own private resources" (including welfare benefits such as state pension or attendance allowance) or top up their local authority residential or domiciliary care funding with additional private spending. The Institute for Public Care estimates that 44.9% of registered care home places in England are self-funded. The proportion of self-funded places in residential care homes is 39.6% and 47.6% in nursing homes. In Kingston self-funders make up a considerable proportion of the residential and nursing care populations. Our best estimate is that approximately 60% of these beds are occupied by people funding their own care".

So the expectations of relatives are important at the point an older person is in need of placement. As the relatives who contributed to this review suggested, not all relatives of older people in care homes know what to expect of the care provided for their family members. And some are unable due to their own circumstances to tackle this issue. Once an older person is in a placement, part of the role of the professionals in the local safeguarding system is to test out whether concerns raised by some relatives are in fact applicable to a wider group of residents, even if the families of some profess to be satisfied with the quality of care. The Care Quality Commission, at the time this report was being finalised, was about to place a 'Standard Assurance Policy' for Care Homes on its website in recognition that a framework is of value to relatives as well as professionals.

Summary of the Finding
For complex reasons, not all families in Sutton, Surrey and Kingston are well-placed to provide professionals with early warning of worsening standards in care homes, with the consequence that local systems need to operate without making assumptions about relatives' ability to do this, and to compensate for it.
Summary of risks to the safeguarding system: Not all relatives of older people in care homes know what to expect of the care provided for their family members. And some are unable due to their own

circumstances to tackle this issue. The strength or weakness of the local safeguarding system lies in the extent to which it recognises this and uses other data to test out how safe all residents are.
Questions and considerations for the board • How far does this fit with your knowledge of care home residents and their relatives locally? • How much does the Sutton SAB need to know about the data gathered locally on relatives' perceptions of care to their family members? • How do local partners measure the effectiveness of information that is provided to relatives about how to recognise good care? • What opportunities do SAB members see for using discussions with family members about Deprivation of Liberty to understand and respond to relatives' concerns?

Finding Two

Different professionals with different powers go into residential and nursing homes to review either individual care, or the running of the establishment, with the consequence that, despite bringing this intelligence together, where providers have multiple care homes, risks across those homes are not certain to be picked up, and adults are left at potential risk.

How did the issue appear in this case?

There were rapidly escalating safeguarding concerns about Grantley Court from the summer of 2014, and London Borough of Sutton worked to identify levels of risk, liaise with other local authorities and Clinical Commissioning Groups, and the Care Quality Commission, recognising that this was institutional safeguarding, and needed to be treated as such. The London inspection team at the Care Quality Commission, dealing with Grantley Court, identified its connection to Merok Park, and shared it with their colleagues from the regional team that covered Merok Park in September 2014. Professionals were hampered in their efforts by a lack of cooperation from the owner.

Why is it underlying and not only present in this case?

Around the time of the safeguarding issues at Grantley Court and Merok Park, and since then, the commissioners and the CQC were gaining increasing experience of working together to manage situations where local care home providers were at risk of failing. The Review Team members spend a considerable amount of their time, and

have developed expertise over the years, in predicting and trying to prevent the failure of large providers in the local care market - and they gave a number of examples of situations with both home care and with residential and nursing home providers where they had done this. Additionally there is now a local mechanism for gathering 'soft' intelligence - the Joint Intelligence Group (JIG) - where such issues as a spike in admissions from a particular care home to the local hospital can be discussed and its implications explored. Groups such as the JIG do not provide a clear interface between local authority areas though, and Review Team members were less able to articulate how these work. Surrey and Sutton do however join in Surrey's Provider Failure meetings when these affect residents from both local authorities These interfaces are of particular importance in the rare cases when care providers do not cooperate, as with the owner of Grantley Court and Merok Park.

How widespread and how prevalent is the issue?

Everywhere the pattern seen in Sutton is replicated - different professionals with different powers go into residential and nursing homes to review either aspects of individual care, or the running of the establishment. The Lead Reviewer's experience of safeguarding systems in other parts of the country is that each area has developed mechanisms for sharing intelligence, in recognition of the distinct roles of the main professional groups in this work. For London, this was discussed at the London Safeguarding Adults' Board in January 2017 as an area that local safeguarding boards could help marshal more effectively. Each borough has an information sharing panel for provider concerns, but these have apparently evolved in different ways, with some involving NHS Clinical Commissioning Group colleagues and others not. Meanwhile the NHS at London regional level has three Quality Surveillance Groups covering the capital - established following the enquiry into the Mid Staffordshire Hospital Trust, where patterns of neglectful care were never spotted and acted upon. Local authorities are invited but are not always engaged, with the result that data is collected in two different forums but not necessarily used to do the very things that this Finding is about. The London Safeguarding Adults Board will be developing a work stream to follow up on this.

