Safeguarding Adults Review

Thematic analysis of safeguarding enquiries within a residential care setting in Gateshead

February 2025

Reviewers: Fiona Bateman and Sarah Williams
Independent Safeguarding Consultants, Safeguarding Circle

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Glossary

ASC	Adult social care
AMHP	Approved mental health professional
CHC	Continuing healthcare
CQC	Care Quality Commission
CNTW	Cumbria Northumberland Tyne and Wear NHS Mental Health Trust
DBS	Disclosure and Barring Service
DoLS	Deprivation of Liberty Safeguards
DHSC	Department for Health and Social Care
ECHR	European Convention on Human Rights
HCPC	Health Care Proficiency Council
GHFT	Gateshead Health Foundation NHS Trust
GMC	General Medical Council
GSAB	Gateshead Safeguarding Adults Board
ICB	Integrated Care Board
IMR	Individual management review
LADO	Local authority designated officer
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983, as amended
MSP	Making Safeguarding Personal
NEAS	North-East Ambulance Service
NHSE	NHS England
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
PACH	Person alleged to have caused harm
PIPOT	Person in position of trust
PSIRF	NHS Patient Safety Incident Report Framework
SAR	Safeguarding Adult Review
SAT	Gateshead Council's Safeguarding Adults Team
SPC	Serious Provider Concerns

1. Introduction

1.1. In April 2024 Gateshead Safeguarding Adults Board ['GSAB'] decided to commission a mandatory independent review under s44 of the Care Act 2014[1] following national media reports in December 2023 that had raised allegations of poor quality of care and safeguarding concerns within a local residential care setting. The purpose of a SAR is not to re-investigate or to apportion blame, rather brings together findings and recommendations for future action which:

- Address any lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- Review the effectiveness of procedures (both multi-agency and of individual organisations);
- Inform and improve local interagency practice and improve practice by acting on learning (developing best practice).

1.2. The focus of this review is therefore to explore the robustness of multi-agency enquiries undertaken in respect of concerns identified by the provider, practitioners, residents and family or friends regarding the care of residents to ascertain what, if any, learning there is for local multi-agency safeguarding and quality of care processes. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect residents from harm. The learning produced concerns 'systems findings'; these identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

1.3. Prior to this review taking place and immediately following the national media contacting agencies to obtain their comments in advance of the media report, several parallel investigations were undertaken. These included multi-agency investigation by commissioners in line with the Council's Serious Provider Concerns Process. The provider engaged with the process, agreeing an action plan to address identified issues. In November 2024 the process concluded sufficient improvements had been made to remove an embargo on placements. CQC undertook a full inspection of the home. Their findings were published in May 2024 and concluded overall the home was inadequate. In addition, the Police and Home Office also completed investigations in line with their respective jurisdictions given the nature of concerns raised within media reports. Whilst this review is aware of those investigations, the scope of this review (as defined by the terms of reference detailed below) reflect the purpose of all SARs and will not duplicate those processes.

1.4. The terms of reference for this review were agreed by a panel of representatives[2] from relevant GSAB partner agencies in July 2024. The period under review is from December 2021- December 2023 and the key lines of enquiry were to:

I. Explore the safeguarding triage process and understanding of s42 thresholds across the partnership
II. Understand how involved referrers, providers, adults at risk and their families/carers are within s42 enquiries, assessed with reference to Mental Capacity Act [MCA] and 'making safeguarding personal' principles.
III. Evaluate efficiency of agencies in identifying cumulative concerns and quality of care issues. Is the system robustly identifying organisational abuse.
IV. Consider if SAB partners (including commissioners and regulators) secure assurance of sufficient oversight that providers are reporting safeguarding and quality of care issues.
V. Ascertain if escalation processes, whistleblowing or freedom to speak up policies are used where there is professional disagreement regarding s42 enquiry outcomes.
VI. Explore if the GSAB SAR process is understood and applied by practitioners, providers, adults at risk and their families/ carers.

1.5. The review was supported by an independent social worker who reviewed 83 residents' case records held by the Council, providing detailed breakdown of the residents' needs, the nature and type of complaint, safeguarding or quality of care concerns raised, how this was raised and an evaluation of

[1] s.44(4) of the Care Act 2014 "An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)."
[2] These were drawn from Gateshead Council's Adult social care and commissioning teams, Northeast and North Cumbria Integrated Care Board's designated GP, safeguarding adults lead and commissioners, Northumbria Police, Gateshead Health NHS Foundation NHS Trust, North East Ambulance Service and the local advocacy provider.

each incident response. In addition, some relevant partners (including local authorities who placed clients within the care setting outside their local area), completed individual management reviews [IMR] of their case files and commented on whether their local policies and best practice standards were applied. GSAB also provided some ICB data which was used to inform this report. The reviewers also met with family members and residents (offering both in-person and video-conference meetings to support broad engagement) and were supported by active engagement from the Independent Advocacy provider[3] within the panel and at multi-agency learning events which involved frontline practitioners who worked with residents in this care setting and senior managers responsible for oversight of policy implementation.[4] The ICB provided a substantive individual management review (although only information on three individual cases were provided in the agreed timescales) and the CQC[5] provided an IMR, only after the reviewers had met with families, residents and staff. Information provided by ICB and CQC has therefore been reflected in this report, but it was not possible to check that with people directly involved in the review. The agencies have also had an opportunity to comment on the report's findings and recommendations. Family members will also be invited to review the report prior to publication.

1.6. The provider declined to be directly involved in the review and, mindful of commercial sensitivities, the panel concluded it would not be necessary or proportionate to invite an alternative provider to support the panel. The final report will be shared with the provider prior to publication and GSAB partners will be advised of any representations they may wish to make.

2. National and local safeguarding adults policy context

2.1. In 2015 s42 of the Care Act 2014 extended previous adult safeguarding policy expectations for professionals to 'alert' local authorities of any safeguarding adult concerns. Now all 'relevant partners'[6] are expected to cooperate with the local authority in the exercise of its safeguarding function to prevent abuse and neglect, recognise, report and respond appropriately when abuse or neglect occurs. The Care and Support statutory guidance[7] also set clear safeguarding obligations for professionals, providers, commissioners, and regulators to meet expectations to work collaboratively in response to safeguarding concerns. The guidance [ch.14.9] is also explicit that the safeguarding duty is not a substitute for providers' responsibilities to provide safe, high-quality care; commissioners' responsibilities to regularly assure themselves of the safety of services; CQC's obligation to ensure regulated providers comply with fundamental standards or care; or core duties of the police to prevent and detect crime. These expectations are also replicated locally within GSAB's safeguarding adults' policy.

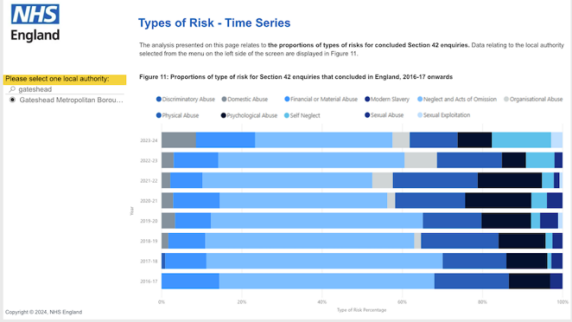
2.2. In 2024 a national SAR analysis[8] identified a significant rise in SARs where neglect was a feature since 2019 (from 37% to 46%, n.299). By contrast there was a marked reduction in the number of SARs conducted in respect of organisational abuse between 2019-23 (from 14% to 4%, n24). The report noted that the distinction between this and neglect or acts of omission can be difficult to draw. In recent years there have been a number of high profile SARs examining neglect by care providers and organisational abuse (such as Whorton Hall and Cawston Park)[9] which have identified common system findings, for example the need for stronger guidance on due diligence required by local authority and ICB commissioners, the need for closer working between CQC (as the regulator) and commissioners within the s42 enquiry process, robust oversight of advocacy for adults within institutional settings and professional curiosity that respects views of family and residents. Those findings, as well as responses from national agencies to those reviews, were used to inform the key lines of enquiry in this report.

3. Local Context

3.1. There are 48 residential care settings in Gateshead. Alongside monitoring quality of care within residential care settings, Gateshead Council is required to lead on responses for all safeguarding

[3] Commissioned to provide advocacy support in Gateshead since April 2023.
[4] The council's SAT, integrated care team. learning disability, locality and DoLS team as well as commissioners attended. So too did the advocacy provider and practitioners, GHFT, NENC ICB and ICN commissioning and Designated GP. Northumberland police also attended.
[5] GSAB and CQC have confirmed they will develop processes to enable early engagement and that this will be shared regionally.
[6] defined by s6(7) Care Act 2014 and including police, NHS bodies, the DWP, prisons and probation services.
[7] Care and support statutory guidance - GOV.UK
[8] Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2019-march-2023-executive-summary.
[9] Available at: https://www.norfolksafeguardingadultsboard.info/publications-info-resources/safeguarding-adults-reviews/joanna-jon-and-ben-published-september-2021

concerns raised in respect of 'adults at risk'[10]. NHS Digital data reports that in 2023-24 Gateshead Council saw a significant increase in safeguarding concerns from 987 in 2022-23 to 2555 per 100,000 adults (n4045), compared with 1361 nationally). In the same period Gateshead completed 870 enquiries (549 per 100,000 adults, compared with 390 nationally). Over time, it has also seen a change in the type of risks (table A, NHS Digital). Of note for this review there has been a reduction in neglect/acts of omission, though this remains the most frequent type of abuse reported. In 2023-24, 66% of enquiries were conducted for adults at risk, not in residential care settings (table B, NHS Digital).



Risk	Other - Known to Individual	Other - Unknown to Individual	Service Provider
Care Home - Nursing	15	20	35
Care Home - Residential	50	50	65
Hospital - Acute	0	0	0
Hospital - Community	5	0	0
Hospital - Mental Health	0	0	0
In a community service	10	5	10
In the community (excluding community services)	20	15	0
Other	30	5	0
Own Home	280	55	40

3.2. The care home at the centre of this thematic review provides personal and nursing care to up to 70 older people, many are living with dementia. During the period under review the home was designated as a 'preferred provider' to support the hospital discharge to assess model with an additional staff member on the rota above the normal dependency requirements, to facilitate support for complex needs, especially those admitted on a short-term basis (as an interim arrangement) under pathway 2-3 of the 'hospital discharge to assess' guidance as well as those with long term needs.[11] It admits residents who privately fund their placements as well as those who are placed by the Council and ICB. During the review period, it also admitted 14 residents placed by other local authorities as 'out of area' placements. 46 of the 76 residents involved in this review lacked capacity but required continuous supervision and control and were not free to leave, so had in place DoLS authorisations[12] to allow the care home to lawfully deprive them of their liberty, for their safety. Two other residents were assessed as meeting the criteria for care under the Mental Health Act [MHA] during the review period.[13] Case records noted 6 others lacked capacity to agree care arrangements which required continuous supervision and control, but their care plans lacked clarity on how their Article 5 rights were protected. It is unclear whether the care home's managing authority[14] had correctly identified that the individuals were under continuous supervision, or had made the appropriate referrals to the local authority.

3.3. During the 2-year period the local authority was notified of 159 separate incidents which were considered under either safeguarding, complaints or quality of care processes. These related to 83 residents. However, following detailed analysis, the reviewers concluded 14 incidents (relating to 7 residents) were out of the scope of this review. Families, friends and residents raised 46 concerns or complaints directly to the Council regarding quality of care or safeguarding concerns. These are broken down by type in the chart below.

