Orchid View

Serious Case Review

June 2014

WEST SUSSEX
ADULTS
SAFEGUARDING
BOARD

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Acknowledgements

I want to record my thanks to the relatives of residents of Orchid View. I am grateful for the time they gave me. It was very helpful to meet them and to hear directly about what their relatives experienced in the home. This was not always easy for relatives who told me about the poor treatment and standards of care their relatives had endured. A former resident at Orchid View also agreed to give her views about her experience at the home and I am grateful for this personal perspective.

In compiling the Findings and Recommendations from this Serious Case Review, I have attempted to frame and respond to the questions raised by relatives in the considerations of the review.

The West Sussex Senior Coroner shared information with me from the outset of this review, and I am very appreciative of the availability of this material and for her time as this work progressed.

I have asked a lot of the Serious Case Review panel who contributed openly and fully to this review. This positive approach from the range of agencies involved in West Sussex will now need to be sustained as the West Sussex Adults Safeguarding Board takes forward actions to implement the recommendations in this review.

Nick Georgiou
Independent Chair of the Serious Case Review Panel
June 2014

Executive summary

1 Orchid View was a nursing home owned and managed by Southern Cross Healthcare. It was registered with the Care Quality Commission (CQC) as a care home with nursing to accommodate up to 87 people in the categories of old age and dementia.

2 Orchid View opened in November 2009 and was closed by Southern Cross Healthcare in October 2011. While it was open there were a number of safeguarding alerts and investigations, including the deployment within the home from August 2011 of a team of health and social care staff to mitigate the poor quality of care, leadership and management within the home and provided by Southern Cross Healthcare at regional and national levels.

3 Following an anonymous alert to the police in August 2011, there was sustained police involvement in the safeguarding investigations and in the pursuit of possible criminal offences. Five members of staff were arrested and questioned but in the event the Crown Prosecution Service (CPS) determined that there was insufficient evidence to pursue criminal charges. An inquest was concluded in October 2013 when the Senior Coroner found that five people had "died from natural causes attributed to by neglect" and that several other people "died as a result of natural causes" with "insufficient evidence before me to show that this suboptimal care was directly causative" of their deaths. It is also the case that this suboptimal care caused distress, poor care and discomfort to residents and the families of people who were not the subject of the Inquest.

4 Since the closure of Orchid View and the inquest, the Department of Health and the CQC have published a number of consultation documents, some of which are a direct follow on from the Francis Report into care at The Mid Staffordshire NHS Foundation Trust published in February 2013. These documents are referred to throughout this Serious Case Review and a significant feature they have in common is to extend actions identified in the Francis Report into the wider sphere of service providers beyond the NHS.

5 These developments are very welcome and reflect the reality that increasingly we, as a society, are entrusting the care of vulnerable people to independent sector organisations. So, just as in the NHS, it is necessary to strengthen quality, governance and financial monitoring, it is necessary to do so with independent organisations, be they "not for profit" trusts and charities or commercial businesses such as Southern Cross Healthcare.

6 This Serious Case Review (SCR) was commissioned by the West Sussex Adults Safeguarding Board (WSASB) and commenced work in October 2013. It has focused on safeguarding in line with its terms of reference. The range of considerations that inform these findings and recommendations are set out throughout the report, however, they are presented here in relation to the questions raised by relatives. By their nature, some of these findings and recommendations go beyond any particular question area, and where this is the case the recommendation has been located in relation to the question that it is most relevant to.

7 The questions raised by relatives have been synthesised into the following four questions and the recommendations are set out in relation to each of the questions.

Question 1
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 from the public purse?

Question 2
How can people be confident that they or their relative will be safe and well cared for?

Question 3
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?

Question 4
How can organisations and individual professionals be held accountable for the safety, quality and practice in their services?

8 Orchid View was a regulated service, and as such was subject to a regulatory framework, specific requirements in line with that framework and inspection by the CQC. We know from the CQC's own assessment and the work of this SCR that this was inadequate at Orchid View.

9 The CQC has recognised this and is publishing its own internal review in June 2014: Investigation Report. Southern Cross, Orchid View September 2009 – October 2011: An analysis of the CQC's responses to events at Orchid View identifying the key lessons for the commission and outlining its actions taken or planned.

10 At some point all services are likely to have safeguarding concerns that need to be investigated. A safeguarding alert does not of itself mean that a service is poor. It is though a serious event and there is an onus on the service provider to treat it as such and to remedy the concern. A sign of a good service is how they rectify things that go wrong. What happened at Orchid View was more an avoidance of positive action to rectify problems, and a series of ineffectual action plans that were not acted on.

Findings and recommendations
There are numerous considerations within the body of this report. The recommendations set out below are intended to promote strengthened scrutiny of organisations and the services they provide. These recommendations all relate to specific concerns at Orchid View or to how businesses, increasingly important in providing health and social care, are managed and regulated. A number of them might seem very obvious. However, the experience of looking in detail in what happened in this care setting does mean that they are necessary. The numbering of the recommendations is as they appear in the body of the report together with a reference to their location within the report.

Question 1

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 from the public purse?**

Recommendations relating to the governance and scrutiny of care service providers

During the timescale of this SCR the Department of Health has issued consultation documents in regard to independent sector organisations having a Duty of Candour, and to Fit and Proper Person scrutiny for senior appointments. These developments are very positive and are discussed in the body of the report. Similarly, the CQC has issued its consultation documents on its extended powers. In addition, the anticipated Care Act in 2015 should provide an improved framework promoting better governance and scrutiny of independent sector service providers. As these new arrangements are being promoted, no specific recommendations are made in this SCR.

The recommendation below relates to the increasingly important role that independent sector nursing homes have in providing health care. They are however currently explicitly exempted from the NHS Provider Licence requirements of NHS organisations. The government has committed to a review of how well this exemption is working in 2016/17 and the recommendation seeks specific consideration of this issue in the general review. It is not appropriate to apply this requirement on small homes but does propose that it applies to large businesses with a turnover in excess of £10m annually which is equivalent to the requirement on NHS Trusts.

Recommendation 7 (SEE 6.22)
That in its review of how the exemptions regime is working the Department of Health specifically considers the possible extension of the provider licence to care homes owned and managed by large national businesses with a turnover, from all sources, in excess of £10m.

*****

This recommendation is drawn from the experience of the CQC when the quality

of their inspections was adversely affected because of the heavy load placed on them to re-register some 25,000 homes in line with new legislation. It is essential that when such an additional burden is placed on an organisation it is resourced and managed to carry out its ordinary responsibilities while dealing with its new or extended remit at the same time.

Recommendation 8 (SEE 7.19)
That where large scale reorganisation and the introduction of additional responsibilities to meet legislative change is being implemented, it is imperative that an impact assessment is undertaken to ensure the organisation maintains the ability to carry out their routine responsibilities while at the same time implementing the reorganisation.

*****

Recommendations relating to the service provider's responsibility to ensure a competent and well managed workforce

When Orchid View was in development and on its opening there was inadequate development of a workforce strategy or consideration given to recruitment, support and development of staff competent to deliver the care required.

This recommendation recognises that it can be difficult to recruit staff, particularly in areas where there are other employment options, as is the case in this part of West Sussex. Health and social care businesses are dependent on a good and skilled workforce and need to evidence that they have robust arrangements in place to secure such a workforce. There is no indication that Southern Cross Healthcare implemented an effective workforce recruitment and development strategy.

The Cavendish Report,[1] promoting improved training and status for health and social care assistants, is strongly supported by this SCR and provides a way forward, nationally, with its implementation. Additionally it is important that care businesses can evidence and deliver effective workforce recruitment, training and support.

Recommendation 6 (SEE 6.17)
That care businesses in development and currently trading, can evidence robust plans to recruit and sustain a trained workforce to meet the needs of those people dependent on the care they as individuals, or the statutory sector, purchase to meet their needs. Delivery of this requirement should be monitored by the CQC.

*****

There was too much tolerance given to Orchid View as they operated without a registered manager for most of the time they were open. It is understood that this requirement is being enforced more rigorously now in West Sussex by the CQC and is identified in the CQC consultation documents as a requirement they will enforce more strongly. This SCR supports such action and also that information about the absence of a registered manager is publicised on the CQC website,

Recommendation 10 (SEE 7.31)
That where there is no registered manager in place this information is made public by the CQC on its website.

*****

Management and leadership of the service was inconsistent and weak. These recommendations relate to the responsibilities carried by a service provider and their registered manager for the staff group. An essential element of this is a responsibility for the performance and competence of staff, qualified and unqualified within their team. As such they should be explicitly required to demonstrate managerial as well as clinical competence to carry out this

[1] The Cavendish Report, An independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, July 2013, published as a follow up to the Francis Report

responsibility, showing qualities of leadership and compassion.

These recommendations relate to the importance of established professional development opportunities and that the regulator satisfies itself that these are actually being delivered and are not just a paper exercise.

Recommendation 5 (SEE 4.1.39)
Recognising the increased potential for nursing staff to work in more isolated settings, providers of nursing home care should provide and facilitate the continuing professional development of their staff. Information about the training undertaken should be provided to the CQC and local commissioners.

Recommendation 29 (SEE 10.10)
That service providers are required to demonstrate to the CQC that they have established training, supervision and appraisal processes for their staff, both qualified and unqualified, and that the regulator spot checks training records – with the necessary agreements as required.

This recommendation is made as it was remarked on that for a number of staff there were some language difficulties as English was not their first language. It is not evident that Southern Cross Healthcare sought to provide support and training to help these staff to improve their communication skills. Difficulties in communication would have impeded the relationships with residents, with relatives and potentially with other members of staff. It may also have impeded their understanding of procedures and access to information with the result that it could have been detrimental to the overall quality of the service. This should have been factored into both induction and continuing training for care staff individually and as a group in the home.

Recommendation 30 (SEE 10.14)
Where there are specific needs to be addressed among care staff such as in cultural understanding, communication and language difficulties, there are evidenced processes to mitigate any possible diminution in the quality of care offered as these needs are addressed.

*****

This recommendation relates to concerns in regard to the thoroughness with which Southern Cross Healthcare checked the qualifications of nursing staff they recruited. This related to a particular nurse and while it cannot be ascertained if they had a particular failing in this regard, it does prompt a specific recommendation that is essentially stating the obvious, but this experience suggests it is nonetheless necessary.

Recommendation 28 (SEE 10.8)
That stringent checks are carried out by the employer to be confident that staff do have the qualifications they claim and that where appropriate their professional registration is current. In the case of professionally registered staff this will include obtaining the person's registration PIN.

*****

At Orchid View it would seem that some residents were admitted from hospital to the home who were inadequately assessed by Orchid View staff prior to their acceptance and admission. Accepting people who are at the margin of the home's competence and capacity will have a detrimental impact on existing residents as well as the person being assessed. Nursing homes must be competently staffed and managed to be able to provide care to people with significant needs in line with their CQC conditions of registration. They are becoming increasingly important as care providers for people with significant healthcare and nursing care needs, so it is critically important that they have levels of competence to enable them to deliver care in line with their registration criteria.

Given the increasing pressure across the whole health and social care system this will become increasingly important. This

SCR therefore recommends that the CQC explicitly includes in its inspections the quality, inclusivity and timeliness of pre-admission assessment by the responsible registered home.

Recommendation 2 (SEE 4.1.25)
That the process, timeliness and quality of pre-admission assessment from hospital settings is explicitly tested within the CQC inspection process with an emphasis on the staffing levels and skills within the home to deliver safe and good quality care within the home's conditions of registration.

*****

This recommendation relates to the importance of staff knowing and acting on existing policies and procedures so that they are in use on a daily basis and not just left on the shelf. This particular illustration is in regard to taking timely action when there is a death in the setting, but can be interpreted more widely.

Recommendation 3 SEE 4.1.35)
That all service providers are required to ensure that their induction of new employees and the continuing training of staff includes clear guidance on the necessary procedures and actions where a death occurs, be it an expected or unexpected death.

*****

Recommendation relating to the CQC's engagement with relatives of people using care services

At present there is little scope for relatives of people in care homes to be involved in CQC inspections. This recommendation is to extend the inspection process to involve relatives, or residents' advocates as necessary, to include the offer of face to face meetings with relatives

Recommendation 9 (SEE 7.24)
That as the CQC develops its inspection framework and process, specific attention is given to invite and include discussion with the relatives of residents, and offers the opportunity of private discussion with a member of the inspection team.

Question 2

How can people be confident that they or their relative will be safe and well cared for?

These recommendations relate to a number of practice and process issues that will improve safeguarding work in the future

Recommendations to improve safeguarding processes

The quality of care plans at Orchid View was very poor. They did not contribute to the care needed for that person, or identify anything personal to the individual. Additionally they were often out of date and did not contain core information necessary to provide good quality and safe care for the person.

Recommendation 1 (SEE 4.1.17)
That all care homes with nursing ensure that Care Plans contain the name of the responsible nurse for the resident and that the resident and their relatives or advocate know the name and contact arrangements for this member of staff.

*****

This recommendation relates to the difficulty reported by emergency services on getting a response often experienced at night when they have been called out to a residential home.

Recommendation 4 (SEE 4.1.35)
That care homes are required to provide contact details, e.g. a named person, contact phone number that will be answered, method of entry, etc. to the emergency services when they contact them, especially important at night, to enable access to the home without delay.

*****

Individual safeguarding cases were investigated and although themes were identified at Orchid View, information from all agencies was not consistently gathered in all cases. It is important that emerging themes are identified and shared with relevant agencies so that they all have as full a picture as possible as they deal individually and jointly with individual cases. The new information system being introduced should provide the potential for improved awareness and coordination of information in regard to services commissioned locally.

There is no overarching information system across all the agencies established in any part of England so this is not an issue unique to West Sussex. There is however a positive approach to improving access and sharing of information across agencies and further work is necessary to ensure that access and sharing arrangements are as open and full as can be managed.

Recommendation 11 (SEE 8.1.11)
WSCC and partner agencies should review the current processes and systems available for collating information relevant to safeguarding, in order to identify emerging patterns or concerns. This should include analysis of the impact and effectiveness of action plans over time where a number of investigations have been required in relation to the same provider service.

*****

It is difficult to track patterns of deaths in particular settings. The Coroner's Officer does have information that could be used to identify concerning patterns and unusually high numbers of deaths linked to individual homes and services. This is retrospective information relating to deaths that have occurred but it might be possible to identify patterns from this data, which could be referred onto the police. At present this happens with information conveyed informally. Such information should be conveyed more formally using the formal police crime and intelligence systems.

Recommendation 17 (SEE 8.3.10)
Concerns raised by Coroner's Officers about possible patterns or high numbers of deaths linked to individual services or organisations are reported to the police using the formal police crime and intelligence systems. Any new safeguarding concerns are alerted directly to adult social care.

*****

Both WSCC Adult Services and the primary care practice GPs identified that information and working together in safeguarding investigations could be improved. In this case there was notification and involvement, particularly with the practice nurse, but nationally the input and involvement of GPs in safeguarding investigations is patchy.

Continuing dialogue, joint learning and information sharing events are important in fostering the improved understanding of the respective roles, responsibilities and procedures desired. Additionally, given the increasing pressure that practitioners in all aspects of health and social care experience, the availability of key information and support at key times sharing intelligence and working collaboratively is critical.

Recommendation 15 (SEE 8.2.15)
That discussions are progressed between the WSASB and the NHS England Area Team and local CCGs to develop information sharing and involvement of primary care practices in safeguarding work.

*****

Although it was not an issue in this case there is a recent evidence review about partnership working between GPs, care home residents and care homes. This describes a tapestry of relationships and arrangements nationally and as an evidence review does provide helpful information about areas of contact, positive and negative, that suggest there is no one way of primary care and residential settings working together. It is a matter for local development but within a clear national framework drawing down on best practice. It is particularly important, as GPs take on the specific responsibility of named accountability for people aged 75 and over, that there is a clarity of expectations in regard to working with nursing homes in their practice area. This is a national issue that prompts the following recommendation.

Recommendation 13 (SEE 8.2.6)
That NHS England ensures that GPs are provided with clear guidance about their responsibilities in regard to care homes in their practice area as provided for within the General Medical Services contract.

*****

Informed by their experience with Orchid View, the local primary care practice has developed a model of engagement with local care homes and with individual residents that could be shared with other practices.

Recommendation 14 (SEE 8.2.11)
That this good practice in providing personalised healthcare is promoted by the local CCG/NHS England encouraging primary care practices across the UK to adopt such positive engagement by local GPs with residents and staff in their local home(s).

*****

When such large scale investigations are necessary it is important to recognise the very significant additional strain this causes to services already under pressure and the importance of providing good emotional and practical support to those staff directly involved. This was done in West Sussex by the health and social care teams in this case and this is an experience that could be positively shared with other safeguarding boards.

Recommendation 12 (SEE 8.1.31)
That the WSASB make available information to safeguarding boards across the UK about their approach, experience and learning points from the work carried out within Orchid View by the joint health and social care team.

*****

The South East Coast Ambulance Service (SECAmb) attended Orchid View 153 times, with many of these contacts for straightforward hospital transport requests, 54 of the contacts were 999 calls. This is not considered to be a high level of contact given the frailty of many of the residents. It would have been helpful for SECAmb to have been aware of the volume of safeguarding investigations at the home to help them have a fuller understanding of the circumstances there. This approach would be positive with other emergency services and so is extended beyond the ambulance service.

Recommendation 16 (SEE 8.2.25)
WSASB to establish as part of its process that the emergency services are notified of all Level 3 and 4 safeguarding investigations within their catchment area. This has a dual purpose: firstly they can be asked for information as part of the investigation and secondly that the concern can be flagged and the information accessible to staff from the emergency services.

*****

Two recommendations are made in relation to the pharmacy service at the home. The pharmacist who visited Orchid View on Pharmacy Advisory Visits had checked a recent CQC inspection and understood that the CQC had concerns about the home. When she visited and experienced very poor standards she did not refer this as a safeguarding alert because her understanding was that the CQC were dealing with the home. In the event this did not affect the care provided after her visit because the alert to the police followed shortly afterwards. But the information would have reinforced the concerns about the home, and underscores the importance of raising safeguarding concerns.

Recommendation 18 (SEE 8.5.6)
That WSASB and the Royal Pharmaceutical Society reinforce with all pharmacies the importance of raising an alert in circumstances where there is an immediate concern with regard to the safe management and administration of medication, even if there is a belief that the issue has been identified by the CQC.

*****

Orchid View did not adhere to the contractual arrangements in place in regard to its medication management and its practice was very poor. It is clearly the responsibility of the home to ensure that it has good medicine storage, administration of the management and ordering systems in place. However, the regulator and commissioners do need to be alert to this important dimension of the home's management and practice.

Recommendation 19 (SEE 8.5.6)
That care commissioners and the CQC check that contractual arrangements are in place between nursing homes and pharmacists and that these arrangements are being adhered to.

*****

There was a significant cost to the public in providing the necessary health and social care direct input into the home because of the poor quality of Southern Cross Healthcare's regional and home management. In the final settlement with Southern Cross Healthcare's Administrator, the local authority made payment of some £61,000, part of the sum that it had withheld while the home was open because of the safeguarding concerns and the suspension of placements in the home for a period. However, in the event the local authority did not have a sustainable case legally for withholding this payment to the Administrator. While appreciating that contractual terms will be difficult to formulate, greater protection of public resources is desirable and a review of the contractual terms is recommended.

Recommendation 20 (SEE 8.7.17)
That commissioners of health and social care services review their contracts to ensure that they have robust contractual clauses to protect the public purse against claims from organisations that do not deliver the quality of care stipulated in the contract.

Question 3

What support and information is available to residents and their relatives? How do they know about it and are they able to use it if there are concerns about the service?

The unfortunate reality for people going into nursing home care without the support of the NHS or local authority is that though they might find limited and possibly partial, information about the home, they are unlikely to be well enough informed about what to look for in the care setting. They will also most probably be making the decision under pressure.

These recommendations will go some way to addressing this and enable people to make better more informed choices.

With the explicit requirement in the Care Bill on local authorities to take responsibility for people who pay for their own care, in the event of the service provider going out of business, it is critically important that local authorities know of privately paying residents in care homes. It has not always been easy for the local authority to gain this information and it certainly was not at Orchid View. This recommendation is to require service providers to share such information with their relevant local authority.

Recommendation 21 (SEE 9.5)
That the CQC develops guidance to service providers in consultation with their national organisation and local authorities about information to be shared with commissioners regarding people who pay for their own care.

*****

One of the issues raised by relatives was having to make crucial decisions with insufficient information and support at key times. Some of these concerns are addressed in relation to the safeguarding recommendations.

There is general information available to the public about what to look for when choosing a care home, local service directories where local homes are advertised and improved information in, for example, NHS Choices and from the independent sector with the progressive development of the "Your Care Rating" survey.

However the reality is that full information is not shared with the public where there are concerns about specific homes. In part this is understandable because it would not be appropriate to publicise all levels of safeguarding concerns, as some may be unsubstantiated and there is a balance to be achieved in order to promote positive safeguarding reporting. Local authorities are inhibited from sharing their concerns about the quality and specific worries with the public, and with individuals who are considering the particular home because they are worried that they may face a legal challenge from the service provider that they have damaged their business by what they have said about that business.

This is unsatisfactory and provides unwarranted protection to poor quality service providers. Local authorities and NHS commissioners are responsible and impartial bodies. In line with their increased responsibilities in the Care Bill to promote improved information and advice, and linked with the Duty of Candour,[2] they need to more confidently develop guidance to social work and commissioning staff enabling them to share their knowledge about the suitability of a setting, in measured terms, to prospective residents and their relatives. This would complement the improved information on the CQC website.

[2] Department of Health Introducing the Statutory Duty of Candour, A consultation on proposals to introduce a new CQC registration regulation, March 2014

Recommendation 24 (SEE 9.19)
Local authority and NHS commissioners share impartial information about concerns in services with existing and prospective residents and their families. This will support people to make informed decisions about the suitability of the service to meet their needs.

When safeguarding investigations were taking place at Orchid View, potential residents were not aware of these concerns. It should be possible to share information about safeguarding investigations in a considered way and when the concerns are at a significant level that will promote more informed decision making by prospective residents and make current residents and their relatives more aware of issues within the home. It would be counter productive to share information about all levels of safeguarding concerns and there would also be issues of confidentiality to manage. However, developing a protocol and process for information sharing would be beneficial and this recommendation is intended to promote this development.

Recommendation 25 (SEE 9.22)
That the WSASB develop a threshold for informing the public about significant safeguarding concerns, and a means of making the public aware that they can access this information.

*****

The information on the CQC website describing Orchid View as “Good” was available for some 18 months. This was misleading.There are issues in relation to information being current, which the CQC is addressing, and also in regard to its accessibility. Information on websites, be they CQC or local authority, can only be accessed by people who know to look on the website. In time, such information can be expected to be made publicly available through an App. Perhaps now is the time for the CQC to take on this development as it changes its approach and with the introduction of the Care Bill.

Recommendation 22 (SEE 9.17)
That the CQC pursues the development of an information App that provides up to date information about care services that proactively enables public awareness of services they might be using or be interested in using.

In West Sussex an electronic Care Directory is being developed that gives the local authority a similar opportunity to develop immediately accessible information in the form of an App that could inform people of concerns, as well as flag up homes where there might be vacancies.

Recommendation 23 (SEE 9.18)
That WSCC pursues the development of an information App as part of the development of the electronic Care Directory.

*****

Relatives considered that there was no obvious setting where their concerns might have been raised, or indeed a forum where it might have been possible to talk with other relatives who might have been experiencing similar concerns. Nor did they have confidence that if there had been such a forum they could express concerns without possible negative implications for their relative. This recommendation, including sharing the minutes of such open sessions with local commissioners, is intended to provide such a setting and for the commissioners to also be aware of any issues of concern and topics under discussion.

Recommendation 26 (SEE 9.23)
Care providers should be contractually required to hold open meetings with residents and their relatives on a regular basis to discuss issues of general concern and to make relatives aware of any significant safeguarding concerns in their home. The local authority should be notified of such meetings and able to attend, with minutes from them shared with commissioners.

*****

Relatives expressed concern that there was little information on display in the public areas at Orchid View in relation to how they might complain or who to express concerns to other than the care provider. A stronger contractual requirement on homes to display and promote neutral agencies such as the local Healthwatch as a means for taking up concerns without having to go through the home's management structure would also be a positive development. As would better contact information in regard to the CQC and the organisation's own complaint process.

Recommendation 27 (SEE 9.24)
Care homes to be required as part of their contractual terms, to display in prominent communal areas their complaint process, as well as guidance to neutral agencies such as local Healthwatch to facilitate relatives' and residents' ability to raise concerns, minimising any anxiety about the possible consequence to the resident.

Question 4

How can organisations and individual professionals be held accountable for the safety, quality and practice in their services?

There was considerable frustration that no individuals or Southern Cross Healthcare were held accountable for what happened at Orchid View. To some measure the proposals in the consultation documents on a Fit and Proper Person test, on introducing a Duty of Candour and extending the definition of Wilful Neglect coupled with the CQC's stronger powers, will have a positive impact and introduce greater accountability. These are all to be welcomed and no specific recommendations are therefore made in this SCR in these areas.

There are however other recommendations relating to improved accountability.

Southern Cross Healthcare were requested to refer identified staff to the Nursing and Midwifery Council because of issues that were identified in the safeguarding work, but it does not appear that the referrals were made in a timely way and in the case of one nurse the time delay was such that he had left the country before any action could be taken. The performance of service providers in making, or as in this case not making such referrals needs to be monitored.

Recommendation 31 (SEE 11.6)
As part of its regulatory role the CQC should require information from service providers on all referrals made to the Nursing and Midwifery Council (NMC) and the Disclosure and Barring Service. This information to include the person's PIN where applicable.

*****

It is important that there is a stronger understanding by Safeguarding Boards of the regulatory framework for nurses in care homes and also that the NMC understands the nature of safeguarding in independent sector service provision. To facilitate this it is proposed that WSASB takes this forward drawing on the experience from this situation at Orchid View.

Recommendation 32 (SEE 11.7)
The WSASB to take forward discussion with the NMC to explore learning from this situation that is more generally applicable in respect of nurses working in independent sector settings in both practice and managerial positions.

*****

In discussion with the CPS it was recognised that safeguarding cases such as these require the development of better understanding and processes within the CPS. There is a willingness at the CPS to gain greater understanding that can strengthen consideration of possible prosecution of offences relating to safeguarding and neglect. To support this development within the CPS these two recommendations are made.

Recommendation 33 (SEE 11.19)
That the CPS commissions learning events/awareness training in relation to the types of situations that prompt safeguarding concerns and the potential for criminal activities with regard to ill-treatment or wilful neglect.

Recommendation 34 (SEE 11.19)
That the CPS should obtain expert advice when considering possible offences relating to neglect and safeguarding, to better understand the expected practices and procedures of care settings.

1. Introduction

Orchid View

1.1 In its response to the Francis Report[3] into the care at the Mid Staffordshire NHS Foundation Trust the Government identified five main areas covered by the 290 recommendations. These were:

- Compassion and Care
- Values and standards
- Openness and transparency
- Leadership
- Information.

The headings used in the government response to the Francis Report are just as pertinent at Orchid View with failings in all of these same areas. This was a care home with nursing not a hospital setting, but a number of the people dependent on the care they received in the home were as dependent as many hospital patients.

1.2 Over the past few months, various reports and proposals that have emanated from the Francis Report have been produced.[4] These are to be welcomed and have been incorporated here because they are at least as significant in independent sector health and social care settings as they are in the NHS. In this SCR, rather than repeat the actions and recommendations contained in these reports, they have been referenced in the text and reflected in the recommendations.

1.3 The implementation of the Care Bill[5] should facilitate achieving the objectives contained in the recommendations in this report. It is also the case that the Care Quality Commission (CQC)[6] has published its plans for more proactive inspection in the future in its recent consultation documents.[7]

1.4 The onus now is on the independent sector – working with the CQC and local authority and NHS commissioners – to ensure that the services they provide live up to the expectations of their residents and their relatives. That they have learned from what happened at Orchid View and with Southern Cross Healthcare, and that their organisations are well managed at all levels to meet the needs that they can be expected to play an increasingly large part in delivering.