Why does it matter?

Depending on the size of the provider, large numbers of residents can be left at risk if these connections are not made, and relatives who might feel differently about whether they want a family member to stay with a particular care provider do not have the information that allows them to consider this. However, collectively the local authority

and NHS commissioners, and the Care Quality Commission support owners who are willing and able to do so, to pull back services from the brink of closure avoiding the distress for residents associated with this - as well as the impact on the entire local safeguarding system that results.

Summary of the Finding
Different professionals with different powers go into residential and nursing homes to review either individual care, or the running of the establishment, with the consequence that, despite bringing this intelligence together, where providers have multiple care homes, risks across those homes are not certain to be picked up, and adults are left at potential risk.
Summary of the risks to the safeguarding system: Depending on the size of the provider, large numbers of residents can be left at risk if these connections are not made. Where owners are willing to do so, commissioners can help pull services back from the brink of closure, avoiding the distress for residents associated with this - as well as the impact on the entire local safeguarding system that results.
Questions and considerations for the Board • Given the presence of large care home providers in Sutton, do SAB members feel sufficiently sighted on the issues that arise when these providers struggle to provide safe care? • This review has indicated growing collaboration between the commissioners and the Care Quality Commission - can board members support the further development of this work in any way that will enhance strategic safeguarding? • How well do board members think that the routine sharing of concerns between commissioners and CQC works in Sutton?

When providers do suddenly close, how can local safeguarding systems best respond to the crisis?

Finding 3

Sutton, Surrey and Kingston use increasingly well-developed Provider Failure protocols, but at the point when failure occurs, there is no mechanism for making sure that sufficient messages are getting passed back - with implications for adults most at

risk of falling through the net of checklists, who may be left too long and moved too late.

How did the issue appear in this case?

At the time of the closures, Surrey County Council had a provider failure protocol, which has since been developed further, and London Borough of Sutton has subsequently developed one. Both fit with the safeguarding guidance from the Association of Directors of Adult Services (ADASS 2016) about out-of-area adult safeguarding arrangements. Despite having checklists to work to, unusual or unanticipated circumstances, by their very nature, fell outside the checklist actions. For example, the professional attending provider failure meetings organised by Sutton on behalf of one authority, Kingston did not report back to their organisation. Arrangements for Kingston residents were therefore made in some haste, although they left Grantley Court two days before its closure. The home-owner's uncooperative attitude also made it more difficult for professionals, and delayed and complicated their efforts to secure an accurate list of residents. This left self-funding residents potentially more vulnerable because it was a more complex task to identify them and their families than those residents who had been placed by local commissioners.

Why is it underlying and not only present in this case?

Sutton care homes have residents from nearby and further afield, and although Surrey and Kingston were the main partners to this particular review, other local authorities had residents placed in Grantley Court. This is replicated in all the care homes in the area. Surrey, Sutton and Kingston have all developed protocols, for example (Surrey 2015); (LB Sutton 2016) which recognise and respond to the issue of a local care home market that involves residents who are never exclusively from the local borough. The current Sutton checklist that is used alongside the Provider Failure protocol recognises this, with one of the actions on the checklist being to "Agree responsibility for assessing or reassessing residents' needs, including any self-funding or out of LA area residents (this could be LA or CCG)". Although it is less usual to have a situation where care providers cannot or will not give commissioners a list of service users, Grantley Court was not the only instance of this. One home care agency that was closed after enforcement action in the area recently was so poor that it did not even have one consistent list of service users.

How widespread and how prevalent is the issue?

Despite the development of protocols to respond to provider failure, the Review Team

outlined the difficulties in identifying the full range of commissioners who have placed residents with a provider. This can still be reliant on sending a message out across the London network of local authority adult safeguarding leads. During the review, Care Quality Commission colleagues explained that this is a also a task they can help with, by providing a list of where residents come from - it would appear that this offer is not well known amongst commissioners. In addition, whilst the review was under way, NHS England published *Managing Care Home Closures* (NHS England 2016), guidance endorsed by all the relevant professional national bodies and in recognition of the scale of stress that care home closure places on local systems.

Why does it matter?

Getting messages back to the full range of placing agencies, when there are safeguarding concerns at a care home, has a direct effect on their ability to respond and protect adults who are at risk. It also enables the identification of those residents who are self-funding, and any who are reluctant or unwilling to move and for whom there are additional risks as the majority of residents move out.