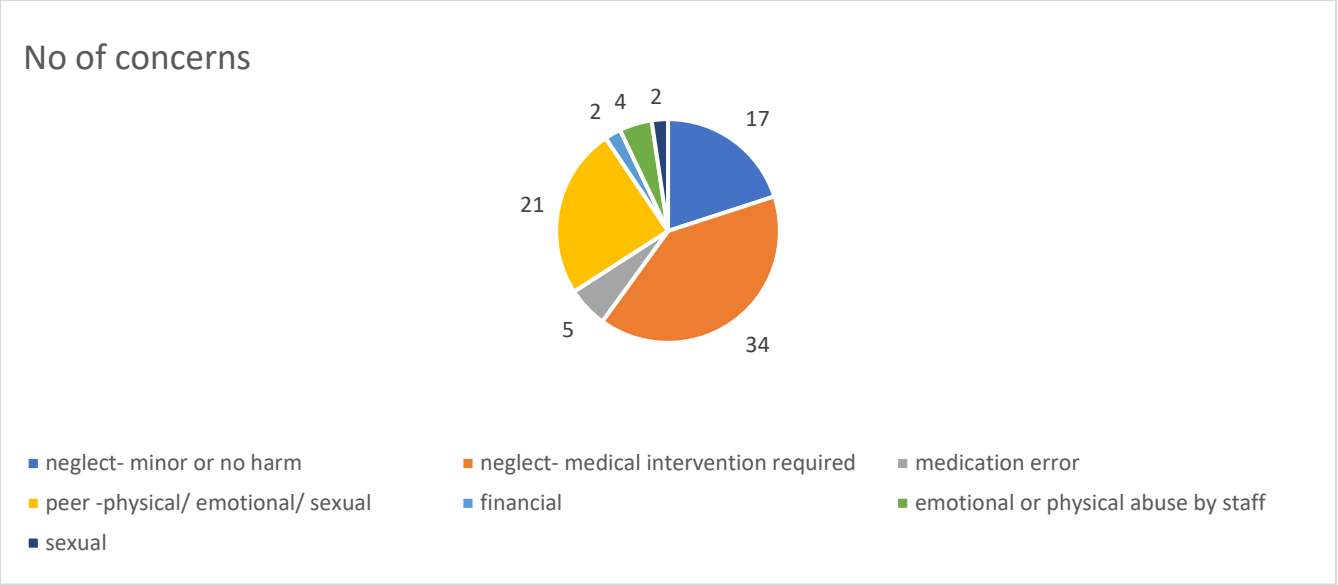
[10] Defined with s42(1) Care Act 2014 as adults who have care and support needs, are experiencing or at risk of experiencing abuse or neglect and are unable to protect themselves because of their care and support needs.

[11] This model was first introduced in August 2020 to support the rapid discharge from hospital for patients who were deemed 'medically optimised'. Over the review period, NHS England and the Department for Health and Social Care issued further guidance on the pathways and processes that should be applied locally to enable discharge into community settings prior to assessments of need having been completed. More information is available at: https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/ and the most recent guidance (issued January 2024) is available: https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance

[12] In line with duties conferred by Schedule AA1 of the Mental Capacity Act 2005

[13] There are two primary pieces of UK legislation that provide a legal framework to deprive someone of their liberty because they are of 'unsound mind', the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA)..

[14] In the case of care homes and independent hospitals, the managing authority is the person registered under Part 2 of the Care Standards Act 2000 in respect of the care home or hospital.



4. Analysis

KLOE 1: Safeguarding Adults thresholds and triage processes in Gateshead.

This section explores if safeguarding concerns were identified when raised through safeguarding referrals or other processes such as quality of care issues, complaints, members enquiries and provider inspections. If so, it considered if appropriate organisations were involved in the s42 enquiry and if professional curiosity was demonstrated in respect of information provided by the care provider.

4.1. Initial triage of any contact with the Council regarding adult social care responsibilities is undertaken by the Council's Adult social care front door customer services. If front door staff or the referrer identify safeguarding concerns, this is recorded on the adult at risk's electronic case record and then forwarded to the Safeguarding Adult Team [SAT]. Between Dec 2021- June 2023 triage of all safeguarding concerns was undertaken by 4 experienced Safeguarding Adults Coordinators via a daily duty rota. They reported this involved reviewing all concerns and logging these into a spreadsheet, evaluating whether each concern met the criteria (according to s42(1) of the Care Act) to progress to an enquiry, liaising with the provider, adult or their representative and the referrer. In line with national practice and local policy[15], where circumstances warrant a safeguarding enquiry, these were allocated to a specific coordinator linked to each provider. The provider, as part of s42(2) duty, could be tasked with carrying out a 'provider enquiry' to review the circumstances of the concern and provide assurance that a suitable safety plan was in place for the resident. All registered care providers in the area had a named safeguarding coordinator who was responsible for retaining oversight of any safeguarding concerns that met the criteria for an enquiry and the coordinator remained responsible for quality assuring and decision making throughout the s42 enquiry process. The named coordinator also had access to the SAT's spreadsheet so could review all concerns raised within that setting, including those that had closed at the concern stage or following the completion of a provider enquiry report. This arrangement was designed to enable the named coordinator to develop relational practice with providers, residents and families as well as other practitioners reporting concerns within one care setting. Prior to closing any concern or enquiry, the coordinator was expected also, if deemed necessary, discuss any concerns or possible patterns (including if there had been multiple concerns regarding a resident) with the Council's ASC localities or commissioning teams.

4.2. During the review period, in June 2022 the GSAB introduced a decision tool[16] aimed at supporting providers understand the alternative pathways in response to incidents. This comprehensive document sets out 4 alternative pathways to enable multi-agency oversight of any incident, including near misses or errors where no harm resulted. Within the guidance there are 4 distinctions based on the level of harm, namely: 'non-reportable' incidents, care and support concerns that should trigger a needs assessment or review of treatment /care plans, a provider quality-of-care issue and a s42 safeguarding concern. The document links to national guidance (including on different roles and

[15] In line with s42(2) Care Act, s14.68 Care and Support guidance and local safeguarding policy [see 3.0.3(8)].
[16] Available at: https://trixcms.trixonline.co.uk/api/assets/gatesheadadultsg/b0d619fb-a8ca-4c7f-857c-cd67472e18a7/gateshead-sab-decision-making-tool.pdf

responsibilities[17] of partner agencies) and the local multi-agency safeguarding adult policy was updated to reflect expectations under this guidance.

4.3. Despite extensive training offered to providers at the time the tool was introduced, practitioners and managers acknowledged adherence was not uniform across providers working in Gateshead. Many felt the headings used (such as 'non-reportable' where no or minor harm resulted) conflicted with expectations within local and national provider concerns policies, or legal requirements CQC has of registered providers.[18] Consequently, some providers reported an obligation to apply their own organisation's policies instead which usually required all 'non-reportables' to be reported under the s42 process. In addition, practitioners felt the descriptors used within the tool were too subjective and did not adequately consider the frequency of incidents, nature of abuse or severity of impact on the person. One practitioner gave the example that, under the tool, it wasn't clear how data in respect of 20 unexplained bruises (over time to one person, or recorded by numerous residents in one setting) should be reported. However, all were aware of the Council's SAT offer to provide ongoing support to anyone using the tool.

4.4. In response to internal and external reviews significant changes were also introduced to improve the s42 safeguarding adults process in July 2023. The Council's safeguarding process was revised via the introduction of a triage pilot. This required triage workers to review all concerns referred to the team via the Council's front door service, apply s42(1) criteria and consider if an alternative pathway may be more appropriate. If the s42 process was the most appropriate, the triage team conducted initial enquiries, undertook tasks to enable the enquiry to comply with Making Safeguarding Personal[19] principles, contacted the provider to ensure an immediate safety plan was in place for the adult at risk and thereafter referred the matter to the relevant ASC locality team manager for allocation to a suitably experienced member of that team to conduct the s42 enquiry. Where concerns related to a provider, again this was allocated to a linked SAT safeguarding coordinator within the team to mirror the good practice used under the earlier process. There may also have been an allocated worker from an assessment team to support the enquiry with care and support responsibilities. The SAT triage team reported they were not expected to use GSAB's decision tool as this was designed to support referrers to determine which referral pathway to follow and did not displace the 3-stage test applied by the local authority under s42(1), but SAT triage would routinely notify ASC commissioners of any concerns, even if these were closed prior to enquiry stage. SAT triage staff were also no longer required to maintain the SAT concerns spreadsheet. The rationale for this change in process was so that safeguarding responsibility (and relevant skills) were owned across all ASC assessment teams.

4.5. All s42 concerns and enquiries decisions are recorded on the resident's electronic case record. At the start of the review process this was the 'Care First' system. This restricted any narrative information to 4000 characters per section of the s42 form, which may explain some of the recording issues identified elsewhere within this report. Later in the period, Gateshead moved to the 'Mosaic' case recording platform. This change of IT case recording system made it difficult to identify repeated patterns over the period. In addition, limited quality assurance functionality in both systems (including linking safeguarding concerns by address) made it harder to obtain system oversight of emerging provider issues. Practitioners and senior managers within the Council confirmed Mosaic had improved data and case reporting, but accepted this remained a work in progress.

4.6. There is evidence from information submitted to this review, that practitioners from across partner agencies used the s42 process to report concerns arising in the care home. For example concerns relating to neglect of 40 people were correctly referred by family or the resident (n12), the provider (n12), NHS trust staff or NEAS (n12), the community nurses linked to the home (n9), CQC (n1), a Best Interest Assessor (n1) and the police (n1).[20] In addition, there was evidence that even prior to the implementation of the decision tool, decision making involved appropriate partner agencies, including through the daily PITSTOP meeting between ASC and police. Police were notified by the provider of all peer-on-peer incidents resulting in harm, initial police investigations were undertaken

[17] Available at: https://www.local.gov.uk/sites/default/files/documents/safeguarding-adults-roles-3e9.pdf
[18] Failure by a provider to adhere to the expectations to report statutory notifications may result in a range of actions, including sharing of information with other statutory bodies as well as enforcement action if thresholds for this are met.
[19] Making Safeguarding Personal | Local Government Association
[20] Some concerns were reported from more than one source.

and, although all were recorded an 'crime undetected' (in line with national crime reporting requirements), police report their investigation outcomes were reported to the Council.

4.7. The provider[21] notified the Council of approximately 68 incidents during the review period relating to 33 residents, all were identified by provider staff as requiring a safeguarding response, though our independent analysis would suggest 9 residents had experienced quality of care issues, 17 incidents of neglect could be determined as within the tool's 'non-reportable' pathway as no or only minor harm resulted. In consultation with the reviewers, practitioners confirmed they were aware that the care home manager at the time acknowledged difficulties understanding the decision tool. During the same period the provider notified the ICB of 82 incidents in respect of 46 people. This is discussed in more detail under KLOE 3.

4.8. In one case, disclosures made by family and the residents during a review of care needs resulted in a safeguarding concern being raised. In another case the ICB's continuing healthcare [CHC] assessor raised a concern internally to the ICB but did not refer concerns to the Council. Further, whilst 8 separate medication errors were reported to the Council during the period, these were all closed under the s42 process. Each enquiry focused only on the adult at risk and the specific medication error. There is no evidence, despite explicit concerns being raised by a relevant clinician to the Council as their reason for requesting a s42 enquiry, that consideration was given to undertaking an investigation to ensure the provider's medication management was robust or the nurses employed by the provider had the relevant skills or practice knowledge to adhere to expected NICE guidelines or NMC standards. Family members also raised concerns to the reviewers that medication management was poor; they gave examples of times when they found medication in their loved one's room untaken, which was then disposed of rather than properly administered. One person was told that carers had been advised only to ask a resident twice to take tablets, after which they were required by the home to remove them. It seems unlikely any clinical prescriber would have authorised such an approach, particularly for residents who lacked capacity to understand the risk of not taking medication. The review did not have sight of the provider's policy or any local guidance on medication administration. Further, family members noted that issues they had raised as complaints with the provider, some of which would have met the criteria for a safeguarding referral, had not been passed by the provider to the Council.