1.5 Orchid View was a particular nursing home[8] owned and managed by Southern Cross Healthcare. Where issues are considered in this report and go from the particular to the general it does so in relation to issues that may be pertinent to other agencies and their homes; to the regulatory framework within which all relevant homes operate; and in regard to good quality safeguarding practice applicable to all.

1.6 Where there is extrapolation from the events in Orchid View to care homes in general this does not imply that the same poor practices and care is prevalent across all nursing homes.

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[3] The Francis Report: The Mid Staffordshire NHS Foundation Trust Public Inquiry, published February 2013.
[4] Consultation documents referenced in this report: Cavendish Report; Wilful Neglect; Duty of Candour; Fit and Proper Person.
[5] Care Bill anticipated date of enactment April 2015.
[6] Care Quality Commission regulates and inspects health and social care services including care homes with nursing.
[7] Several CQC publications in April 2014, most relevantly in relation to Adult Social Care summarised in Overview to the Provider Handbook for Adult Social Care April. 2014, and in more detail in the Chief Inspector of Adult Social Care Regulatory Impact Assessment: Changes to the way we regulate and inspect adult social care.
[8] Please note that throughout this report the term 'nursing home' is used for convenience to refer to Orchid View though it's actual CQC registration category was as a care home with nursing.

Available information when choosing a care home

1.7 The usual circumstance when a person or their family is looking for residential care for themselves or for a relative is that they do so in a situation when they are pressured because of the position they or their loved one is in. It might be that they have suffered a traumatic illness or event such as a fall and been admitted to hospital, or it might be that their carer, often their elderly partner, has died or is otherwise unable to continue to cope. Whatever the particular circumstance, the common feature is often of great anxiety and a lack of knowledge about what sort of care might be available, what might be best for them, what it will cost and how they can obtain it.

1.8 At this time it is critically important that people know where they can go to for help in making their judgement about the right setting for them. There is help available from, for example, national and local voluntary organisations in general terms or the local social services that will in most cases have available a brochure produced in conjunction with local care providers describing what is available. This will point families in the right direction but if the family or individual is paying for the provision themselves, the reality is that they will get little direct guidance.

1.9 Those people who are funded in nursing home care by the local authority or their local NHS Clinical Commissioning Group (CCG), because they have what is defined as continuing healthcare needs, and whose costs are met by the statutory sector, will be supported in making their decision. They may also have a greater measure of assurance about the quality of the home because the statutory sector has determined that the home satisfies their criteria and they will commission services from them.

1.10 All homes are required to meet the standards and registration requirements laid down by the CQC. These set what might be called a minimum standard that permits the home to operate while meeting them. If on inspection they are found to fall short, they are able to continue to operate while steps are taken to put right the inadequacies in their care at the time of inspection. This can mean, as was the case with Orchid View that the home is operating while there are known and serious inadequacies in the care they provide. At the time when people were considering Orchid View prior to the police being alerted in August 2011 the CQC website showed that they rated Orchid View as "Good."

1.11 It was also the case that in the early months of the home's operation there were a number of safeguarding alerts that the local authority was investigating. In line with common practice in a number of local authorities the WSASB safeguarding procedures, which are pan-Sussex,[9] identify four levels of seriousness relating to safeguarding alerts; the safeguarding alerts being investigated during this time were a combination of Level, 1, 2 and 3 Alerts. These levels of safeguarding concern are fully described in Appendix 4. In general terms the higher the level, the greater the concern and this is reflected in the approach to investigation. Local authorities do not all use the same banding system for identifying the seriousness of safeguarding alerts, however there is consistency across the local authorities in Sussex with the pan-Sussex procedures.

Southern Cross Healthcare

1.12 At its peak Southern Cross Healthcare was by far the largest independent care home business in the UK with over 700 care homes nationally providing almost 40,000 places

[9] Sussex Multi-Agency Procedures for Safeguarding Adults at Risk. Pan-Sussex procedures are used by all the local authorities and partner agencies in West Sussex, East Sussex and Brighton and Hove City Council.

in residential settings. As an organisation it had grown from the mid 1990s when it was established.

1.13 In 2002 it increased in size when it was bought by a venture capital company. Two years later an American private equity firm Blackstone bought the company, which by that stage had 162 care homes. Blackstone's stated ambition was to make Southern Cross Healthcare the leading company in the elderly care market. Under this approach a number of other homes were acquired and in 2006 Southern Cross Healthcare was floated on the London stock market. A deliberate financial strategy adopted by Southern Cross Healthcare was to sell on properties that it had acquired which they then leased back on long leases. Southern Cross Healthcare performed well initially with this strategy as a stock market quoted company, nearly doubling its share price during the first year. Blackstone sold the company in March 2007.

1.14 In 2008 Southern Cross Healthcare began to experience significant financial stress caused by the cost of the long leases it had on the properties it had acquired and the declining ability of the public sector to meet care home costs affecting both occupancy levels and the income from residents paid for by local authorities.

1.15 Over the next three years Southern Cross Healthcare had extensive negotiations with banks and landlords with the intention of maintaining the homes. Particularly during 2011 there was significant discussion with the Department of Health, the CQC and the Association of Directors of Adult Social Services[10] initially to try to maintain the services, then to achieve an orderly and safe transfer of homes to other organisations. In the main, this was achieved, with the majority of homes transferring safely to other care organisations.

1.16 In the case of Orchid View, a similar process of negotiation for transfer was underway. However, this was not progressed and in early October 2011, because of the extent of the quality concerns at the home and its future viability with residents being moved out of the home, the preferred operator withdrew from the negotiation.

1.17 In 2011 Southern Cross Healthcare had five care homes in West Sussex with a total of 235 places. There were approximately 50 people in these homes whose costs were being met by West Sussex County Council or the local NHS.

1.18 The growth and demise of Southern Cross Healthcare indicates rapid growth and complex financial arrangements at the root of the company's size and profitability. This SCR does not consider such organisational arrangements and developmental strategies. However, we are concerned with the implications when such arrangements fail, as in the case of Southern Cross Healthcare in its management of Orchid View.

1.19 The impact of this was felt directly by vulnerable people who experienced poor quality care and their relatives who experienced anxiety and distress at the way their loved ones were cared for. There was a significant additional cost to the public purse.

1.20 The end result of what happened with Southern Cross Healthcare was that its financial strategy and inadequate focus on care by its responsible managers put vulnerable people at risk. Increasingly such large scale businesses can be expected to play a major role in care provision, in both residential and home care services.

1.21 Following on from the Francis Report and the government's consultation on corporate responsibility[11] the Department of

[10] Association of Directors of Adult Social Services (ADASS) is the membership association representing designated directors of adult services.

[11] DH Strengthening corporate accountability in health and social care, July 2013.

Health has recently published its proposals for implementing a new "Fit and Proper Person" requirement for service providers registered with the CQC.[12] This requirement will require service providers to ensure that all Board members or equivalent appointments meet the "Fit and Proper Person" requirements. There will be clear criteria and process established. It is encouraging that this new power is located within the network of improved regulation and inspection set out in the raft of consultations issued in recent months by the Department of Health.

What is Safeguarding?

1.22 Before reviewing the safeguarding work this brief summary of what safeguarding is might be helpful in providing a context for the review.

1.23 The Care Bill describes safeguarding as follows:

"Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect. It is an important part of what many public services do, and a key responsibility of local authorities.

Safeguarding is mainly aimed at people who may be in vulnerable circumstances and at risk of abuse or neglect by others. In these cases, local services must work together to spot those at risk and take steps to protect them."[14]

1.24 There is a possibility that in the future, with the implementation of the anticipated Care Act in 2015, the terminology used in safeguarding work may change with the term "investigation" used when the police are actively engaged, and the work of safeguarding teams referred to as "enquiries".

1.25 Local authorities have the lead responsibility for adult safeguarding in their geographic area. West Sussex County Council has established the West Sussex Adults Safeguarding Board with partners from the statutory services, including NHS agencies and the police.

1.26 Safeguarding work is carried out on a multi-agency basis in line with the local procedures; in this case those of West Sussex Adults Safeguarding Board. During the operation of Orchid View the procedures were updated but the core elements of the procedures and requirements of staff using them remained essentially the same. The procedures used in West Sussex are pan-Sussex to promote consistency, especially for those agencies whose responsibilities are broader than just the county area of West Sussex.

1.27 All professionals have a responsibility to report concerns and the local authority Adult Services team has a duty to act on any alerts that it receives indicating that a person might be at risk of harm.

1.28 There are various categories of harm; those most relevant in regard to residents of Orchid View are physical abuse, emotional abuse, financial abuse, neglect and institutional abuse. Where a concern is suspected by a member of staff of any agency, including staff working in residential settings such as at Orchid View, there is an unequivocal requirement that the concern is reported.

1.29 On receipt of a safeguarding alert the local authority as the lead agency will assess the situation and as necessary establish an investigation at the appropriate level dependent on the circumstances in the particular situation. This might be at level 1 through to level 4 and may include possible indicators of institutional abuse or possibly criminal activity or intent.

1.30 Safeguarding work is complex and demanding. There is a recognised

[12] DH Strengthening corporate accountability in health and social care: Consultation on the fit and proper person regulations, March 2014.

[13] DH Factsheet 7 The Care Bill – Protecting adults from abuse or neglect.

investigation process involving strategy meetings, multi-agency engagement and the identification of people charged with investigating the concern to reach an outcome. The appointed Investigating Officer will have skills to carry out this investigation. For example, in many of the cases at Orchid View there was a Health Investigating Officer with nursing expertise. The conclusion of the investigation will be to find the concern Substantiated, Unsubstantiated or Inconclusive on the balance of probabilities and to set in place relevant actions to remedy the concerns.

1.31 The safeguarding process is focussed on working with the person to identify and meet the outcomes that they want to achieve; on safeguarding the person against identified risks and to put in place arrangements to minimise them for the person and other adults who might be at risk.

1.32 In this work there can be tensions between the outcomes sought by the different participants; that is the professionals involved, the person themselves and sometimes their families. For example it was the case at Orchid View that some residents and their relatives were reluctant to accept that they might have been at risk and did not want to move from Orchid View. Working through these sorts of issues is demanding and requires the development of trust and confidence between all those involved and for the staff involved to demonstrate professionalism and resilience.

1.33 This process should include the person about whom there is a concern and, assuming that they have mental capacity and agree, their family, relevant professionals including the service provider, and possibly an advocate where necessary if the person lacks capacity[14] and has no relative to consider their interests. It is for this reason that POhWER, an Independent Mental Capacity Advocacy service, were asked for an Individual Management Review. In the event, there was no involvement with any of the residents at Orchid View and all the residents involved in safeguarding work had relatives with whom the safeguarding team had contact.

1.34 At level 1 it is appropriate, as was the case in some of the alerts at Orchid View, to require the manager of the home to take forward the investigation. However, it is possible and proper to escalate the concern, as was the case at Orchid View, if the provider does not carry through a proper investigation or set of actions to address concerns.

1.35 It is important that care providers are encouraged to carry through safeguarding work, partly so they can learn from it and remedy possible inadequacies within their service. As a society with an increasing reliance on care being provided by independent businesses there is a mutual interest in them delivering what they promise when they promote their values and commitment to providing good quality decent and safe care. It is sound business for residential care companies to provide good care and to the benefit of people dependent on such services. Carrying through their safeguarding responsibilities is an integral part of the provision of their care service.

1.36 However, there can also be a tension if reporting safeguarding concerns is perceived as reflecting badly on the care provider, as appeared to be the case with Southern Cross Healthcare at regional level, at least in relation to Orchid View. The reality is that frail elderly people such as the increasing majority of people in settings such as Orchid View will be subject to injury that might be suggestive of safeguarding concerns. For example some people will bruise easily, might be unsteady

[14] Mental Capacity Act 2005.

on their feet or subject to pressure sores, mislay their possessions, and might lack the mental capacity to say what has happened to them. Evidence of any of these might be a trigger to prompt an alert for consideration, but an injury in itself does not mean that there is occasion to institute a safeguarding investigation.

1.37 This requires good professional judgement with consideration of a number of factors, for example, is there evidence of a pattern of similar injuries? At level 1, has the service provider manager carried out an adequate investigation, are there concerns about particular members of staff and if so have they been addressed?

1.38 A number of families wanted to know why Southern Cross Healthcare, when subject to safeguarding investigation, was able to continue to advertise and continue to take residents into Orchid View.

1.39 This does prompt consideration of the importance of information available to people on a "need to know basis" that might be provided by the home themselves and/ or the local authority or health service. It is important to stress that the existence of lower level safeguarding concerns does not of itself mean that the home is an unsafe setting. However, it is perverse that when there are more serious concerns, members of the public who might be considering entering a home, or that their loved one might enter, or those who are already residing there do not have full access to information.

1.40 This is also very unsatisfactory for public sector commissioners in local authorities and the NHS who currently cannot publicly divulge their concerns and reservations about a home because of the risk that the company may hold them liable for a restriction of trade. There may also be adverse effects with people not wanting to go into the home, staff leaving and the situation in a home worsening quickly. This situation is unsatisfactory and is discussed in section 9. Both the proposed Duty of Candour and proposals in the Care Bill promote ways this might be addressed.

2. Background

2.1 Orchid View

2.1.2 Orchid View was a nursing home owned and managed by Southern Cross Healthcare. It was registered with the Care Quality Commission (CQC) as a care home with nursing to accommodate up to 87 people in the categories of old age and dementia.

2.1.3 It opened in September 2009 and closed in October 2011. During that period there were several safeguarding alerts investigated by the responsible safeguarding authority, West Sussex County Council, in partnership with local NHS services and Sussex Police. The alerts were notified to the CQC who became involved in some of the investigations, particularly those at the higher levels of severity potentially affecting more people.

2.1.4 In August 2011 Sussex Police received an anonymous alert asserting that there had been five deaths and four people admitted to hospital in the past fortnight as a consequence of poor care in the home. The police ascertained shortly afterwards, that this alert was from the Business Manager at Orchid View and maintained her anonymity throughout their subsequent inquiries.

2.1.5 A Level 4 safeguarding alert was immediately put in place by the local authority and police working together to investigate possible criminal offences and to safeguard the residents of Orchid View.

2.1.6 West Sussex County Council Adults Services, West Sussex Primary Care Trust[15] (PCT) and Sussex Community NHS Trust put together a team drawn from their social work and nursing staff to work directly in the home to support the staff of Orchid View and safeguard its residents. Then, as the home neared closure, the team arranged alternative settings with residents and relatives.

2.1.7 The records show that the leadership, management and clinical practice within the home were very poor. At the conclusion of an inquest into the deaths of 19 people within a defined timescale of six months the West Sussex Senior Coroner found that five people died of natural causes which had been attributed to by neglect, and that eight other people had endured "suboptimal" care at Orchid View though their deaths were from natural causes.

2.1.8 Southern Cross Healthcare had been the largest provider of residential care in the UK but in 2008 began to experience significant financial stress caused primarily by unsustainable complex financial arrangements.

2.1.9 Over the next three years Southern Cross Healthcare had extensive negotiations with banks and landlords with the intention of maintaining the homes. Particularly during 2011 there was significant discussion with the Department of Health, the CQC and the Association of Directors of Adult Social Services initially to try to maintain the services, then to achieve an orderly and safe transfer of homes to other organisations. In the main this was achieved with the majority of homes transferring safely to other care organisations.

2.1.10 In the case of Orchid View, a similar process of negotiation for transfer was underway. However, this was not progressed

[15] West Sussex PCT was abolished in April 2013 to be replaced by local Clinical Commissioning Groups as part of the national reorganisation of the NHS.

as the "preferred operator"[16] withdrew in early October because of the enormity of the problems at Orchid View. Also in early October 2011 Southern Cross Healthcare closed the home.

2.1.11 The end result of what happened with Southern Cross Healthcare was that both its financial strategy and the inadequate focus on care by its responsible managers put vulnerable people at risk.

2.2 Commissioning this Serious Case Review

2.2.1 This independent SCR was commissioned by WSASB on the 5 September 2013.

2.2.2 The need for a Serious Case Review was identified in August 2011 when the police alert was raised with the formal process instituted in August 2013 at the conclusion of the police investigation and the safeguarding investigations. This is because a criminal police investigation takes primacy over any other investigation and until that is concluded it would be inappropriate to commence other investigations.

2.2.3 The formal request for a Serious Case Review (SCR) was made by the WSCC Operations Manager in August 2013 on the grounds of:

- Numerous substantiated Safeguarding Adult investigations encompassing most categories of abuse including institutional abuse
- 19 deaths will be considered by the Coroner during the period the home was open (2009 – 2011)
- Police Major Crime Unit investigation
- 6 referrals to the Nursing & Midwifery Council
- 4 referrals to the Disclosure & Barring Service.

2.2.4 Initiating the SCR was deferred until the completion of the Inquest held by the West Sussex Senior Coroner in October 2013.

2.2.5 The Terms of Reference for this SCR were finalised in October 2013 and are at Appendix 1.

2.3 Questions posed by the relatives of people resident at Orchid View

2.3.1 In addition to the terms of reference, a number of questions were raised in discussion with the families of people affected by what happened at Orchid View. This report tries to address them, and in doing so considers the broader context within which care was provided and the possible impact of these issues in other settings in the future.

2.3.2 These concerns have been synthesised into four interrelated questions:

Question 1
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 from the public purse?

Question 2
How can people be confident that they or their relative will be safe and well cared for?

Question 3
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?

Question 4
How can organisations and individual professionals be held accountable for the

[16] This is the technical term used at the time to describe the prospective new operator of Southern Cross Healthcare homes after they ceased business.

safety, quality and practice in their services?

2.3.3 Addressing these questions draws on the information and experiences available from the safeguarding work carried out with residents of Orchid View; in relation to Southern Cross Healthcare's management and organisation of Orchid View; and the involvement of other agencies from the opening of Orchid View to the conclusion of the Inquest in October 2013 carried out by the West Sussex Senior Coroner.

2.3.4 Information from the Inquest was made available at the outset of the SCR and the Senior Coroner's Findings have been incorporated in this review.

3. Chronology of events and safeguarding work at Orchid View

3 Chronology of events and safeguarding work at Orchid View

The chronology in the sections below contains information relating to a significant number of alerts and issues that arose from the opening to the closure of Orchid View. Because there were so many contacts and issues of concern during this period, not every single contact or concern has been documented in this report. However, all safeguarding concerns are included within the chronology. The major task and intention in this chronology is to identify the patterns of issues and alerts and to analyse their impact on the care of people at Orchid View and how actions might be taken in the future to reduce the potential for such a pattern of poor care including failures to provide basic care.

Where residents are referred to this is done anonymously with the attribution of Mrs A or Mr B and so on alphabetically. This is because although the names of a number of residents who were at Orchid View are in the public domain, not all are and this report is focused primarily on more general concerns rather than a reinvestigation of the issues in regard to the individual residents.

3.1 Phase 1 – From the planning of the home and its opening until the police alert at the beginning of August 2011

3.1.1 On 1 September 2009 Orchid View was registered as a service with the Care Quality Commission (CQC). It was owned and managed by Southern Cross Healthcare. A manager registered with the CQC[17] was in place. On 1 October 2009 a contract began between Orchid View and West Sussex County Council (WSCC). A contract also began between Orchid View and Boots the Chemist Crawley. Residents began moving into Orchid View – some funded by WSCC and other Local Authorities, some funded by the (then) NHS PCT because they had significant healthcare needs and were assessed as needing continuing healthcare. Some people were privately funded.

3.1.2 In December 2009 the first safeguarding concerns were raised regarding the care of Mrs A who had recently joined her husband as a resident at Orchid View. Adult Services began an Adult Safeguarding Investigation at level 1. There was not an appropriate and timely response from the management of Orchid View and the level of investigation was changed from a level 1 to a 3.

3.1.3 Over the next few months, further concerns were raised regarding the care of both Mr and Mrs A. At a Case Conference in May 2010, neglect was substantiated for both Mr and Mrs A (the concerns related to nutritional care and medication). An allegation of emotional abuse was found to be inconclusive. This related to a nurse who lied to the safeguarding Investigating Officer and made false allegations against the family of the resident. The nurse was referred to the Independent Safeguarding Authority (now the Disclosure and Barring Service[18]) by the WSCC Investigation Manager. A Southern Cross Healthcare manager was requested to refer this nurse to the Nursing and Midwifery Council[19] as an outcome of the safeguarding

[17] CQC requires a manger registered with them to be in place in services regulated by them. CQC state of the registered manger that "Strong leadership is fundamental to the provision of high quality care. To be effective, leadership must be rooted in strong values, and based on a clear, shared understanding that it involves accountability for whatever is done in the name of care". CQC: Registration under the Health and Social Care Act 2008: Supporting information and guidance, July 2013.

investigation. Southern Cross Healthcare was required to produce an action plan to address the concerns.

3.1.4 January 2010 On 28 January 2010 Orchid View was inspected by the CQC and rated as a two star "Good" service. At the time of the inspection the service had 16 residents. At the time of the visit staff records on the supervision of staff were not up to date and it is recorded that the registered manager was addressing this.

3.1.5 February 2010 At the end of February 2010 an Adult Safeguarding Alert was raised by a social worker regarding Mrs B. This related to unexplained bruising and poor medication administration. Mrs B had advanced dementia which impaired her mental capacity. There were also concerns regarding staffing levels in the home. When the safeguarding investigation was concluded and at a Case Conference in mid April 2010 neglect was substantiated regarding the medication concerns. Various actions were required from Southern Cross and further meetings were planned.

3.1.6 March 2010 On 1 March 2010 the CQC received a Safeguarding notification from WSCC in relation to Mrs L. A week or so later the CQC received notification from Orchid View that WSCC were undertaking a Level 3 Adult Safeguarding Investigation but that the home were continuing to admit residents funded both privately and from WSCC.

3.1.7 On 21 March 2010 an ambulance was called at 09:56. The ambulance crew were informed that a resident had passed away at 04:30. The ambulance crew reported that the staff at Orchid View were unsure of the procedures to follow regarding an unexpected death.

3.1.8 On 31 March 2010 an Adult Safeguarding Alert was raised by a District Nurse regarding the catheter care of Mr C. CQC received notification of this alert relating to Mr C from WSCC on 7 April 2010 and from Orchid View on 13 April 2010. There were also concerns regarding staffing levels and skill mix. At a Case Conference on 11 June 2010, neglect regarding the catheter care was unsubstantiated and the staff issue was found to be inconclusive. Various actions were agreed and a further meeting was planned for 8 July 2010.

3.1.9 April 2010 An Adult Safeguarding alert was raised by Crawley hospital regarding Mr D. Concerns were that he was dehydrated and appeared neglected. He had only been at Orchid View for a couple of weeks. Mr D passed away shortly after his admission to hospital. An investigation found that neglect was inconclusive. There were concerns about the pre-admission assessment of Mr D before he went into the home for respite care. Actions from Southern Cross Healthcare were required regarding pre-admission assessments as an outcome of this investigation.

3.1.10 On 3 April an ambulance was called at 09:03 for a patient who had fallen and injured her wrist at 04:30 some five hours earlier. Also in April an Adult Safeguarding Alert was raised regarding Mrs E by a Social Worker. The concerns were regarding poor care and medication matters. At a Case Conference on 11 June 2010 neglect was found to be unsubstantiated. Various actions were agreed and another meeting was planned for 8 July 2010.

3.1.11 May 2010 At the beginning of May 2010 Sussex Police were called by a nurse asking for assistance with a resident who he was escorting on a walk outside the home who

[18] The Independent Safeguarding Authority was established in 2009 with its responsibilities transferred to the Disclosure and Barring Service (DBS) in January 2012. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The DBS is an executive non-departmental public body of the Home Office.

[19] The Nursing and Midwifery Council is the regulatory body for the nursing profession.

had become agitated and did not want to return.

3.1.12 An Adult Safeguarding alert was raised regarding Mrs F following concerns raised by her family in February and May. There were specific and similar concerns about the same nurse as in a safeguarding alert in December (see 3.1.3). There were also concerns in regard to staffing levels. At a Case Conference in June neglect by this nurse was substantiated. Neglect with regards to staffing levels was found to be unsubstantiated. By this stage the nurse had been referred to the Independent Safeguarding Authority (ISA) but had already left Orchid View and the UK by the time of the Case Conference.

3.1.13 The CQC received notification from WSCC that they were undertaking a Level 4 Safeguarding Investigation.

3.1.14 In mid May an Adult Safeguarding Strategy Meeting was held to discuss the concerns raised regarding the residents for whom alerts had recently been raised: Mr C, Mr D, Mrs E, Mrs F, and Mrs G. Various actions were agreed to investigate the concerns further and a Case Conference to discuss the outcomes was planned for June.

3.1.15 **June and July 2010** At Case Conferences in June and July, outcomes and actions were agreed for each of the five residents. Concerns of neglect were substantiated with regard to Mrs F. With regards to the other four residents, neglect was found to be either unsubstantiated or inconclusive. Various actions were agreed by the Orchid View home manager who had changed in the period between these meetings. CQC were not in attendance at the conferences but did receive copies of the minutes and investigation reports.

3.1.16 In June 2010, Boots the Chemist completed their first annual Pharmacist Advice Visit. Advice given covered the provision of controlled drug medication and improvements to records on Medication Administration Record (MAR) sheets.

3.1.17 Also in June 2010 the registered manager who had opened the home left Orchid View and was replaced by a new manager in July who was a qualified nurse but not registered with the CQC.

3.1.18 On 15 July 2010 the CQC received a complaint regarding change of management, staff levels being cut and concerns over quality of care. These concerns were noted by the CQC and a letter was sent to the provider.

3.1.19 On 19 July 2010 further alerts were raised to Adult Services by the District Nurse regarding inadequate catheter care by the same nurse as with her previous concern about catheter care (see 3.1.8). Neglect was unsubstantiated because the nurse had sought advice. There was an overall concern noted that Orchid View were not appointing competent staff or supporting their clinical practice. Actions were agreed, with the new manager in post at the time, to address this.

3.1.20 On 27 July 2010 the Orchid View Administrator (who later became the Business Manager) contacted the police regarding some petty thefts which she suspected were being carried out by a member of staff.

3.1.21 **August 2010** At the beginning of August an Adult Safeguarding Alert for resident Mr H was raised regarding a serious medication error made by the new manager. A Level 3 Investigation involving the police was completed. New placements at Orchid View by WSCC and the PCT were suspended from 5 August 2010. No criminal charges were made against the manager who accepted responsibility for her error and referred herself to the Nursing and Midwifery Council. The manager was dismissed by Southern Cross Healthcare and the Southern Cross Healthcare Regional Management Safeguarding Lead was tasked with making referrals to the (then) Independent Safeguarding Authority and to the Nursing and Midwifery Council. The allegation of neglect was substantiated.

3.1.22 Also at this time Sussex Police were contacted by staff at Orchid View when they were unable to locate a resident, Mrs K. She was eventually found in another resident's room.

3.1.23 In mid August a new manager at the home, who was again not compliant as the registered manager with the CQC, contacted Boots the Chemist to request a visit as records of the previous Pharmacist Advice Visit notes could not be found. However, on the day of the planned visit in September, the home manager was not available. The pharmacist left contact details inviting the manager to make another appointment.

3.1.24 In August 2010 the CQC initiated the re-registration of the home in line with the transition programme of re-registrations of all homes, see section 7. The CQC contacted Southern Cross Healthcare asking them to confirm compliance with the regulations in light of the recent safeguarding investigations and concerns about the management of medicines. On 8 September 2010 an Action Plan was received by the CQC from Southern Cross Healthcare detailing how they would achieve compliance.

3.1.25 **September 2010** On 9 September re-registration under the Health and Social Care Act was completed registering Orchid View to provide accommodation for people who require nursing or personal care, diagnostic and screening services, and treatment, disease disorder and injury. Conditions at registration were that there were no more than 87 service users and there must be a Registered Manager in place by 1 October 2010. At that time there would have been about 20 people resident at Orchid View on the ground and first floors. People with dementia were located on the first floor. The top floor of the building was never brought into use.

