Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

SAR 021

Overview Report

Independent Overview Report Author: Heather Roach

Date agreed by NSAB : 26th October 2023

Contents

1. Introduction

1.1 This Safeguarding Adults Review (SAR) relates to the care and treatment of people who were resident at Temple Court Care Home, Albert Street, Kettering, Northamptonshire, between January and May 2020. 19 residents sadly died during the period under review, 12 of them at the care home and the others in acute hospital settings. Four of the deaths were recorded as resulting from COVID 19[1], however, the reliability of information at this early stage of the pandemic is problematic due to a lack of testing and appropriate reporting. This review has not tracked individual residents during this period.

Concerns about significant levels of neglect within the establishment were raised by Northamptonshire County Council (NCC)[2] to Northamptonshire Safeguarding Adults Board on 12th May 2020 for the consideration of commissioning a safeguarding adults review.

1.2 Temple Court Care Home ("the care home") was a nursing home for older people and those living with dementia. The home was registered to provide personal care for up to 54 people and was run by Amicura Limited under the umbrella of the Minster Care Group. From 27th February 2020 the care home was registered solely to Amicura Limited.

1.3 The care home was inspected by the Care Quality Commission (CQC) in May 2019 and a report was published on 25th June 2019 recording an overall rating for the home as "Requires Improvement". The care home was subject to an action plan to make improvements in relation to the recommendations in the CQC report. The provider was found to have been in breach of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and conditions were placed on its registration.

1.4 With the outbreak of the Covid- 19 pandemic, 23 patients were transferred to the care home from other health care settings, mainly the two acute hospitals, Northamptonshire General Hospital and Kettering General Hospital between 19th March 2020 and 3rd April 2020. Care Home Selection Healthcare were requested by Northamptonshire Clinical Commissioning Group (CCG) to undertake these hospital transfers.

1.5 In April 2020, concerns were raised with CQC anonymously in relation to the residents at the care home and in particular around their nursing care, health needs, medicine management, wound care, nutrition and hydration needs. Joint action between the Local Authority and the CCG led to a Health tactical team being deployed into the care home, initially attempting to support it to care for its residents.

1.6 As a result of concerns held by the Local Authority and the CCG at this time, a decision was taken on 11th May 2020 to transfer all remaining residents to alternative accommodation.

1.7 The CQC carried out a further inspection on 12th May 2021 focusing only on the inspection domains of "safe, effective and well-led" and concluding that the care home was "Inadequate".

1.8 A Safeguarding Adults Review (SAR) was commissioned by Northamptonshire Safeguarding Adults Board (NSAB) on 16th July 2020. There were a number of parallel processes in place at the same time including a criminal investigation which concluded in December 2020 that resulted in a delay of the commencement of the SAR. The situation was regularly discussed and monitored at the NSAB SAR Sub Group and on 28th April 2021, it was agreed to progress the SAR. A draft report was completed in March 2022 which was then followed by a period of review and constructive challenge from the organisations represented on the SAR panel. A further executive level meeting with public bodies and additional information was also requested by the author.

1.9 The author would like to acknowledge the patience and understanding of each of the families who contributed to the review. Despite the extended time period taken to examine the themes within this review, their experiences were invaluable.

[1] Data from list provided by Northamptonshire Police during police enquiry

[2] As of 1st April 2021, Northamptonshire County Council ceased to exist and was replaced by West Northamptonshire Council and North Northamptonshire Council. For the purpose of this SAR, Northamptonshire County Councill will be referred to as the Local Authority.

2. Context of SARs

2.1 The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. The SAR requires outcomes that:

a. Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies work together to safeguard adults.
b. Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
c. Review the effectiveness of procedures both of individual organisations and multi-agency arrangements.
d. Improve practice by acting on the findings and developing best practice across organisations.
e. Improve inter-agency working to better safeguard adults.
f. Make a difference for adults at risk of abuse and neglect.

2.2 This SAR is a thematic learning review to examine the processes and systems of agencies which supported a number of elderly residents at the care home, and some of whom died during the period under review.

2.3 The Care Act 2014 (section 44) requires Safeguarding Adult Boards to carry out safeguarding adult reviews involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if –

a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) Condition 1 or 2 is met

(2) Condition 1 is met if –

a) the adult has died and

b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse of neglect before the adult died)

(3) Condition 2 is met if

a) the adult is still alive and

b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A 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)

2.4 This SAR is commissioned under Section 44 (1) of the Care Act 2014.

3. Terms of reference and methodology

3.1 The review has focused on the time period between 1st January 2020 and 31st May 2020, but also includes any relevant information from outside of this time period.