System finding:

4.9. Threshold and pathways were not fully understood or applied consistently across providers and partner agencies to enable appropriate triage when incidents occurred. As noted above, during the review period Gateshead Council reported a sizable increase in referred concerns suggesting that the decision tool was not applied as intended, but instead providers and partner agencies defaulted to recording each incident as a safeguarding concern. Senior ASC managers acknowledged more work is needed to ensure the decision tool correlates with providers' legal obligations[22] overseen by CQC and commissioners. However, partners (including the police and ICB as statutory safeguarding partners) must also consider how they support the proper application of the tool e.g. detailing how ICB's CHC team will support care and treatment reviews, or how police will respond to neglect with a view to preventative/ disruption activity or early identification and consistent evidence gathering of possible willful neglect, ill treatment or other offences against older people[23]. Commissioners and regulators should also actively engage with the revision of the tool to ensure it can effectively aid multi-agency decision making support for robust triage of adult safeguarding and signposting to alternative responses, including the Serious Provider Concerns process.

4.10. Partner agencies should agree mechanisms for providing oversight of outcomes so strategic leaders can be assured risk is reduced where incidents are diverted to alternative pathways under the tool. Current practice results in an overreliance across the partnership that the Council's SAT will act as first responders to all incidents within provider settings. This creates duplication, it also conflicts with the expectation (within ch14.9 of the Care and Support guidance) that responsibility to prevent harm sits with providers, commissioners and the regulator. Given the marked increase in safeguarding

[21] These were referred from various people including the care home manager, the compliance manager and by the area manager. It was difficult to see
[22] Care Quality Commission (Registration) Regulations 2009
[23] Neglect may amount to a criminal offence under section 44 of the Mental Capacity Act 2005 (ill-treatment or neglect of a person lacking capacity), section 127 of the Mental Health Act 1983 (ill-treatment or neglect of mental hospital patients) or sections 20 and 21 of the Criminal Justice and Courts Act 2015 (ill-treatment or neglect by care workers or care providers). But see also CPS guidance on prosecuting offences against older people: https://www.cps.gov.uk/legal-guidance/older-people-prosecuting-crimes-against#c5

concerns for adults with care needs across Gateshead, including those living in their own home, the reliance on the SAT to oversee all incidents within provider settings is not sustainable without significant additional resource for the SAT team. That team would also benefit significantly from the introduction of dedicated police and clinical expert resource to support multi-agency information gathering prior to triage. Recommendations 1 and 2 relates to these findings.

KLOE 2: Safeguarding adults enquiry process

This section considered how referrers and the individuals/families are involved in safeguarding enquiries and resulting plans. It explores if feedback loops are effective and informed by the principles of the Mental Capacity Act 2005 and Making Safeguarding Personal.

4.11. Family members of 32/76 residents subject to a concern or quality of care issue were involved in the resulting s42 enquiry. A further 16/76 families were partially involved. There are only 3/76 people (4 concerns) where there is no record of family or advocacy being involved, but these individuals may not necessarily have been assessed as requiring this assistance, as some residents retained capacity. There was also evidence on the case files that the referrer received feedback regarding the triage decision in approximately 50% of concerns; this was more likely if the provider was the referrer. Practitioners understood the difficulty to provide feedback to all referrers, accepting that, in reality, many professionals still follow a 'recognise and report' model rather than expect to be part of the ongoing enquiry or subsequent safety plan. SAT staff confirmed they are now required to provide an outcome letter which explains their decision making to all referrers. Other practitioners agreed this had improved feedback practice.

4.12. Understandably (given national and local policy), our analysis evidenced it was also much more likely that the referrer was involved in enquiry if this was the provider. NEAS reported they had '*located 223 calls within the scoping period linked to 62 of the residents named within the review*'[24]. Council records suggest NEAS raised concerns in respect of 5 people registered as living at the placement. However, they did not receive feedback, nor were they invited to support the enquiry process. Whilst feedback directly to the crew who had raised concerns would not be necessary, NEAS highlighted they had designated safeguarding leads who were well placed to provide additional clinical expertise and provide case information to support effective triage, enquiries and safety planning. CNTW MH Trust reported they have since amended their incident reporting process to prompt clinicians to chase any referral after 5 days. Some teams have also now adopted practice so that incident reports are not closed when an external referral has been made, until they have received the outcome. As with NEAS, CNTW have dedicated safeguarding leads who can work with SAT to support safeguarding enquiries and safety planning for adults at risk with mental health conditions. CNTW report data to the ICB quarterly on their safeguarding activity, including the number of concerns raised to the Council.

4.13. The second national SAR analysis identified common failings to adhere to MSP principles, particularly where the adult at risk had additional communication needs, including where this arose from cognitive decline. It also found advocacy remains underused.[25] There was evidence within case files that staff applied the making safeguarding personal principles for 18 residents (n36 concerns) and that these were partially applied for a further 14 residents (n28 concerns). There were some examples where adults at risk were known to be subject to DoLS or s117 MHA aftercare, but were not supported by family or an advocate during s42 process due to unavailability of the service or because '*it was only progressing to SPC it was unnecessary and disproportionate to get an advocate.*'[26] The SAT confirmed they reviewed each of the 3/76 cases and were satisfied the legal duty under s68 Care Act did not arise as only minor harm had resulted in those cases. They provided assurance that they understood the vital role played by advocates in ensuring procedural processes are applied in a way that is consistent with the person's statutory and human rights.

4.14. During the review process the advocacy provider changed. Whilst advocates transferred to the new provider, historical case records did not. Independent advocacy practitioners involved in this review explained they were routinely instructed to support the DoLS authorisation process, in such situations they found provider staff to be engaged and supportive. They felt confident they had not seen

[24] Taken from NEAS' IMR report, not all of these triggered a s42 concern from NEAS crew.

[25] Report 2 of the Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%20%28branded%20and%20proofread%29%20v6-19.pdf

[26] Taken from the case summary for one resident subject to a safeguarding concern following an act of omission that had led to minor harm

anything that gave them cause to suspect abuse or neglect. The advocacy service confirmed that during the review period three people were supported by an advocate where safeguarding concerns arose. Only one was referred for the service because they were subject to a safeguarding enquiry. The other two were referred for advocacy support as they were subject to DoLS authorisations, but in both cases the advocate raised safeguarding and quality of care issues directly to the Council. They reported, within their IMR, not receiving feedback on the outcome of those enquiries.

4.15. ASC's IMR also recognised there was '*less evidence of care management teams putting in safeguarding referrals*' and acknowledged that presumptions that residents within the care home would not be included in decision making. This, they reported, started at the point of referral where very little information was made available to the SAT triage about what the resident's views or desired outcome was. They agreed this should be challenged. Understandably, given the rise in safeguarding concerns, responsibility to apply MSP principles should not fall entirely on the SAT.

4.16. Within their IMR, ASC concluded overall responses appeared to adhere more closely to MSP principles when the adult at risk was already known to Gateshead ASC. Whilst it was usually noted in case records if the adult had been placed from another area into Gateshead, there were very few examples that out of area local authorities were actively involved in s42 enquiries, even when notified by the Council of the enquiry. It was also difficult to ascertain from the case files how the local or out of area ICBs or Councils' assessment teams or commissioners were involved in safeguarding enquiries. Practitioners spoke of good relational practice between local teams, including the ICB's CHC staff. They explained the gap is likely a recording issue as those conversations were often informal or undertaken at more senior level. They also accepted that service demand was an issue across health and social care, but particularly during this review period for the CHC team.

4.17. Family members reported how there appeared to be conflict between processes, particularly if there was a police investigation. Some families reported, in those circumstances, it felt as if other partners stepped away to give primacy to the police investigation. SAT reported they felt there was good communication with police at triage and throughout enquiries, though this wasn't always apparent within case records shared with this review. Local procedures [s4] set out expectations for police and the Council to agree through a strategy discussion how they would collate information to ensure credible evidence would be available in all relevant civil and criminal jurisdictions. Currently local and national policy require police are involved early, but lack clarity on how parallel processes could be strategically planned to prevent against any subsequent allegation (in civil or criminal proceedings) that evidence had been contaminated by such close working. Conversely, other family members reported that in circumstances where they felt an accumulation of concerns should have triggered consideration of whether their loved one was experiencing neglect, police involvement was not secured at an early stage, losing the opportunity to gather accurate evidence.

4.18. Many case records reported the closure of s42 process was deemed proportionate as the provider's enquiry had confirmed a safety plan was in place, but it was not always clear from residents' case files if this information had been triangulated with allocated professionals or commissioners. It was rare to see a record of how the person's care had been reviewed to ensure the home could safely meet their needs. Within their IMR, ASC explained that demand for assessments and reviews was (and remains) managed by a waiting list, prioritisation was according to risk which favoured individuals awaiting hospital discharge (in line with government policy) and in the community over people within residential care. They also noted that even where a s42 enquiry identified complex risks there was no evidence a social worker had been allocated to undertake a review. This accorded to feedback at the learning events from practitioners, though it was noted that following the reported concerns from the national media, concerted effort was made to ensure the care needs of residents within the care home were reviewed and that, mirroring the SAT coordinator/triage team's good practice, those were undertaken by linked social workers. Some family members felt the response after media concerns were raised was 'performative', other family members felt this had resulted in significant improvements within the home. Many families explained they found it hard to understand how the s42 process ensured their loved one's care was safe. Several family members commented that whilst they understood their loved one received 1:1 funding, they remained unsure whether quality 1:1 care was actually provided. For example, one family member raised concern about a large number of unobserved falls, or inconsistent explanations for serious falls, when their loved one was supposed to be receiving 1:1 support. Contract monitoring staff explained the provider had developed a tool to record if a resident had 1:1 care, and that since 2021, these packages were reviewed as part

of the care review every 3 months with a requirement for the provider to evidence that these 1:1s were still required and delivered. However, at times the provider had instigated informal 1:1 care without a care review taking place, which would not have had oversight from the local authority.

4.19. Families reported finding 1:1 support (often agency staff) asleep, on their mobiles or watching TV rather than engaging with residents. Others reported significant deterioration in their relative's health following placement within the home. Other professionals also raised concerns regarding inadequate 1:1 support, but there was little evidence these concerns (if processed via s42, care reviews or quality of care processes) resulted in improved risk management. SAT reported that, as part of the s42 process, they had notified relevant teams of their safety planning at triage and sought to support more effective management of complex needs. Again, this overreliance on the SAT to manage care planning functions is unsustainable. Some families reported to this review that when they raised concerns regarding understaffing or lack of stimulation or skills within the provider's workforce to manage basic nutritional or mobility needs well, they felt these were ignored by both the care provider and during safeguarding meetings. Commissioners explained they had limited ability to verify the delivery of quality 1:1 care, mostly this was done through 'floor walks' during an annual monitoring visit. Families explained in response to their concerns, at best they received assurance that agency staff would not be reemployed within the home,[27] but felt very little was done to ensure that staff had the required skills to support adults with dementia. Families understood the difficulties of caring for adults with dementia, most had provided significant levels of daily care to their loved ones prior to their placement. They provided examples of how they had offered to help staff provide more person-centred care, by explaining what worked to reduce risks. Equally they spoke highly of members of staff within the setting who were skilled, friendly and caring and were very conscious that they did not want all the care staff to be the target of criticism.

System Findings

4.20. There are examples within the case files of principles under MCA and MSP being applied. Changes to the SAT process may improve adherence, but this is likely only to have minor impact unless the legal and practical reasons for those measures are understood more widely across relevant partners, provider, care management and commissioning staff. Commissioners recognise the need to change practice so incidents, complaints and safeguarding concerns data are used proactively to shape strategic preventative interventions. Senior leaders also understand that key performance measures (such as data to evidence compliance with MSP or MCA principles) require closer scrutiny so this does not remain a '*transactional task*'[28]. GSAB partners must agree how to capture a systemwide overview of practice (including across geographical boundaries) that demonstrates active compliance with the duty to promote wellbeing (s1 Care Act). Recommendations 3,4 and 5 relates to these findings.