3.1.26 In late September SECAmb were called to transport a patient to A & E. They commented that there were no staff to travel with the patient as there were only three staff in the building to care for all the residents and that there was a very poor handover.

3.1.27 **October 2010** On 7 October Adult Services received an anonymous Adult Safeguarding alert regarding the staffing level and quality of care. Particular concerns were noted regarding the nurse previously referenced because of their inability to provide catheter care. Various actions were completed to investigate the concerns, including visits to Orchid View by WSCC Adult Services and the Contracts Team. The Southern Cross Healthcare Safeguarding Lead provided an action plan stating how they would address these concerns. Further individual alerts were raised following joint visits to the home by Adult Services and a Health Investigation Officer.

3.1.28 On 25 October 2010 an ambulance was called for a patient who had fallen the previous day and whom the ambulance crew believed had been in a lot of pain since then.

3.1.29 **December 2010** At a Case Conference in mid December, outcomes were agreed for alerts raised regarding Mr I (neglect regarding pressure care was found to be unsubstantiated), and Mrs E and Mrs J (verbal abuse by a staff member was substantiated). This staff member was subsequently dismissed. Orchid View had also started disciplinary procedures in regard to the nurse complained of in October (see 3.1.27) who left shortly afterwards. Various actions were agreed including referring the staff member to the ISA. There were two relief managers at Orchid View at the time. The CQC attended the Case Conference which had been called by WSCC in response to the systemic failings regarding medication administration.

3.1.30 On 3 December 2010 at 12:02 an ambulance was called for a patient who had been complaining of chest pain since 21:30 the previous evening, over 14 hours later.

3.1.31 **January 2011** On the 5 January there was a joint visit to the home by Adult

Services and the WSCC Contracts Unit to review the action plan. On the 7 January 2011 the suspension of WSCC placements was lifted following satisfactory completion of the Action Plan and discussion between the WSCC Adult Services operational and commissioning teams and discussion with the primary care practice. The manager who had taken up the position in August 2010 left Orchid View to be replaced by a fourth manager who was again not the registered manager with the CQC.

3.1.32 February 2011 On 21 February an Adult Safeguarding alert was raised by staff at the home regarding the behaviour of one resident, Mrs E, towards another. This was addressed by the care management team and not considered to be a safeguarding matter.

3.1.33 March 2011 On 2 March an Adult Safeguarding Alert was raised by the district nurse regarding the care of Mrs L. An investigation took place and at a Case Conference on 22 June 2011 neglect was substantiated. A new manager was in place though not as the registered manager with the CQC. Various actions were agreed to address the concerns and it was agreed that the district nurse would visit in August to review how the actions were being implemented. Also in March the fourth manager left the home and there was no designated manager in post, registered or otherwise until May.

3.1.34 On 15 March 2011 an ambulance was called for a patient who was unresponsive and who had been lethargic and less responsive than usual for 36 hours.

3.1.35 April 2011 On 1 April 2011 an ambulance was called for a patient who fell on the 20 March and had since been mobile but staff had noticed swelling on 30 March 2011. In April 2011 there were a relatively high number of ambulance attendances, relative to calls made in other months in this period, for issues such as complications to chest infections.

3.1.36 A national briefing note was issued by the Association of Directors of Adult Social Services regarding the work underway with Southern Cross Healthcare and the CQC to try and arrange safe transfers of care to other providers of the hundreds of homes Southern Cross Healthcare had established and were responsible for. As a result on 26 April 2011 there was a WSCC briefing note for senior managers and an information and planning meeting regarding the financial difficulties with Southern Cross Healthcare nationally.

3.1.37 In May the fifth manager at Orchid View took up post, again not the CQC registered manager.

3.1.38 June 2011 On 1 June 2011 an Adult Safeguarding Alert was raised by a local GP following a letter of concern from the daughter of Mrs N regarding poor care practices at Orchid View, particularly with regard to medication. The outcome of this investigation was that neglect was substantiated. This outcome was not formally recorded until a Case Conference in September 2012 following the completion of the wider safeguarding and police investigation, an approach previously agreed at a multi-agency meeting, at Orchid View. At an inquest in October 2013 the Senior Coroner concluded that Mrs N had died from natural causes attributed to by neglect.

3.1.39 A letter of complaint was received by Adult Services from a resident of Orchid View on 3 June, Mrs M. The concerns were mainly around food and staff practice. The home manager was asked to investigate this level 1 alert.

3.1.40 On 13 June the CQC received a further letter of concern from the relative of Mrs N. The planned inspection visit was brought forward to 27 June.

3.1.41 On 16 June an Adult Safeguarding alert was raised regarding Mrs E following concerns raised by her daughters about her

care, particularly medication management and unexplained bruising. A Level 4 Investigation was started to look at all the concerns being raised. Further concerns later raised regarding the care of Mrs E were investigated as part of the on-going police and Adult Services Investigation. Therefore there was a delay in formally reaching an outcome. However, at a Case Conference in May 2013 an outcome of substantiated for neglect relating to Mrs E was recorded. At an inquest in October 2013 the Senior Coroner concluded that Mrs E had died from natural causes attributed to by neglect.

3.1.42 On 27 June 2011 the CQC carried out an inspection at Orchid View. Non-compliance with a number of Standards was identified and required Outcomes were noted in several areas. An action plan was required by the CQC from Southern Cross Healthcare setting out how these deficiencies would be put right.

3.1.43 **July 2011** On 15 July an ambulance was called for a patient complaining of abdominal pain and the ambulance crew reported that the care home staff were unable to provide sufficient history.

3.1.44 On 22 July 2011 in response to growing concerns about Southern Cross Healthcare as a sustainable business, WSCC Contracts department carried out Contract Quality checks on all Southern Cross services in West Sussex including Orchid View. This noted issues around staffing, care plans and management cover at Orchid View.

3.1.45 On 29 July 2011 an ambulance was called for a patient but the ambulance staff reported a delay in being able to find the patient as there were no staff waiting for them on arrival and no staff around to ask. They also reported that the staff at the home were unable to provide patient records.

3.1.46 On 26 July 2011 the pharmacist from Boots carried out an annual Pharmacist Advice Visit. Prior to visiting she had checked the CQC report and noted that the home was found to be non-compliant with standards. The home manager did not accompany the pharmacist during her visit and therefore feedback was given at the end of the visit, including her serious concerns about the storage and mismanagement of medication. However, the home manager was called away during this discussion and therefore the pharmacist made an appointment to return in September due to their respective holidays. The pharmacist believed that medication issues were being followed up by the CQC as the regulator.

3.1.47 On 27 July 2011 the CQC received an Action Plan from Orchid View detailing how they would achieve compliance following on from their inspection carried out the previous month

3.1.48 **August 2011** On the 2 August the police were alerted anonymously to serious concerns about resident deaths and hospital admissions during the previous two weeks.

3.1.49 The police ascertained shortly afterwards, that this alert was from the Business Manager at Orchid View and maintained her anonymity throughout their subsequent inquiries.

3.2 PHASE 2
The Level 4 Adult Safeguarding Investigation until the closure by Southern Cross Healthcare in October 2011.

3.2.1 In this period there was a great deal of intervention and direct work with staff in Orchid View, by the agencies working together; communication and contractual work with Southern Cross Healthcare, and the investigation of individual safeguarding alerts. In addition to the Case Conferences for individual investigations listed in this chronology, numerous other incidents of a less significant nature were also recorded and investigated by the health and social care team. During this period numerous concerns

were progressively uncovered and responded to under the auspices of the safeguarding investigations.

3.2.2 **August 2011** On 2 August 2011 an Adult Safeguarding Alert was raised following an anonymous call that evening shortly after 8pm to the police regarding the deaths of five residents and the hospital admission of four residents. An anonymous letter relating to the deaths of seven residents was also sent to the Senior Coroner.

3.2.3 On 3 August 2011 there was an Adult Safeguarding Strategy Meeting to discuss the concerns. This was a multi-agency meeting involving the police; the CQC did not attend this meeting. One of the outcomes of this meeting was that the police would interview the person who had contacted them anonymously.

3.2.4 On 4 August 2011 a further alert was raised by the manager of Orchid View. The alert alleged twenty four medication errors affecting five residents and named a particular nurse, as responsible. The alert stated that the nurse had resigned.

3.2.5 Also on the 4 August 2011 a second Strategy Meeting was held. There was agreement that there would be a Level 4 Safeguarding Investigation and that there would be an unannounced visit to the home by both the police and Adult Services. The current home manager was implicated in some of the concerns. The visit took place later that day and records for thirteen residents were taken away by the police. Southern Cross Healthcare was asked to notify all residents and their families of the investigation – they were provided with a draft letter to use giving contact details of the WSCC safeguarding staff involved in the investigation. However, it later transpired via feedback from families that this letter had not been sent.

3.2.6 WSCC suspended new admissions to the home and other Local Authorities and PCTs were informed of this although Orchid View could, and did, still admit privately funded people. Over the coming weeks a team was established of health and social care staff, who attended Orchid View on a daily basis to investigate the concerns, review the needs of the residents and work with Orchid View management to address the concerns.

3.2.7 On 5 August 2011, as requested by the WSCC Contracts Department, Southern Cross Healthcare supplied a calendar detailing how they would provide senior management cover over the next three weeks and the respective responsibilities of the identified managers.

3.2.8 On 8 August 2011 an overview of the key areas of concern was sent to Southern Cross Healthcare operational staff and senior managers by WSCC Contracts Department.

3.2.9 On 11 August 2011 there was a third multi-agency Strategy Meeting to review the information gathered so far and agree further actions.

3.2.10 On 14 August 2011 the Boots pharmacy audit revealed 28 further concerns in relation to medication errors. The audit related to a visit at the end of July.

3.2.11 On 15 August 2011 the joint health and social care team agreed to provide written feedback every day to the designated Southern Cross Healthcare manager, their Senior Quality Advisor, who undertook to ensure that concerns were addressed.

3.2.12 On 15 August 2011 the CQC received an anonymous letter alleging lack of qualified staff and poor medicine administration.

3.2.13 The Health and Social Care team continued to visit the home daily; additional concerns relating to individual residents were raised during their visits. These included further concerns about medication errors, failure to manage pain, nutritional issues and the hydration of residents. There were also further concerns about thefts of money and items of sentimental value from residents,

abusive behaviour and concerns about staffing competencies and levels of staffing throughout the day and night.

3.2.14 On 22 August 2011 there was a fourth multi-agency strategy meeting and an agreement to widen the investigation further and review a further 29 residents.

3.2.15 On 25 August 2011 the Boots pharmacist visited Orchid View and gave feedback to the home manager. There was little evidence of improvements since her earlier visit; this information was shared with the Adult Safeguarding Investigation Team.

3.2.16 **September 2011** The home manager was replaced with a sixth manager, again not the registered manager with CQC, who remained in place until the closure of the home in October 2011. On 7 September the Health Investigation Officer gave feedback to the Adult Services Investigation Manager that there were still concerns about the level of care being provided.

3.2.17 On 7 September 2011 the pharmacist visited Orchid View again and noted that few improvements had been made since her visits in July and August.

3.2.18 On 12 September 2011 a fifth multi-agency strategy meeting was held where updates from all those involved were given and further actions to address the concerns were discussed.

3.2.19 On 14 September 2011 Adult Services and WSCC Contracts Department met with Southern Cross Healthcare representatives to discuss the on-going concerns. Southern Cross Healthcare advised at that time that they had put in a team of three people who were concentrating on quality control and that there was a new manager in post. Southern Cross Healthcare gave a number of assurances: not to accept any new referrals, to send a letter drafted by WSCC to all residents and families informing them of the safeguarding concerns, and that they would take appropriate actions to remedy continuing poor performance.

3.2.20 The health and social care team continued to visit daily and there were frequent communications between all the agencies and Southern Cross Healthcare during this time.

3.2.21 On 20 September 2011 the CQC completed a follow-up inspection at Orchid View where they found major concerns and non-compliance with a number of Outcomes.

3.2.22 Concerns continued to be raised on a daily basis by the health and social care team visiting Orchid View. On 22 September 2011 there was a further multi-agency planning meeting. Due to the on-going risk to residents, a decision was made to start offering residents alternative accommodation in a phased way, beginning with those who were assessed as being at most risk. A contingency plan was discussed in case Southern Cross Healthcare decided to close the home and daily planning meetings were agreed to ensure that concerns were being monitored and responded to.

3.2.23 On 23 September 2011 the CQC made a decision to issue seven Warning Notices.[20]

3.2.24 On 24 September 2011 it was agreed that the health and social care team should continue to visit over the weekends due to the seriousness of the on-going concerns.

3.2.25 On 26 September 2011 WSCC issued a Contract Default Notice[21] to Southern Cross Healthcare. At a level 4 Safeguarding strategy meeting a decision was made to prepare people for a move out of the home and as a result health and social care staff began

[20] A Warning Notice can be served when the service provider has not complied with relevant Regulations, or a section of the Health and Social Care Act, or a "relevant enactment" or condition placed on registration has not been complied with.

[21] A Contract Default Notice is a formal notification that the service provider is not meeting a contractual requirement.

meeting with residents and families to discuss residents moving out. The CQC had issued an Enforcement Notice.[22]

3.2.26 On 27 September 2011 a letter was sent by the CQC advising Southern Cross Healthcare's Nominated Individual[23] of serious concerns and that Warning Notices would be issued in respect of the service.

3.2.27 On 29 September 2011 WSCC Contracts Department sent a reminder letter to Southern Cross Healthcare as they had not received a response regarding the Contract Default Notice issued on 26 September. A response was received from the company's solicitors seeking further time to implement their Action Plan, accusing WSCC staff of misleading residents and their families and of causing concern and distress to residents and Southern Cross Healthcare's staff. This is discussed in section 8.7. WSCC Contracts Department recorded that there were difficulties in the communication with the different levels of management at Orchid View and Southern Cross Healthcare.

3.2.28 At the end of September the first nurse was arrested and interviewed by the police.

3.2.29 **October 2011** The health and social care team continued to visit Orchid View daily and moved people in a planned and phased way. Concerns continued to be raised regarding poor care during this time. CQC issued the Warning Notices in respect of seven outcome areas as proposed in September.

3.2.30 Two other nurses, including the manager were arrested and interviewed by the police in early October. Further records were also seized from the home during October.

3.2.31 On 6 October 2011 WSCC convened a meeting with senior managers of Southern Cross Healthcare, the CQC, the PCT and included the prospective new service provider at Orchid View. The record of the meeting shows further unresolved safeguarding concerns, plans to relocate residents within Orchid View "from the dementia floor down to the ground floor", and increased staffing ratios to be put in place.

3.2.32 On the 7 October 2011, Southern Cross Healthcare advised WSCC that their management team had met on the 6 October and decided to close Orchid View.

3.2.33 On the 10 October 2011 it is recorded by WSCC that some relatives had only found out about the home closure from the local media despite Southern Cross Healthcare being previously asked to inform all residents. On the 12 October 2011 the last resident moved from Orchid View.

3.3 PHASE 3
Completion of safeguarding investigations after the closure of Orchid View

3.3.1 **October 2011 onwards** Following the closure of Orchid View the multi-agency investigation into the concerns raised regarding individual residents continued, including regular meetings with WSCC, the Police and West Sussex PCT.

3.3.2 There was consideration throughout this time about possible referrals to the NMC, other relevant professional bodies and the Independent Safeguarding Authority. In the event 15 individuals who had worked for Southern Cross Healthcare were referred to the NMC.

3.3.3 In November 2011 Sussex Police elevated the investigation into a force level investigation by the Major Crime Team. Throughout the investigation, a large volume of records were examined by the police with a view to possible prosecutions of individual

[22] An Enforcement Notice relates to CQC taking enforcement action where there is a serious breach of regulations or where compliance action has not worked.

[23] A Nominated Individual is the nominated main contact of the business with CQC. CQC suggest that this person is "responsible for supervising the management of each activity and we suggest that they should, therefore, be a director, manager or secretary of the business."

members of staff and also the management of Orchid View.

3.3.4 Between September 2011 and October 2012, the Police arrested and interviewed five members of staff from Orchid View. Files were sent to the Crown Prosecution Service together with reports from the health and social care support team. Eventually the CPS advised that there was insufficient evidence to prosecute any of the individuals.

3.3.5 There was limited correspondence between the WSCC Contracts team and Southern Cross Healthcare in November and December 2011 which is discussed in 8.7.

3.3.6 In June 2012, Adult Social Care was informed by the Police that the Senior Coroner had set a date for an inquest in October 2013.

3.3.7 The health and social care team continued to liaise with the Police regarding Adult Safeguarding Investigations relating to individual residents of Orchid View and Case Conferences were held as each investigation was completed. It should be noted that more people were considered within the framework of safeguarding investigations than were subject to the Inquest. In line with the agreed multi-agency approach, a number of the safeguarding investigations were not concluded until police inquiries had been completed.

3.3.8 In July 2012 Adult Safeguarding Case Conferences were held for Mr O (neglect and financial abuse substantiated), Mrs Q (neglect and emotional abuse substantiated), Mrs R (neglect and financial abuse substantiated), and Mrs V (neglect substantiated). At the Inquest in October 2013, it was recorded that Mr O had died as a result of natural causes and that the care provided to him had been suboptimal. The Inquest recorded that Mrs V had died of natural causes.

3.3.9 In September 2012 Adult Safeguarding Case Conferences were held for Mrs N (neglect substantiated), Mrs T (neglect and financial abuse substantiated), Mrs U (neglect substantiated), Mrs W (neglect substantiated) and Mrs X (neglect substantiated). At the Inquest in October 2013, it was recorded that Mrs N had died from natural causes attributed to by neglect. At the Inquest it was recorded that Mrs U and Mrs X had died from natural causes.

3.3.10 In December 2012 Adult Safeguarding Case Conferences were held regarding Mrs P (neglect, financial and emotional abuse substantiated), Mrs S (neglect, physical and financial abuse substantiated), Mrs Y (neglect substantiated), Mrs Z (neglect, physical and emotional abuse substantiated), Mr AA (neglect, physical and financial abuse substantiated) and Mr BB (neglect substantiated). At the Inquest in October 2013 it was recorded that Mrs P and Mrs S had died from natural causes and that the care provided to them had been suboptimal. It was recorded that Mr AA had died from natural causes.

3.3.11 In February 2013 an overarching Adult Safeguarding Case Conference was held regarding Orchid View at which it was recorded that institutional abuse had been substantiated.

3.3.12 In May and June 2013 Adult Safeguarding Case Conferences were held for Mrs E (substantiated) and Mr DD (neglect recorded as inconclusive). At the Inquest in October 2013 it was recorded that Mr E and Mr DD had died as a result of natural causes attributed to by neglect.

3.3.13 In August 2013 an Adult Safeguarding Investigation was held regarding Mr EE (neglect substantiated). At the Inquest in October 2013 it was recorded that Mr EE died from natural causes attributed to by neglect.

3.3.14 In October 2013 the Inquest was completed on the deaths of 19 people who had been residents of Orchid View. Some of the people considered at the Inquest

were not subject to safeguarding alerts or investigations and not all were still at Orchid View at the time of their death.

3.3.15 The outcome of the Inquest for those residents for whom an Adult Safeguarding Case Conference had been held has already been recorded in the chronology above. In addition the Inquest recorded that Mrs HH and Mrs J had died from natural causes. The Inquest recorded that Mrs GG, Mrs B, Mr FF, and Mr and Mrs CC died from natural causes and that the care provided to them was suboptimal.

4. Review and recommendations: safeguarding concerns and actions

4.1 Phase 1
In the period from the home's opening to the alert to the Police in August 2011

Early safeguarding alerts

4.1.1 As is shown in section 3 there were several safeguarding alerts from the opening of Orchid View to the point at the beginning of August 2011 when the police were alerted to concerns from within the home.

4.1.2 These alerts were in relation to 14 individual people and two were raised about general concerns by a district nurse. Common themes included medication management, nursing care, unexplained bruising, nutrition, pain relief, inadequate staffing levels and practices.

4.1.3 Each alert was considered in its own right in the context of the home and what was known at the time. Though some of these safeguarding alerts were not substantiated or were inconclusive, they all contributed to a developing picture of a poorly managed home offering inadequate care, now with the benefit of hindsight very apparent.

4.1.4 It is the case that the investigation of a safeguarding alert, whether abuse is found or not, will, as an integral part of the process, consider the person's care and will identify actions to improve their situation. This means that the process and focus on the individual and the outcomes they want, has intrinsic value and that actions will be identified without having to wait for a conclusion to an investigation where there are concerns

4.1.5 The first alert in December 2009 concerned Mrs A, who had been assessed as needing continuing healthcare funding because of the degree of her needs and requirement for nursing. In retrospect it is particularly significant that an aspect of the alert related to the family having problems resolving matters with Orchid View's staff. The alert was assessed at level 1 safeguarding concern, and in line with usual practice the manager of the home was asked to investigate.

4.1.6 The home had taken on the business of caring for people and it was their responsibility to investigate this safeguarding concern. Particularly, as this was the first alert at Orchid View it was appropriate to follow the normal process and ask the home to investigate and act. In the event the safeguarding work was not carried out within the agreed timescale by the manager at Orchid View and the issue was escalated to Southern Cross Healthcare's Area Management and heightened to level 3. Having to escalate up the management chain was unusual.

4.1.7 In this case part of the safeguarding concern relates specifically to the poor pre-admission assessment carried out in relation to Mr A, who was the husband of Mrs A. There was clearly a positive consideration of the benefits of continuing to provide a setting for this married couple, however, even with the positive benefit of the joint placement it is the case that Mr A's nursing and health care needs were not met and his condition worsened.

4.1.8 Additionally Mrs A experienced unexplained bruising and in the course of the safeguarding investigation one particular nurse was found to have lied and made untrue allegations about the family of Mr and Mrs A. Neglect as a safeguarding category in relation to failure to assess for pain relief was

substantiated, Emotional Abuse however, was not.

4.1.9 These early alerts illustrate the complexity of an effective commissioning and practice interface between health and social care staff, and the complexity of safeguarding investigations. Each was seen as an individual investigation; carried out and seen in the context of a new home settling down.

People with Continuing Healthcare needs

4.1.10 Some of the alerts concerned continuing healthcare funded residents as well as those people funded by the local authority and those self-funding their place at Orchid View. People receiving continuing healthcare have highly complex needs requiring significant levels of care and will need proficient and reliable care into the future. The team responsible for initially assessing a person's eligibility for continuing healthcare is not necessarily responsible for the provision of their nursing care. If the person is in a nursing home responsibility is with the nursing care home staff, as is the completion of a pre-admission assessment. Completion of a continuing healthcare eligibility assessment will take place where the person is at that time, which could be, for example, in their own home or in hospital.

4.1.11 Continuing healthcare funded residents are subject to review of their eligibility for continuing healthcare funding at least annually. The Continuing Healthcare Team is responsible for the review of eligibility and then for the case management of that person once funding is established. Case management responsibility refers to the commissioning and procurement of care for the eligible person, and the on-going review of that person's eligibility and the suitability of the care procured for them. The Continuing Healthcare Team also have responsibility for ensuring that the quality of the care procured is of the standard that is required as commissioners, and that it meets the individual's needs. A continuing healthcare funded person remains entitled to receive any other NHS services that they may require. As with all other people aged 75 and over they will have a named accountable GP with overall responsibility for their healthcare from June 2014.

4.1.12 Continuing responsibility for their placement, as opposed to the management of their care, is the responsibility of the relevant CCG and this was reinforced by the Department of Health in November 2013[24] "where an individual is eligible for NHS continuing healthcare, the CCG is responsible for (ensuring that the care provider carries out competent) care planning, commissioning services and for case management."

4.1.13 Since April 2013 the management of the West Sussex Continuing Healthcare Team and function now comes under WSCC Health and Social Care Commissioning, but the resource to meet the costs of continuing healthcare, and nursing staff within the team remain with the CCG. The staff and financial arrangements of the Continuing Healthcare Team are clearly defined under a Section 75 Agreement (S75). This arrangement is not unique to West Sussex and negotiations involving the local authority and continuing healthcare are progressing towards a more integrated approach.

4.1.14 The separation of responsibility between the health and social care services did not have an adverse effect on any of the people eligible for continuing healthcare at Orchid View. However, this separation can generate conflicting messages about where responsibility rests that, with an uninformed service provider, could generate confusion. This is being addressed by publishing clearer messages about information sharing, a more collaborative approach to working arrangements, and shared responsibilities

[24] DH: National framework for NHS continuing healthcare and NHS funded nursing care, November 2013

under the recently established Care Governance Board.

4.1.15 Further work is planned to establish better joined up commissioning arrangements for people with continuing healthcare needs between the local authority and the NHS. The planned outcome from this work is that all continuing healthcare placements are procured using an integrated approach to the market with the same contractual terms applied by both WSCC and the CCG where appropriate.

4.1.16 Support plans for all those people with continuing healthcare needs and funding, as for all residents, should be detailed in the person's Care Plan actively used within the home. Included in the information in the Care Plan, and particularly important for people with continuing healthcare needs, should be detail about responsible healthcare clinicians, e.g. the GP and any consultants treating the person for their specific condition.

4.1.17 To ensure safe and good quality care in the home, and clear communication and external contact with their responsible clinician it is important that there is a designated responsible nurse in the home for the resident.

Recommendation 1

That all care homes with nursing ensure that Care Plans contain the name of the responsible nurse for the resident, and that the resident and their relatives or advocate know the name and contact arrangements for this member of staff.

Admissions to care homes from hospital

4.1.18 NHS hospital trusts and local authorities carry statutory responsibilities under the Community Care Delayed Discharges Act 2003 to follow agreed procedures, involving the patient or their representative if the person does not have mental capacity, to achieve a positive discharge to a satisfactory setting. This might be to care home provision or back to the person's own home with suitable supports in place. This process is intended to ensure an appropriate assessment of the person's needs prior to discharge, forward planning for their discharge, including notification to the local authority of any future care needs.

4.1.19 This process will often be carried out in a stressful situation given the high pressure on hospitals to achieve effective throughput, encompassing admission, treatment and discharge with local authorities facilitating such discharge within tight timeframes and resource constraints. Right across the health and social care services nationally patients, their relatives and health and social care professionals are often put in a position requiring them to make life changing decisions quickly and often with a paucity of options available to them.

4.1.20 The engagement of the service provider in pre-admission assessment is critically important and reflects their engagement as a key part of the whole systems approach of health and social care, hospital, residential, primary and community care. It is necessary to achieve positive hospital discharge in a timely way with appropriate supports in place – be they care home or community based.

4.1.21 With hindsight it is clear that inadequate pre-admission assessments were made by staff from Orchid View. In some cases this adversely affected the general quality of care received by residents of Orchid View, for example Mr A's assessment specifically failed to meet his nutritional needs.

4.1.22 It is critically important that this pre-admission assessment is realistic and that a home carries through the process professionally and does not take responsibility in its home for people to whom it cannot provide adequate care. Saying no to any particular person might have an impact on the income of the home and that may influence the home to take responsibility for someone it

cannot adequately care for, as may have been the case at Orchid View.

4.1.23 However, it is also important that nursing homes are competently staffed and managed to be able to provide care to people with significant needs in line with their CQC conditions of registration. They are becoming increasingly important as care providers for people with significant healthcare and nursing care needs, so it is critically important that they have levels of competence to enable them to deliver care in line with their registration criteria.

4.1.24 Additionally it may well be the case that taking responsibility for a resident who is at the margin of the home's competence and capacity might have a detrimental impact on existing residents as well as the person being assessed. It maybe that they will require additional expertise or staffing support that the home cannot provide without jeopardizing the levels of skills and support to existing residents. It is the home's responsibility to ensure that it can manage such situations without causing increased risk to its residents.

4.1.25 Orchid View was a new home and it may be that there needs to be particular scrutiny and awareness when a home is establishing itself or is developing new service provision such as a specialist unit or specialism. Pre-admission assessment at such times is particularly important as the skill mix and staffing levels are more likely to be tested. This is a pressure likely to intensify and we therefore recommend that the CQC explicitly includes in its inspections the quality, inclusivity and timeliness of the pre-admission assessment by the responsible registered home. This should also take account of the possible impact on the home's ability to meet the needs of its existing residents.