3.2 The specific terms of reference to assist in identifying key learning are as follows:

a. Were all agencies clear about their roles and responsibilities with regard specifically to the commissioning and delivery of the service and the necessary oversight and support when it was apparent the home was not achieving the required standards?
b. How was the system and framework which regulates the service and standards applied locally and was it sufficiently robust and effective, if not, what barriers prevented it from being so?
c. What was the impact of the COVID 19 pandemic on the care home; did they ask for help and if so, what support did they seek and what appropriate support did they receive from relevant agencies?

d. What was the impact of the COVID 19 pandemic upon partner agencies to be able to manage the risk to service users and keep residents and staff safe? Were there any processes or systems that affected the ability of agencies to do so – this should be considered against the backdrop of national Government guidance and its local application?
e. Did partner agencies have sufficient information about the individuals/residents concerned to be able to meet their individual needs effectively, if not what barriers stopped this from occurring?
f. Were there any barriers between or within agencies that affected the care provided to residents?
g. Did agencies identify safeguarding issues; did they have the appropriate safeguarding policies and procedures in place, and did they ensure effective safeguarding activity formed part of their service delivery – was it seen as 'everyone's business & responsibility'?
h. Have there been any changes to local systems and processes as a result of these circumstances or what still needs to change or be done differently – how can the learning assist local Commissioners, Providers and Regulators in the oversight and management of service standards?

3.3 The review used a hybrid methodology. Agencies involved in the SAR were asked to provide their responses to a set of focused questions from the independent authors.

3.4 Two learning events involving front line practitioners and managers were also held to focus specifically upon the processes in place at the time, the context individuals were working in, identifying any barriers to effective practice and highlighting areas of good or improved practice.

4. The Review Process

4.1 The review undertook the following activity:

a. Initial SAR Review Panel on 24th June 2021 discussed and agreed the terms of reference and scope of the SAR.
b. Questionnaire provided to all relevant agencies for completion by 23rd August 2021 and subsequent summarising of the contents of that information.
c. Initial contacts made with relatives of residents forming the review and follow up interview meetings during September 2021.
d. Summarising and identifying key themes emerging from the families' interviews.
e. A review panel held on 7th October 2021 explored the key themes emerging from the interviews with family members.
f. Full panel review meetings were subsequently held 3rd November 2021, 13th December 2021, 11th February 2022, 1st June 2022 and 29th June 2022 to present and discuss the contents of the agency questionnaires and responses to further questions.
g. A chronology was developed by the independent author to identify key dates and relevant events.
h. Two learning events were held on 1st and 2nd February 2022 with front-line practitioners and with managers. Each agency had the opportunity to invite who they considered it was appropriate to attend from their agency.
i. A meeting was held with Chief Executives (or their representatives) from Kettering and Northampton General Hospitals, Northamptonshire Healthcare NHS Foundation Trust, North and West Northamptonshire Councils, and Northamptonshire Integrated Care Board (formerly Northamptonshire CCG) on 28th October 2022.
j. A full overview report was agreed by the review panel on 20.09.2023.

5. The Independent Authors

5.1 The SAR was to be initially co-authored by two reviewers, however, Barry Earnshaw was unable to continue for personal reasons and so, Heather Roach has completed the review.

5.2 Heather Roach is a current Safeguarding Adults Board independent chair covering two counties and has also been the independent chair for a Safeguarding Adults Review Sub Group, managing the SAR process and implementing recommendations from those reviews. A former senior police officer of thirty years, she has a background in criminal investigation and safeguarding of both children and

adults. She has also conducted reviews for the Diocese of Southwell and Nottingham and for the Department for Health and Social Care in the Isle of Man.

5.3 Barry Earnshaw is the independent chair of the Diocese Safeguarding Advisory Panel in Southwell and Nottingham. He has a wide range of experience having undertaken non-executive roles with a housing provider, Lincolnshire Care Association and was a former safeguarding adult's board independent chair. He was involved in the initial scoping of this review, assisted in developing the questionnaire completed by agencies and also conducted some of the interviews with the families of residents of the care home.

The author would like to thank the Northamptonshire Safeguarding Adults Board's Manager and Administrator for their significant support and organisational skills in helping to deliver this overview report.