KLOE 3: Systemwide assurance of care quality within residential care

This section evaluates the efficiency of agencies in identifying cumulative concerns and quality of care issues and if current policy and practice helps partners to quickly identify organisational abuse concerns.

4.21. There were 23 residents where 3 or more incidents or concern was raised during the review period relating to concerns of neglect and acts of omission, abuse by provider staff or peer-on-peer abuse. One resident experienced numerous incidents, including of two separate incidents of poor-quality care resulting first in a tissue viability issue and later in a significant injury. There were also concerns raised that his money had gone missing and one allegation of physical abuse by an agency staff member. Whilst substantial complex enquiries were undertaken by SAT staff, the resulting s42 enquiry was closed because the provider confirmed they would not reuse that agency member of staff and the police queried if there was sufficient evidence to complete a criminal investigation. Within the case files there is evidence that the home or local authority referred concerns to the employment agency, but no evidence of feedback to either the local authority or the provider that the employment agency conducted an enquiry or considered a referral to the Disclosure and Barring Service [DBS]. This was also replicated in a least one other case. The Care and Support guidance explicitly states that if the provider or agency has not complied with their legal duty to make a referral to the DBS, the local authority can do so [ch.14.75]; however, this means that locally, a feedback process is required to enable the local authority to take such a step if needed. Within the Care and Support Guidance

[27] There is evidence that the home or local authority referred concerns regarding quality of care to the employment agency, but no evidence of feedback to either the local authority or the provider regarding what action the employment agency had provided. This is explored in more detail in response to KLOE 3.
[28] Taken from ASC's. IMR

[ch.14.124] there is a requirement to refer any conduct that might impact on the worker's suitability to work with children to the relevant local authority's designated officer [LADO]. There is no corresponding duty to refer if the conduct relates to an adult with care and support needs. This gap has already been identified as a significant omission within high profile SARs into organisational abuse and escalated to the Department of Health and Social Care [DHSC] to address. At the time of writing this report, this gap remains and recommendation 7 is intended to underpin the urgency for the DHSC to address this.

4.22. In 2 cases involving sexual abuse allegations it was difficult to ascertain the police involvement from the Council's case records. In one case, there was a delay of 5 months to determine no further action would be taken. In the other, the s42 enquiry was closed '*although the statutory criteria for safeguarding was met [sic]… because this concern will be considered as part of an ongoing enquiry*'.[29] There was evidence of challenge by SAT practitioners against an assumption that the resident raising the concern lacked capacity. Family also reported at the time that mental health professionals had determined the resident had capacity. The matter was reported to the police by both the Council and Gateshead Health NHS Foundation Trust [GHFT] staff. It was not reported to the Council or ICB by the provider, adding weight to families' assertions that their concerns were not always appropriately passed on by the care home manager or the provider's senior leadership. Practitioners spoke of attempting to pull together a coherent investigation plan, including to ascertain the resident's capacity, but reported this was difficult to achieve within the s42 enquiry as they lack the line management authority to compel partner agencies to make available clinical expertise. Eventually the s42 enquiry was closed prior to completion of the police investigation, in line with local s42 procedure, as the resident was moved out of the area. During the course of this review, assurances were provided that the criminal investigation was robust (involving medical and psychological evaluation) and triangulation with the provider's staffing logs before it was determined that the adult's account was as a consequence a 'delusional disorder'. Practitioners spoke of the relief of discovering the outcome during the learning event. They explained often it could be extremely difficult to agree how a person's capacity would be assessed and how that determination might impact on the enquiry process. Practitioners appeared confident that the serious nature of the allegation would ensure senior managerial oversight, but this is not always clearly recorded within the case file or s42 outcome.

4.23. It is understood that local s42 procedure was amended to require closure of a s42 enquiry whenever the adult at risk dies or moves out of area. This policy is explored further below in KLOE 6. However, the practice of closing enquiries in those circumstances makes it harder to demonstrate compliance with the GSAB policy expectations on responding to allegations against staff or people in positions of trust [PiPoT]. This is explored in more detail within KLOE 5.

4.24. Two residents were identified as the PACH in 4 separate peer-on-peer abuse concerns. Each were closed when provider confirmed they had in place a safety plan. Family members of one victim (assaulted on 2 separate occasions by the same person, despite being told that a safety plan had been put in place after the first incident) understood the person causing harm lacked culpability due to their cognitive impairment, but highlighted neither the ICB (responsible for the resident's care plan) or the provider had put in place adequate protection for other residents in breach of their duty of care. They queried why, even after numerous concerns, this was not picked up and acted on by other partners in line with regulatory or safeguarding functions as potential organisational abuse. Another resident was informed that the acts of omission which resulted in a loss of her dignity were because '*staff were too pushed with helping upstairs lot'*.[30] Again the s42 enquiry was closed without triggering notification to commissioners or regulators as, according to the Council's case file, the provider confirmed within their provider enquiry *'an effective safety plan was in place'*.

4.25. The care home manager had acknowledged difficulties understanding the decision tool so continued to refer each incident via the s42 process. Commissioners acknowledge this would not have been in breach of the provider's contract as these had not been amended to reflect the introduction of the tool. Practitioners within the Council's safeguarding and hospital discharge teams spoke of the considerable support they offered the care home manager during this period, including frequent contact with the provider's senior leadership team to ensure they had suitable support in place. Within

[29] Taken from the case summary (from ASC case notes)
[30] Taken from the resident's case summary prepared for this review

their IMR and during learning events, the Council explained the home's status as a preferred provider under the discharge to assess model meant additional support was offered to support rapid reassessment of any resident's needs. They also confirmed that requests from the home for 1:1 care were usually granted urgently pending assessment, though the need for clear processes to enable timely reviews and urgent 1:1 care arrangements going forward was recognised.

4.26. In common with practitioners, family members reported the situation deteriorated markedly after a new care home manager came into post during the review period and that it has subsequently improved now the home is under a new manager. Practitioners were able to detail comprehensive offers to support the manager. For example, in August 2022 the SAT coordinator, after receiving correspondence from the home's link GP in July 2022 giving a view that the care home "*should be, at the least, in special measures"* and recognising a pattern of concerns could indicate the quality of care was likely diminishing, worked with the Council's commissioners to arrange a multi-agency meeting to offer additional support to facilitate safe transfers under the hospital discharge to assess pathway. Whilst this included hospital and community based clinical and assessment staff, the ICB and Council's commissioning team and the provider's senior management it was not recorded as part of the usual contract monitoring arrangements or Serious Provider Concerns process [SPC]. This is explored in more detail within KLOE 4. The SAT coordinator did, however, confirm that in response to that meeting the provider's senior management agreed to offer more support to the care home manager, consequently they felt practice improved and risks were reduced. This improvement proved temporary. Importantly, during that meeting no consideration given to suspending the usual process of asking the care home manager to undertake the provider enquiry (unders42(2) Care Act and s s3.0.3.8 of the local safeguarding policy) until such a time as the SAT, commissioners and her own line managers were able to evidence she was competent to fulfil this task and that no conflict of interest arose. Recommendation 5 is in response to this.

4.27. Overreliance on the s42 process to respond to all incidents also resulted in underuse of alternative support available to the provider to meet needs safety. For example, family members reported their requests for alternative equipment or even to fix broken equipment were turned down by the provider on the grounds of cost. Some reflected they were astonished that care home staff were selling raffle tickets to fund the purchase of garden furniture, particularly in light of the providers' considerable profits identified within the national media report. Others commented that essential equipment (such as mobility hoists) were routinely not used due to poor training and staff shortages within the home. Instead there were frequent incidents, including video evidence, of drag lifts being used putting residents at risk. Family gave examples of escalating their concerns directly to commissioners and CQC, but were unaware that action was taken. CQC confirmed (as detailed within this report) where they had concerns, these were passed to the Council as safeguarding concerns. However, practitioners and panel members explained, usually these were passed without additional commentary or verification from the records that would have been available to CQC.[31] One family also questioned why when other regulated professionals employed by GHFT were also witnessed using a drag lift, the duty of candour duty was not applied. The Trust confirmed they have since provided a verbal apology, met with and written to the family to explain they were not made aware of the incident until after national media coverage. Their correspondence also detailed the rationale for decisions taken at the time and the steps they had taken with staff involved in the incident to improve future care. Frequently, we heard from families that, despite the parallel investigations (detailed above), they had not received detailed responses to individual complaints. They explained they raised concerns and complaints to get assurance that the provider would be closely monitored so practice met expected safe standards. They acknowledged that, following the media attention, family meetings had been arranged by the provider but explained only general assurances were given at that meeting and it wasn't always clear which agency was leading on follow up action as professionals hadn't all introduced themselves or explained their role in the ongoing processes. Statutory partners noted that they were not always invited to the family meetings organised by the provider. Some family members also felt they had been intentionally excluded from some meetings, and in one case, an individual who had raised several safeguarding concerns was reported to be personally targeted by the care provider during a meeting, a situation that was not challenged by the statutory partners in attendance. This was despite the fact that these concerns mirrored issues that had been raised by health professionals attending the home in 2021 and again in 2022.

[31] CQC explained they do not have access to personal information regarding recipients of health or social care services so any verification would be limited to high level concerns regarding the provider. This would usually be shared via the SPC process.

4.28. SAT coordinators reported that as part of the s42 triage or enquiry, they routinely contacted the provider's named contract manager or the community nurse practitioners and linked GP within the home to verify information. However, those discussions were not always clearly recorded within the resident's case file. They acknowledged that during the review period, staffing changes at the GP practice made inter-agency working more difficult, but reported this had improved considerably since the national media report. The SAT coordinators also attended team meetings (e.g. with the integrated care team) or met monthly with CQC and Council's commissioning team to share soft intelligence about spikes in concerns from certain providers. The ASC's IMR explained, having undertaken this task, the expectation was that others would then take responsibility for monitoring patterns and preventing harm. However, as explored below in KLOE4, confusion over which formal process to use reduced accountability for follow up actions.

4.29. Practitioners from other disciplines also explained it could be difficult to obtain sufficient information to understand risk in context because information was only shared with respect to the nature of the response expected. For example, in one incident of peer-on-peer physical harm where serious harm resulted (a resident died shortly after the incident) police were informed and conducted preliminary enquiries before determining no crime was detected. Shortly after the incident (approximately 2 hours later) a local authority approved mental health professional [AMHP] attended to assess the person who had caused harm. The AMHP was not provided any information about the victim or the person she was required to assess, nor was she given details about the incident as the care home manager and staff had left at the end of the shift and the staff present did not know the person well. Staff from the hospital also reflected how sometimes responses to their concerns could be met with negative or defensive behaviours from the care home manager. They gave an example where they had raised a s42 concern in respect of one resident only to be told the home had made a counter allegation against their staff. They felt this was petty, but did not escalate this further as they were unaware of the wider concerns or support going in to manage risks within the home.

4.30. Separately to the Council's processes, NHS providers are also required by their own internal policy and NHS England's patient safety incident reporting framework [PSIRF] (which was also revised during the review period) to collate any safeguarding or patient safety concerns. As GSAB partners they would also be aware of GSAB's decision tool and the revised s42 process. Helpfully, GHFT (responsible for the community nursing practitioners who supported this provider with weekly ward rounds and QE hospital, where many residents requiring A&E or admissions following incidents were taken) reported they recorded these within their Datix reports[32]. During the review period QE staff reported 27 incidents to the ICB relating to 18 residents of the care home. As noted above, the provider also notified the ICB of 82 incidents in respect of 46 people. This data should have been immediately available for the ICB senior leaders to review. However, the ICB's safeguarding leads explained they are not able to directly access information recorded on Datix, a fact that frontline health professionals appeared unaware of. Importantly, it appeared from correspondence during this period that those practitioners believed that by recording incidents on Datix or through SIRMS (the recording system for PSIRF), a safeguarding referral would have been generated, and they therefore understood the local authority SAT team would have had sight of these, which was not the case. This is discussed further at KLOE 4.