Recommendation 2

That the process, timeliness and quality of pre-admission assessment from hospital settings is explicitly tested within the CQC inspection process with an emphasis on the staffing levels and skills within the home to deliver safe and good quality care within the home's conditions of registration.

4.1.26 There was unexplained bruising apparent in some of the safeguarding alerts, including the first alert after Orchid View opened. Bruising with older people is quite common and does not in itself mean that there has been abuse. When bruising is apparent, the practice is that the safeguarding Investigating Manager makes a professional judgement on whether the explanation for it is satisfactory. If it is considered that a member of staff is implicated in inflicting injury the police are informed immediately. This judgement is based on a triangulation of available information including whether similar incidents had happened previously.

4.1.27 Understanding the cause of bruising does present a dilemma for both the home's staff and those involved in safeguarding work. It is important to consider the nature of the bruising, e.g. where it is, if there have been similar types of bruises in the past, if the person is receiving medication that might make bruising more likely or pronounced. There is a concern that if this is treated at level 1 there is a period of 14 days for the organisation to investigate and respond; during that period the bruising and so the evidence would be less apparent. Though not necessary in all cases, but where in the judgement of the safeguarding investigating manager it is, this can be dealt with by photographing (with relevant consent) the bruises and the provision of what are called body maps showing where possible injury had occurred. In these circumstances, the value of multi-disciplinary work, particularly involving the police and healthcare professionals is critical.

4.1.28 A further alert was raised in February 2010 concerning staffing shortages, unexplained bruising and medication management. The investigation substantiated

the medication concern only with the other two concerns considered to be inconclusive.

4.1.29 Although not a safeguarding alert there is concern that following the death of a resident at 04.30am in March, the police were not called by Orchid View until some five hours later, when they were called by the ambulance service. It appears that this delay reflected a faulty understanding by care staff about their responsibility when a resident has died. From discussion of this issue, major concerns emerged from the police and the ambulance service about the consequence of this in addition to the failure of understanding in the home about the action to take when a resident appeared to have died.

4.1.30 It is not uncommon in the experience of the ambulance service that staff are unclear about responsibility for certifying a death. This cannot be done by a nurse in circumstances where, unexpectedly, a resident has died. It may be that the person can be resuscitated by prompt intervention by the Ambulance service, but this possible opportunity will be lost if there is a delay in calling the emergency service. The care home staff should call an ambulance who will seek to get to the home within the 8 minute target time. If the death is that of someone receiving palliative care and the death was expected, and there is a qualified nurse able to recognize that a death has occurred, then an ambulance call may not be required.

4.1.31 A further issue is that with a five hour delay, as in this case, it would mean that if there was any cause for suspicion in relation to the death, investigation would be harder to pursue given the time delay.

4.1.32 Both the police and the ambulance service commented that it is not uncommon for them to attend homes during the night following a call out and then to find it hard to access the home. Anecdotally they attribute this difficulty to staff being harder to locate at night because they are very stretched with the cover they have to provide at a time when staffing levels are reduced.

4.1.33 As part of their ordinary responsibilities nursing homes are required to provide a 24 hour service with an adequate staffing level throughout this period to meet the care needs of residents able to demonstrate competence and availability.

4.1.34 The ambulance service was concerned that no safeguarding alert was raised in regard to the delay and its possible implications.

4.1.35 Although this has not been evidenced in this SCR it is probable that Southern Cross Healthcare did provide procedural guidance to staff, that was available to the night staff at Orchid View in regard to the unexpected death of a resident. This is based on the CQC view that when it inspected the home in January 2010 it identified that there were relevant policies and procedures in place. The issue is whether they were known about, understood and applied by all staff and from this instance and others it would appear that they were not.

Recommendation 3

That all service providers are required to ensure that their induction of new employees and the continuing training of staff includes clear guidance on the necessary procedures and actions where a death occurs, be it an expected or unexpected death.

Recommendation 4

That care homes are required to provide contact details, e.g., a named person, contact phone number that will be answered, method of entry, etc., to the emergency services when they contact them, especially important at night, to enable access to the home without delay.

4.1.36 A further alert at the end of March 2010 concerned failing to manage catheter care. As a safeguarding alert it was unsubstantiated because it was judged that

the nurse did the right thing in requesting external help for something they did not have sufficient expertise to do. However, it is remarkable that a registered nurse in a nursing home should not be able to carry out this procedure or gain support and supervision within the home to carry it out. A registered nurse should be able to provide catheter care other than in the most exceptional circumstances, which was not the case on this occasion. Similarly the nursing home has a responsibility to ensure that its nursing staff are competent to carry out such procedures.

4.1.37 The home management should have known of any weaknesses in skills and provided training as necessary. Some nursing skills needed in a nursing home might not be used very often. It can be argued that nurses working in these settings are more isolated from day to day informal learning opportunities than might be the case in a hospital or community team setting. It could therefore be more probable that a nurse would become out of date with core competencies. This reinforces the importance of the responsible organisation to provide training opportunities and to enable continuing professional development for clinical staff. It is also the registered nurses' responsibility to ensure they are up to date with their own professional development.

4.1.38 Though not completely analogous, a nursing home manager carries a level of responsibility similar to that of a ward manager in a hospital, though probably in a more isolated setting. This includes a responsibility for the performance and competence of staff, qualified and unqualified within their team. As such they should be explicitly required to demonstrate managerial as well as clinical competence to carry out this responsibility.

4.1.39 In line with the proposed improvements in CQC guidance relating to the learning and guidance of staff working in adult social care set out in the April 2014 CQC consultation,[25] the CQC, possibly in conjunction with a training agency, should include assessment of the delivery of continuing professional development as part of its regulatory role.

Recommendation 5

Recognising the increased potential for nursing staff to work in more isolated settings, providers of nursing home care should provide and facilitate the continuing professional development of their staff. Information about the training undertaken should be provided to the CQC and local commissioners.

4.1.40 It is notable that in March 2010 the CQC were notified by Southern Cross Healthcare of the safeguarding alerts and investigations carried out or underway by WSCC, including the level 3 investigation. It also seems that Orchid View informed the CQC that the PCT was no longer placing people with continuing healthcare needs with them at that time, though this is not recorded in the commissioning records and may have been an informal comment made by a nurse because of the skills deficit in the home.

4.1.41 Neither of the two safeguarding alerts and investigations in April were conclusive in their findings. Both related to the poor quality of nursing care and neglect, one was raised by a social worker and the other by Crawley Hospital concerning the poor state of a resident when he was admitted to the hospital where he was dehydrated, had a pressure sore and looked neglected.

4.1.42 Mr D had been in Orchid View for some two weeks for respite when he was taken to hospital, and he died shortly afterwards. Both his wife and their friend expressed their concerns to the social worker during the investigation in relation to the care he had received at the home and that a pressure sore had developed while he was at the home.

[25] CQC Consultation April 2014, Overview to the provider handbooks for adult social care.

However the review of the documentation was not able to substantiate neglect but this case does provoke a number of concerns. The records do not make it clear why Mr D was admitted to Crawley Hospital and nor is it clear how he was transported to the hospital, the SECAmb service was not involved though a private service may have been. The police were not informed of this alert, and particularly given the concern about neglect there is a strong argument that they should have been.

4.1.43 The police received an unusual request in May for support from an Orchid View nurse who said he was having problems with a resident he was escorting outside the home who refused to return. A police constable did respond to the call and was able to persuade the resident to return to Orchid View and did not record that the person expressed concerns about the home. It was noted that if the police had received prior awareness generated by previous safeguarding alerts they might have reacted differently to this request. It was exceptional and it should be within the competency of a nurse, except in the most exceptional of circumstances, to manage such an issue without recourse to police involvement.

4.1.44 A further alert in May 2010 concerned neglect by a nurse who had also caused concern previously about his rude and dismissive attitude and behaviour. Later in July 2012 a retrospective alert was raised when it became known, regarding the same nurse who was alleged to have pulled a frail elderly lady who was not mobile to a standing position from her wheelchair. While it was acknowledged that there is no certainty that this allegation would have led to a criminal investigation had it been known of when it happened, it would, at least, have contributed to the developing picture and to the multi-agency intelligence gathering.

4.1.45 It is also the case that after relatives made complaints to staff about the incident above, the manager at Orchid View implemented restrictions on visiting times. This decision was changed by Orchid View management at a later date.

4.1.46 The WSCC Out of Hours team attended Orchid View in May after a relative contacted the emergency line. She had had a dispute with nursing staff after raising concerns about staffing levels, unanswered call bells and poor care. In the event the resident went home with his daughter and the home refused to have the resident back. The Out-of Hours manager did visit Orchid View and found that there were sufficient staff on duty and no immediate concerns. Feedback was given to the area Adult Social Care Team.

4.1.47 At this time a retrospective picture and detailed investigation of the broader picture shows that safeguarding alerts had been raised for the equivalent of about half the residents at the home, eight people, over the seven months it had been open. Even though many were unsubstantiated or inconclusive it does seem that there was an increasing awareness of poor practice.

4.1.48 However identifying and acting on such a trend is not easy. In the main local authorities want to encourage homes to raise safeguarding alerts rather than to disregard or seek to minimize safeguarding concerns. All homes have a duty to raise safeguarding alerts and the local authority will want to respond positively not wanting to dissuade the home from identifying and raising concerns.

4.1.49 Deciding when to take action requires good intelligence about any emerging themes and trends and professional judgement about how to pool such information and determine any next steps. There are likely to be safeguarding concerns at some point in any care service; what matters is how they deal with the concerns. A sign of a good service is how they rectify things that go wrong. What happened at Orchid View was more an avoidance of positive action to rectify

problems, and a series of ineffectual action plans that were not acted on.

4.1.50 The Pan-Sussex Safeguarding Procedures already identify the importance of a multi-agency professionals meeting, including the service provider, to jointly identify concerns, remedial actions and next steps. Especially when there are successive issues and concern about the impact and effectiveness of action plans over time, the importance of such a meeting has to be reinforced.

4.1.51 A new information system is planned to go live in West Sussex in June 2014 which will provide better and more accessible information in relation to the specific contracts held with service providers and in relation to the quality and any safeguarding concerns there might be in respect of particular service providers. This combination of hard and soft intelligence will be available to health and social care practitioners and to the CQC. It is understood that the development of the system will be closely monitored and developed over the coming months to ensure that it contains pertinent and up to date information accessible by authorised key partners.

4.1.52 By the time of the next safeguarding alert in July 2010, the manager who had been in post since the opening of Orchid View (and was the only manager registered by the CQC during the period Orchid View was open) had left and a new manager was in place. This alert was a virtual re-run of an alert raised in relation to the same nurse in March 2010 by the same district nurse about poor catheter care. This alert was addressed at level 1 by the new manager. Although it was unsubstantiated as a safeguarding issue (because the nurse had sought help) the fact that nothing had been done to achieve change and safe nursing practice by Orchid View's management in five months is unacceptable.

4.1.53 With hindsight, this inactivity by Orchid View management could have been identified more strongly as indicative of their continuing organisational and managerial failing, or lack of interest or ability to improve practice.

4.1.54 It does appear that Orchid View would acknowledge issues that came up in the safeguarding work but there is no evidence that acknowledgment of an issue led to any sustainable action to address specific or general concerns on their part.

4.1.55 There were some thefts at the home during July 2010 that the home informed the police about. The police did log the contact and the neighbourhood police officer visited Orchid View but it appears that this was dealt with on an informal basis.

4.1.56 Also in July, the CQC received a complaint about a reduced staffing level and reduced care levels identifying only two qualified staff for nine service users, three of whom were confined to their beds. The CQC had also received notifications of the safeguarding concerns from WSCC, not all of which were substantiated or conclusive. These and issues raised in the following paragraphs, prompted correspondence between the CQC and Southern Cross Healthcare seeking compliance with the registration requirements.

4.1.57 In August 2010 there was a serious medication error made by the home manager when administering a controlled drug. The police were involved and the nurse involved made a full and remorseful acknowledgement of the mistake on her part and self-reported her error to the Nursing and Midwifery Council. Southern Cross Healthcare dismissed her from their employment.

4.1.58 This action and the substantiated safeguarding alert led to the suspension of placements by WSCC in August 2010, a suspension that remained in place until January 2011. An action plan was required

of Orchid View to better manage their medication which it is evident, from this analysis, had been a continual problem in the home and which they never achieved.

4.1.59 That the local authority and PCT did not have sufficient confidence in Orchid View was not known to existing and prospective residents or their relatives. Dealing with this sort of situation is not straightforward and there are legal and safeguarding risks faced by a local authority if it makes known its concerns. This was a Level 3 investigation and WSCC does ask providers with Level 3 or 4 safeguarding investigations to inform their residents on a case by case basis that the concern exists.

4.1.60 Though on the face of it, it might seem obvious that such information should be shared outside statutory agencies; the fact is that the local authority faces the possibility that a business will challenge sharing such information as causing damage to its business, and it may cause homes, and other sorts of care providers, to seek to hide poor practices or specific incidents increasing the risk to specific vulnerable people. On balance these concerns are not an adequate reason for not sharing information. Better information sharing with residents, prospective residents, their families and the wider public is needed. The current consultation on introducing a Duty of Candour is pertinent to service providers and commissioners in ensuring that the public get better information to enable them to make informed choices at this critical time.

4.1.61 In August 2010 a resident was reported missing to the police but was found by staff shortly afterwards in another resident's room. It seems that there might not have been enough staff on duty to search the building properly. Staff should have been following a missing person's procedure. In its initial inspection CQC had commented positively on the policies and procedures in the home. These, presumably would be the national Southern Cross Healthcare procedures and do not appear to have been understood or followed on all occasions at Orchid View.

4.1.62 Boots had made an initial annual pharmaceutical visit in June and had identified improvement recommendations. In August they were asked to visit by the new manager who had no knowledge of the previous visit so, presumably, the home had neither recorded nor followed their recommendations. Following this contact a new appointment was made but when the Boots pharmacist arrived at the Home the manager was not there. She left details for the manager to contact her, which he did not do. Boots do not appear to have followed this up.

4.1.63 There were no other safeguarding concerns until October 2010 when the local authority received an anonymous alert detailing general staffing and quality of care concerns consistent with the medication and nursing failures previously received and investigated. There was also a specific concern about a qualified nurse, the same one who had been incapable of providing catheter care.

4.1.64 There was a joint health and social care response to this alert and a level 4 investigation instigated with the concerns substantiated. The investigation considered specific residents as well as more general care concerns at Orchid View. This investigation focused on a similar range of poor practices as those in previous investigations with residents with pressure sores, poor quality dressings, low staffing levels, staff sleeping at night and rudeness towards residents. Southern Cross Healthcare dismissed the member of staff who had abused a resident and it appears that the internal disciplinary procedure in regard to a nurse who left his unit unattended was also commenced. The local authority required of them a further action plan addressing the range of issues and with specific training required.

4.1.65 The local authority did pursue their investigation and concerns with the Southern Cross Healthcare Safeguarding Lead Manager about the action plan, suspension of placements and the investigation in regard to the three residents during November and December 2010. At this time there were 22 residents.

4.1.66 In the first half of 2011 there were further safeguarding alerts made by health care professionals. In March, by the district nurse who had previously raised concerns about poor nursing care, in particular an inadequate pre-assessment of the wound care necessary for a particular resident and the home's inability to dress the wound properly; associated pain management and ensuring that it had the necessary supply of dressings required for the resident group. The Primary Care Practice was also concerned about these issues and about haphazard prescription and medication requests.

4.1.67 The GP, in discussion with a resident's daughter raised a safeguarding alert in regard to pre-admission assessment, understanding of her mother's medication needs and the importance of complying with a medication regime. A further level 3 investigation was instigated with both health and social care staff involved.

4.1.68 Neglect was substantiated in the safeguarding investigation and specific actions were agreed with the Southern Cross Healthcare Quality Assurance Manager and the home manager in regard to better care plans and care planning. Orchid View also reviewed its medication management arrangements. It is of note that the number of residents had increased to 30; it is not clear that there had been the necessary increase in staffing; qualified and unqualified, to provide care to this increased number of dependent people.

4.1.65 There was one further safeguarding investigation in June 2011, prior to the police alert, when a resident's daughter reported bruising and poor care of her mother. The concerns were similar to others that had been raised, and at this point a level 4 investigation was commenced.

4.1.69 At the same time the police also attended the home after a resident's daughter had contacted them about money taken from her room. This remained unresolved, and no safeguarding alert was raised by the police when it should have been. Since this time procedures have been improved and now such a contact would generate a safeguarding referral.

4.1.70 Both the CQC and WSCC were alerted to a number of concerns in June, and this prompted the CQC to bring forward its planned inspection to the 27 June. This inspection identified non-compliance with a number of Standards and required Outcomes in several areas and an action plan was required by the CQC from Southern Cross Healthcare setting out how these deficiencies would be put right.

4.1.71 By June 2011 the number of residents at Orchid View had increased to 40, and as with the increase earlier in 2011, it is not apparent that staffing levels had been increased to match this increased volume of people needing care.

4.1.72 The number of staff needed and the skills they have is not fixed and will need to be constantly reviewed to ensure it meets the increasing complexity of the resident group and any growth in the number of residents. The information available from discussions held with Southern Cross Healthcare by the health and social care team, the service commissioners and information from the Inquest indicate that the appropriate level and skill of staff at Orchid View was never achieved, a situation compounded by the instruction by the Regional Manager that no agency cover was permitted.

4.1.73 In response to growing concerns about

Southern Cross Healthcare generally as well as specifically at Orchid View, WSCC contracts department carried out contract quality checks on all Southern Cross services in West Sussex. This noted issues around staffing, care plans and management cover at Orchid View.

4.1.74 It was also in July that the Boots pharmacist visited and on her Advisory Visit came across chaotic and unhygienic storage of medicines, poor management of supplies and an apparent lack of management interest in what she had to say. These concerns were not passed on as a safeguarding alert at the time, but it would appear from information given to this SCR by Boots and evidence of a stronger awareness of safeguarding currently, that any similar finding now would prompt an alert.

4.1.75 The police were alerted anonymously at the beginning of August 2011 by the Business Manager in the home (though at that time and subsequently her identity was not known to other staff members) to her concern about five people who had died and four other people admitted to hospital in the preceding two weeks.

4.1.76 Immediately on receiving this alert a level 4 safeguarding investigation involving the police and health and social care staff was instigated.

4.1.77 From the opening of the home in October 2009 to August 2011 there are a number of considerations regarding the safeguarding work including:

- Actions were taken to safeguard the individual residents, however funded, during the investigations.
- There were a number of incidents identified and responded to with safeguarding investigations set in place at differing levels of concern and complexity.
- In a number of these investigations the concerns could not be substantiated, or were inconclusive for a variety of reasons.
- There was close work between health and social care staff in the investigation of concerns, and actions taken in respect of the individuals about whom there was the concern. However, there was a pattern of the same inadequacies repeated in a number of the alerts and it is not clear that the trends were seen and acted upon as a whole sufficiently swiftly.
- There were occasions when services were involved with specific incidents that were not treated as safeguarding incidents and did not generate alerts. Though this approach was appropriate they did reflect the poor quality management of the home and a wider awareness of them would have generated a more comprehensive understanding.
- Although the local authority and the then Primary Care Trust had suspended placing people at Orchid View because of their shared concern at its competence and quality, this was not known to the public and people still went into the home privately funded.
- The CQC were kept informed about the range and levels of concerns throughout this period.
- As well as the alerts raised by families there were also alerts raised by social workers, a district nurse and a GP.
- The responses of Southern Cross Healthcare were consistently inadequate, for example action plan requirements that were not delivered. During this time and although various actions were discussed and said to be set in train there was no evidence of improvement in the actual care provided
- Southern Cross Healthcare increased its occupancy rates gradually since the home opened. However, there was a sharp increase in the numbers of residents after the initial year or so of being open. This was at a time of increasing financial failure of the business nationally and its attempts to secure the transfer of the homes and its responsibilities to other care businesses.

4.1.78 Many of these considerations are addressed throughout the different sections of

this Serious Case Review. There is also a more general thought about the strong wish for Orchid View to succeed, some founded on the hard facts of the pressures faced:

- There was (and continues to be) a shortage of suitable places in the north of West Sussex coupled with increasing demand and pressure within the NHS for people to be discharged from hospital care as soon as they are deemed clinically well enough.
- Homes such as Orchid View are the likely destination for many frail elderly people with increasing care needs and were Orchid View to fail, as of course it eventually did, not only is the resource lost but there is immense distress and risk to existing residents and to their families if it is necessary to move people to other settings.
- From within Orchid View it is understood that the argument was made that resources were needed to make improvements and that more residents would help to generate additional income that would be put to good use locally to improve the care offered.
- There is a cost to providing good quality care and a requirement for high quality professional and unqualified staff. Southern Cross Healthcare would have factored in the developing income as the number of residents increased in tandem with the marginal costs of supporting this increase in residents. They had an income from residents of the home, both publically and privately funded, but it does not appear that, for whatever reason, applying this income to meet the costs entailed in providing good quality services was ever achieved.

4.1.79 As well as these hard facts, there were probably less tangible considerations at play too:

- Maybe there was too high an expectation that new managers and the increasing involvement of Southern Cross Healthcare regional staff would secure improvement? Though it is the case that this expectation faded with experience.
- It was a new building with good facilities and the potential to provide good quality care so those involved in the safeguarding alerts and investigations wanted to support it as well as they could to achieve a good service.
- Other homes had been turned around successfully with the assistance of local commissioning and professional staff, and there was a belief that this could also be achieved at Orchid View.
- Southern Cross Healthcare did have other homes in West Sussex and neighbouring authority areas that were satisfactory.
- As a large organisation there was an expectation that it would make greater effort to achieve improvement. Though as the national difficulties increased this will have negatively affected the abilities within the organisation to achieve improvement.

4.1.80 There are lessons to learn when there is an accumulation of issues and concerns as they were here and successive inadequate responses from the home.

4.2 Phase 2 – In the period from August 2011 to the conclusion of investigations

There was positive action by the local authority as the lead safeguarding authority in conjunction with the police and Sussex Community NHS Trust. A Level 4 investigation was instituted and a team of staff identified to work directly with and in Orchid View, composed of social work and nursing professionals.

4.2.1 This team worked closely with the police and there were extensive early actions and discussions with the CQC, with senior staff in Southern Cross Healthcare and more specifically with the manager of Orchid View. Among these actions was the seizure of case records, a strong request for Orchid View to inform residents and their relatives of the seriousness of the concerns and actions being taken, and the suspension of admissions by the local authority and PCT.

4.2.2 The CQC were aware of the concerns and their seriousness and undertook inspections in June 2011 and September 2011. These inspections focused on a number of Outcomes based on concerns identified that informed the inspection visits.

The inspection in June 2011 included a specialist pharmacy inspector and focused on medication issues. In its IMR, the CQC summarises this inspection as follows:

"The inspectors found non compliance with six regulations and, given the subsequent findings, the absence of specialist nursing input into this inspection probably limited the extent of the evidence they uncovered. The impact on people for the breaches of the two regulations covering care and welfare (regulation 9) and suitable staffing (regulation 22) were judged to be moderate. The non compliance with four other regulations concerning dignity and respect (regulation 17), meeting nutritional needs (regulation 14), safe management of medicines (regulation 13) and staffing (regulation 23) were judged to have minor impact on people. The CQC inspection report advised the provider that improvements were needed to achieve compliance with these regulations, and as a result an action plan was received from the service as to how they would comply with the Regulations."

This inspection is not reflective of the serious concerns there were among the agencies involved in safeguarding work and the concerns expressed by relatives that had brought forward the inspection. This is recognised in the CQC IMR which states: "There was a clear pattern of concern being raised by relatives related to people using the service, other agencies and potential triggers from information including in notifications. Taken together these should have culminated in an overarching risk assessment leading to recognition of and response to the systematic failures and for swift enforcement action to be taken."

The inspection in September 2011 did include an NHS safeguarding practitioner with a nursing background and identified continuing breaches of key regulations that informed the inspection Outcomes. The CQC states that "The impact on people of each of these breaches was judged to be major. It was found that although the provider had made resources available to try to improve the quality of care at Orchid View, there had not been a significant improvement in the care people were receiving in the home."

4.2.3 Initially the police activity was concerned to work with its statutory partners to safeguard residents and to establish if there were crimes that could be further investigated. In doing this they considered the possibility of neglect contrary to the Mental Capacity Act. Over the next few months the police considered the possibilities of neglect in regard to identified individuals and seized care records relating to them.

4.2.4 In November 2011 new information came to light in relation to the shredding and falsification of the Medication Administration Record in regard to Mrs F's medication. With this possibility of a serious criminal offence having been committed the local Sussex Police Adult Protection Team passed the case over to the Major Crime Team for further consideration for prosecution. There had previously been arrests, during September and October, of nursing staff within the home.

4.2.5 The joint health and social care team working within Orchid View describe a hostile environment where their engagement was sometimes resisted. They tried to model good nursing and personal care and attitudes but report that it was very hard to achieve changed approaches, or an understanding or commitment to the importance of changing the way the home was managed and care provided.

4.2.6 Throughout their engagement the team report that they felt that staff from Southern Cross Healthcare, at both local

home management and regional level were uncooperative. An example of this is that when a meeting with relatives was called by Southern Cross Healthcare at the behest of WSCC, none of the multi-agency team working in and with the home from the statutory services was informed of the time and date for the meeting. The team learned of it the following day when a relative wanted to know why they had refused to attend, as had been reported in an apparently deliberate misleading statement by a Southern Cross Healthcare regional manager.

4.2.7 A number of this team were frustrated and angry at the incompetence and casual attitudes of members of the nursing profession working at the home; at their very low standards, the lack of leadership by senior staff that had permitted this state to develop and that insufficient effort was made to put right the wrongs in the home.

4.2.8 There was a good deal of sympathy for the predominantly inexperienced and unqualified staff who were trying to work well in intolerable circumstances who had not had training and development opportunities.

4.2.9 There were several formal safeguarding strategy and planning meetings with senior staff from Southern Cross Healthcare seeking to improve and maintain the service during these months, which involved service commissioners as well as safeguarding staff.

4.2.10 As well as seeking to address this range of concerns there was also an understandable level of anxiety by relatives and residents during this time. Some residents and their families reported a positive experience when they were at Orchid View and were concerned that there would be disruption to their care. Part of the context for this was that another home had been closed by its provider and a number of people had already experienced a compulsory move from another home to Orchid View and were anxious that they may have to go through that experience again.

4.2.11 In the period leading up to the closure of Orchid View by Southern Cross Healthcare there had been discussions with the CQC and both the local authority and health commissioners. Care in the home remained inadequate and Southern Cross Healthcare nationally was under increasing financial and political pressure to resolve the transfer of its homes to other providers.

4.2.12 The preferred operator to take over at Orchid View from Southern Cross Healthcare as a going concern had been party to discussions about concerns with Orchid View during the late summer of 2011. They were also aware of the actions by the local authority to issue a Default Notice to Southern Cross Healthcare and of CQC's concerns during September. In the event, at the beginning of October they decided not to take the home on the basis of a lease assignment for an operational home and withdrew their interest.

4.2.13 On the 6 October 2011 Southern Cross Healthcare took the decision to close the home. They did at that time give a commitment to continue to liaise with the local authority about the various issues to be settled on closure and that there could be contact with a Southern Cross Healthcare representative until the end of December 2011.

4.2.14 Subsequently the records show that despite the assurance to maintain dialogue with the local authority, Southern Cross Healthcare were unresponsive to future contact from the end of November 2011

4.2.15 The Administrator for Southern Cross Healthcare, through their solicitors issued court proceedings against WSCC to recover payments outstanding from the summer 2011 to the home's closure. In the event this was settled in March 2012 with a payment in the order of £61,000 by WSCC to the Administrator of Southern Cross Healthcare. The initial figure sought had been circa £84,000 but this was reduced as the WSCC

counterclaimed circa £23,000 for additional costs it had incurred in paying overtime to its staff going into the home to support residents to mitigate the poor care provided by the home.