Summary of the Finding
Sutton, Surrey and Kingston use increasingly well-developed Provider Failure protocols, but at the point when failure occurs, there is no mechanism for making sure that sufficient messages are getting passed back - with implications for adults most at risk of falling through the net of checklists, who may be left too long and moved too late.
Summary of the risks Getting messages back to the full range of placing agencies, when there are safeguarding concerns at a care home, has a direct effect on their ability to respond and protect adults who are at risk.
Questions and considerations for the Board • How familiar are board members with the issues raised in this finding? Does it capture your local experience? • This review has been a good example of three safeguarding adults boards collaborating - looking to the future, could there be benefit in any more routine cross-board collaboration based on the findings of this review?

Finding 4

In Sutton, coordination of multi-agency networks at time of care home closure could be further developed, because current reliance on a small group of committed practitioners has the consequence that future closures might not be so well supported

How did the issue appear in this case?

The Case Group contained the 3 or 4 individuals who had found alternative placements and helped residents to move. They acknowledged that it had been stressful and had an impact on them. Their managers identified that there was an issue not just for wellbeing of these workers, but also that they had not created time for them to share their reflections and record them for the future. The workshop day brought these individuals, some of whom were from different organisations, together for the first time since they had helped move the residents out, and the chance to talk about the experience was clearly of value to some of them. In February 2015 there as was a 'mop up' meeting for Surrey and Sutton to reflect on the closure processes at the two nursing homes, involving the police, the local authorities, and Clinical Commissioning Groups. Surrey held an internal staff mop up also attended by the Care Quality Commission, and Sutton did not.

In addition, professionals in the services that received residents who were moved at short notice were affected by the condition in which the residents came to them. This was true of the staff at a resource centre in Kingston where three residents went, who were the last to leave Grantley Court.

There was also considerable learning from the experience - ranging from how to run an operations room (which Surrey did) to the detailed feedback from the social workers and placements officers who supported residents through the moves - some of this feedback has informed the checklist in the Surrey provider failure protocol and could help promote the dignity of frail care home residents in future situations - but it may not all have been written down for the future.

Why is it underlying and not only present in this case?

There have been subsequent examples across Sutton, Kingston and Surrey, of providers being at risk of closing suddenly.

How widespread and how prevalent is the issue?

Reason (2008) has written extensively about the 'human as a hero, as the single force that on a significant number of occasions has saved systems from disaster'. One of his conclusions is that the single most important contributing factor to what he terms 'heroic recovery' is having the right people in the right place, at the right time. However organisations need to move beyond this to achieve resilience in the way that was identified for local systems during this review.

Why does it matter?

Managers in the Review Team recognised that relying on a few individuals not only has an impact on those professionals in terms of stress, but also that organisational memory needs to be developed around the mechanics of responding to enforced care home closures, otherwise there is a risk that increasingly well developed protocols and procedures will not be matched by the ability to put them into practice.

Summary of the Finding
In Sutton, coordination of multi-agency networks at time of care home closure could be further developed, because current reliance on a small group of committed practitioners has the consequence that future closures might not be so well supported
Summary of the risks Organisational memory needs to be developed around the mechanics of responding to enforced care home closures, otherwise there is a risk that increasingly well developed protocols and procedures will not be matched by the ability to put them into practice
Questions and considerations for the Board • Does the issue of 'organisational memory' in safeguarding resonate with board members? • Has this finding outlined the issue in a way that is helpful for the board? • What could the Sutton SAB do to promote organisational resilience in readiness for any future situations that mirror that of the Grantley Court closure? • Is there anything more that the SAB could ask of member agencies in terms of support for professionals who carry out the complex and stressful safeguarding tasks that those involved in this review did?

Finding 5

There is a lack of clarity about what can be communicated to relatives and residents at a time of enforced care home closure with the consequence that a very stressful time is made more so, unnecessarily, and options insufficiently discussed.

How did this issue appear in the review?

In Sutton workers told the Review Team that they felt unable to say anything to relatives when the homes were at the point of closure, and lacked the guidance to enable them to address this. As a result they said nothing to some relatives, leaving them to read about it in the Daily Mail. One of the Review Team members from Sutton was of the view that the action by the Care Quality Commission over the county border in Surrey, at Merok Park, also caused difficulty. Sutton local authority staff, who were trying to identity new placements for Sutton residents placed in Merok Park were told that they could not say anything to families until the CQC served notice. The situation as they understood it, was that while matters were with the CQC's lawyers, all that the local inspector could do was indicate that closure was likely. One practitioner from the local authority felt this dilemma particularly keenly, as she was working directly with families. One family began to ask questions such as 'Why, if there's a safeguarding, weren't we told?'. The Care Quality Commission did not, in the instance of Merok Park, serve a letter of intent (to close).