4.31. Community nursing staff advised they had tried to escalate concerns to ICB commissioners, but were advised to use organisational reporting formats (e.g. through Datix). GHFT managers explained they held system briefings, drawing on learning from Datix data and that the ICB safeguarding leads attended these, but it wasn't clear how that information was passed to commissioning or assessment teams within the ICB. ICB staff attending the learning review reported they were expected to report concerns to their designated safeguarding lead, but did not thereafter routinely receive information on residents even if responsible for commissioning the care because of the way the ICB had been restructured during the review period. ICB commissioners confirmed, had they been aware of the nature of many of the concerns, specialist equipment would have been made available if it were required to meet nursing needs. Likewise the challenging behaviour team would also have been made available to address patterns of behaviour to reduce risks to other residents of peer-on-peer abuse. They confirmed they have set up a task and finish group within the ICB to explore if new IT systems might help to pull together trend analysis from provider incidents.

[32] The Datix reporting system is a database used by some NHS Trusts to record and learn from medical incidents, complaints, claims, risks and safety alerts.

4.32. CQC reported that they received 334 statutory notifications from the care home during the period under review. They did not believe this was an unusually high amount, given the size and nature of the home. Of those 120 related to abuse or allegations of abuse, 29 related to serious injury, 3 related to a police incident. 14 related to unexpected deaths. In addition, within their IMR CQC reported they had 14 enquiries which related to concerns or complaints about the service. Nine concerns were raised by family members, 1 was made by a GP and 4 were freedom to speak up/ whistleblowing anonymous concerns relating to untrained staff, high use of agency staff, concerns about unprofessional staff behaviour, recruitment practice and infection prevention and control issues. CQC also disclosed they raised 11 safeguarding referrals in respect of 8 residents within the care home during the review period. There were safeguarding enquiries conducted in 5/8 of the resident's cases. One concern was closed as it was considered a quality of care issue (though the Council now accept it should have been subject to a safeguarding enquiry). Another concern raised quality of care issues for a resident placed by another authority and, whilst the issue did not meet the criteria for a safeguarding enquiry, the information was passed to the Council responsible for the resident's care. In two of the cases incorrect details were sent, though further enquiries by the Council's SAT manager enabled an investigation into one of the cases which considered allegations of poor-quality care (arising from unsafe manual handling techniques used by staff). None of the referrals triggered SPC or s42 enquiry processes to investigate concerns regarding organisational abuse. In conversation with reviewers, senior managers commented that the SPC and safeguarding processes are still seen as distinct activities. They explained too frequently practitioners with regulatory or commissioning expertise alert the Council's SAT where they have concerns, but rarely provide wider context such as any ongoing concerns about the provider making it much more difficult for SAT triage staff to demonstrate it would be proportionate to initiate a s42 enquiry into organisational abuse.

4.33. On notification of national media reports in November 2023, CQC did hold a management review meeting to consider '*the appropriate regulatory response*' in line with their relevant enforcement powers[33] and were invited (and contributed) to the subsequent SPC process, led by the local authority. CQC reported their teams carried out 4 inspection visits between the 16-24.11.23. CQC reported that had explored whether the provider could be potentially criminally liable[34] with respect to 4 incidents where residents have sustained avoidable harm including death, been exposed to a significant risk of avoidable harm or suffered loss of money or property as a result of failure by the provider. Ultimately, they did not believe there was sufficient justification to escalate those 4 incidents for a criminal investigation as their regulatory powers are limited and '*our thresholds were not met*'.[35] One further case remains under review. The service was placed under special measures and the provider was served a warning notice. In December 2023, CQC suspended the provider's rating of good, later concluding the service should be rated inadequate overall as the provider had failed to ensure:

- *An effective system was in place to support people and their relatives to be involved in their care*
- *Safeguarding allegations were appropriately managed and monitored*
- *Records demonstrated how complaints were responded to or how the service was meeting the duty of candour requirements.*[36]

4.34. Police felt confident their specialist investigative teams would identify cumulative concerns where peer-on-peer harm was reported, but were unable to remember if this had ever triggered an enquiry or SPC meeting. Usually, senior managers across the partnership agreed they would come together to discuss any surge in peer-on-peer assaults, but conceded this may be done informally. They also accepted the oversight of 1:1 care delivery within residential settings needed greater transparency and oversight by health partners to ensure accountability. Practitioners spoke of the benefit of the daily PITSTOP meeting between police and social care to support proportionate, multi-agency decision making in Adult Concerns Notifications made direct from frontline police officers. They accepted this was used most frequently to address community safeguarding concerns (i.e. not raised against people in residential settings) so would not routinely explore if cumulative concerns regarding neglect or acts of omission indicated thresholds to investigate organisational abuse had been met.

System findings:

[33] Available at: https://www.cqc.org.uk/guidance-regulation/providers/enforcement/enforcement-policy/purpose-and-principles-enforcement
[34] Under s91 and 92 Health and Social Care Act 2008
[35] Taken from CQC's IMR prepared for this review
[36] Taken from CQC's IMR prepared for this review

4.35. Families understandably felt residents were badly let down by failures on behalf of commissioners and the regulator to act collectively to either spot patterns of neglect or consider triggering either the SPC process or a s42 enquiry into organisational abuse prior to notification of the media reports. They rightly questioned how repeated neglect concerns, peer-on-peer assaults or unwitnessed falls could take place if, as they had been assured by the provider, 1:1 support was provided. Whilst systems exist within the Council, ICB and CQC to enable trend analysis, triangulation of information from safeguarding leads, commissioners and regulators is still fragmented. The relational practice between services resulted in informal discussions which lacked the required structure meaning that numerous concerns, quality of care concerns and complaints about care within this care home did not trigger coordinated action. Families, practitioners and managers were keen to see better systems of communication about provider concerns. Clarity, within the SPC process, of roles and responsibilities and more assertive reporting requirements is required to ensure GSAB can '*hold partners to account and gain assurance of the effectiveness of its arrangements*'[37] Recommendations 3, 4, 5 and 6 relates to these findings.

KLOE 4: Strategic oversight of safeguarding and quality of care incident reporting

Here the review considered what oversight is available to the partnership in respect of the consistency of self-reporting of safeguarding concerns and quality of care issues by providers?

4.36. Family members voiced unease that many of the issues they raised directly with the care home manager were not acted on or referred on to the Council and this was the case irrespective of safeguarding, reassessment requests or quality of care issues. Instead, families reported, too often any resulting safety plan felt punitive to victims. For example, one victim of repeated peer-on-peer abuse was told to remain in their room to avoid contact with the other resident. The resident became increasingly isolated and distressed with no attempt by staff to provide contact or reassurance. Families were also acutely aware that if improvement actions were agreed by the home as part of a safeguarding plan, they had no way to ensure tasks were undertaken. They reported feeling powerless to ensure safety and could only act by escalating concerns to the Council (many reported never receiving acknowledgements to those concerns) or making additional complaints. Families gave examples of seeking to discuss their fears with Police, ICB or CQC but felt these weren't taken seriously. Remarkably, there was an example where a family raising concerns over a period of time resulted in a decision by the provider to terminate the adult's placement without a best interest consultation with the family or ASC. Other family members raised concerns they weren't consulted to agree interim safety plans. Others spoke about having to beg to get support to move residents from the home into a suitable alternative placement.

4.37. Presently the Council requires that all providers have an annual announced contract monitoring visit, prior to which the provider must complete a Quality Assessment Framework self-assessment [QAF] to be validated by a contract management officer at the visit. The SPC procedures requires the named contract management officer to review any data detailing quality of care issues or safeguarding concerns on a regular basis. Practitioners were of the opinion that across Gateshead compliance was patchy, as some providers felt it could be detrimental to their business to report. As noted above, the care home manager had submitted a significant number of safeguarding concerns during the review period, but objective analysis of residents' case files demonstrates there were a significantly higher number of incidents that should have been reported to commissioners. In line with national and local policy, the onus is primarily on the provider and registered manager to exercise professional judgement in respect of record keeping and reporting concerns.[38]

4.38. Under the SPC process, where there are a '*high number or serious nature of death, safeguarding, commissioning or whistleblower concerns*' this triggers an 'information gathering meeting'. Similarly, the process permits anyone to raise serious provider concerns directly to the Council's lead commissioner. Any non-compliance with quality standards is recorded and an action plan for improvements agreed. If action plans are not progressed in a timely way a partnership meeting 'may be convened' and unannounced visits can be made. CQC, ICB and relevant professionals are expected to be involved in stage 2 of the SPC. Thereafter a 4/5-stage escalation process should resolve concerns, but the final stage will result in decommissioning the provider. The SPC process

[37] A core function of the SAB as set out in 14.139 Care and Support Guidance and reiterated within s3.1 of the GSAB memorandum of understanding.
[38] Managers are required to register with CQC. The applicant and provider are expected to verify the manager is of good character, able to preform tasks and has 'necessary qualifications, competence, skills and experience to manage the regulated activity'. Reg.7 Health and Social Care Act 2008 (regulated activities) Regulations 2014.

asserts ‘relevant stakeholders’ and providers should receive feedback, but it is unclear if this includes residents and families who have raised concerns. Within the SPC process the mechanism for reporting outcomes is an annual review of SPC interventions to provide learning to the GSAB QA subgroup or GSCP.

4.39. In addition to the Council’s QAF for commissioning, another process determined fee rates that providers can charge. This is known as a Quality Evaluation Framework and involves a three day, detailed inspection which was completed in January 2023 for this provider with no areas of concern identified. Since the review period this process has been amalgamated to the QAF; both remain outside of the SPC process.

4.40. Whilst practitioners from SAT and the Council’s commissioning confirmed they regularly shared information about concerns, the data and case analysis indicate incidents in respect of only 5/76 residents triggered consideration of the information gathering stage of the SPC process. Case records suggest 5 families raised complaints or concerns directly to commissioners identifying issues regarding staffing, nutrition, quality of care, hygiene and documentation. In one case the provider’s operational manager was asked to investigate, another the provider was told to respond to the family via their complaints process. The 11 referrals CQC submitted also did not appear to result in further action under the SPC process, even after 5/8 residents were subject to s42 enquiries and required safety plans as part of those enquiries.

4.41. There were a number of occasions when the healthcare professionals who regularly attended the care home raised significant concerns about the overall management of the home, which they believed was placing residents at risk. In December 2021, the CCG (now ICB) held a meeting to discuss concerns about 4 care homes, including concerns about the care home at the centre of this review, identifying concerns about the quality of nursing and care and that some GPs felt “*unsafe*” to do ward rounds in the home, but when the issues were raised with senior manager, the home raised concern about working arrangements by the GP practice. This resulted in a visit to the home from the CCG quality lead. A further information sharing meeting took place in March 2022 between the CCG, GP, community practice nurses and SAT, again discussing unexplained injuries to residents, medication errors, pressure damage, concerns that nursing staff in the care home failed to recognise clinical changes or comply with clinical advice from GPs during ward rounds, identifying that communication difficulties may be arising due a to a “*language barrier*”. The CCG Safeguarding nurse emphasised the important of submitting Datix, SIRMs and safeguarding referrals, although it is not clear that the differences in these processes were explained to the frontline practitioners. On 1 July 2022, ICBs replaced the role of CCGs.