5. Review and recommendations: Orchid View's development and opening

5.1. Records available from the commissioning team at WSCC indicate that Orchid View was planned by Southern Cross Healthcare in its location geographically to attract residents from a wide range of southern England. It was purpose built and the target market was people able to meet the costs of their care without dependence on the public purse through the local authority.

5.2 The record held by the local authority indicates that there was concern about the location of the care home on the grounds that Southern Cross Healthcare could find it difficult to recruit staff in the area, particularly professionally unqualified care staff. This was considered to be the case because of the proximity to Gatwick Airport and the work opportunities provided there. Indeed staffing and recruitment did prove to be problematic in this area.

5.3 In deciding to develop and open Orchid View, there is no record that Southern Cross Healthcare made any contact with either the local NHS or WSCC to gauge the likely demand for the setting in relation to the needs of the local population or their interest in commissioning places in this new residential setting.

5.4 As a new build, Southern Cross Healthcare did need to obtain planning permission from Mid Sussex District Council. Separately, Southern Cross Healthcare needed to take into account issues in regard to the actual running of the home and the issues that might affect that, most notably to do with securing staff and their ability to travel to the site on public transport if they did not have access to private transport. The documents seen by the WSCC Commissioners did not include any travel plans for staff.

5.5 Since this time, arrangements have been put in place with district and borough councils informing WSCC about any relevant planning applications.

5.6 There was no consideration of the more local impact on support services, such as the primary care practice, which only learned of the home's development through the local newspaper. They then sought discussion with Southern Cross Healthcare about the development but report that there was a lack of interest from the organisation and no willingness to engage with the practice about the implications of this large development within their practice area. This is further discussed in section 8.2.

5.7 Southern Cross (Copthorne) OPCO Ltd was the registered provider of Orchid View as a care home with nursing from 1 September 2009 when it was registered to accommodate 87 people in the categories of old age and dementia. This registration was under the existing legislation of the time: the Care Standards Act 2000. The home opened in October 2009.

5.8 A contract was signed with Boots the Chemist to provide prescribing and pharmacy support in August 2009. The local authority and PCT contracted with Orchid View at the beginning of October 2009 and the records indicate that the first Continuing Healthcare NHS funded person was admitted to the home in October 2009.

6. Review and recommendations: regulation of the financial and governance robustness of care providers

6.1 It is beyond the scope of this SCR to develop detailed proposals for how such independent businesses are required to provide better assurance about their robustness, governance and how they balance their profits against the costs required to provide good quality care to vulnerable people.

6.2 This is a matter of significant public concern recognised as such by the Department of Health in recent publications, 'Strengthening corporate accountability in health and social care: Consultation on the fit and proper person regulations, March 2014' making it clear that there is a direct responsibility on the service provider. The consultation states that "the responsibility for ensuring individuals are fit and proper will lie with the organisation…signed off by the chair or the provider." This will be overseen by the CQC: "CQC will assess fitness on initial registration and could refuse to register a provider if they thought that a director was unfit; CQC could impose a condition to require the removal of an unfit director following inspection or where they were notified of a new appointment."[26]

6.3 The Department of Health also refers directly to Southern Cross Healthcare in identifying the role of local authorities in the event of provider failure, or in the words of the Minister of State – Care Services "if the company in charge of their care goes bust."

6.4 The Department of Health describes the problem in information in relation to the Care Bill: "There is currently not a formal system in place for checking how well a care provider is managing its own finances. This means there is no 'early warning' that a problem might be coming, nor anything in place to help resolve the problems it may cause people. The failure of a large care provider, Southern Cross Healthcare, in 2010 highlighted these issues. It is unacceptable for care users to be left without the services they need. The interruption of care services, or the worry that this might happen, can affect the wellbeing of care users. It can place stress on them, their families, friends and carers."[27]

6.5 The Care Bill will impose a legal responsibility on local authorities where a provider fails, and this applies to both residential and home care services. This responsibility extends to all people receiving care specifically including those who pay for such care themselves.

6.6 Anticipating this extended responsibility and in the light of experience of home closures, WSCC have taken a number of steps to increase their market intelligence to mitigate the possibility of service failures and their ability to respond in such an event. They have developed a clause in their contract with service providers permitting the examination of providers' accounts which is now done as a matter of course. The Contracts and Commissioning Team also asks service providers to indicate the ratio of their residents funded by WSCC, by the NHS using continuing healthcare funding or receiving Funded Nursing Care,[28] people funded by other local authorities and those people who are

[26] DH Strengthening corporate accountability in health and social care: Consultation on the fit and proper person regulations, March 2014

[27] Department of Health Factsheet 10 The Care Bill – market oversight and provider failure

[28] NHS-funded nursing care is care provided by a registered nurse, paid for by the NHS, for people who live in a care home

privately funded, which helps to understand the risks and viability of their business model. Included in this analysis is also consideration of the occupancy levels, cross subsidies within the home and the rates charged to residents.

6.7 The CQC's remit is also extended in the Care Bill which "proposes to give the CQC specific powers to monitor the financial strength of approximately 50 to 60 care providers whose financial collapse could trigger a local crisis in the delivery of care". The CQC will have the authority to require sustainability plans and an independent business review. These actions are to be welcomed as contributing to the maintenance of services and lessening of the risk of provider failure. However, whether such powers are sufficient remains to be seen.

6.8 It is the case that in January 2014 the Parliamentary Health Select Committee expressed concerns about whether the CQC is the appropriate body to undertake the financial monitoring of social care and recommended "that the Government should reconsider its decision to allocate this responsibility to CQC and it is essential that they procure the right skills to fulfill this role."[29] They proposed that Monitor, the sector regulator for health services in England, should focus on financial performance as it does in regard to NHS Trusts.

6.9 The CQC took a different view on the grounds that it is not possible to "separate finances from issues of quality – they are two sides of the same coin."[30] At that time the care provider organisation, Care England Chief Executive is quoted as questioning the actions of the auditors of Southern Cross saying that "there is not necessarily a need for new legislation and processes." But that if such scrutiny is to proceed with either, that both Monitor and the CQC would have to improve their capacity to carry out such a remit, appearing to favour Monitor carrying out such a role "because they've already got a bit more of a specialist remit in that area."[31]

6.10 Care homes with nursing such as this one are providing services similar in nature to those provided by the NHS and are reliant upon good quality nursing care to their residents. In addition to imposing the additional duty on local authorities in respect of people who fund their own care, it is obviously desirable to try to stop such failures occurring in the first place. Scrutiny of the financial security of businesses can be expected to facilitate this.

6.11 The CQC already has a recognised need to improve its core quality monitoring and assurance performance, and has set this out in a number of documents: A Fresh Start for inspecting adult social care services[32] and most recently in its consultation documents in relation to how the CQC regulates, inspects and rates regulated services.[33] It would be unfortunate if this further extension of its responsibilities into financial scrutiny inhibited improvements in respect of the quality of its prime responsibilities in regard to inspection and regulation.

6.12 Given the significant change and improvement agenda the CQC is already engaged in, no doubt the Parliamentary Health Select Committee can be expected to take an interest in the efficacy of the CQC carrying out this new responsibility of financial scrutiny.

6.13 The Terms of Reference of this SCR do not extend to include the technical competence to consider in detail the complex governance and financial arrangements

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[29] Health Committee –Sixth report, 2013 accountability hearing with the Care Quality Commission, January 2014

[30] CQC Chair David Prior quoted in Community Care E-magazine quoted in January 2014

[31] Care England Chief Executive Martin Green also quoted in Community Care E-magazine, January 2014

[32] CQC A Fresh Start for the Regulation and Inspection of Adult Social Care, October 2013

in respect of Southern Cross Healthcare as a business operating throughout the UK. However, a number of the concerns raised may also be pertinent to other large scale businesses that provide social and health care, such as that at Orchid View. Increasingly, such care is being provided by private businesses and it is right that the public can have confidence both in the quality of their care, and in their governance and financial robustness which, as is apparent in this case, can have such a damaging impact on individual vulnerable residents when the organisation is fragile or unfocused on providing good quality care as its primary goal.

6.14 At the time of the development of the home in 2009 there was insufficient consideration or planning by Southern Cross Healthcare into its continuing ability as an organisation to recruit, support and train staff. In order to provide safe nursing care services at Orchid View, both in terms of the competence of its staff and the numbers of staff required to meet the requirements in its registration criteria, a workforce strategy was needed, and there is no evidence in practice that such a strategy existed.

6.15 Difficulty in staffing a resource is not a reason for not developing a service for which there is demand. With the growing numbers of elderly people in our society there is a continuing need to develop support services for older people, be they in a nursing home setting or by providing community support to people in their own homes. In both cases it is important to be confident that organisations who are in, or entering into, the care business are required to demonstrate that they have robust and viable plans to ensure that they can satisfactorily staff their businesses to deliver and maintain good quality care.

6.16 Although the focus here is clearly on a nursing home setting, there are known to be similar difficulties in recruiting and maintaining basic level care staff across the interdependent spectrum of care services. Nationally, the care industry tends to pay care workers at the minimum wage. In an area such as Crawley, where there are a number of employment options open to people who Southern Cross Healthcare and similar agencies would want to recruit, it is imperative that clear, adequate and attractive remuneration and career developmental plans are in place. The implementation of these plans needs to be monitored with direct consequences for the providers if they fail thereby putting at risk vulnerable people whose care is the basis of their business.

6.17 This is an issue that was extensively discussed in the Cavendish Review[34] published in July 2013, with recommendations pertinent to the opening, management and staffing of Orchid View. See section 10.

Recommendation 6

That care businesses in development, and currently trading, can evidence robust plans to recruit and sustain a trained workforce to meet the needs of those people dependent on the care they as individuals, or the statutory sector, purchase to meet their needs. Delivery of this requirement should be monitored by the CQC

6.18 The guidance produced by the Department of Health Protecting and promoting patients' interests; Licence exemptions: guidance for providers[35] makes it clear that "Providers of only NHS funded nursing care or continuing health care (eg care homes who provide no other NHS health care services)" are "automatically exempt from the requirement to hold a licence from Monitor."

[33] Several CQC publications in April 2014, most relevantly in relation to Adult Social Care summarised in Overview to the provider handbook for adult social care April 2014, and in more detail in the Chief Inspector of Adult Social Care Regulatory Impact assessment: Changes to the way we regulate and inspect adult social care

[34] The Cavendish Review, An independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, July 2013, published as a follow up to the Francis Report.

[35] TDH Protecting and promoting patients' interests; Licence exemptions: guidance for providers, December 2013

The effect of this is that businesses providing such care are not required to meet specific requirements that will strengthen and assure their ability to provide healthcare in nursing home settings.

6.19 There is an exemption in this guidance relating to "Small and micro providers (those with less than £10m applicable NHS turnover)." There is a need to demonstrate to the public, as evidenced by the understandable reactions of relatives to what happened at Orchid View, that organisations that are becoming increasingly important in delivering care to some of the most vulnerable people in our society are properly scrutinised and where they are providing healthcare funded by the NHS have satisfied the licensing conditions.

6.20 The exemption from the licensing requirement on grounds of turnover is understandable and it would not seem desirable to increase the bureaucracy and impose an undue layer of scrutiny on smaller providers. However, it may be that large health and social care providers working nationally with a turnover of £10m, possibly from all sources, i.e. the NHS, local authorities and private self-funders, are required to hold such a licence, or the equivalent, regulated by the CQC to fulfil the powers set out in respect of the NHS provider licence:

- "set prices for NHS funded care…"
- "enable integrated care"
- "safeguard choice and prevent anti-competitive behaviour which is against the interests of patient"
- "support commissioners to protect essential health services for patients if a provider gets into financial difficulties"; and
- "oversee the way that NHS foundation trusts are governed."

6.21 It is recognised that not all these powers will be appropriate as they stand for independent sector providers and it may be that the CQC will provide the necessary measure of scrutiny and will carry out the purposes of the licence with its extended role.

6.22 The Department of Health has committed to "a full review during 2016/17 of how the exemptions regime is working in practice" and notes that this was widely welcomed in its consultation.[36] This SCR also welcomes the review and urges the consideration of a possible extension of appropriate aspects of the NHS Provider Licence to care home settings owned and managed by large national businesses.

Recommendation 7

That in its review of how the exemptions regime is working the Department of Health specifically considers the possible extension of the provider licence to care homes owned and managed by large national businesses with a turnover, from all sources, in excess of £10m.

[36] DH Explanatory Memorandum To The National Health Service (Licence Exemptions Etc) Regulations 2013, 2013 No.2677

7. Review and recommendations: Care Quality Commission's work with Orchid View

Early inspection and regulatory issues

7.1 The first inspection of the home by the CQC in January 2010 was very positive, recording that from the three care records they looked at, and the staff, visitors and residents they spoke with reported favourably on their experience at the home. There were at that time sixteen residents in the home; there is reference to one visitor to the home saying that there were not always enough staff on duty. The only concern raised in the inspection report, however, was that staff supervision records were not up to date.

7.2 This was an unannounced inspection. The CQC state in their IMR report to the SCR that "the report focuses heavily on policies, procedures and records and there is limited triangulation of evidence to demonstrate knowledge or implementation".

7.3 The requirement for an appropriately qualified registered manager of the home was met by a post holder who was a registered nurse, and it was understood by CQC that she would be addressing the staff supervision issue.

7.4 The outcome of this inspection was that Orchid View was rated as Good by the CQC and that rating was posted on the CQC website and remained as the available judgement by the regulator to the public until July 2011.

7.5 The CQC states in its IMR that "awarding a good rating so soon after the service opened when it had only 16 residents out of a total of 87 available places was premature, although in line with the methodology at the time." The IMR goes on to recognise the implication of that judgement for the inspection regime that was then put in place because the rating of good "influenced the frequency of future inspections based on quality and risk. For Orchid View this would have meant another inspection would not have been planned for at least a year unless there was concerning information about it." Unfortunately it is the case that although there was continuing concern throughout the rest of 2010 and the first half of 2011, the next inspection was not until June 2011 prompted by increasing concerns expressed by Adult Safeguarding staff to the CQC. This is a failing recognised by the CQC and discussed below.

7.6 From the point of view of the information about Orchid View available to the public on the CQC website, significant especially for those people and families arranging their own care without the support of statutory sector commissioners, this gave a misleadingly positive, and therefore reassuring, description of the home. Many of the families have said both in the Inquest and in talking with the Chair of this SCR, that the building and facilities available and purported to be available at the home were attractive. The CQC acknowledge that "the good rating was continuously used by Southern Cross Healthcare to attract new residents", and this coupled with the way Southern Cross Healthcare managed the perception of the Home, did present a positive appeal to families seeking a good quality setting for their relative.

7.7 Since this time the CQC has introduced a banner onto its website giving more current information about homes where concerns have been raised. Here are examples:

CQC has warned ABC Care (St Hugh's) Limited that they must make improvements within a given timescale at St Hugh's House.
Read more here (see link on the CQC website)

This service was not meeting all CQC national standards and we require improvements.
Read more here (see link on the CQC website)

Action is being taken against this provider. Click through for more information
Read more here (see link on the CQC website)

We are currently reviewing this service
Read more here (see link on the CQC website)

7.8 The public is more aware than it would have been in 2010/2011 when it only had information relating to an inspection that may have been carried out over a year earlier. This development is welcomed by the SCR and would urge the CQC to ensure that it continues to review the effectiveness of such messages with a view to improving the information they contain in the light of experience.

7.9 The CQC is critical in its IMR about the inspection method and approach used in January 2010, detailing its concerns: "focus of the first inspection on the home's documentation without triangulation with staff understanding and practice, case tracking or user experience and without seeking the contributory views of other professionals also brings into question the robustness of this first judgement." The approach to inspections has changed since 2010, which is acknowledged to have been a difficult period for the CQC as it began to work within a changed legislative framework and with a heavy workload, which is discussed below.

Initial Rating of Good

7.10 The CQC acknowledge in their IMR to this SCR that the rating of "Good" given to the home after the inspection carried out in January 2010 was premature, and was based too much on the existence of Southern Cross Healthcare's national policies and procedures, but, and especially with so few residents at the time, this was not tested against the actual practice in the home.

7.11 The effect of this was that Southern Cross was able to trade on this rating of "Good" to attract new residents for some 18 months despite the safeguarding concerns apparent to the local authority and communicated to the CQC. It is also probable that this description lessened the level of pressure to act within the CQC when the safeguarding concerns started to become apparent.

Inspections in June and September 2011

7.12 The CQC became aware of the concerns and their seriousness and undertook inspections in June 2011 and September 2011. These inspections focused on a number of Outcomes based on concerns identified which informed the inspection visits.

The inspection in June 2011 included a specialist pharmacy inspector and focused on medication issues. In its IMR the CQC summarises this inspection as follows:

"The inspectors found non compliance with six regulations and, given the subsequent findings, the absence of specialist nursing input into this inspection probably limited the extent of the evidence they uncovered. The impact on people for the breaches of the two regulations covering care and welfare (regulation 9) and suitable staffing (regulation 22) were judged to be moderate. The non compliance with four other regulations concerning dignity and respect (regulation 17), meeting nutritional needs (regulation 14), safe management of medicines (regulation 13) and staffing (regulation 23) were judged to have minor impact on people. The CQC inspection report advised the provider that improvements were needed to achieve compliance with these regulations, and as a result an action plan was received from the

service as to how they would comply with the Regulations."

This inspection is not reflective of the serious concerns there were among the agencies involved in safeguarding work, and the concerns expressed by relatives that had brought forward the inspection. This is recognised in the CQC IMR which states: "There was a clear pattern of concern being raised by relatives related to people using the service, other agencies and potential triggers from information including in notifications. Taken together these should have culminated in an overarching risk assessment leading to recognition of and response to the systematic failures and for swift enforcement action to be taken."

7.13 The inspection in September 2011 did include an independent NHS safeguarding practitioner with a nursing background and identified continuing breaches of key regulations that informed the inspection Outcomes. The CQC states that "The impact on people of each of these breaches was judged to be major. It was found that although the provider had made resources available to try to improve the quality of care at Orchid View, there had not been a significant improvement in the care people were receiving in the home."

National and legislative transition issues

7.14 At the time of the CQC inspection in late January 2010, the CQC was a relatively new organisation having been formed at the beginning of April 2009. It was also dealing with the planned introduction a year later in 2010/11 of what the CQC has described as a "significant change to the underpinning legislation, policy and methodology within which the CQC operates and providers are registered and regulated".

7.15 It is also the case that at this time, the CQC was involved in work with Southern Cross Healthcare on a national basis and were tasked with helping to find a solution involving the safe transfer of hundreds of homes and residents to other care providers.

7.16 The CQC were also heavily overcommitted to achieving transitional registration as all services were required to change their registration and the CQC to change its regulatory and enforcement policies and practices in line with the introduction of the Health and Social Care Act 2008. This required the (re)registration of some 25,000 existing providers. The CQC acknowledge that at this time their approach was essentially light touch with the view that if the providers were subsequently non compliant with requirements they could be subject to stronger enforcement powers. This impacted negatively on the number of inspections undertaken in the period from June 2010 to April 2011. It also affected the availability of inspection time, the consistency and experience of the CQC inspectors which the CQC acknowledge negatively affected the quality of their work at the time

7.17 There is something perverse about the negative impact that the push for change, improvement and sustaining services nationally had on the engagement of the CQC on the poor service people experienced at Orchid View. When such change is being introduced, greater consideration to the possible negative impact on maintaining day to day work is required.

7.18 It is important that time and resource is committed to help organisations achieve major change as the CQC was doing at the time. This is an issue that goes beyond the CQC and it is important that as the range of public services and regulatory bodies experience change, there is recognition that the day job has to be, at least maintained and preferably improved while this additional work is undertaken.

7.19 The CQC recognise this in the recommendations they make in their IMR so no specific recommendation is made in

respect of the CQC. However, this is a concern that goes wider than just the CQC, and at a national and local level it is important that national and local government and NHS England recognise the need to maintain good quality services while promoting wide scale change that can negatively affect the capacity of staff at the local level to safely deliver their ordinary duties.

Recommendation 8

That where large scale reorganisation and the introduction of additional responsibilities to meet legislative change is being implemented, it is imperative that an impact assessment is undertaken to ensure the organisation maintains the ability to carry out their routine responsibilities while at the same time implementing the reorganisation.

Future regulation approach from October 2014

7.20 The changes that the CQC describe in Fresh Start[37] have already been referred to. They are set out in its new inspection and regulatory framework in October 2013. This is intended to strengthen the process, quality, relevance and reliability of the CQC's work and will come into force in October 2014. The CQC describes these changes as a new focus on five key questions they will probe on their, at least annual, inspections into the future:

- are the Services Safe?
- are they Effective?
- is the setting and its staff Caring?
- is it Responsive to the needs of residents?
- and is it Well-led?

Using these questions to inform the inspection, the CQC will form a judgement of the rating to give to the setting which will be one of the following: Inadequate; Requiring Improvement; Good, or Outstanding.

7.21 This SCR welcomes the introduction of the new framework with its intention to address the areas above which Orchid View failed in and which the CQC acknowledges they took insufficient action to understand and remedy in this home.

7.22 The recent consultation documents issued by the CQC have already been referred to and describe the proposed extension of CQC responsibilities in respect of adult social care. These are to be welcomed and represent a significant range of changes to all aspects of regulation, inspection and rating the quality of the service.

7.23 Among the changes proposed is a greater use of specialist advisors and experts by experience. The CQC has recognised that it needs greater expertise in future inspections in regard to nursing and pharmacy awareness, which is illustrated in the internal recommendations the CQC has itself identified and in the consultation proposals. However, from the experience of this SCR there is scope for greater involvement of an expert by experience with the perspective of a relative in the inspection process and/or of involving actual relatives in the inspection of particular services.

7.24 In the NHS there is now an established practice of the CQC holding listening events with staff and with patients. Such listening events would be a positive addition to the CQC inspections carried out with the independent sector.

Recommendation 9

That as the CQC develops its inspection framework and process, specific attention is given to invite and include discussion with the relatives of residents, and offers the opportunity of private discussion with a member of the inspection team.

[37] CQC A Fresh Start for the Regulation and Inspection of Adult Social Care, October 2013.

Registered Manager

7.25 The information put forward at the inquest shows that there were six different managers from the opening to the closure of Orchid View. Of these, only one was ever registered in accordance with the CQC's requirements. The manager who opened Orchid View was the only manager to be registered. She was at the home from its opening until June 2010; the second manager was at the home over the summer of 2010 from July to September; the third manager was at Orchid View for six months from August 2010 to January 2011; the fourth manager was again very short term from January to March 2011; after an apparent gap the fifth manager took up the role in May and was in post until September 2011; a sixth manager was in place from September to the closure of the home in October 2011.

7.26 This succession of managers illustrates unstable management at Orchid View with the effect for the staff at the home that there was inconsistent leadership and direction. Externally it should have been identified as an indicator of the fragility of the home's management that needed to be addressed by Southern Cross Healthcare and incorporated in the CQC's view of the home.

7.27 There is a practical issue if the registered manager should leave without giving adequate notice to recruit a registered manager or if the home has not planned for a departing manager's replacement. In such a case there might be an interregnum while a new manager achieves registration, and the possibility of this is allowed for by the CQC for practical reasons although a warning notice is issued.

7.28 However, this is not an option that should be open for any length of time and in its recent consultation documents,[38] the CQC makes it clear that they will consult further on their enforcement approach and "will be tougher on providers who consistently fail to meet the fundamental standards set out in regulations…This will include fining providers who are without a registered manager for long periods, despite this being a condition of their registration with CQC."

7.29 In this case this pragmatic arrangement does appear to have been exploited by Southern Cross Healthcare with a succession of unregistered managers in the home, including the manager in post during the police investigation initiated in August 2011. It is of note that he had not begun to work at Orchid View with a view to becoming the manager but had taken up a developmental role before becoming the manager. This reflected the lack of planning and leadership of regional Southern Cross Healthcare managers who appeared to, at best, let Orchid View drift, and at worst, had no interest in carrying out their responsibilities or management arrangements to achieve good quality care at the home.

7.30 The CQC were not strong enough in pressing for this issue to be resolved. This is a reflection of their overall lack of engagement at Orchid View. This issue is not addressed in the nine recommendations that the CQC makes in regard to its future actions in the IMR. However, it is within the recent consultation documents and it is understood that, in practice, certainly in West Sussex, the CQC is taking a more robust line and have imposed financial penalties where a registered manager is not in post, even where recruitment efforts can be demonstrated. This SCR supports this stronger line by the CQC.

7.31 Among the actions coming out of this investigation is that the CQC publicises the absence of an appropriately qualified and registered manager. This could be clearly stated in one of the information boxes it has

[38] Chief Inspector of Adult Social Care Regulatory Impact assessment: Changes to the way we regulate and inspect adult social care.

introduced onto the website information about specific homes.

Recommendation 10

That where there is no registered manager in place this information is made public by the CQC on its website.

7.32 There is a broader debate about the role of the registered home manager than just in relation to Orchid View. Currently, as this report is being drafted, research is underway by the National Institute for Health Research School for Social Care Research (SSCR)[39] into the role of the registered care manager. This is to be welcomed because, as the research documentation points out "little is known about care home managers, their careers, training and the supervision and support they receive from home owners or regional managers."

7.33 The outcome of this research will be helpful in building a profile of the skills and attributes of registered home managers and may also help to shape the perspective on the key requirements that should be incorporated in an essential set of competencies and skills that could be embodied in a core job specification for such post holders. The notion of core competencies is important in promoting consistency of qualifications and clinical and professional management responsibilities given that the registered home manager might be also the home owner with just a single home, or part of a large company. The CQC does issue helpful guidance to people putting themselves forward to become registered managers[40] which gives a clear description of the process and importance of the role in regulated services.

7.34 The registered home manager, like ward managers and team leaders in other care settings, is critically important in setting the tone and standards of the setting for which they are immediately responsible. However, this tone is not set just by the registered manager, particularly when they are employed by a large organisation with national coverage and management structure. There will be systems and supports in place additional and different to those of a home which is broadly owned and managed by an individual, which are intended to provide support to the registered manager within the security of a larger organisation. However, as was demonstrated at Orchid View being part of a large organisation does not guarantee such support.

CQC's own review and recommendations

7.35 This SCR has not made extensive recommendations in regard to the CQC, partly in recognition of the changes that it is making to its regulatory and inspection work with the new approach to inspection from October 2014. Repeated here are the Recommendations for Action identified by the CQC, which they state will inform future practice together with the internal review being undertaken:

1. When introducing ratings for care homes in 2014, the CQC should be mindful of the risks of awarding a good or outstanding rating to a service before it is fully operational and ensure that it seeks out any concerns of other professionals.
2. The scope and trends of notifications received, particularly about safeguarding concerns, need to be systematically presented and analysed to enable inspectors to identify emerging risks and to take effective regulatory action. This needs to be a priority for the development of an intelligent monitoring system in adult social care.

[39] National Institute for Health Research School for Social Care Research (SSCR) scoping work commenced in December 2013 with a report date of 31 March 2014

[40] CQC Guide to the application process: Guidance for new registered managers, July 2011

3. Include in the induction of new and training of existing staff specific around risk assessment when assessing the quality of care and the safety of people who use services. This should include identification and recognition of patterns and trends so that remedial action is initiated.
4. The CQC should remind staff of their regulatory duties and responsibilities linked to safeguarding concerns within the new inspection frameworks. In particular as part of their portfolio management inspectors should continuously review whether individual concerns suggest more systemic issues in the service and whether these should trigger an early inspection.
5. The importance, when dealing with safeguarding concerns, of effective communication and clarity of roles between the CQC and local safeguarding teams should be reiterated to managers and inspectors. The CQC should also seek assurance that its guidance for staff regarding their contribution to or attendance at strategy meetings is being consistently followed.
6. Managers and inspectors must be reminded of the central importance of Management Review Meetings (these are meetings internal to the CQC) in providing a summary chronology of concerns and determining and recording decisions about actions to be taken (or not taken) and the reasons for this when serious concerns arise.
7. There must be clarity and guidance for staff concerning the need to include nurse specialists on inspections of care homes with nursing that are looking after people with complex and multiple high care needs.
8. The CQC should ensure that when it is assessing re-registration applications for existing and continuing services it takes full account of any concerns known to the CQC about the provider and service and if they are registered that any remaining issues are clearly communicated to the next allocated inspector.
9. As it approaches another period of transition with consequent changes to many inspector portfolios, managers and inspectors must ensure they identify all regulated services of concern and record these on risk registers together with actions planned, and that hand over to another inspector of any of these services is done effectively.