6. Partner agencies forming the review panel (Agency involvement – Appendix A)

The following agencies formed the review panel:

1. Northamptonshire County Council including Public Health – now North and West Northamptonshire Councils
2. NHS Northamptonshire Clinical Commissioning Group – now NHS Northamptonshire Integrated Care Board[3]
3. Northamptonshire Police
4. Kettering General Hospital NHS Foundation Trust
5. Northampton General Hospital NHS Trust
6. Northamptonshire Healthcare Foundation Trust
7. Care Home Selection Health Care
8. Amicura Limited
9. East Midlands Ambulance Service

7. The experience of residents and families

7.1 The author is immensely grateful to all of the families who gave their time and shared their experiences relating to this review. The review panel and authors would like to extend their condolences to all of the families involved who lost loved ones during this period of time. The review panel recognises that through their candid input they heard about some remarkable people who should have spent their twilight years being properly cared for and treated with the upmost dignity.

7.2 51 residents were identified by the review panel as falling within the scope of the review. With the support of the NSAB Board Manager and Administrator, 47 of the families were contacted about the SAR. Those families that were not contacted had either moved or there were no contact details available. It is recognised that the accounts and recollections provided by the families and relatives of residents were made approximately 18 months after these events and after the closure of the home. The SAR has not specifically investigated the circumstances of each incident reported to the author.

7.3 The relatives of 15 residents met with the authors either via the telephone, face to face or via video conferencing facilities. In cases where the resident was alive, the authors discussed with the families whether or not they were able to contribute to the review and sadly none of them were able to do so.

7.4 All of the families spoken to have expressed sympathy for the staff working within the care home during the difficult period of the first national lockdown. The national lockdown commenced on 23rd March 2020 and was a Government directive in response to the increased risk posed by the spread of Covid 19. The lockdown saw all "non-essential" businesses close and the public were required to stay at home unless there was a specific exemption which permitted this. Care homes significantly restricted the visiting arrangements for all non-essential purposes, again in a concerted effort to reduce the spread of the virus.

[3] As of 1st July 2022, Northamptonshire Clinical Commissioning Group ceased to exist and was replaced by Northamptonshire Integrated Care Board. The report will refer to the CCG throughout, but any recommendations will be for the ICB.

There was acknowledgement from the families that there were some excellent nurses and carers supporting their relatives. However, there was clearly a significant reliance on agency staff within the care home and as the effects of the pandemic began to take hold, the families raise a legitimate question with the author around where the managers and owners of the care home were at this point and what help they sought in light of the apparent difficulties the home was experiencing.

7.5 Families report that they had little contact with the care home as the situation deteriorated and many described their guilt at not knowing what was happening to their loved ones and their personal feelings of helplessness around the situation. One relative said "I feel I've failed him (father-in-law aged 93). I couldn't do anything, and I promised I would never let him down". Another said "I don't know what the scene [in the care home] was like when almost half had died. What had he [their dad] seen and experienced, it must have been Bedlam?".

Residents who had lived at Temple Court Care Home prior to the pandemic

7.6 Some residents had lived at the care home from around 2017/2018. Those families all reported that their initial impressions and first few months/years at the care home were good. The manager at the time was described as proactive, in fact "super keen". The care home was refurbished in 2018 and at this time the residents did experience a range of activities. Whilst there seemed to be a difficulty even then in securing sufficient staff, the families felt that the staff were doing their best. The son of one resident stated that there were some very good nursing staff but there were also others who he felt had not received enough training and were ill equipped to deal with dementia patients.

7.7 As time progressed the families reported that with a change of manager at the care home the routines and attention to the care of their relatives seemed to deteriorate down to a very basic level of provision, with their relatives looking unclean and somewhat dishevelled. It is not evident which change of manager these comments relate to but the care home had three managers between June 2018 and September 2020.

7.8 The daughter of one resident stated that the new manager never came out of her office and despite numerous complaints to her about the treatment of her father, she considered that little changed. She had complained about him being allowed to sleep in the TV room, food being taken away from him when no-one was available to help him eat it and the general uncleanliness of his room.

7.9 Another relative whose grandmother had been a resident at the care home since 2019 said that the care home went from "being a care home to a business" following the departure of the first manager. She said that there were seldom nurses or carers in the rooms with the residents in order to monitor their welfare. The residents' personal preferences around food were ignored and there was no importance attached to keeping the residents properly hydrated.