4.42. In mid-July 2022, the link GP wrote to the ICB Designated Nurse, again, raising concern about unexplained injuries, medication errors, continuing pressure damage, violence by residents to staff and other residents, stating their view that the care home should be in *“special measures*”, and offering to speak to the CQC during its upcoming inspection. The email stated “*You should have had multiple safeguarding referrals crossing your desk from the CNPs*”. This was shared with the local authority through its commissioning team, which at that time was a joint service between the local authority and ICB (though these functions have since been separated). The Council’s commissioning team asked for confirmation that safeguarding referrals had been made to the SAT team, and the GP confirmed that they had. However, the SAT team identified that relatively few safeguarding referrals had been made and it appears that, as noted above, this had been due to a misunderstanding on the part of frontline practitioners that Datix and SIRM recordings equated to safeguarding referrals. Despite this apparent error, there is no evidence that the Datix/SIRM records were then reviewed by the Trust to identify patterns of concern and relay their findings back to safeguarding partners who could not access these records. It appears that at some point during exploration of these concerns, the GP practice raised concern about the potential for modern slavery in respect of the workforce in the care home, and also made a referral to the Modern Slavery Helpline. The Council also confirmed their SAT raised concerns to 101 on the 04.08.22.

4.43. Rather than pursue individual safeguarding enquiries or progress the matter through the SPC process, partners relied on an unannounced inspection by the CQC in late July 2022 to investigate the concerns. CQC reviewed staffing and recruitment as part of this inspection, but reported that they had focussed on care plans, risk assessments, and pressure damage management, as well as speaking with staff, residents and families and had been unable to find evidence of the allegations

raised by the GP, identifying issues only in relation to recording of administration of medication. It is unclear whether the CQC also spoke to the GP practice to understand the reasons they had raised these concerns. Because the CQC reported that their visit had been positive and that the care home managers had raised issues about the GP ward round, a multi-agency meeting was convened with the care home and a new GP provider service, discussed at paragraph 4.47.

4.44. The tone of subsequent emails between senior leaders and during discussions at learning events, suggest that focus had shifted from the legitimate concerns being raised by the GP practice to a view that this was a relational issue between the surgery and the home. While it is reasonable to fully explore concerns to carry out a balanced investigation it is vital that partners are cautious of counter allegations used as a diversion from real issues as this could undermine confidence of safeguarding partners to make referrals. Similarly, leaders discussed that prior to this situation, they had used the SPC process in respect of another care home provider when serious concerns had arisen, which had resulted in a legal challenge. Although they had revised the SPC process as a result of this, the experience may have made leaders more hesitant to use the SPC process to address the concerns in this case.

4.45. It does not appear that a referral was made through the National Referral Mechanism, as the CQC had not found evidence of this during their inspection visit. The Modern Slavery Act 2015 reiterates existing powers and introduced new powers in relation to trafficking and exploitation. Under the act, agencies have a statutory 'Duty to Notify' in relation to anyone who is believed to be a victim of Human Trafficking (including internal trafficking within the UK). Public bodies have responsibilities to identify potential victims of modern slavery and recognise the indicators of modern slavery, gather information in order to understand what has happened to them and refer victims into the National Referral Mechanism (NRM). Leaders acknowledged that Gateshead would benefit from a clear partnership policy in respect of how to investigate allegations of modern slavery.

4.46. It was somewhat perplexing that during the course of this review, the IMRs from the local authority's SAT team, commissioning team and the Trust did not reference the concerns raised by the GP and CNPs, and although discussed by community nurses during the practitioner event in the context of their experience of the partnership response (set out below), no substantive documentation was received to explain events until the ICB's IMR was received in December 2024, after the first draft of this report had been circulated. This information was key to understanding some of the concerns highlighted in the national media report, in particular, the view of some practitioners that the partnership response to concerns they had raised had been inadequate. This clearly demonstrates the difficulty in ensuring effective record keeping of more generalised organisational safeguarding concerns, when these are not raised in respect of a specific resident.

4.47. Separately, at this time community nurse practitioners had reported to their own GHFT management significant tensions had arisen because they had raised what they felt were legitimate concerns to the care home manager regarding numerous incidents of poor medication management or quality of care. This had become of such concern that the GHFT manager met with the care home manager to agree effective interagency working. They reported during the learning events within this review that the meeting dissolved as the care home manager became agitated and defensive such that the GHFT manager felt it was inappropriate to expose her staff to continued criticism and ended the meeting. Other practitioners, including commissioning and safeguarding leads at the learning event expressed surprise that this had not been known to the wider system at the time. During the practitioner learning event, community nurse practitioners commented that had they been aware of the similarly hostile response that some family members had experienced when raising complaints, they may have felt more confident to challenge this situation further.

4.48. There was evidence of some triangulation of concerns, resulting in multi-agency information gathering in line with the SPC during the meeting in August 2022. Those present at that meeting were unaware of the tensions between GHFT staff and the provider so did not factor their concerns or how tensions might impact on any action plan. The meeting concluded actions would fall to health colleagues to monitor in fortnightly meetings with the providers, named GP and community nurse practitioners as it related to medication management and falls prevention. It isn't clear whether the GP or GHFT nursing staff were advised of their responsibilities under the plan and, during the learning events, it was accepted it wasn't clear under the SPC who would be responsible for doing so and monitoring actions

led to practice improvement. In fact those meetings did not happen, no one was able to explain why, but this was a significant missed opportunity to initiate the SPC process or, separately, a s42 enquiry into organisational abuse.

4.49. During this period, following the establishment of ICBs, a local restructure saw the removal of named clinical leads for care homes. Operationally, each home still retained the link GP and community nurse practitioners, but (as noted above) relations were strained. During the learning events health practitioners and managers concluded confusion over the various pathways and different names for quality evaluation together with a lack of clarity within the SPC and their organisational quality assurance frameworks meant that no-one across health had responsibly for strategic oversight or understood the importance of escalation when the meetings did not happen. Failure by ICB commissioner or safeguarding leads to monitor the action plan and thereafter hold the provider or registered manager to account for poor clinical judgement was compounded, firstly as contract monitoring staff saw a reduction in referrals from the home[39] but also because Council's commissioners and SAT reasonably (given the SPC shared responsibility) believed any subsequent concerns would be referred so that stage 2 of the SPC could start.

4.50. In January 2024 the Council introduced a new operating system to triangulate concerns and incident reporting. This remains under development but brings together safeguarding concerns from the Council, Police, Health partners and Healthwatch into one dashboard. The GSAB subgroup can analyse the dashboard within their quarterly meetings, but partners recognise value in embedding data analysis into operational teams[40] so strategic oversight is supported with narrative information from practitioners in real time about what the data is showing and how well partners have responded to remove or reduce risk. Senior managers gave examples of regular forums they attend, such as the Quality Management Meeting, Locality multi-disciplinary meetings to discuss high risk residents and the Gateshead System meeting forum. There are also plans to introduce more frequent 'Enter and View' visits with Healthwatch. At present it remains unclear how those forums report outcomes to GSAB or into SPC process to inform operational or strategic priorities. Senior managers explained the next phase of development will explore how to involve data from providers and numerous multi-agency meetings set up to share information on 'low-level concerns' to give a more comprehensive appraisal of the effectiveness of the SPC process. It is clear that the current procedure, where 'unreportable' incidents are logged by the provider and available to view during commissioning visits, but not formally collated by commissioners, does not offer sufficient oversight to fully analyse cumulative concerns across different residents that may be indicative of a risk of organisational abuse or neglect. Senior managers also recognise any development will need to also carefully consider the changes to the NHS's incident investigation responsibilities introduced by NHSE's Patient Safety Incident Response Framework.[41]

4.51. Families involved in this review also spoke about attempts to report directly to CQC but were left feeling their concerns were dismissed. Within their 2022 report CQC specified concerns regarding medication management, unmet care needs, understaffing and poor leadership justified an inspection of the provider in July and August 2022. CQC reported this was a focused inspection to '*review the key questions of safe, responsive and well-led only. The overall rating for the service was not changed and remained good based on the findings of this inspection. We recommended that the provider ensured that records relating to 'as required' medicines and topical medicines were fully reviewed*.'[42] Following that inspection, the home was rated 'good' for the safe, responsive and well-led domains.

4.52. Within their IMR, CQC state they do not have powers under the Health and Social Care Act 2008 to investigate complaints from people. This is the responsibility for the provider. However, as noted above, failure by providers to respond to complaints should affect a provider's rating. CQC explained within their IMR that do have a 'handling and responding to information of concern policy' which would come into effective if a person was at risk of significant abuse or neglect. As such a risk would constitute 'safeguarding', under the policy they are expected to make a referral to the local authority. Thereafter, they accept they have a responsibility to seek regulatory assurances that other people

[39] In part because of temporary improvements once the provider's area manager offered increased support to the care home manager, but thereafter as information on 'non-reportables' was lost.
[40] Which should be easier once PowerBI dashboards are more widely available.
[41] More information is available at: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[42] Taken from CQC's IMR prepared for this review

using the service are also safeguarded. Within their IMR CQC highlight their inspectors referred concerns relating to 11 adults at risk. They accepted, they could not evidence complete adherence to their policy as, following their referrals, they had no evidence staff had sought assurance of the action taken or the outcomes in those cases as this was not always recorded. Consequentially CQC were left unsighted on the wider risks, so did not discuss triggering the local SPC process with the Council.

4.53. As noted above, the care home's CQC rating was subsequently revised to 'Inadequate' in 2024 following media reports of poor-quality care. Whilst outside the time period under review, it may be relevant to the national context that in October 2024, the Government published a review into the operational effectiveness of CQC. That report identified the introduction (during the relevant time period for this review) of new national IT systems and a new Single Assessment Framework, as well as significant internal restructuring (which resulted in a loss of expertise at senior level and a loss of relationships across CQC and providers) significantly adversely impacted CQC's operational performance nationally. In particular, this has adversely impacted on the quality of inspections and interventions by the regulator nationally. Locally, in response to this review, CQC requested additional time to review if these issues had a similar impact locally. It is, however, noted, as detailed above, locally CQC staff took part in SPC discussions following the national media report in December 2023. Presently, there is insufficient evidence that, prior to the inspections in November 2023, local inspectors used data or intelligence from the ICB or Council to inform their inspections. Whilst panel did not believe it would be proportionate to delay the completion of this report, recommendation 8 is designed to enable the regulator to report directly to GSAB on their effectiveness locally and describe how they engage with multi-agency responses to address any gaps in care quality given the families' ongoing concerns.

System Finding:

4.54. There is insufficient evidence within the materials provided to this review that commissioners were triangulating concerns, with family complaints or quality of care issues or holding the provider to account when these fell below expected standards within the provider contract. There is significant difference in the number of notifications sent by the provider to the Council (n159), CQC (n334) and ICB (n82) which, had these been triangulated prior to national media reports, would have evidenced inconsistency of practice such that should have warranted inspections and remedial action prior to November 2023. The lack of clarity throughout the period of how the s42 process correlated to commissioners' and regulators' responsibilities, coupled with changes in strategic oversight of care homes and confusion over the purpose of different multi-agency forums, resulted in a loss of intelligence that could have identified serious provider concerns sooner. Simplifying reporting and escalation routes locally is necessary, but this must be a collaborative process with the provider sector, across health, social care and policing and with local senior CQC representatives. Any amendments to the decision tool, SPC, PiPoT and Modern Slavery policies must be reflected in each partners' organisational safeguarding and operational guidance. Recommendations 3, 4, 5, 6 and 8 relates to these findings.

KLOE 5: Professional obligations to escalate concerns, 'speak up' and whistle blow.

Within this section the review explores local escalation processes. It considers if whistleblowing or freedom to speak up policies were used if professionals disagreed about s42 enquiry outcomes or unsafe practices?

4.55. As noted in KLOE 1, there is evidence practitioners from across partner agencies appropriately raised concerns that the quality of care could result in serious harm to residents via the s42 process, but as noted above those concerns were too often quickly closed following a 'provider enquiry'. There was good practice on the part of the GP practice, as although practitioners erroneously believed that Datix and SIRM recordings would result in the safeguarding notification to the SAT, the GP was diligent in pursuing this by directly contacting the ICB's Designated Safeguarding lead, explicitly stating that they considered this to be an organisational issue, offering to contribute to any enquiries and following this up with partners repeatedly by email when they were not provided with feedback about how the matter was being progressed. Otherwise, there was no evidence that partner agencies, including ICB leads with system oversight capabilities (via Datix reporting)[43] challenged decisions to close s42 enquiries, requested an enquiry into organisational abuse or initiated the SPC process until after notification of issues raised by the national media report in December 2023. CQC also accepted they had not followed up concerns in respect of 4 anonymous freedom to speak up reports.