This SCR supports these recommendations.

8. Review and recommendations: safeguarding awareness and agencies working together

A number of professionals and agencies either visited Orchid View or had contact with residents of the home when they made use of their resources, for example in hospital settings. Some of these agencies raised safeguarding alerts that have been referred to in the analysis of the safeguarding work.

West Sussex County Council Adult Social Care: period from opening in 2009 to August 2011

8.1.1 West Sussex Adult Social Care has the lead responsibility for safeguarding in the county. As such they led on the safeguarding work as individual alerts were raised from the opening of Orchid View to July 2011. Subsequently when the major Level 4 safeguarding investigation was commenced in August 2011 after the alert to the police, the investigation into possible criminal activity was led by the police alongside the safeguarding work to ensure the safety of people coordinated by WSCC Adult Social Care.

8.1.2 During the first phase the multi-agency safeguarding procedures were followed and work was carried out within reasonable timescales and in concert with other agencies as needed. Mostly the concerns were relatively low level, although it is of note that the very first alert in December 2009 had to be escalated because the home's management at that time did not respond appropriately to the safeguarding alert by conducting a Level 1 investigation as they should have in line with the West Sussex procedures.

8.1.3 It is the case that some of the alerts were inconclusive, or unsubstantiated because there was insufficient evidence to make a conclusive finding. Action Plans for individuals were developed in cases where no conclusive finding of substantiated was made. It is important to recognise that the primary issue in safeguarding work is not the finding as such, but the actions taken in the course of investigating the alert to identify the person's circumstances, the outcomes they want from the safeguarding work, and to safeguard them and anyone else who might be affected.

8.1.4 The individual safeguarding records indicates that families were informed, though this is not the perception of all the families subsequently. There is one case where a resident's daughter raised a concern in June 2011, which was acted upon, but this daughter states that she had in fact raised her concerns much earlier though there is no record of this in the resident's electronic file.

8.1.5 With the benefit of hindsight, what emerges is a picture where individual alerts were responded to appropriately but what does not appear to have happened is that the nature and pattern of alerts was sufficient to take stronger action, until the serious medication error with the syringe driver in August 2010 brought about the suspension of placements by WSCC. Safeguarding staff were aware of the build up of alerts and it is clear that this did influence their perception of Orchid View as providing poor quality care.

8.1.6 As is recognised in the IMR, themes were emerging very early on in February 2010, in relation to staffing competencies, failure to meet basic dietary needs, safe handling of medication and Southern Cross Healthcare's failure to take action against a particular member of their nursing staff. This was soon compounded later in the spring with specific concerns about a nurses' competence and insufficient staffing levels.

8.1.7 The trigger for this safeguarding alert at Level 3 investigation, with police involvement and the suspension of placements at the home by the local authority, was the serious error in respect of the administration of a controlled drug. It is recognised by the agencies involved that this was a genuine mistake by a caring nurse who was appalled by her error and referred herself to the Nursing and Midwifery Council, and it is understood has ceased her nursing career. This nurse acknowledging her error and taking responsibility for it was in contrast to the lack of recognition of the poor practice of other managers and nursing staff in the home.

8.1.8 Concern was further escalated in October 2010 following an anonymous alert and a joint health and social care Level 4 investigation was established. This investigation again touched on numerous issues: staffing levels, practice at night, nursing competency, specific problems with dressings and medication management. One member of staff was dismissed and Southern Cross Healthcare were required to put in place an Action Plan to address staffing and training issues in particular.

8.1.9 During this period there was appropriate discussion and sharing of information with WSCC and the NHS Commissioners. The CQC were also kept informed but to the frustration of those carrying out the safeguarding work did not engage adequately in the individual cases or with Southern Cross Healthcare. This probably lessened the ability of the local authority as the lead safeguarding agency to act more strongly during this first phase and in unison with the CQC.

8.1.10 It is important that emerging themes are identified and shared with relevant agencies so that they all have as full a picture as possible as they deal individually and jointly with individual cases. The new information system being introduced should provide the potential for improved awareness and coordination of information in regard to services commissioned locally.

8.1.11 There is no overarching information system across all the agencies established in any part of England so this is not an issue unique to West Sussex. There is however a positive approach to improving access and sharing of information across agencies and further work is necessary to ensure that access and sharing arrangements are as open and full as can be managed.

Recommendation 11

WSCC and partner agencies should review the current processes and systems available for collating information relevant to safeguarding, in order to identify emerging patterns or concerns. This should include analysis of the impact and effectiveness of action plans over time where a number of investigations have been required in relation to the same provider service.

After the safeguarding alert in August 2011

8.1.12 The record shows immediate and positive action by the local authority, police and local NHS working together jointly to institute the Level 4 safeguarding investigation and to put a team in place at Orchid View to address safeguarding concerns promptly and coherently.

8.1.13 This was a tight team that worked well in trying to get those actually responsible for the delivery and management of care to improve. However, they had limited success in achieving this given the reticence and lack of action by Southern Cross Healthcare.

8.1.14 Staff from Orchid View and at a more senior level in the Southern Cross Healthcare management structure were properly involved and they were requested to carry out specific tasks and communications to residents and relatives.

8.1.15 There were a number of actions put

in place and strategy meetings were held appropriately to address concerns and to review the care being delivered to specific residents.

8.1.16 During this time there were new alerts relating to medication and the CQC responded to correspondence and to the information being conveyed to them by the safeguarding team. The team was also responding to new concerns through their investigations that they were addressing as they uncovered them.

8.1.17 During this time there was resistance to the investigation by some Orchid View staff in the home and those in Southern Cross Healthcare's regional management structure responsible for dealing with the quality problems in the home. There was a reluctance to share information and instances of misinformation about the commitment and engagement of this team.

8.1.18 A number of residents did move from Orchid View to other nursing homes during this time. The transfer of older people from one home to another can be detrimental to their well-being, health and survival and such moves are avoided wherever possible. Deciding that it is in the person's best interest to move to another setting is a fine judgment and such moves need to be carefully planned and managed to minimise impact.

8.1.19 At Orchid View those staff involved from all the statutory agencies involved were continually assessing and balancing the risk to these vulnerable people. This was an intense and emotive situation where there was no ideal solution, only a best outcome.

8.1.20 Significant effort was made to improve the care in the home. But when the tipping point was reached and it became clear that improved care could not be maintained and sustained then the decision was taken to move people, minimising the associated risk.

8.1.21 In carrying out this range of safeguarding work, several investigations were not concluded until after the home had closed – in late 2012 and at the beginning of 2013. Multi-agency meetings continued during this period with an agreed approach, information sharing and an identification of which cases could be concluded in relation to the safeguarding investigations. Others were not concluded because of continuing police investigations, the volume of evidence, the complexity of the investigation and need to interview witnesses who might have been called in any possible criminal cases.

8.1.22 Although the criminal investigation took priority over the completion of the safeguarding investigations, work to safeguard people during the time that Orchid View was open and in the transfer of some people to other residential settings, continued.

8.1.23 Some information was shared with relatives by the safeguarding investigation team at this time. But the responsibility for providing information rested with Southern Cross Healthcare and the agencies involved in the safeguarding work were constrained in regard to what they could share with residents and relatives.

8.1.24 There was a considerable cost to the public purse providing the support team within Orchid View. There is always a balance to be struck at such times when the statutory sector feel it is necessary to step in because of the failings of the business entity responsible for the care provided in their home. This is discussed in section 8.7.

8.1.25 It emerged when the Administrator of Southern Cross Healthcare issued court proceedings against WSCC in February 2012 that WSCC estimated that the overtime cost to the council (excluding the ordinary salary costs of WSCC and NHS staff who were deployed within Orchid View and the investigatory cost in pursuing the safeguarding cases) was just short of £23,000 which the council subtracted from the settlement it reached with the solicitors acting for the Administrator. It is estimated that the

additional cost to the NHS was of a similar magnitude.

8.1.26 It is also possible that by deploying competent local authority and NHS professionals within a home that is failing, they in effect prop-up the home artificially. As with the judgement to move people from one setting to another, this requires very careful consideration, including the point at which it might be concluded that it is in the best interests of residents and the public purse to cease this support and provide alternative settings.

8.1.27 This is not just a judgement for the local authority and NHS commissioners to make and requires the active engagement of the CQC. Maintaining the home in line with the registration criteria and ensuring a good quality and safe setting is the responsibility of the home owner.

8.1.28 However, not withstanding these considerations and the cost incurred, it is important that key members of health and social care staff experienced in safeguarding in complex institutional settings are available to manage the pressures generated by the failure of a home.

8.1.29 The WSCC Adult Services IMR recognises this and the lessons learned in this case have been deployed in more recent safeguarding investigations.

8.1.30 Regrettably, providing for this contingency is a national issue and reinforces the importance of sharing best practice across local authority areas.

8.1.31 Increasingly, as a national issue, agencies involved in safeguarding work do so at a time of increasing pressure on their diminishing resources. When such large scale investigations are necessary it is important to recognise the very significant additional strain this causes to services with little margin, and the importance of providing good emotional and practical support to those staff directly involved. This was done in West Sussex by the health and social care teams in this case and this is an experience that could be positively shared with other safeguarding boards.

Recommendation 12

That the WSASB make available information to safeguarding boards across the UK about their approach, experience and learning points from the work carried out within Orchid View by the joint health and social care team.

8.1.32 Nationally there is no systematic approach to learning from Serious Case Reviews, from any of the national bodies involved in social care or health care to facilitate such learning. With the introduction of the Care Act in 2015 a proactive approach to learning from SCRs by the Department of Health would be a welcome initiative.

8.2 NHS Services

In regard to NHS services, there is no specific heading in this SCR relating to the (then) PCT which was abolished as part of the NHS Reforms in April 2013. There is reference in particular areas of discussion but adding in a specific set of considerations referring to the PCT's engagement in the safeguarding work would generate additional complexity to an already complex set of considerations.

Primary Care

8.2.1 Reference has already been made to the fact that when Orchid View was opened there was no contact made by Southern Cross Healthcare with the local primary care practice who could be expected to bear the brunt of this increase in the number of vulnerable elderly people in the locality.

8.2.2 Since Orchid View's closure WSCC has established a process with local district and borough council planning authorities that the Contracts and Commissioning team is notified of all planning applications relating to the opening of nursing home facilities in their area. The Contracts and Commissioning team then forward information onto the local CCG of any relevant applications.

8.2.3 Although residents in nursing home provision have certain services provided by the home, other services and expertise, in addition to medical care, are available to them as to all other citizens. Whether and how these are accessed is variable and does appear to depend on local arrangements that the NHS CCG has made, possibly in conjunction with the local authority and local care home providers.

8.2.4 It is interesting to note though that recent guidance by the National Institute for Health and Care Excellence,[41] (NICE) promotes the rights of care home residents to consultation and engagement, specifically in this case in regard to medication, as with anyone else living in the community.

8.2.5 People who move into residential care will almost certainly become patients of the local primary care practice in the area. It is unlikely that they will retain their previous GP for geographic reasons, and indeed it is also the case that people entering a home for a short period of respite care are also likely to make call on the local practice if they have a medical need while in the home.

8.2.6 While not a significant issue in respect of Orchid View and this primary care practice, a number of the key issues relating to the relationship between care homes, their residents and GP services was recently reviewed by the Social Care Institute for Excellence (SCIE): Evidence review on partnership working between GPs, care home residents and care homes, December 2013. This describes a tapestry of relationships and arrangements nationally and as an evidence review does provide helpful information about areas of contact, positive and negative, that suggest there is no one way of primary care and residential settings working together. It is important, particularly as GPs take on the specific responsibility of named accountability for people aged 75 and over, that there is a clarity of expectations in regard to working with nursing homes in their practice area. This is a national issue that prompts the following recommendation.

Recommendation 13

That NHS England ensures that GPs are provided with clear guidance about their responsibilities in regard to care homes in their practice area as provided for within the General Medical Services contract.

8.2.7 The local primary care practice had a lot of contact with residents and staff in Orchid View. Their experience of Orchid View was of a setting with very highly dependent frail elderly people, often with dementia and multiple medical conditions requiring skilled and consistent nursing care.

8.2.8 An unfavourable comparison was made between Orchid View and the former NHS Cottage and Community Hospitals where the care and support necessary was provided. Today's nursing home residents have greater needs because of their often greater age and their multiple medical conditions, including severe dementia, (at its highest occupancy level, 32 residents were recorded as having dementia out of 48 people) that can now be better managed medically but who need good quality nursing care. This reinforces the importance of good multiagency care planning, including the service provider, for people who will have multiple and complex needs.

8.2.9 Local GPs described chaotic management in the home with fragmented communication with them, haphazard requests for prescriptions and frequently from unqualified nursing staff at the home. In their experience of Orchid View; care plans were almost non existent and there was a lack of consistency in the care provided to people and in the management of the home, and there did not seem to be enough staff for the patient group, qualified or unqualified.

[41] National Institute for Health and Care Excellence, Managing Medicines in care homes, March 2014

8.2.10 It was not the experience of the GPs in the practice that all staff were culpable for the poor care at Orchid View. There were staff who tried hard to provide care consistent with their professional values and care for the residents, but they were hampered from doing so by the inadequate staffing levels and the mismanagement of the home. It was observed that the practice of good members of staff had been dragged down at Orchid View and they had their careers adversely affected by working at the home.

8.2.11 Medication management was a major source of concern. It was not uncommon for a member of staff to turn up at the surgery asking for prescriptions in an unplanned way. This was reflective of the lack of leadership, organisation and management at the home.

8.2.12 Informed by their experience with Orchid View, the GPs engagement with care homes has developed and improved. A model of regular sessions at the home has been established with GPs attending on a regular basis to see individual residents in their rooms. GPs now carry out a 5 day review of new residents, a practice that is contributory to the development of individual care plans, which were virtually nonexistent at Orchid View.

Recommendation 14

That this good practice in providing personalised healthcare is promoted by the local CCG/NHS England encouraging primary care practices across the UK to adopt such positive engagement by local GPs with residents and staff in their local home(s).

8.2.13 The practice did raise a safeguarding alert, but not all members of the practice were aware of the level of concern and of other alerts prior to the police alert. This awareness could be improved with notification of safeguarding alerts in homes in their catchment area into the practice as part of an automatic process. It may well be that the practice would not have a specific role to play with any particular alert but it would raise the general level of awareness about concerns within the home and be positive information when particular individuals were seen.

8.2.14 It is of note that the Adult Services IMR regrets that the involvement of local GPs in safeguarding discussions and especially in formal planning meetings, was limited. The records indicate that the practice was informed of safeguarding strategy meetings, and indeed there was consistent involvement by a nurse attached to the practice, and on occasions by the practice manager, whose role is very important as the lynchpin between the practice and partner agencies and within the practice. The view of the primary care practice is that they would also have liked to be more involved, and with more information to help them build a picture in relation to their residents in Orchid View.

8.2.15 So while there was involvement it would seem that neither Adult Services nor the primary care practice felt it to be adequate. This is not unusual and both these views are common across the country; it is important that given this specific case and the concerns it has generated that the wish for closer engagement by all the partners is taken forward.

8.2.16 Continuing dialogue, joint learning and information sharing events are important in fostering the improved understanding of the respective roles, responsibilities and procedures desired. Additionally, given the increasing pressure that practitioners in all aspects of health and social care experience, the availability of key information and support at key times providing mutual understanding and support is critical.

Recommendation 15

That discussions are progressed between the WSASB and the NHS England Area Team and local CCGs to develop information sharing and involvement of primary care practices in safeguarding work.

Hospital Care

8.2.17 A number of residents attended out-patient appointments at hospitals in the area covered by Surrey and Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust, and the Sussex Community NHS Trust.

8.2.18 There were safeguarding alerts raised in regard to some residents where the hospitals were concerned at the condition of the person, for example by East Surrey Hospital in April, in July (twice) and in October 2011, and by Crawley Hospital in April 2010.

8.2.19 People attending hospital from care homes may be in poor health, and it may additionally be that they have suffered an injury such as a fall that will have caused them to attend Accident and Emergency (A&E). Judgement is required by nursing and medical staff about the possible cause of such injuries and whether they might indicate poor or negligent care. Each case will be different and treated individually as it should be. However, in addition it is important to build an accessible knowledge base about specific settings in order that any possible pattern in any particular residential setting can be seen.

8.2.20 The need for vigilance about the cause and number of hospital attendances and the importance of systems to identify trends from any particular residential home is underlined in respect of what happened in Orchid View.

South East Coast Ambulance Service (SECAmb)

8.2.21 Over the period when Orchid View was operating, SECAmb had 153 contacts with the home. Of these, 99 contacts were concerned with transporting people on admission to Orchid View from hospital, routine outpatient appointments and, as Orchid View was closing, with transporting people to other care settings.

8.2.22 The SECAmb IMR shows that 54 of these contacts were 999 calls for a range of conditions including falls, cardiac arrest, overall decline and unconsciousness. SECAmb state that this is a relatively low level of calls from such a setting but due to the complex nature of care settings, it is not possible to qualify this further.

8.2.23 Of the 999 calls the SECAmb breakdown reflects that 17 of these might relate to the quality of patient care. Their analysis is that two calls can be categorized as unexplained/generalised bruising; two calls that were raised by family members on behalf of their relatives; two calls relating to a shortage of staff being available with poor handover and 11 calls in regard to a delay in home staff seeking treatment for residents. In total 49 of the 54 calls resulted in the patient being taken to hospital.

8.2.24 SECAmb acknowledge that vulnerable person referrals should have been considered for the cases identified above, pointing out though, that it is possible that the ambulance crew staff may have felt that they had discharged their duty once the patient had been taken to A&E. SECAmb also consider the high ratio of transportation rates minimised the risks of crews not escalating concerns. They are reinforcing the need for staff to use the vulnerable person referral system and that a verbal handover to hospital staff does not discharge their safeguarding duties.

8.2.25 Retrospectively SECAmb have become aware of an anecdotal view among ambulance crews that Orchid View provided poor care. This reinforces the importance of ensuring that crews do raise safeguarding concerns directly themselves and do not rest on the assumption that their handover to hospital staff is sufficient. This is being progressed by SECAmb so no specific recommendation is made, but the SCR strongly supports this action.

8.2.26 SECAmb also consider that opportunities for early detection and possible prevention of safeguarding issues may have been hindered by their lack of awareness of the concerns relating to the home by other

agencies. This reinforces the importance of information sharing between agencies involved in safeguarding work, and as with the recommendation in regard to primary care, greater awareness does need to be promoted.

Recommendation 16

WSASB to establish as part of its process that the emergency services are notified of all Level 3 and 4 safeguarding investigations within their catchment area. This has a dual purpose: firstly they can be asked for information as part of the investigation and secondly that the concern can be flagged and the information accessible to staff from the emergency services.

Community Nursing

8.2.27 Community nurses were involved in visits to the home and it is noticeable that the district nurse on two occasions, in March and in July 2010 raised alerts. In both cases the concerns were about poor quality nursing.

8.2.28 Nursing staff were extensively involved as safeguarding health investigating officers working with colleagues from the local authority's Adult Social Care team in respect of identified residents, both prior to the alert to the police and subsequently. They also worked closely with health colleagues in primary care and in hospital settings.

8.2.29 The IMR identifies a specific case where information could have been shared more widely with social care staff and recognises that this would have contributed to a holistic picture of the attitude of the staff delivering care at Orchid View.

8.2.30 After the alert to the police in August 2011, nurses and social workers were formed into a cohesive and consistent group working within the home both to investigate safeguarding concerns and to model good practice to Orchid View's staff.

8.2.31 This work was led by the designated safeguarding consultant nurse for the (then) PCT. This was an approach that worked well and provided a team supportive of each other in their work within an inhospitable atmosphere of resentment and hindrance fostered by senior managers from Southern Cross Healthcare.

8.2.32 This was necessary as, from reporting at the time and subsequent discussion, it is clear that staff within this team found the work they were undertaking very stressful. This was particularly so for nursing staff appalled by the casual attitudes and poor quality professional work of their colleagues from the nursing profession.

8.2.33 The approach taken at that time to intervene and mitigate the poor standards within the home is commended and provides a model that other statutory services might learn from should they face such a circumstance.

Continuing Healthcare Team

8.2.34 The Continuing Healthcare Team made a number of placements in the home believing staff had the skills and resources to meet the needs of this particular group of people as they were within the registration criteria of Orchid View. They were subsequently involved in the investigations and moving of people to other locations. When the home first opened a continuing healthcare nurse spent some time with the qualified nursing staff at Orchid View seeking to develop their pre-admission assessments.

8.2.35 The Continuing Healthcare Team raised a safeguarding alert in February 2010 following contact from the daughter of a resident and it was dealt with as a Level 4 investigation. The resident was moved to another nursing home at the request of the family.

8.2.36 There was regular communication between the Continuing Healthcare Team, other nursing staff and WSCC commissioning and social work staff. These staff worked in tandem during the safeguarding investigations

and in the planned move of residents to other homes. Information was shared appropriately and teams worked well together, reflecting on their observations and supporting each other. The role of the continuing healthcare nurses was to talk with residents and relatives supporting them through their move to new and suitable placements. They also assessed other people, not already funded by the NHS, to identify anyone who may have required consideration for eligibility for continuing healthcare funding.

8.3 Sussex Police

8.3.1 The response by the police with their colleagues in the health and social care services on the raising of the alert in August 2011 was prompt and positive. There was good communication and information and intelligence sharing from this time with the local Police Adult Protection Team and the health and social care team working to remedy practices in the home.

8.3.2 Early investigation by the police in safeguarding work such as this is concerned to establish if there is a crime to pursue or if the concern is essentially about poor practice without criminal intent. The staff member who raised the alert and made the allegations was seen on several occasions and raised her concerns about files being destroyed or falsified, essentially the MAR charts in November 2011. This action was directly linked to one resident who was admitted to hospital with a MAR chart that contained falsified and therefore wrong information about her medication intake.

8.3.3 The significant error in medication administration with the syringe driver for the administration of a controlled drug did trigger a safeguarding investigation and full police inquiry.

8.3.4 There was also consideration of the mental capacity of residents, some of whom might be assessed as having capacity but who would nonetheless have difficulty in making an informed decision in the care context they experienced at Orchid View which did not facilitate full understanding and informed decision making.

8.3.5 Police involvement was transferred from the local Adult Protection Team to the Major Crimes Team in November 2011. This team pursued the possibility of criminal prosecutions with the Crown Prosecution Service having identified particular residents who had suffered possible wilful neglect. With the agreement of the Senior Coroner they had reviewed residents who had died within a six month timeframe, and identified as potentially manslaughter, the death of the resident who had suffered an overdose of warfarin and the falsification of her MAR chart.

8.3.6 The police were also in contact with the Crown Prosecution Service at this time about their options in regard to possible criminal proceedings. Three members of staff at Orchid View were arrested, interviewed and bailed in September and October 2011.

8.3.7 There was consideration of possible criminal charges against named individual members of staff and Southern Cross Healthcare as an entity but in the event, in discussion with the Crown Prosecution Service it was not felt possible to pursue either option, this is discussed in section 11.

8.3.8 Coroner's Officers monitor all deaths and collect information for the Coroner, who has a statutory responsibility to investigate deaths when violence is suspected or there is an unnatural or unknown cause. The police role in cases of unexpected death is to establish if a crime has taken place and also to support the Coroner's investigation. Coroner's Officers in West Sussex work for the West Sussex Senior Coroner but are located within Sussex Police buildings and are administratively line managed by a police officer.

8.3.9 Of the 19 deaths of residents and former residents at Orchid View, six people

died whilst at Orchid View, five people died in hospital and the remaining eight died after moving to other nursing homes. Three unexpected deaths were reported at Orchid View and were attended by police officers but none of these were considered to be suspicious deaths caused by criminal or negligent acts. The other 16 linked deaths were not dealt with as unexpected deaths and were recorded as natural causes.

8.3.10 The Coroner's Officer does have information that could be used to identify concerning patterns and unusual high numbers of deaths linked to individual homes and services. This is retrospective information relating to deaths that have occurred but it might be possible to identify patterns from this data. Coroner's Officers report any concerns about the volume and types of deaths to the Senior Coroner who in turn may make recommendations for this information to be brought to the attention of the police or adult social care. At present this happens with information conveyed informally. Such information should be conveyed more formally using the formal police crime and intelligence systems.

Recommendation 17

Concerns raised by Coroner's Officers about possible patterns or high numbers of deaths linked to individual services or organisations are reported to the police using the formal police crime and intelligence systems. Any new safeguarding concerns are alerted directly to adult social care.

8.3.11 Prior to the alert to Sussex Police in August 2011 there was sporadic contact with Orchid View. These contacts, relating to theft and missing residents, could have triggered safeguarding alerts. The view of those, from across the agencies working in safeguarding in West Sussex, is that such examples would now prompt alerts and this is reflective of changed procedures and more positive safeguarding practice.

8.4 The CQC's direct engagement with the safeguarding investigations

8.4.1 The CQC acknowledges in its IMR that they were kept informed by the local authority of the safeguarding concerns as they emerged, but that the CQC did not respond adequately to this information and did not attend safeguarding meetings, as they should have, given the frequency of incidents reported and the likelihood of systematic problems.

8.4.2 The emerging picture was not identified or acted upon quickly enough, and indeed the potential to incorporate this information about individual alerts and the overall safeguarding concerns was not considered alongside inspection information. The CQC recognise that they did not have in place a systematic approach to review the scope and trends of these alerts and death notifications (including some notifications from Orchid View) to build a cumulative picture.

8.4.3 The CQC recognise that such information and the approach to recording, storing and reviewing information could have meant that they acted more positively in respect of Orchid View. However, it is probable that the inspector was hindered in doing so by both the introduction of a new operating system that made the immediate availability of historic information more difficult to access, and – probably reflecting the changes the CQC were undergoing – the fact that they had three different inspectors allocated to Orchid View while it was open.

8.4.4 In reviewing the information available to the CQC about Orchid View and their role there is a frank admission in their IMR that "…there were on-going recorded concerns from safeguarding professionals that staff failings at Orchid View reflected systemic inadequacies in the company to provide adequate and on-going training. The CQC records show the view of the inspector was that past dealings with other Southern Cross homes had shown systemic failings in staff

training and cohesive management.

It is evident that the information held by the CQC about the history of concerns at this service should have prompted an in depth inspection early in 2011 to check compliance, irrespective of actions other agencies may have been taking to safeguard individuals or to restrict making placements."

8.4.5 The CQC has acknowledged in its IMR that its response during the early safeguarding work was inadequate, and has identified areas for improvement and more robust inspection arrangements.

8.4.6 The CQC were contacted by a relative at the end of May 2011 relating to her experience of poor care practices, medicines administration and management of Orchid View. The CQC received a further contact in regard to this same resident in mid June and were also in contact with the local authority and with Orchid View. As a result of this accumulating concern they brought forward their planned inspection in June 2011.

8.4.7 This inspection team included a pharmacist and there was a focus on medicine management. However, the CQC note that they should also have included specialist nursing input and that they did not do so, limited the extent of the evidence they uncovered.

8.4.8 Following on from this inspection the CQC required an action plan of Southern Cross Healthcare to achieve compliance with the Regulations they were found to be in breach of at the time of the inspection.

8.4.9 After the police alert, the CQC were slow to respond to the urgency of the situation and did not attend the initial strategy meeting in early August 2011. However, their participation did increase after this though they did not attend all the subsequent strategy meetings.