The other complexity that surfaced during this review was that of self-funders - older residents who were assessed as having sufficient capital to pay for their own placements, and who had made their own arrangements to enter the two nursing homes. It was unclear whether the owner had written to relatives but the review suggests not.

For relatives, it felt like this:

Exactly a week before it closed – on a Tuesday- I went to the home as my mum was being assessed for CHC – continuing health care. The home manager was there for the assessment and talked to me afterwards. The CQC had been in the day before. He told me that they weren't happy with the home and that it was going to close.

In the next few days I saw two large skips outside the home and some chairs in it. They had plumbers from a water company on the Thursday and Friday the week before it closed on the Tuesday.

Nothing happened for a week. Why did they suddenly decide? It seemed that the care home was doing something substantial to improve but the decision to close was sudden. I was in contact with the guy from Sutton but he knew nothing. He said he might have to find accommodation for the Sutton clients.

And:

Another relative told the review that no one communicated with her, and she was 'ready to blow her top' as her initial feeling was anger, driven by huge worry about where her brother was. She thinks it took one or two days to find out where he was, and it turned out he had been walked along the street to a another nursing home - but no one from that home let her know where he was either. She has no complaints about either Grantley Court or the new home, but the suddenness of the closure and not knowing where her brother was, were distressing.

Why is it underlying and not only present in this case?

Review Team members were clear that the issue of communication is one they grapple with in every care provider closure - "We don't have the equivalent of a Gold Command for care home closure" (a reference to the agreed national framework for managing the local multi-agency response to, and recovery from, emergencies). Once again, needing a particular response tailored to self-funders was cited as something that recurred. One practitioner described more recent difficulties following the closure of a home care agency, where she had to put notes through neighbours' doors in relation to some of the service users in an attempt not just to identify family members, but also to open up communication with them. Currently the Care Quality Commission do send a letter of intent to providers when they intend to take urgent action. They copy this letter to the local authority and NHS Clinical Commissioning Group, but not to relatives. Whether the CQC then take urgent action or not will depend on the response from providers to the letter of intent. There are occasions where the CQC have had joint meetings with the local authority to talk to relatives to explain the closure of services. The CQC position on this is to be open, and to advise commissioners in the instances when inspectors' concerns about a service have reached the point where the Commission is applying to a magistrate to issue a notice

to cancel the registration of a provider. The final decision is made by the magistrate - and the intention of inspectors is to let commissioners know a decision as soon as they themselves know it. Experiences referred to during this review suggested that the point where confusion arises, as in this case, is over who will say what to families, rather than in the communication between professionals that goes before.

How widespread and prevalent is the issue?

A Guardian journalist in 2015 (Hardy 2015) reported on the impact of a sudden care home closure in Bedfordshire, and the difficulties of coordination because of the range of organisations who had originally placed residents.

Greg Jeffreys, from Bedfordshire, has seen first-hand what happens when a care home closes suddenly. His aunt Anne Jeffreys, 88, had been a resident of the Old Village School Nursing Home in Bedfordshire for just over a year when it was forced to close this August after regulator the Care Quality Commission (CQC) found it to be inadequate and unsafe); the report states: "People were at serious risk of harm."
The first Jeffreys heard of the closure was when he got a phone call from Merton clinical commissioning group, which arranged his aunt's care, around two days before the home closed. He was shocked: "Going in on a daily basis I'd seen no indication that there was any particular issue with her care."

Why does it matter?

Without clear information to communicate to family members about the future of care provision, professionals are unable to have transparent discussions that enable the most appropriate alternative plans to be made for older residents. It also means time is lost which could be spent identifying placements. It also allows unscrupulous providers to get their own messages out to relatives causing those relatives to feel confused and also question the motivation behind decisions to close a provider down.

Summary of the Finding
There is a lack of clarity about what can be communicated to relatives and residents at a time of enforced care home closure with the consequence that a very stressful time is made more so, unnecessarily, and options insufficiently discussed
Summary of the risks Without clear information to communicate to family members about the future of care provision, professionals are unable to have transparent discussions that enable the

most appropriate alternative plans to be made for older residents. It also means time is lost which could be spent identifying placements.
Questions and considerations for the Board • How much of a surprise is it to board members that information sharing with relatives was the cause of the levels of stress described in the report? • How much clarity is there now, and understanding between the Care Quality Commission and other partners around the Sutton SAB, about what the CQC can share at different phases of the enforcement process, and what it is acceptable for others to pass on? • Is there any transferable learning that board members can see from existing information sharing that works well in Sutton that could assist with this multiagency issue?