[43] ICB safeguarding leads were only given system oversight of Datix from July 2024

4.56. Notably, the local safeguarding adult policy [s3.0.6] requires any concerns that a person in position of trust [PiPoT] has harmed a vulnerable adult is raised via the relevant organisation whistleblowing processes. Almost as an aside it states, if the criteria under s42 is met, a concern should also be reported to the local authority. However, this is not an accurate reflection of the proper processes for staff to follow. Whistleblowing[44] is a term used when an employee passes on information about wrongdoing within their workplace in a manner which legally entitles them to protection from victimisation. Whistleblowing processes should be applied within a workplace when, for example, a staff member makes allegations about another member of staff committing a crime or a manager failing to investigate this properly, to ensure they are not treated unfairly by colleagues or their employer as a consequence. However, making a report to the local authority and/or the police that a PiPoT has harmed a vulnerable adult will always be consistent with any partner agency's internal safeguarding requirements and where applicable, the relevant professional standards. It is important that the local safeguarding adult policy reinforces this message, rather than implying that in making such a report, a practitioner is in some way acting outside their duties as an employee.

4.57. In approximately 70% of incidents[45] during the review period concerns raised related to staff as the person alleged to have caused harm [PACH]. Again, there is evidence that some concerns relating to allegations against staff members or PiPoT were referred to the local authority, though this was not universal. For example, families frequently reported (to the care home manager, council and CQC) concerns regarding poor practice by care staff within the home. However, the review found very little evidence that practitioners from any partner agency had escalated their concerns via the freedom to speak up or whistleblowing routes. Moreover, little evidence could be seen that practitioners had challenged the outcome of safeguarding referrals in circumstances where they disagreed with the decision making, or sought management support to escalate such concerns in accordance with GSAB's escalation policy. As noted above, police involvement in investigations against staff members was also difficult to ascertain from the case files. Senior managers confirmed, as far as their records showed, no employee requested protections under whistleblowing or freedom to speak up policies. Senior managers confirmed duties to speak up and protections afforded to staff through whistleblowing policies are on the syllabus for safeguarding training.

4.58. PiPoT policies are intended to give effect to legal obligations on employers, volunteer managers or personnel suppliers[46] to refer a matter to the DBS whenever permission for a person to engage in regulated activity with children or vulnerable adults is withdrawn or they are moved to another area of work that isn't regulated, they have been convicted or cautioned for a relevant offence or they have engaged in conduct that has harmed a child or vulnerable adult. There is also discretion to apply even if the conditions are not met. The GSAB multi-agency safeguarding adults procedure [s3.0.3.9] explains that whilst the service provider (including an employment agency) is responsible for taking any action, if the provider fails to notify the DBS then the local authority should do so. This is part of their core non-delegable safeguarding duty. Commissioners, in discussion with reviewers, explained they would expect this to be done under the s42 process as they would not engage (as part of contract monitoring provisions or the SPC process) with personnel or employment agencies.

4.59. The provider chose not to engage directly with this review, so there is no data on whether their staff exercised whistleblowing duties internally. Partner agencies confirmed they were not aware of any provider staff raising organisational abuse concerns. Within that context, it is important to recognise national reports[47] into significant workforce vacancy rates in independent care homes during the period under review (between 8.8- 7.4%). To address this chronic shortage, in February 2022 people from abroad with relevant experience and skills could apply for a visa to enter the UK as care workers. CQC's 2024 State of Care report warns, though this has improved vacancy rates- now reported at 5.4%, this may only be temporary as '*there has been a steep fall in the number of overseas workers applying for health and care worker visas- representing an 81% decrease in April-July 2024, compared to the same period in 2023*.' They also report a threefold rise in referrals to partner agencies raising concerns about modern slavery (n106). This corresponds with data from the

[44] Employment Rights Act 1996 (as amended by the Public Interest Disclosure Act 1998)
[45] This figure was estimated by discounting peer-on-peer allegations, though many of those incidents also raised queries about neglect by the provider or their staff for not adhering to 1:1 care arrangements or inadequate risk management.
[46] https://www.safer-jobs.com/
[47] See for example, skills for care **(**https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/Summary-of-care-home-services-with-nursing-2023.pdf) and CQC report 'State of Care' 2024 (https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/summary).

Modern Slavery Hotline and Gangmasters and Labour Abuse Authority [GLAA] which reported a 400% rise in cases referred since the inclusion of care workers on Skilled Worker visa list.

4.60. Modern slavery concerns are beyond the scope of this review as these were explored in parallel investigations by the relevant agencies. However, the adverse impact of vacancy rates, coupled with poor monitoring arrangements to oversee competency and protect against exploitative employer practices is increasingly coming to the attention of Safeguarding Adults Boards due to poor quality care giving rise to significant harm of those being cared for in residential settings. There was evidence of families raising concerns that some staff in the care home may lack linguistic skills or competency to manage nursing tasks. Practitioners and managers involved in this review felt there was insufficient clarity within current guidelines to support triangulation across relevant agencies, including national bodies overseeing providers' licenses re oversees recruitment. The proposed amendments within the Employment Rights Bill[48] may, in time, introduce improvements. Until then recommendation 7 is intended to support partner agencies to consider local responses to system pressures experienced nationally.

System finding:

4.61. Whilst CQC received 4 anonymous concerns submitted under the freedom to speak up/ whistleblowing and reported referring these concerns on via the s42 safeguarding process, it does not appear these were ever considered or acted on. CQC accept they have no records of following up those concerns to ensure action had been taken and other residents' safety addressed. As such, it is reasonable to conclude that freedom to speak up, whistleblowing and formal escalation processes were not used effectively during the review period, despite sufficient information (had this been triangulated) to warrant an enquiry into organisational abuse. These are important protections within the safeguarding infrastructure as these nurture a culture of openness and accountability. Such protections can be easily undermined in practice particularly where there is a paucity of alternative provision, substantial gaps in the sustainability of a skilled workforce and a lack of specificity within local policy about the primacy of professional obligations to recognise and report safeguarding concerns (required by anyone regulated by the NMC, GMA, HCPC) even if this conflicts with employee duties. Whistleblowing should not be identified as the first action or pathway within the local safeguarding policy. Rather, local policy should properly explain how whistleblowing legal protections, freedom to speak up policy initiatives and use of escalation processes to resolve concerns, underscore the principle that safeguarding duties are everyone's business. Recommendation 4 and 7 relate to these findings.

KLOE 6: Interface between duties to conduct enquiry (s42) and learn lessons (s44)

This section explores the interface between s42 enquiry duties and the s44 SAR process to ascertain if this is understood and applied by practitioners, providers, adults at risk and their families/ carers?

4.62. As noted above, a number of s42 enquiries were closed because the person had died or moved out of the area. Families, practitioners and managers all confirmed this was their understanding of the local policy and that this was instigated following legal advice and recommendations from a previous SAR. However, the local procedure confirms even after the adult at risk dies an enquiry can progress if '*there are reasons to be concerned about risks to other adults, enquiries may need to be made to decide whether action needs to be taken to protect them. For example, this will often be necessary following a death in an organisational setting where other adults are continuing to receive a service.*' [s7.2] In one case, several safeguarding concerns raised[49] were closed as it was deemed '*no longer necessary or proportionate'* following the individual's death a few days after serious injuries were sustained whilst the adult was receiving 1:1 care. The s42 enquiry closure decision relied heavily on the 'provider enquiry'. Within this report, the provider acknowledged the 1:1 agency carer had not responded in line with safe care expectations and had somehow not noticed bleeding following a laceration on the resident's neck and hand. The case notes record the provider enquiry was 'discussed at PITSTOP'. The police reported '*no evidence he had been assaulted or that the room had been cleaned in order to remove evidence*'. This explanation may, perhaps unintentionally,

[48] More information available at: https://assets.publishing.service.gov.uk/media/67125ae0e94bb9726918ee38/fair-work-agency.pdf

[49] One enquiry was initiated following video evidence (disclosed as part of the national media report) that staff and external professionals had been involved in a drag lift, the second enquiry commenced after he fell and suffered a broken hip by the family against the hospital after they had used a trusted assessor to agree discharge to the home despite ongoing safeguarding concerns. An additional enquiry was triggered by concerns raised by the care provider and NEAS crew following a subsequent fall where the resident sustained life threatening injuries to his neck (described within the provider enquiry as a cut from 'one side of his neck to the other') because staff accounts of the incident were inconsistent with the scene. NEAS crew and family also raised concerns that the room was cleaned before any photographs of the scene were taken. The provider enquiry noted they 'could not rule out an assault by the agency worker'.

suggest police must be satisfied of criminal intent before investigating. Whilst we fully understand the need to be proportionate with policing resource, had the officer considered other offences against vulnerable adults (including wilful neglect) they could have, potentially, concluded this crossed the threshold of reasonable grounds to suspect an offence was committed therefore enabling a comprehensive investigation, including any organisational investigations if required.[50] In line with issues already noted above, there was also no evidence that steps were taken by the provider or local authority to verify with the agency worker's employer whether they had completed an investigation in line with DBS expectations.

4.63. In another case, detailed above, the safeguarding enquiry into possible sexual abuse was closed as the resident moved out of area to an alternative provider. Again, no consideration was given to whether the case could have provided an opportunity, under s44, for proportionate learning for providers around sexual safety and non-discriminatory practice. There was evidence of good challenge by SAT professionals, concerned that the care home manager had advised against a forensic examination, believing the resident to be 'deluded'. Whilst this was the term used within the case records, police staff involved in this review felt it was important to challenge use of such language. Northumbria Police are currently working to increase awareness within their staff of the benefits of trauma-informed practice and that using terms such as this could introduce presumptions which can impact on how (or even if) investigations progress.

4.64. Senior safeguarding professionals raised a lack of resource locally to secure clinical forensic judgement where a non-accidental injury might be suspected. Whilst there is a local service if a child's presents with suspicious injuries, there is very limited guidance available (either locally or nationally[51]) to support decisions regarding forensic examinations where adults at risk is injured. Whilst NENC ICB (working with NHSE and the Faculty of Legal and Forensic Medicine) have piloted training to GPs in the area and Police explained they can request forensic investigators if serious crimes are reported, it is accepted more work is needed to improve access to specialist forensic advice so enhance strategic planning at the earliest opportunity following a notification of a concern. As noted within KLOE 1, often a lack of detail within referrals regarding the nature, frequency and level of harm prevents this consideration. Recommendation 7 is intended to address the need for practice improvement in this area.

4.65. Families, including in the cases above, were advised following a resident's death that the safeguarding process had terminated and that, if they wished to explore the concerns further, they would need to apply for disclosure of information under alternative deceased person processes. The SAT confirmed that they had offered meetings with families and provided safeguarding enquiry minutes and outcome letters, but were prohibited by local policy from providing full records unless this was requested by an executor. Thereafter they advised families to use the complaint process or notify CQC of any concerns directly. There does not appear to be an appeal mechanism and the GSAB escalation policy applies only if there is professional dispute with the decision to close an enquiry. There is no evidence of practitioners escalating or challenging a decision to close any s42 enquiry during the review period.

4.66. Local procedure also sets out the expectation for an enquiry officer, following a death, to refer cases that meet the s44 criteria [s7.3], but recommend that where these are single agency issues/failures these should be reported to the CQC or the appropriate regulator, and/or commissioning team and coroner [s.7.4-6]. The onus is on the enquiry officer to undertake this task, not family members. There is a risk that defining the duties almost as if they are sequential obscures distinct purposes that sits behind these functions. The s44 duty is to ensure organisations can apply learning to reduce future harm. It does not replace obligations for commissioners and regulators to complete their investigations and, where necessary, apply their legal powers to hold providers to account for any breach of regulations or contract.