8.4.10 There was continuing concern about the number of unexpected deaths at this time and this, coupled with a letter of complaint in mid-August (after the initial alert to the police), prompted the PCT and local authority to review recent deaths in the home which CQC monitored.

8.4.11 The inspection by the CQC in September did include a specialist nurse, and at this inspection continuing breaches were identified with what the CQC judged to have major negative impact on residents. They acknowledged that Southern Cross Healthcare had made some resources available to try and improve the quality of care but the reality was there had been no significant improvement in the care residents received at Orchid View.

8.4.12 As a result of this inspection, the CQC considered either applying for an Urgent Cancellation[42] or serving a Notice of Proposal[43] to cancel registration. Of these options, only the first could, after due process, have caused the home to be closed immediately, and was in effect the only option available. However, neither option was pursued, in part because of the broader context of Southern Cross Healthcare homes being transferred to other providers and it was considered that the impact of either action would have been detrimental to a transfer to the proposed new provider and to the residents of the home.

8.4.13 The CQC appears to have weighed up the options and implications available at that time and reached an understandable decision given the parlous state of Southern Cross Healthcare as a business entity and the strong desire by the professional staff of local agencies to minimise further risk to residents and their safe transfer to a new company responsible for their care into the future.

[42] "Urgent Cancellation is used where a registered service or activity presents a serious risk to a person's life, health or wellbeing." Quoted from CQC's Guidance for registered persons, May 2010 This is the written notice CQC is required to issue.

[43] This is the written notice CQC is required to issue.

8.4.14 In the event, the CQC served Warning Notices in early October for breaches of seven regulations on Southern Cross Healthcare with a requirement that these were addressed by 31 October with the prospect of a further inspection on 1 November 2011. To reinforce this action; the CQC also wrote to a senior manager at national level in Southern Cross Healthcare known as the Nominated Individual.

8.4.15 In October 2011 there was correspondence between the CQC Compliance Manager and Southern Cross Healthcare's Regional Director and their Director of Care which indicated that the company questioned the veracity of the information the CQC considered and which partly prompted the Warning Notices.

8.5 Boots Pharmacy

8.5.1 Southern Cross Healthcare had a contract with the local branch of Boots Chemists to provide a pharmacy support service to Orchid View. This included annual visits to the home, dispensing of prescriptions, training for home staff in using the Boots system and various other matters. The contract was established in August 2009 in readiness for the opening of the home in October and included pre-opening training in the Boots systems.

8.5.2 The pharmacist made two visits to the home to carry out annual Pharmacy Advice Visits. It seems from the IMR supplied by Boots that Orchid View lost the advice provided to them by the pharmacist on the first of these in June 2010. Her advice at that time included the provision of controlled drugs and to make improvements to the MAR sheets.

8.5.3 The new manager at Orchid View contacted the pharmacist in August 2010 to request a visit as the record of the June visit could not be found. The pharmacist arranged to visit in September but when she did the responsible person at the home was not available. This is another illustration of the poor organisation and management at the home. A message was left with the home to get back to the pharmacist but this did not happen and there was no follow up by Boots when Orchid View did not come back to them.

8.5.4 Prior to the second annual visit towards the end of July 2011 the pharmacist sought out the information contained in the recent CQC inspection carried out at the end of June 2011. The CQC judgement was clear that the home was judged to be non-compliant with Outcome 8 relating to Cleanliness and Infection Control. On this visit the pharmacist's experience of the home was very negative both in what she found and the apparent level of disinterest or disorganisation of the home manager in relation to the pharmacist's work.

8.5.5 It is understood that this was not made into a safeguarding alert at the time because the pharmacist had a belief that as the concerns had been identified in the CQC report they were being followed up by the CQC. This was a mistaken belief and raising a safeguarding alert on the back of the findings in the pharmacy visit should have happened given the level of concern. So while it is understandable that no referral was made given the belief that the CQC would act, nevertheless this was a material concern that merited a safeguarding alert.

8.5.6 In part at least the alert was not made because of this mistaken belief that having identified poor practice, the CQC would be following through at that time, and therefore no action on the part of the pharmacist was necessary. In the event, the lack of an alert in late July did not have a detrimental impact affecting the safety of residents because the police alert was made shortly afterwards. But had the alert been made it would have provided more information about the inability of Orchid View to put in place Action Plans in regard to medication issues, which would at the least reinforce the significance of the issue and raise its profile.

Recommendation 18

That WSASB and the Royal Pharmaceutical Society reinforce with all pharmacies the importance of raising an alert in circumstances where there is an immediate concern with regard to the safe management and administration of medication, even if there is a belief that the issue has been identified by the CQC.

Recommendation 19

That care commissioners and the CQC check that contractual arrangements are in place between nursing homes and pharmacists and that these arrangements are being adhered to.

8.5.7 There has been learning from the experience at Orchid View. It is reassuring to see that Boots have used the experience of the poor standards of hygiene and haphazard medication management as a case study in their In-house Newsletter for pharmacists, The Professional Standard, January 2014, intended to improve awareness and professional standards throughout the company.

8.5.8 Medication management is specifically referred to in the Pan Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk (May 2012) as it was in the version dated July 2011, and also in previous versions of the procedures applicable in the early period at Orchid View.

8.5.9 The Royal Pharmaceutical Society helpfully responded to a request for information about the guidance provided to registered pharmacists working in the UK. They were able to provide clear evidence of the guidance they provide in regard to safeguarding, raising concerns and whistleblowing.

8.6 The Service Provider – Southern Cross Healthcare

8.6.1 This SCR has not been able to access any of Southern Cross Healthcare's records and has been dependent on the information contained within the records of the agencies involved in the safeguarding and commissioning work with the business, and on the comments made during this SCR process by individual practitioners and relatives.

8.6.2 The safeguarding records indicate from very early on that Orchid View management was unreliable in complying with requests made to it in respect of individual safeguarding concerns prior to the alert to the police in August 2011.

8.6.3 There is direct information from within the health and social care team who had to carry out significant safeguarding work within the home and to provide basic care to a number of residents because Southern Cross Healthcare were incapable of doing so, even with the engagement of their regional quality assurance and management staff.

8.6.4 It is apparent that a senior Southern Cross Healthcare regional manager's approach was to minimise to an unreasonable level the use of agency staff when the home was understaffed. The effect of this could have been that the home operated at times with unsafe staffing levels, that staff were stressed and unable to cope, however hard they tried.

8.6.5 It does seem that budgetary concerns were considered more important than the care of residents. Whether this reflected wider company policy or was unique to that manager is impossible to say definitively. But there can be no doubt that the leadership vacuum apparent within the home was also apparent at regional management level, at least, in Southern Cross Healthcare.

8.6.6 Safeguarding alerts were rarely raised from within the home and there is a strong perception that regional and home management operated on the basis of not raising safeguarding alerts when the circumstances would have merited it. The Regional Safeguarding Lead Manager is recorded as having advised her management within Southern Cross Healthcare of the level

and frequency of safeguarding concerns but when records secured from Orchid View were examined there was no evidence that this had happened as no such record in the home was found.

8.6.7 There is also evidence that WSCC requested that Southern Cross Healthcare meet with relatives to keep them informed of the situation and to include WSCC in that meeting. However, the regional manager did not invite or notify WSCC of this meeting held in late September and misrepresented the local authority with relatives, stating that they had refused to attend.

8.6.8 During the summer of 2011 Southern Cross Healthcare nationally was in disarray, and it is very probable that this broader context had an adverse influence on their work locally. This is a situation that reinforces the recommendations in this SCR relating to the need for stronger assurance by the regulator about the competence of the business, its governance, values and financial robustness.

8.6.9 Right to the point at which Southern Cross Healthcare took the decision to close Orchid View on 14 October 2011 it was an unwilling partner in the safeguarding investigation(s) and disinclined to remedy its poor practices that triggered the safeguarding concerns.

8.7 Local Authority and NHS Commissioning

8.7.1 In September 2009 WSCC contracted with Southern Cross Healthcare to provide residential placements. WSCC had thirty nine places in their five homes in West Sussex, of these eleven placements were in Orchid View. They also contracted for four places in homes in other local authority areas where people who were West Sussex's responsibility were placed. Additionally the NHS purchased twelve placements in their homes in West Sussex for people assessed as having continuing healthcare needs for whom the NHS has a funding responsibility; there were another two people with this same description in neighbouring local authority areas.

8.7.2 It is of note that the local authority was a minority purchaser of their provision in West Sussex purchasing some 26 % of the available places, while the national picture at that time was that the public purse, local authorities and the NHS, represented some 78 % of Southern Cross Healthcare's revenue at that time.

8.7.3 Throughout the lifetime of Orchid View the WSCC Contracts and Commissioning team worked collaboratively with the NHS PCT Commissioners to promote a unified approach to their dealings with Southern Cross Healthcare.

8.7.4 They were also extensively involved in the safeguarding work, both before and after the alert to the police. There was commendably close working with social work and nursing practitioners throughout so that the actions in regard to Orchid View were well coordinated.

8.7.5 Placements at Orchid View were suspended by the commissioners in August 2010 following the serious medication administration error. Other local authorities and PCTs were informed of this suspension in line with normal practice. Also at this time a level 3 safeguarding investigation and police enquiries were underway in regard to this incident.

8.7.6 Correspondence with Southern Cross Healthcare at that time and in the following months shows that actions were needed by Southern Cross Healthcare in regard to the following concerns:

- poor pre-admission assessments
- poor Care Plans
- lack of training in relation to catheter care
- no training in dementia care
- staff unaware of safeguarding
- no clear complaints procedures
- Medication policy
- End of life care and gold standards
- Poor continuing healthcare checklists and

no understanding of the need for the full decision support tool in regard to this
- Poor communication between the home and the GP.

Seeking to address these issues an action plan with training as a priority was agreed between WSCC Contracts and Commissioning Team and Southern Cross Healthcare.

8.7.7 There was improvement evidenced over a period of time sufficient for the placement suspension to be lifted in January 2011. At this time there was also sustained pressure within both the health and social care system for residential places. While there is no indication that this caused the suspension to be lifted inappropriately or prematurely, it is the case that the local services could ill afford to operate with fewer resources available to them with the loss of availability of these places.

8.7.8 While the suspension was in place it was still possible for Southern Cross Healthcare to advertise the resource and to take in new admissions from people who were funding their own care, and indeed they continued to do so until shortly before they closed Orchid View.

8.7.9 The major engagement of the WSCC Contracts and Commissioning Team was in the summer of 2011 after the police alert. They were party to safeguarding strategy meetings and contributed strongly to this work with partners from the health service, the CQC and the police.

8.7.10 They were also in active communication with Southern Cross Healthcare throughout this time to ensure that there was full understanding with the business about the contractual obligations and options and the process being followed. It was also necessary to ensure that they followed due process and that this was informed by the possible actions that the CQC might take at that time.

8.7.11 There are detailed letters on file dated 26 and 29 September to the Regional Director of Southern Cross Healthcare and copied to the Chief Executive issuing a contract Default Notice because of their numerous failings and inability to put these right. As there was no response to the first letter seeking urgent action, a second letter was sent on the 29 September 2011.

8.7.12 The response to this letter was made by solicitors representing Southern Cross Healthcare on the 30 September. The essence of this response was to seek further time to implement their Action Plan, to accuse the WSCC staff of misleading residents and their families and to have caused concern and distress to both residents and Southern Cross Healthcare's staff.

8.7.13 While it is not surprising that the solicitor's letter adopted a particular stance, it is noticeable how similar it is in its failure to recognise and accept the seriousness of the care failings and responsibility for them, that Orchid View staff and Southern Cross Healthcare's management reflected throughout.

8.7.14 After the closure of Orchid View the WSCC Contracts and Commissioning Team continued unsuccessfully to seek dialogue with Southern Cross Healthcare with regard to the safeguarding concerns and contractual matters. The record indicates that there was contact with their Director of Care during November. She indicated that, though a number of staff were no longer available, there were some designated people that could be communicated with, namely the Company Secretary and the Regional Area Manager until the end of December 2011. However, in the event it was not possible to get a response from either of these people after the end of November 2011.

8.7.15 On the 14 November WSCC received, as did other local authorities, a round robin "Message from Jamie Buchan Chief Executive

of Southern Cross Healthcare" giving an update on the national Transition Programme of its homes. It reported that "we now have seamlessly transferred 743 homes to date and the remaining 5 open homes are expected to transfer within the next four weeks…." An email in response to correspondence from the WSCC Contracts and Commissioning Team two days later dated 16 November stated that the Chief Executive had already resigned and left the company and that correspondence had been forwarded to the Company Secretary. Subsequent correspondence directed to the Company Secretary went unanswered.

8.7.16 There was however contact from solicitors on behalf of the Southern Cross Healthcare Administrator pursuing WSCC for payment of fees that the council had suspended in the summer of 2011 because of the poor performance at the home. Court recovery proceedings were issued against the council. After protracted negotiation a settlement was reached whereby the council made payment in the order of £61,000. The initial figure sought had been circa £84,000 but this was reduced as the WSCC counterclaimed circa £23,000 for additional costs it had incurred in paying overtime to its staff going into the home to support residents to mitigate the poor care provided by the home.

8.7.17 While appreciating that contractual terms will be difficult to formulate, it does appear that the WSCC and the local NHS incurred additional costs generated through the failings of the care service provider, and were then also liable to meet the contracted fee costs for residents receiving identified "suboptimal" care.

Recommendation 20

That commissioners of health and social care services review their contracts to ensure that they have robust contractual clauses to protect the public purse against claims from organisations that do not deliver the quality of care stipulated in the contract.

8.7.18 These records show a proactive contribution from the WSCC Contracts and Commissioning Team working well in concert with practitioner colleagues. Regrettably, Southern Cross remained unhelpful to the end.

8.7.19 Since the events at Orchid View WSCC has established a Care Governance Board. This Board works to ensure a clear strategic approach to working with local service. It is composed of senior health and social care commissioners and seeks to "strengthen the market – working with providers at all levels in what is described as a proactive, supportive and proportionate way." It is establishing an integrated process whereby the same contractual terms are applied by both the WSCC and the CCG where appropriate, in regard to people with continuing healthcare needs.

8.7.20 The Care Governance Board reviews safeguarding concerns in the context of the wider market issues that could ultimately lead to quality and safety concerns and the possibility of market destabilisation through identified risks to any specific local businesses or the market more widely. An example of this work is the development by the Care Governance Board of a risk matrix that is used to review all local providers with those at highest risk being visited by a senior commissioning officer and those at lower risk undergoing a desk top review and subject to fewer visits

8.7.21 Information from the Care Governance Board incorporates both contractual and operational information shared with relevant agencies including the CQC, and the NHS Regionally focused Quality Surveillance Group. There is also the development of a "real time" information system that is intended to become available to relevant identified people in agencies other that WSCC, together with a refined Information Sharing protocol. It is also understood that as part of this approach there will be a redesign and development of the existing provider forums that are currently

hosted by WSCC to include more relevant and interactive content.

8.7.22 The development of this, in conjunction with the local CCGs for health services, is welcomed as is the evidence of recently recruited additional staff to undertake this role and plans to extend this contact to all local providers during the course of all this year.

8.7.23 Since the closure of Orchid View, the NHS has restructured and the Primary Care Teams and Strategic Health Authorities have been abolished. In April 2013, NHS England was established, with 27 Area Teams; the local Area Team covers Surrey and Sussex.

8.7.24 One of the roles of the Area Team was to establish Quality Surveillance Groups (QSG) to identify risks to the quality of services commissioned by the NHS. Membership of the QSG includes NHS Commissioners (CCG and Area Team), the CQC, Local Authority, Healthwatch, Monitor, the NHS Trust Development Agency, Health Education England and Public Health England. Working with the QSG has already proved effective as an early warning of failing providers.

8.7.25 The QSG draws on factual data and also soft intelligence (verbal experiences of patients/staff). There is evidence that the QSG has facilitated and enhanced local partnerships in identifying and managing quality risks and concerns about service providers. A tried and effective approach has been established enabling multi-agency assessment of risk at an early stage.

8.7.26 Additionally, under the auspices of the QSG, single provider focused Intelligence Sharing Meetings are convened with local representatives as necessary and have included additional partner agencies such as the police and (in relation to Children's services) the Local Authority Designated Officer. These have been effective in piecing together the picture of an organisation and agreeing appropriate actions by the statutory agencies.

8.7.27 These are welcome developments that should enable swift and timely intervention when care falls below an acceptable standard.

8.7.28 In addition to the work of the local authority and NHS, CQC also has a mechanism through its Corporate Provider Team for monitoring the quality of service across corporate service providers, monitoring, assessing and reporting on their compliance with regulations.

9. Review and recommendations: people in privately funded care and information for potential residents and their relatives

9.1 When Orchid View was opened there was no prior consultation with health or social care commissioners and it does seem that the target market for the home was primarily people who were funding their own care.

9.2 The home was newly built and attractive, advertised itself well and it is hardly surprising that it attracted residents early on. It is also the case that the NHS made early use of the home for people who were assessed as having continuing healthcare needs. Such people require good quality nursing care and had their care met by the public purse as they continue to be regarded as requiring NHS level nursing care.

Information for people considering entering a home

9.3 The unfortunate reality for people going into nursing home care without the support of the NHS or local authority is that though they might find limited, and possibly partial, information about the home, they are unlikely to be well enough informed about what to look for in the care setting. They will also most probably be making the decision under pressure. There is information from voluntary agencies and charities such as Age UK or the Alzheimer's Society that is helpful, but it is unlikely to be specific to the actual home.

9.4 Once someone has entered a home under their own initiative and are meeting the cost themselves, they currently remain outside the purview of the local authority unless there is a safeguarding concern that triggers social work involvement. So people funding their own care are in a situation where they may decide to go into a particular home with insufficient information and once there be heavily reliant on the information provided to them by the company itself.

9.5 The provision in the Care Bill will extend the responsibility of local authorities to people who are self funding, if the home they are in closes. One of the effects of this is that local authorities will legitimately require information from independent homes about people who pay for their own care. At present it is often difficult for local authorities to get such information from care providers on the grounds of data protection. However, what local authority commissioners need is relatively broad brush information, unless there are problems in which case more detailed information is essential. Given the reluctance of independent providers to share this information with local authority commissioners who will carry this new responsibility, it may be advisable for the CQC to require service providers to share such information, and stipulate the nature of the information to be shared.

Recommendation 21

That the CQC develops guidance to service providers in consultation with their national organisation and local authorities about information to be shared with commissioners regarding people who pay for their own care.

9.6 There are improvements underway in the availability of information about care services, though these are as yet in the early stages and will need more positive promotion to ensure greater public awareness of them.

9.7 For example the NHS Choices website does enable access to the views of residents and (mostly) relatives about care homes. A number of large care home companies subscribe to the Your Care Rating survey which is carried out independently of them and provides some valuable information for prospective residents. This particular survey captures the views of residents, though it is

understood that it might develop a means of capturing relative's views in the future. There is also a similar information set on the Social Care Institute for Excellence website which links to the CQC website as well as providing information helpful in identifying the issues to consider and the options open to people.

9.8 These are positive early steps, though not yet well enough established to have attracted sufficient review to function as an effective Trip Advisor type service, though that is the intention with the NHS Choices approach.

9.9 Impressive as the generalised literature of agencies like Age UK or the Alzheimer's Society is, it is insufficiently well informed about specific settings, and that is what the public needs to make informed choices at a time when they are faced with an often urgent decision.

9.10 Local authorities are tentative in what they say to those who ask for their advice about a specific home. This caution relates to their concern that if they advise against going into a particular home they can be challenged by that home on the grounds that they have caused damage to their business. Similarly, where the local authority knows of safeguarding concerns they are constrained in sharing this information directly with people who ask, for fear of the same challenge from the company operating the home.

9.11 For people to make informed choices it is necessary for them to have information, or at least access to relevant information. Apart from the problem that local authorities have in passing on information about specific homes where a business might hold them liable for a loss of business, there are other considerations too. If the local authority provides a list of, say, three homes that might meet the needs of someone making an inquiry of them, a fourth home might argue that they have been treated unfairly and their business disadvantaged. It is also the case that if there is written information relating to specific concerns in a specific home it will become out of date and just as, in this case, Orchid View was presented as Good by the CQC beyond any point when it could be so described, a home might be described as having concerns after they had been addressed. A further concern is that very often an allegation has been made but not always substantiated or fully investigated at the time when information is requested, or the concern is not considered sufficiently worrying to be more widely shared.

9.12 These are all legitimate concerns that inhibit information sharing, and do need to be addressed. This is shared responsibility between the commissioners, the service providers and the CQC.

9.13 The Francis Report promoted a "duty of candour"[44] which was defined as "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made." The Department of Health has just published a consultation[42] on proposals to apply this duty in adult social care settings including nursing homes. The existing CQC notification of "serious injuries" would be the threshold and "the duty will apply to death, serious injury, some moderate harm and prolonged psychological harm, broadly consistent with the application in the NHS."

9.14 This is a duty on the service provider and if this new duty is established it can be harnessed to promote greater and more up to date information for the public, both on prominent display in the home and on the

[44] Department of Health Introducing the Statutory Duty of Candour, A consultation on proposals to introduce a new CQC registration regulation, March 2014

CQC website that will give the opportunity to for people to make better informed choices.

9.15 The Care Bill is explicit in its requirement of local authorities that they promote information and advice to the public to support people to make informed choices. But this responsibility needs to go beyond the provision of information about services they might access. People also need some help in understanding the quality of services. CQC have moved forward on this with the improved headline information on their website in relation to specific services that can act as a prompt to prospective residents or their relatives to ask more searching questions.

9.16 However, a major concern among relatives of people in Orchid View was that they did not know of safeguarding concerns, or that the local authority had suspended placement at the home because of their concerns about its quality and care practices, while it was actively recruiting new private self funding residents. This is a situation that has to be addressed if people are genuinely going to be enabled to make informed choices. It was a concern for people in Orchid View at the time as well as for those who might be regarded as potential residents.

9.17 Information on websites, be they CQC or local authority, can only be accessed by people who know to look on the website. In time, such information can be expected to be made publicly available through an App. Perhaps now is the time for the CQC to take on this development as it changes its approach and with the introduction of the Care Bill.

Recommendation 22

That the CQC pursues the development of an information App that provides up to date information about care services that proactively enables public awareness of services they might be using or be interested in using.

9.18 In West Sussex an electronic Care Directory is being developed that gives the local authority a similar opportunity to develop immediately accessible information in the form of an App that could inform people of concerns, as well as flag up homes where there might be vacancies.

Recommendation 23

That WSCC pursues the development of an information App as part of the development of the electronic Care Directory.

9.19 Local authorities and NHS commissioners are responsible and impartial bodies. In line with their increased responsibilities in the Care Bill to promote improved information and advice and linked with the Duty of Candour, they need to more confidently develop guidance to social work and commissioning staff enabling them to share their knowledge about the suitability of a setting in measured terms, to prospective residents and their relatives. This would complement the improved information on the CQC website.

Recommendation 24

Local authority and NHS commissioners share impartial information about concerns in services with existing and prospective residents and their families. This will support people to make informed decisions about the suitability of the service to meet their needs.

9.20 Sharing information about safeguarding investigations within a home should be part of this more open approach to enable more informed choice. It is not, however, appropriate to broadcast all levels of safeguarding investigations at all stages. This is for a number of reasons: it could have the perverse effect of organisations keeping quiet about relatively minor concerns that need to be addressed by them as well as the local authority in its lead safeguarding role, it could promote a negative perception of a setting without the concerns being properly investigated, and it could lead to a self fulfilling downwards spiral if it caused staff to leave or vacancies that might destabilize the home thereby generating increased risk to residents.

9.21 Given that there are existing safeguarding bands that broadly reflect levels of concern, be it in regard to a single resident or to a wider group of residents, it is proposed that WSASB develop a threshold of concern and a form of information sharing available to interested members of the public based on the seriousness of the safeguarding concern.

9.22 Such an approach might be based on the need to flag up a concern on the relevant website if there is an investigation at either level 3 or level 4 and to designate specific members of staff who would respond to inquiries from the public who approach them or consult their website. Included in this consideration should be the means by which the public are made aware that they can seek such information and how to do so.

Recommendation 25

That the WSASB develop a threshold for informing the public about significant safeguarding concerns, and a means of making the public aware that they can access this information.

For the resident in the home

9.23 Once a person has entered a home without the support of the statutory services, this SCR exposes the extent to which they and their relatives are on their own and feel isolated. The relatives all felt some degree of apprehension in complaining or criticising the care their loved one received. There was a concern, rightly or wrongly, that this could rebound negatively on their relative. All of the relatives spoken to within the course of this SCR are well informed and capable people, yet in this situation they expressed feelings of isolation and disempowerment.

Recommendation 26

Care providers should be contractually required to hold open meetings with residents and their relatives on a regular basis to discuss issues of general concern, and to make relatives aware of any significant safeguarding concerns in their home. The local authority should be notified of such meetings and able to attend, with minutes from them shared with commissioners.

9.24 Relatives expressed concern that there was little information on display in the public areas at Orchid View in relation to how they might complain or who to express concerns to other than the care provider. A stronger requirement on homes to display and promote neutral agencies such as the local Healthwatch, as a means for taking up concerns without having to go through the home's management structure, would also be a positive development. As would better contact information in regard to the CQC and the organisation's own complaint process.

Recommendation 27

Care homes to be required as part of their contractual terms, to display in prominent communal areas their complaint process, as well as guidance to neutral agencies such as local Healthwatch to facilitate relatives' and residents' ability to raise concerns, minimising any anxiety about the possible consequence to the resident.

9.25 Each resident should have a care plan that they have contributed to, is accessible to them, is reviewed and is adhered to by the care provider. This care plan should contain key information relating to any external clinicians, such as hospital consultants involved in their care. Local authorities are not resourced to become involved with all residents of care homes and they cannot be expected to monitor adherence to this. However, as part of its strengthened inspectorial role the CQC should ensure that it monitors this closely. It is evident in this case that a failure to observe and adhere to residents' care plans, especially with inconsistent staffing, led to haphazard and possibly risky care to the individual. None of

this is new, but it does need to be reinforced in the light of what has emerged in this review of the care provided at Orchid View.

9.26 As part of its stronger inspection regime, the CQC will need to engage with relatives, or advocates, of people in residential settings, particularly, though not exclusively, those people who lack mental capacity. This might be done, for example by including more people as "Experts through Experience" who can contribute to the CQC inspection and who seek to see the care provided from the relatives' perspective, in addition to holding a general meeting and the offer of face to face meetings with relatives.

Paying for care

9.27 People purchasing their own care in a care home are not assured of a care plan, periodic review of their care needs or how their care needs are being met. This may happen, but a care plan and review can only be assured for people placed under the umbrella of the public purse, be they on financial grounds (because they have less than the financial threshold) or have continuing healthcare needs with the NHS.

9.28 It is also probable that they will pay more than those people whose care needs are met through the public purse where it has been possible to negotiate lower fee levels. Certainly, the information from Orchid View was that, especially as Southern Cross Healthcare got into deeper financial problems, residents were charged for items that either were already included in the cost to them of the nursing home place, or they were being charged for items of nursing care delivered by Orchid View staff that they were entitled to as ordinary citizens.

9.29 Nationally the costs to individuals and their families of paying for residential care is a focus of concern and a new system is planned to come into force in 2017 and does not fall within the remit of this SCR.

9.30 It is also the case that a significant percentage of the spend by local authorities on people in residential and nursing home care goes to meet the cost of people who entered homes privately but have subsequently run down their resources to the point where the local authority has to assume the financial responsibility.

9.31 With the introduction of the Care Act in April 2015, self funders will get a little more protection in the event of a service provider failing, when local authorities will be required to ensure that there is a continuation of care to meet their needs. Pertinent to more people is the accessibility of greater information when they are considering moving into a home.

9.32 The overall robustness of the care provider is critically important for people who are entrusting their care to the organisation. This is discussed throughout this SCR and informs the recommendations in relation to financial, governance and managerial issues.