Conclusions

1. What gets in the way of commissioners and regulators in Sutton and the surrounding areas identifying providers who are failing to give safe care, sharing their intelligence and acting together before a point of sudden closure is reached?

Based on the material gathered during this review, commissioners and regulators are becoming increasingly collaborative, and were able to cite several instances of preventing providers from sudden closure whilst improving care. The new local panel - the Joint Intelligence Group - has had a role in pulling together 'soft' intelligence - for example around sudden spikes in admissions to the local hospital from particular care homes - however its effectiveness and impact over time is yet to be measured.

Commissioners need the intelligence that relatives of frail care home residents can provide. Not seeking it out carries the risk that failing providers could have been identified earlier. Assumptions that relatives will routinely raise concerns were explored during this review, and there is recognition in Sutton, Surrey and Kingston that relatives do not routinely know what good care looks like. Surrey County Council and the Care Quality Commission produce information about this, but the concept relies on dialogue. Work with relatives to think about Deprivation of Liberty safeguards was seen as a tool, currently underused, that could support that dialogue.

2. What can be put in place to reduce the likelihood of such situations occurring in the future?

Each of the three local authorities in this case had protocols, some developed more recently than others, but which provide a framework, based on the experience of managing these situations. The experiences of practitioners are not necessarily recorded though, and their learning from this case needs to be written down, and to form part of the local protocols.

Protocols are useful but it is relationships between commissioners, regulators, providers and the adults at risk and their relatives, which are most important in reducing the likelihood of such situations occurring in the future. The Safeguarding Adults Board is one place where the strength of such relationships can be explored.

3. When providers do suddenly close, how can local safeguarding systems best respond to the crisis?

Once closure became a certainty, what mattered most to the relatives of those at the centre of this review were consistent and timely communications. One of the relatives, quoted earlier on in this report, read about the moves in the national press, and spent 24 hours in increasing anxiety, trying to track down her sibling. Although there has been steady work locally to develop protocols for supporting providers who are at risk of sudden closure, the Review Team were not confidently able to cite local communications protocols to add detail to the broader 'provider failure' manuals. Review Team and practitioners alike identified a single point of contact for relatives as essential, should a similar situation arise.

The dedicated and skilled professional who were involved with Grantley Court from the summer of 2014 built relationships with residents and their families which enabled them to understand their needs whilst working at great speed and under pressure. They were hindered though by a lack of clarity about what they could say to relatives about the plans for the home, and this added to their stress, mirroring the effect that this lack of communication had on relatives and residents. It is still unclear what can be shared, and if this review can lead to greater clarity, that would be another important factor in minimising distress and risk should a similar situation be repeated.

Documents provided to the Lead Reviewer and used for this report:

Summary of police investigation - Sutton Borough Command

Root Cause Analysis of internal actions - Care Quality Commission

Briefing note for the SAR - London Borough of Sutton

Chronology - London Borough of Sutton

Presentation material including learning and actions - Surrey County Council

Community And Care Home Provider Closure Protocol 2013 Version 22 - 02.08.13 - Surrey County Council

Joint Community And Care Home Provider And Service Failure Protocol October 2015 - Surrey County Council

References

Association of Directors of Adult Social Services (2016) *Out of Area Safeguarding Adults Arrangements*

Care Quality Commission (2014) Inspection carried out on 13 January 2014- Grantley Court - CQC website, 18th September 2014

Care Quality Commission (2015) *Inspection carried out on 8, 11, 30 September 2014* - Grantley Court - CQC website, 18th June 2015

Care Quality Commission (2015) *Grantley Court Nursing Home: Update* - CQC website 15th January 2015

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

Hardy, R (2015) *Softening the blow for residents when a care home closes,* The Guardian online, 27th November 2015

Holder J, Jolley D (2012) *Forced relocation between nursing homes: residents' health outcomes and potential moderators*, *Reviews in Clinical Gerontology*, 22, 301-319

London Borough of Sutton (2016) *Provider Failure: Business Continuity Plan (draft)*

NHS England (2016) *Managing Care Home Closures*

Reason, J (2008), *The Human Contribution,* Routledge, Abingdon

Relatives and Residents' Association - website relres.org

Royal Borough of Kingston (2016) *statement position,* Royal Borough of Kingston

SCIE (2015) *Safeguarding Adults' Reviews under the Care Act: implementation support;* Social Care Institute for Excellence, London