4.67. Again, there is evidence these responsibilities were not fully understood. For example, one family member was advised on raising concerns that provider neglect and poor care may have contributed to the resident's death, but that this could not be investigated either as a s42 enquiry (because there

[50] e.g. because it is necessary to protect a … vulnerable person from the person in question[pg2.9d] or to allow the prompt and effective investigation [pg2.9e-Code G, PACE Code of Practice for Police Officers.

[51] See for example the proforma developed by Humber CCG as part of their pilot: https://fflm.ac.uk/resources/publications/proforma-forensic-examination-adult-victim-of-suspected-assault-nai/

was no active safeguarding enquiry at the time of her death) or under the s44 duty (as it was a single agency issue). She was advised to raise this directly to the provider or CQC. She also raised a complaint to the Council, after her complaint to the provider was not responded to. This was responded to in June 2024[52]. It is unclear what, if any consideration was given to whether the safeguarding concerns identified by the family member in respect of her loved one could have given rise to immediate concerns for any other residents, that could require safeguarding measures. If such quality-of-care issues did pose wider safety risks for others in the home, this would justify an ongoing s42 process, even when the adult the original referral was made about has died or moved.

4.68. In total 3/76 residents were referred for consideration under the s44 process during the review period. None were deemed to meet the criteria. Advocacy for deceased residents or the views of family members does not appear to have been considered as part of s44 decision-making process. Families wished to commend GSAB's board manager for the concerted effort she had made throughout this review to keep them informed of progress and help them navigate the alternative processes they had been advised to follow, including requests for a review of care need where this involved residents still living within the care home or Gateshead area. They understood this was outside of her role, but felt support for families where there are large numbers of concerns or quality of care issues within a placement should, as a matter of good practice, be made available as part of any investigation (either under s42 or s44) so they have support to understand the relevant processes.

4.69. In response to request for this review, 5 neighbouring local authorities submitted IMRs detailing their involvement or concerns. These confirmed, as noted above, very limited involvement in safeguarding enquiries by the responsible local authorities for the resident's care. For example, in one case A&E staff had raised concerns following disclosures by a resident of possible ill treatment by the care home staff, the IMR noted there was no outcome from any police investigation or if the s42 enquiry had been completed, though the SAT team subsequently confirmed their records demonstrated this feedback was provided directly to the referrer (I.e. A&E staff). The resident was placed by another local authority, their IMR reported there were no safeguarding alerts but did recognise the family had raised significant quality of care issues. This had not prompted a review of the care or placement. Instead the family were advised by the other authority (following the resident's death) to raise their concerns to Gateshead Council directly. Again, in line with KLOE 1 system findings, this overreliance in Gateshead SAT to resolve and reduce risk owed by other organisations and with whom they have no direct sphere of influence is unsafe.

System Finding:

4.70. The presumption that a s42 enquiry should close on the death of an adult at risk or their move out of area must be understood to be a rebuttable presumption. This is in line with national and local safeguarding policy. Families should not be expected, as this is contrary to policy expectation, to lead on referrals for alternative resolution of concerns either via complaints or commissioning.

4.71. Currently accountability for progressing concerns in such processes is unclear. This review only had oversight of decision-making records for the s44 SAR process. Whilst this is consistent with local policy and national expectations, ensuring there is more active consideration of family views and/or advocacy where the adult has died would strengthen the process, including ensuring MSP principles were applied. Accountability for decision making regarding SPC, organisational abuse concerns under s42 or complaints processes lacks strategic oversight within Gateshead Council and across GSAB partners. Families lacked support (via advocacy), so their concerns or complaints, including those made to the ICB and CQC remain unresolved. They were not aware, as CQC, the Council and ICB should have been, of the levels of concerns within the home or of the patterns emerging of poor care. Recommendation 3 Is intended to address these concerns.

5. Conclusion

5.1. Not every resident or family member residing in the care home during the review period experienced poor care. Many family members, including some who had raised concerns, commended some care home staff members as caring, person-centred and professional. However, the frequency, nature and type of concerns raised by families, practitioners and the provider provided clear justification for coordinated enquiries to ensure care was being safely delivered. We have not made a finding that organisational abuse occurred during the period. We are, however, satisfied (as were those attending

[52] This was 7 months after the complaint was raised and 9 months after the resident's death.

the learning events) that the threshold to instigate enquiries under s42 for organisational abuse were met. This should also have triggered stage 2 (the professional meeting and monitoring visits) prior to national media reports in December 2023.

5.2. Whilst we have seen evidence that frontline staff (particularly within the Council's SAT) took steps to seek to triangulate concerns, there were missed opportunities to use information and the relational practice in a coordinated way to respond far sooner to patterns of poor care. Overreliance on the SAT to manage risk was unsafe, particularly as they lacked strategic or organisational support to hold partners and the provider to account. As with all agencies, SAT practitioners had to prioritise resource within their team against rising demand. Understandably, they appeared to focus practice improvements to where their sphere of influence was greatest- e.g. supporting providers to apply the decision tool, developing strong relational practice via linked staff to each provider. The rationale for practice improvements detailed at 4.3 was so that safeguarding responsibility (and relevant skills) were owned across all ASC assessment teams. This overlooks the critical roles and responsibilities owed providers and the responsibility for Council and ICB commissioning teams and CQC to hold providers to account. Their limited engagement in the design and delivery of those innovations distorts organisational responsibility for ensuring quality of care. Families and residents raising concerns deserved better.

6. Recommendations

Prior to completing the report, the panel met to consider how partners were taking forward recommendations and actions to address learning identified in other local reviews. In light of their current workplan, the reviewers recommended GSAB and partners focus on the following recommendations to compliment previous recommendations and further improve responses to organisational abuse concerns.

Recommendation 1: GSAB partners have already started work to revise the decision tool. This should be done in collaboration with Healthwatch, patient safety groups, advocacy, provider representatives, commissioners and regulators. The new tool should clarify[53] how professional judgement much be used to detail the type, nature, severity of impact of each descriptor. Care should be taken to ensure descriptors are in line with NHSE and CQC legal requirements regarding incident reporting and safeguarding duties.

- The term 'non-reportables' should be replaced; it should be explicit with the tool and provider contracts that it is for the provider to maintain a record and report all incidents, including those arising from complaints, to commissioners (ideally monthly or quarterly) so that intelligence can enable re-prioritisation if patterns or spikes in concerns occur. Provider contracts should be amended so that failure to adhere to these requirements would trigger the SPC process.
- Mirroring good practice in SAT to develop relationships and improve understanding of provider strengths and stressors, the ICB and Council assessment teams and contract monitoring officers linked to providers, e.g. on a locality basis. Information sharing meetings, or meetings where provider concerns are raised (especially involving linked workers) should be minuted and fed directly into ICB and Council's commissioning QAF. Minutes should also be available to CQC to inform its inspections.
- Police, ICB teams and CQC should confirm how they will be involved in investigations within notification under the tool's different descriptors for 2 (reviews), 3 (quality of care issues) and 4 (safeguarding enquiries). Each descriptor should clearly describe the referral route and which teams will lead or be involved. Descriptor 1 and 3 should be led by ICB and Council commissioners. Descriptor 2 by ICB and Council assessment teams. For the ICB and NHS Trusts this should be underpinned with s75 agreements. Each of the 4 pathways should have clear reporting mechanisms to GSAB so that outcomes of interventions demonstrate risk is removed or reduced and that processes also comply with MCA and MSP principles.[54]

Recommendation 2: Expanding on the partnership support which is intended to support multi-agency triage of Adult Concern Notifications from the police, GSAB partners should urgently review the s42 triage process for Adult Concern Notifications and s42 concerns so that criminal and clinical expertise is available also for all concerns (including those reported within residential settings) to assist with evidence/ information gathering within the 'golden hour'. The local safeguarding policy and decision tool should also specify within descriptors circumstances where specialist clinician resource or forensic investigations should be requested and set out who is the lead agency for securing that resource in a timely way.

[53] It might be helpful to use the NHS CHC national framework guidance which sets out how nature, frequency, predictability and intensity may influence the impact of each domains' descriptor.
[54] A simple way to do this would be to arrange for these to be reported within the NHS Digital Data as 'other enquiries'.

Recommendation 3: The Council, working with ICB, provider representative and CQC, should revise the Serious Provider Concerns process and align with a revised organisational abuse enquiry process in light of the findings of this review, both to simplify the procedural requirements and offer greater clarity around governance and recordings or decision making. Critically, any revision of both processes should include a role for SAT so that active consideration is given to running the process concurrently with a s42 enquiry into organisational abuse. The information meeting (and all subsequent meetings) should include representation from advocacy or patient safety reps. It should also provide opportunities to triangulate information from friends and family surveys, Healthwatch and set out expectations on providers to facilitate contact with families so that, independently from the provider, families and residents' views are included. Families should be supported, prior to any SPC investigation, to understand what good care looks like[55] and local processes for raising concerns, quality of care issues or complaints. GSAB should also review their s44 decision making process to enable input from friends and family or advocacy.

Recommendation 4: Partner agencies should review their quality assurance and safeguarding policies and confirm to GSAB these clearly set out expectations for commissioners and contract managers to seek assurance from providers they maintain safe staff ratios[56] and review vacancy rates and, evidence of staff competency as part of any contract monitoring. Guidance should also be produced for practitioners and the public about how to challenge and, if necessary escalate when there are disagreements about s42 decisions, and how to raise concerns to national bodies, this will be particularly important to reference within procedures for PiPoT, SPC and organisational abuse enquiries. Where appropriate, residents and family members may need to be offered access to advocacy support for these processes.

Recommendation 5: GSAB partners should agree training requirements for providers to ensure sufficient expertise to undertake 'provider enquiries'. Compliance with this should be monitored as part of the ICB and Council's contract monitoring arrangements. Any newly appointed registered manager should, as part of their induction, be required to evidence they have the required knowledge and skills to conduct a provider enquiry. Where commissioners, SAT or CQC have reasonable concerns that a registered manager lacks expertise or there is a conflict of interest to undertaking 'provider enquires' this practice should be suspended. In such circumstances, specific expertise should come from partner agencies. Equally, where CQC has judged the care home leadership to require improvement or inadequate under any category there should be a presumption that the care home leadership will not be suitable to conduct a 'provider enquiry' under the safeguarding enquiry process.

Recommendation 6: Police, ambulance, ICB and hospital designated leads should work with GSAB to agree clear guidance for emergency responders on gathering information or preserving evidence in sexual abuse, physical abuse or neglect/ act of omission and organisational abuse enquiries so that police and specialist forensic examiners can meet NPCC and CPS expectations in response to offences against vulnerable adults.

Recommendation 7: GSAB should discuss this review at regional level and (if regional leads are in agreement), escalate to national SAB chairs network the risks that emerged in this review due to gaps in national services, guidance or resource in respect of PiPOT/LADO provision, forensic services for adults and clear guidance on the differentiation between repeated neglect/acts of omission within care settings and organisational abuse. GSAB and their partners may want to support the National SAB Chairs Network's call for the regulation of ASC labour providers under the GLAA. The ICB and Council should provide assurance that, in line with their market shaping duties (s5 Care Act), they have oversight of providers' workforce sustainability plans and mechanisms within local quality assurance and safeguarding processes to identify concerns.

Recommendation 8: CQC should provide assurance to GSAB of the actions they have taken to learn lessons from this review. CQC's assurance report should also detail the actions they have taken locally to assess if the findings from the national report apply locally and, if so, their action plan to enact the recommendations.

[55] For example, Age UK provide national guidance at: https://www.ageuk.org.uk/information-advice/care/arranging-care/care-homes/choosing-care-home/
[56] Often done via a dependency tool.