10. Review and recommendations: workforce issues

Managerial

10.1 From its very early days it is clear that there were staffing and management problems in Orchid View. The first home manager was charged with the business of establishing a new enterprise and all that entails with inadequate support and guidance from the regional managers at Southern Cross Healthcare. Her experience was in a small setting for people with learning difficulties, an entirely different set of responsibilities.

10.2 While it is evident that there were inadequacies within the staff group at all levels this has to be put in the context of Southern Cross Healthcare's lack of guidance and support to them. There were undoubtedly staff working in Orchid View that tried hard to provide good care but they were doing so in a context of poor leadership, management and often stressed staffing levels that meant that they could not provide a good service. It is also probable that this poor context contributed to some of the errors experienced in the home because of the chaos and stress experienced by staff.

10.3 It does seem indisputable that the Southern Cross Healthcare Area Manager put budget management above care quality in the way that staffing vacancies or absences were not allowed to be covered.

10.4 Similarly it appears that there was discouragement to staff in regard to making safeguarding alerts when there were matters of concern that should have been raised as alerts.

10.5 It is not possible to be definite about just where responsibility rested for the poor leadership and management of the home. It is too easy to locate this with any of the succession of home managers or registered nurses who contributed to the suboptimal care in the home all the time it was open. Management and leadership at regional level appear to have been casual, haphazard and not focused on addressing the problems known about at Orchid View.

10.6 The problems at Orchid View were sustained, serious and known about. That should have provided enough knowledge up the management chain at both regional and national levels in Southern Cross Healthcare to ensure that they were addressed. That they were not, reinforces the importance of the recommendations in regard to ensuring the robustness of organisational, financial and governance arrangements in service provider organisations.

Professional competence and training

10.7 Throughout the time that Orchid View was open there were significant issues about the competence of nursing staff including in relation to their core nursing competence, preparation and adherence to care plans, medicines management and understanding of safeguarding.

10.8 Concerns were expressed in regard to the thoroughness with which Southern Cross Healthcare checked the qualifications of nursing staff they recruited. This related to a particular nurse, and while it cannot be ascertained if they had a particular failing in this regard, it does prompt a specific recommendation that is essentially stating the obvious, but this experience suggests it is nonetheless necessary.

Recommendation 28

That stringent checks are carried out by the employer to be confident that staff do have

the qualifications they claim and that where appropriate their professional registration is current. In the case of professionally registered staff this will include obtaining the person's registration PIN.

10.9 There were issues in regard to the extent of training staff at different levels experienced. There are repeated references to the need to ensure that Southern Cross Healthcare put in place improved training and professional development opportunities at Orchid View in the Action Plans requested of them. There is little evidence that they complied with these requests.

10.10 Professional development opportunities for qualified nursing staff are particularly important because they will probably be working in settings where there are fewer peer group development opportunities than there would be working within NHS settings. It is incumbent on the company responsible for providing care that they do establish structured and maintained training and professional development opportunities for staff. Alongside this is the need to ensure that there is the space with some protected development time to enable staff to undertake specific training sessions and career development opportunities.

Recommendation 29

That service providers are required to demonstrate to the CQC that they have established training, supervision and appraisal processes for their staff, both qualified and unqualified, and that the regulator spot checks training records– with the necessary agreements as required.

Unqualified care staff

10.11 It does appear that there was a significant issue in recruiting and maintaining health care assistants at Orchid View. In part this was probably because of the proximity of Gatwick airport with its job opportunities. Another contributory factor might be the location of the home and its accessibility by public transport by people without their own transportation.

10.12 It does not appear that this was factored into Southern Cross Healthcare's business plan at the opening of the home or that it was subsequently remedied in terms of transportation or the pay level and employment package to care assistants.

10.13 A number of people from other countries and cultures work in the care industry and make a strong and positive contribution, both within the NHS and in the independent sector, and without this staff group these services would find it more difficult to maintain and adequately staff their services. Employers have an important responsibility to ensure that their staff are trained and supported to carry out their responsibilities and duties fluently.

10.14 It was remarked on that for a number of staff there were some language difficulties as English was not their first language. It is not evident that Southern Cross Healthcare sought to provide support and training to help these staff to improve their communication skills. Difficulties in communication would have impeded the relationships with residents, with relatives and potentially with other members of staff. It may also have impeded their understanding of procedures and access to information that could have been detrimental to the overall quality of the service. This should have been factored into both induction and continuing training for care staff individually and as a group in the home.

Recommendation 30

Where there are specific needs to be addressed among care staff such as in cultural understanding, communication and language difficulties, there are evidenced processes to mitigate any possible diminution in the quality of care offered as these needs are addressed.

10.15 The Cavendish Report published in

July 2013[45] following on from the Francis Report identified that as with healthcare assistants working in the NHS "support workers are increasingly taking on more challenging tasks, having to look after more frail elderly people. Yet their training is hugely variable. Some employers are not meeting their basic duty to ensure their staff are competent." This would certainly seem to have been the case with Southern Cross Healthcare at Orchid View.

10.16 The recommendations from the Cavendish Report are significant and grouped into four sets of concerns, all of them relevant to Orchid View. These recommendations relate to:

- Recruitment, Training and Education
- Making Caring a Career
- Getting the Best out of People: Leadership, Supervision and Support
- Time to Care

10.17 Action on these recommendations and the introduction of the Certificate of Fundamental Care (the Care Certificate) in March 2015 for healthcare assistants and social care support workers can be expected to lead to improvements in care practice, the esteem of this core staff group with greater career opportunities, recognition, remuneration, continuity and improved practice. Work in the care industry would become a more positive career option attracting people and promoting sustainable good quality care.

Concerns raised by employees – alert to the police

10.18 Concerns raised by employees to the police, media or other agencies outside their management and/or employing organisation is often referred to as whistleblowing, and also as confidential reporting. Some are done anonymously such as in this case and after they have exhausted the options within their organisation.

10.19 Southern Cross Healthcare had a whistleblower policy within its company policies and procedures. What is reported is that the person who contacted the police in August 2011 had previously informed the Area Manager of her concerns in relation to specific issues and more general anxieties about the quality of the care in the home.

10.20 Her job was not as manager or as a professional nurse or practitioner but was concerned with the administration and business of the home. However it would seem that because of the vacuum at managerial, professional and leadership levels within the home and at regional level in Southern Cross Healthcare, she progressively was seen, and possibly assumed, to have a stronger overall set of responsibilities.

10.21 It is known that people who report concerns about their organisation to bodies outside their organisation experience significant stress and isolation. At that time the identity of the whistleblower was not known to her colleagues, and it is understood that this remained the case until the inquest in September 2013.

10.22 All of this reinforces the importance of clear procedures within organisations that permit people to discuss their concerns within their management line without the threat, or feeling of threat, to their career if they raise concerns or are seen as a troublemaker. Whatever the quality of stated company policies in regard to whistleblowing it is a difficult and risky undertaking, both emotionally and in practical job and career terms for anyone to undertake.

10.23 This has to be recognised and while good clear policies are needed, in the particular circumstance they are likely to be only as good as the reality of the attitude of the receiving senior person next up the line to whom a concern should be expressed.

[45] DH The Cavendish Review: an independent review into healthcare assistants and support workers in the NHS and social care settings, July 2013

10.24 A number of organisations have external contracts to provide support and an avenue for discussion about concerns they have. Such schemes are becoming increasingly common in care settings such as hospital trusts. People working in independent sector care provision need similar avenues to express and explore their concerns external to their management line where necessary.

10.25 Such schemes are not a panacea, and the major requirement is the development of a positive leadership culture where members of staff can discuss their concerns and anxieties about their work without fear of being labeled a troublemaker with the possible negative consequences that can bring.

10.26 Particularly in settings such as residential and nursing home care it is important that organisations do give guidance within their policies about other agencies such as an off-line service they could access. Staff should also be positively aware of the existence of the CQC and Healthwatch that they might refer their concerns to, if they continue to feel that they have not been taken seriously within the organisation, or troubled by practices that they have raised and that the organisation has not addressed.

10.27 The proposed Duty of Candour within social care and nursing homes should help members of staff and their managers to respond to concerns and report them in a more open way. Under this proposed new duty the service provider should be more open to identifying, addressing and informing significant matters of concern and this will need to be promoted so that is understood by their staff too.

10.28 Healthwatch encourage and support raising concerns as they arise and whistle blowing to their organisation when all attempts through an organisations own management hierarchy have been exhausted. They intend to raise awareness across care and nursing homes in West Sussex, to ensure that staff, residents , professionals or families who have concerns about care know how to contact Healthwatch West Sussex.

11. Review and recommendations: accountability

11.1 Vulnerable people were entrusted to the care of Southern Cross Healthcare at Orchid View. They were let down and experienced what the Senior Coroner described at the inquest as "suboptimal care".

11.2 Relatives have asked how can individuals employed by, or Southern Cross Healthcare itself as an organisation, not be held accountable when there is such a lot of information that demonstrates that poor practice was so prevalent at the home? This section tries to provide a description of the actions and considerations of the key agencies in seeking to bring those responsible to account and to identify the prospects for a greater likelihood of achieving this in the future.

11.3 Staff as individuals had professional responsibility for the care they delivered and Southern Cross Healthcare had management responsibility for ensuring the provision of good care.

Professional regulation

11.4 Some nursing members of staff were referred to their professional regulatory body, the Nursing and Midwifery Council (NMC), but overall relatives are left with a sense of injustice as individuals responsible for the management and governance of Southern Cross Healthcare who were not nurses, and others whose direct care was inadequate, have not been held to account.

11.5 In the event there were 15 referrals to the NMC, and according to the NMC record none of these were referred by Southern Cross Healthcare. Of these seven remain open progressing through the NMC process.

11.6 There was one occasion when a nurse (who had made the error with the syringe driver) had referred herself to the NMC. In other cases Southern Cross Healthcare were requested to refer identified staff, but they were not made in a timely way and in the case of one nurse the time delay was such that he had left the country before any action could be taken.

Recommendation 31
As part of its regulatory role the CQC should require information from service providers on all referrals made to the Nursing and Midwifery Council and the Disclosure and Barring Service. This information to include the person's PIN where applicable.

11.7 There may be a benefit in stronger dialogue between Adult Safeguarding Boards and the NMC to promote greater understanding of safeguarding issues and processes, and also in regard to the processes of the NMC.

Recommendation 32
The WSASB to take forward discussion with the NMC to explore learning from this situation that is more generally applicable in respect of nurses working in independent sector settings in both practice and managerial positions.

Criminal prosecution and legislative framework

11.8 The primary issue in regard to accountability relates to the knowledge generated after the police alert and during the investigation into possible criminal offences either by individuals or collectively by Southern Cross Healthcare as a business entity. In the event, these inquiries involving extensive police investigation and communication with the Crown Prosecution Service did not generate any cases being taken to court.

11.9 Any consideration of a prosecution has to fall within the frame of existing legislation. From discussion with both the police and with the Crown Prosecution Service (CPS) it is clear that prosecution was considered using the Mental Capacity Act 2005 and in relation to corporate manslaughter using the Corporate Manslaughter and Corporate Homicide Act 2007.

11.10 The police arrested five members of staff from Orchid View and sought advice from the CPS about taking these cases to court. It is understood that the CPS considered the possibility of criminal offences under section 44 of the Mental Capacity Act, but was not able to conclude that there had been wilful and deliberate neglect by these staff. It is understood that part of this consideration related to the working environment which allowed poor practice to be unchecked and remedied by managers.

11.11 This failure of management and leadership by Southern Cross Healthcare in effect provided a safety net for individual members of staff whose poor practice was considered to be in line with the norms in the home. Staff were working in a setting where there was a culture of poor practice which was not challenged and an inadequately operated care home was at the root of the problem.

11.12 In this context the CPS felt that pursuing individual members of staff would be unlikely to lead to a successful prosecution; they could blame the lack of guidance from managers, a difficulty compounded by the limitation of the offence of wilful neglect which is limited to people who lack mental capacity.

11.13 The identification of Orchid View as badly run and with a culture of poor practice was also considered in the context of a possible charge of corporate manslaughter. However, this could only have been considered in relation to one of the residents, and after the post mortem outcome this was no longer an option.

11.14 The approach taken was to build up an evidential base against individuals who might be liable to prosecution. Had this succeeded against individuals it does not follow that Southern Cross Healthcare could also have then been prosecuted for the only option considered of possible corporate manslaughter, because managers are not responsible for the criminal conduct of people working in their organisation. There is no vicarious liability in respect of Southern Cross Healthcare or any other organisation for the actions of their staff, if the actions are criminal.

11.15 Where there have been charges or successful guilty findings of neglect in residential care settings the particular situations have been different to those at Orchid View, which was part of a large business enterprise. Where there is a single home or very small business, the connection between the owner with a home is more direct and it is therefore possible to prove more directly a connection between the actions of the home owner and its impact on residents. With Orchid View and Southern Cross Healthcare, pursuing liability up a lengthy management chain is much more difficult and makes progressing any criminal charge to the top of an organisation very difficult.

11.16 There are a number of points that emerge from the experience of the CPS in respect of Orchid View staff and Southern Cross Healthcare as a business entity which the CPS has identified, in discussion, for future consideration and action.

11.17 Determining whether the evidence against individual members of staff was sufficient to proceed to prosecution was defined by the CPS as a complex situation where specialist expertise was needed and a broader consideration of public interest than would normally be the case.

11.18 CPS have recognised that, they would benefit from acquiring greater understanding in relation to cases where there is a need to

safeguard vulnerable people from harm. It is probable that cases where the need to safeguard vulnerable people from harm will be increasingly common and the CPS will need to prepare for this eventuality.

11.19 To support the CPS in dealing with safeguarding issues in the future and to help form a view about the viability and desirability to press a prosecution, further development of understanding within the CPS should include a focus on expected practices and standards in care settings and the implications where there are shortcomings. The following is recommended.

Recommendation 33

That the CPS commissions learning events/ awareness training in relation to the types of situations that prompt safeguarding concerns and the potential for criminal activities with regard to ill-treatment or wilful neglect.

Recommendation 34

That the CPS should obtain expert advice when considering possible offences relating to neglect and safeguarding, to better understand the expected practices and procedures of care settings.

11.20 In cases were there has been clear wrong doing but there are limitations with the available legislation, there may be options for the CPS reviewing lawyer to consider wider, lesser charges; that might not reflect the full extent of the problem but that could result in individuals responsible for dishonest and neglectful practice receiving criminal charges. If there is sufficient evidence of lesser alternative charges in the absence of a reasonable prospect of prosecution for manslaughter or neglect offences, these should always be considered. The public interest test would appear to be met in most cases where the victim is vulnerable; the offender is in a position of trust and without criminal proceedings against them could go on to pose a risk to other vulnerable people.

11.21 As well as reviewing the evidence collected by the police, the CPS have a contribution in advising the police investigating officer in order for them to consider all offences possible in the circumstances. Future risk of harm and the safeguarding effect of court proceedings form part of the CPS lawyer's decision making process.

11.22 At the time of these events at Orchid View, the offence of wilful neglect could be pursued under Section 44 of the Mental Capacity Act 2005 only and applied to those people who had been assessed as lacking mental capacity. This limited the scope of the CPS as, although people at Orchid View were frail and dementing, few people had been formally assessed as lacking mental capacity. One of the implications of this is that two people, with similar levels of frailty and vulnerability, might be subject to the same treatment but as only one of them had been assessed to lack mental capacity; a possible criminal prosecution would be open to that person only.

11.23 In part to address this, the Department of Health have consulted, in February 2014, on a "New offence of ill-treatment or wilful neglect"[46] that would apply to all people and not just those assessed as lacking mental capacity. This proposal arose out of the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust, published in February 2013. The proposals in this consultation document have been generated by the National Advisory Group on the Safety of Patients in England following on from the Francis Report.

11.24 The proposals in the consultation, concluded on the 31 March 2014 are very pertinent to Southern Cross Healthcare

[46] DH: New offence of ill-treatment or wilful neglect Consultation Document February 2014

and Orchid View and would go some way, if implemented, to bring the prospect of greater accountability.

11.25 Summarised below are some of the key elements directly relevant in a situation such as that at Orchid View:

- They open the way to a new offence applicable to all people and not just in relation to those people receiving services from the NHS.
- The National Advisory Group describe neglect as wilful if it is "intentional, reckless or reflects a 'couldn't care less' attitude". This description can be applied to Orchid View.
- It proposes "that the new criminal offence should focus entirely on the conduct of the provider/practitioner, rather than any consideration of the harm caused to the victim of the offence"
- The consultation considers how to identify responsibility for an act that goes beyond the conduct of a particular identified staff member, to the culpability of an organisation as a whole.
- The consultation considers but does not favour, an identification based on the level of seniority of a manager who might be seen as responsible on behalf of the organisation for the possible offence as the "directing mind". Instead it goes on: "Alternatively, we could adopt an approach similar to that which underpinned the development of the corporate manslaughter offence in the Corporate Manslaughter and Corporate Homicide Act 2007. So, the legislation could be framed such that an organisation would be guilty of an offence if the way in which its activities are managed or organised by senior management (a) causes a person to be the subject of ill-treatment or wilful neglect; and (b) amounts to a gross breach of a relevant duty of care owed by the organisation to that person. The test would be whether the conduct of the organisation falls far below what can reasonably be expected in the circumstances. This approach would also allow scrutiny of the collective actions/failings of the organisation's senior management."[47]
- Other issues are also discussed in the consultation such as the possible financial penalties, the scope in relation to formal care settings only, and whether this should also apply to children.
- It is of note that the consultation stresses that this is in relation to a possible new criminal offence and is not intended to be used where a genuine error or accident has occurred but is envisaged to "cover only clear cases of ill-treatment or wilful neglect".

11.26 If such a criminal offence so defined had been in place at the time of the events at Orchid View the CPS would have had alternative options at their disposal about possible prosecutions against any of the individuals or Southern Cross Healthcare and its senior management.

11.27 This SCR welcomes this consultation and the proposals for this new offence. WSASB has responded to the consultation, informed by consideration within this SCR and is supportive of these proposals and would wish to see them enter into legislation.

11.28 Although no criminal charges were brought in this case, it remains that should new evidence emerge, a criminal prosecution could still be recommended although the need for new evidence before there could be reconsideration was stressed.

[47] DH: New offence of ill-treatment or wilful neglect Consultation Document February 2014

Appendix 1
Terms of Reference for this Serious Case Review (SCR)

The Terms of Reference for this SCR were finalised in October 2013.

Independent Serious Case Review into the care of residents at Orchid View Care Home

This independent SCR is commissioned by West Sussex Adults Safeguarding Board (WSASB).

Purpose

To review the progress, timescale and outcomes of the safeguarding investigations relating to Orchid View, from September 2009 when Orchid View opened to October 2013 at the conclusion of the Senior Coroner's Inquest.

The SCR process is based on the West Sussex Safeguarding Vulnerable Adults Serious Case Review Protocol, February 2010 which sets the purpose and process of SCRs commissioned by the WSASB.

The SCR is concerned with learning from the experience of what happened at Orchid View and to extrapolate from this to promote practice, policy and procedural improvements to safeguarding for people living in West Sussex.

It may be helpful to be clear what the SCR will not do as these are beyond its remit:

- The SCR will not re-investigate the details of the safeguarding investigations, and their Findings that have taken place in relation to individuals who were at Orchid View, or the Finding of Institutional Abuse at Orchid View.
- The SCR will not investigate Southern Cross Healthcare as a corporate entity at that time.
- The SCR will not seek to duplicate any of the investigative or legal processes that have taken place in regard to Orchid View or its employees.
- The SCR will not seek to apportion blame to individuals.

The SCR will conduct its work in private but will engage with relatives, their representatives, key agencies and individuals, to ensure that their perceptions, experiences and expectations are incorporated in the work of the SCR.

The SCR will work to present its report to the WSASB in April 2014. If for any reason this should not be possible the SCR will keep interested parties informed of the reason for delay.

Terms of Reference

1. To examine the process, effectiveness and coordination of the process of the individual Safeguarding investigations.
2. To examine multi-agency safeguarding practice and adherence to operational policies and procedures in place at the time.
3. To receive, examine, and respond to the Findings of the Senior Coroner in relation to Orchid View.
4. To examine the management of key relationships, information sharing and national & local protocols before and during the safeguarding process between responsible agencies, including Southern Cross Healthcare and the Care Quality Commission (CQC).
5. To examine the adequacy of collaboration and communication between all of the agencies involved in the care of residents at Orchid View and in the operation of the safeguarding investigations.
6. To examine the degree of understanding, engagement & adherence to safeguarding policies & procedures of agencies that may have had some engagement with Orchid View at the time but were less directly involved with the care of individuals resident there.

7. To examine the involvement, timeliness, available information and related activities and communication of any concerns in relation to Orchid View, and how this was used in contract management with Southern Cross Healthcare by the Local Authority and the (then) PCT, and with any other purchasing authorities and people who were self-funders of care at Orchid View.
8. To examine whether there was effective multi agency working in regard to intelligence sharing and the early detection and possible prevention of safeguarding issues developing.
9. To examine the effectiveness of the sharing of information and communication with residents, relatives and any advocacy or representative agencies involved with people about whom there were concerns about the quality of the care they were receiving, and/or were the subject of a safeguarding investigation.
10. To consider any implications arising from any competing priorities of the different agencies in pursuing their statutory responsibilities to, eg, regulate the service or pursue criminal proceedings
11. To consider the effectiveness of all parties in disclosing relevant information to inform the professional regulatory bodies such as the Nursing and Midwifery Council (NMC) and the national Criminal Records Bureau / Independent Safeguarding Authority/ Disclosure and Barring Service. Note, different bodies were responsible for these functions during this period.
12. To examine safeguarding practice and procedural issues in West Sussex, as depicted in relation to Orchid View, taking account of national as well as local intelligence and information.
13. To identify any good practice and recommend areas for improvement and learning in relation to the multi-agency safeguarding procedures, and the implementation and adherence by agencies to the procedures and to multi agency working.
14. To agree the key points to be included in the SCR report and the proposals for action.
15. Any other matters in the public interest that the SCR considers arise out of the matters above.
16. To prepare an evidenced report containing recommendations so that learning is taken forward to improve care to older people in all types of residential settings with an emphasis on care homes with nursing .
17. To prepare an anonymised Executive Summary that can be made public.
18. To request the WSASB to prepare an Action Plan addressing any SCR recommendations when the report is presented to the WSASB.

Nick Georgiou
Independent Chair of Orchid View
Serious Case Review
23 October 2013

Appendix 2
Panel Membership

Panel Members

• Nick Georgiou	Independent Chair of Serious Case Review
• Vincent Badu	Sussex Partnership NHS Foundation Trust Strategic Director of Social Care and Partnerships
• Sue Cart	West Sussex County Council (WSCC) Head of Health and Social Care Commissioning
• Victoria Daley	Crawley NHS Clinical Commissioning Group (CCG), Horsham and Mid-Sussex CCG Head of Quality/Chief Nurse
• Sue Giddings	Sussex Community NHS Trust Deputy Chief Nurse,
• Adrian Hughes	Care Quality Commission, Regional Director of Operations (South) (joined the Panel in December 2013)
• Helen Lawrence	West Sussex Coroner's Officer
• Jane Mitchell	South East Coast Ambulance NHS Foundation Trust (SECAmb) Safeguarding Lead
• Amanda Radley	Initially Surrey and Sussex Probation Trust Acting Director, (from January 2014 WSCC Early Help Strategic Commissioning Manager)
• Amanda Rogers	WSCC Director of Adults' Services
• Wendy Vodrey	Sussex Police Acting Detective Inspector

Support to SCR meetings

• Bev Morgan	Principal Manager Adult Safeguarding, WSCC Detailed advice on safeguarding procedures
• Abbie Johnson	Senior Project Officer, Business Change WSCC Project work on behalf of the Chair
• Richard Slaughter	Detective Constable Sussex Police Information from the Inquest to the SCR (for initial meeting only)
• Tracie Thomas	Operations Manager, WSCC. Information from the safeguarding investigation and Inquest to the SCR
• Diane Henshaw	Principal Solicitor, Legal Services WSCC
• Roni Burchfield	Independent Chair Adult Safeguarding Unit WSCC
• Jeff Riley	DCI Senior Investigating Officer at Orchid View, Major Crime Team, Sussex police (part of one meeting only)

Notetaker

• Jennifer Forrest	Administrator Support Services

Appendix 3
Methodology

The SCR panel was made up of senior members of staff from the responsible statutory sector agencies. The process, in line with the WSASB's Safeguarding Vulnerable Adults Serious Case Review Protocol 2010, was led by the independent chair of the SCR. This involved meetings with families affected by the suboptimal care at Orchid View; meetings with health and social care staff involved in the safeguarding investigations and moving residents into other settings; with other agencies; reviewing the information contained in the Individual Management Reviews (IMRs) and other requested reports; considering the individual Safeguarding Investigations; chairing Panel meetings and writing the overview report.

Individual Management Reviews (IMR) were commissioned in October 2013 from

- Sussex Police
- West Sussex County Council Adult Services Social Care, Care Management and Commissioning
- Sussex Partnership NHS Foundation Trust
- NHS Clinical Commissioning Groups (CCGs): Crawley CCG, Horsham and Mid-Sussex CCG, in relation to responsibilities previously carried by the Primary Care Trust
- Sussex Community NHS Trust
- South East Coast Ambulance Service (SECAmb)
- Surrey and Sussex Healthcare NHS Trust, in relation to East Surrey Hospital
- Brighton and Sussex University Hospitals in relation to the Princess Royal Hospital, Haywards Heath
- Care Quality Commission
- Continuing Health Care
- POhWER, Independent Mental Capacity Advisory Service in West Sussex

Additionally other agencies were also asked to provide information:

- Care UK Ltd
- Crown Prosecution Service
- The Senior Coroner provided information from the Inquest
- Boots pharmacy
- Royal Pharmaceutical Society

As Southern Cross Healthcare no longer exists there has not been any direct contribution of Southern Cross Healthcare records to this SCR. Where they have been available the agencies have drawn on information they have in relation to their correspondence and dealings with Southern Cross Healthcare and this is incorporated in the individual agency IMRs.

The SCR panel met on seven occasions, the initial meeting was on 21 October 2013, and there were subsequent meetings on 16 December 2013, 10 January 2014, 3 February 2014, 7 March 2014, 7 Apri 2014 and the 9 May 2014.

Appendix 4
Safeguarding

The West Sussex Adult Safeguarding Board (WSASB) – oversee the performance and monitoring of all safeguarding work relating to adults at risk in West Sussex, including agreeing to set up Serious Case Reviews; receive reports from task and focus sub groups; agree policy; seek advice and guidance as appropriate; and make sure it links with other related strategic work.

Sussex Multi-Agency Procedures for Safeguarding Adults at Risk – across Sussex, health services, adult social care services and the police have agreed ways of working together to prevent, respond to and look into the suspected abuse of adults at risk. You can access a full copy of the procedures on the West Sussex County Council website: www.westsussex.gov.uk.

Levels of Investigation

Level 1 – This is when a person who is receiving a particular service appears to have been harmed or might be at risk of being significantly harmed. The Investigation Manager will ask the manager of the service the person is receiving to investigate the matter.

Level 2 – This is when a person appears to have been harmed or might be at risk of being significantly harmed, and where the concern does not relate to a particular service or where it would not be appropriate for the service to investigate.

Level 3 – This is when a person appears to have been significantly harmed.

Level 4 – This is when more than one person appears to have been harmed or significantly harmed, or may be at risk of being significantly harmed. This also includes situations where there may be a range of concerns about a service that could mean more than one person is at risk of harm or significant harm.

Investigation Manager (IM) – the IM oversees and manages the investigation and will work for either West Sussex County Council or Sussex Partnership NHS Foundation Trust.

Investigation Officer (IO) – the IO carries out the Investigation and can work for a number of different organisations depending on the type of concern being investigated.

Decisions regarding concerns (based on a balance of probabilities)

- **Substantiated** – the information gathered suggests that the harm, abuse or neglect probably took place.
- **Unsubstantiated** – the information suggests that the harm, abuse or neglect probably did not take place.
- **Inconclusive** – it has not been possible to make a clear recommendation based on the information gathered.

Notes

Notes

WS1611 June 2014