7.10 One relative stated that in January 2020, his recollection was that the home was half empty and he understood that there had been a plumbing issue which meant that the first floor was out of action. They said there had been a change of manager again and the home appeared to be struggling. It was their view that there was little in the way of activities undertaken over the Christmas period and he said it was noticeable that many residents were lacking in their personal care. Whilst the staff wanted to do more for the residents it appeared to the families that they were struggling to provide even a basic care package. They went on to say that safety equipment e.g., bed safety guards and pressure mats were either not available or were broken.

7.11 Several of the families spoken to reported that their relatives had experienced a significant lack of care during their time at the care home and particularly so during the lockdown period. One elderly lady had been admitted to the care home with ulcers on her feet which required regular treatment. These were reported by the family to be significantly worse by the time the residents were removed from the home in May 2020 following its closure. In another case, following admission to hospital, it was found that one gentleman had untreated bedsores and oral thrush.

7.12 The ability of the care home to appropriately care for residents with specific health needs was also highlighted by a relative whose husband was transferred to the care home in February 2020 for respite

care following a hospital stay. Her understanding was that he would be rehabilitated at the care home with the outcome being that he should return home following this period. He had significant breathing issues and required the monitoring of his oxygen saturation levels on a regular basis. Following numerous phone calls to check on his oxygen saturation levels she began to doubt the validity of what she was being told when every time the readings were reportedly in the 90% range. When visiting she also discovered bottles of "build up" drink stacking up at his bedside, potentially indicating that he wasn't being fed and she began to wonder who was telling the truth. On one evening she telephoned the care home to speak to him and was told that he wasn't able to speak as he was constantly coughing. She asked if he had seen a GP and when informed that he hadn't, she requested that be done as soon as possible. At that point, the manager and senior nurse were off sick and there were several agency staff managing the resident's care. She then requested the help of a community team "Rocket", who had previous experience of her husband's condition. Rocket is a team of doctors, nurses, and physiotherapists specialising in patients with respiratory disease and based at Kettering General Hospital. She asked them to visit him in the care home and they were able to attend the next day. He was immediately transferred to Kettering General Hospital that day and treated with oxygen and antibiotics. Within 24 hours he was deemed fit to return to the care home but only managed to remain at the care home for 24 hours. He was then returned to hospital, tested positive for Covid-19 and sadly died shortly afterwards.

Staffing levels

7.13 All of the families spoken to, highlighted the turnover of managers at the care home as being very obvious, reporting that there had been three managers in charge of the home in 18 months. There was a general concern that the care home was being managed differently and that the same level of care and attention was not evident following the departure of the first manager.

7.14 Concern around the levels of staffing within the care home were reported to the author by one of the relatives and dated back to 2018 when the care home was refurbished and re-opened. This relative and one other, reported to the author that some of the staff had poor English skills and their perception was that they had a lack of awareness or appropriate training in dealing with elderly dementia patients. Other relatives whose family members had been admitted to the care home in 2019 and early 2020 also reported it was their belief that there was an increasing reliance upon agency staff within the care home.

7.15 The overall hygiene and cleanliness at the care home was commented upon by nearly all of the residents' families, describing dirty tables, bathrooms and floors. It was stated that food and drink was left at the residents' bedside and there was no evidence that staff members assisted them if their relatives could not feed themselves. It was reported to the author that residents were left for long periods of time, completely inactive and unstimulated in the lounge area or their rooms with no interaction with staff.

7.16 Several families also commented that the lack of staff meant that some residents appeared to be left in distress, with some heard shouting from their rooms. In one case while a family member was visiting her husband at the end of his life, she heard another resident continually asking for help. No-one went to the resident's aid and when she tried to intervene, she could not locate any member of staff to assist.

7.17 One of the relatives reported that their family member had a fall at the care home and whilst various explanations were given as to the cause and circumstances, she felt that the records were lacking and when both she and her mother (next of kin) asked for a record of the incident nothing was ever provided. It is acknowledged that this specific incident has not been explored further by the author. Amicura Limited have stated that that the care home could only share information where there are lawful grounds to do so, for example, where relatives have Lasting Powers of Attorney in place. It is good practice that relatives would be informed of incidents such as falls under the general duty of candour, however it is only a statutory obligation where such an incident causes a level of moderate harm or higher.

7.18 Planning for the discharge of residents from the care home was reported as an issue for one family when their father who was 91 years old had spent three weeks at the care home for rehabilitation following a stay in hospital. During the time he spent at the care home he was not seen by his family due to Covid-19 visiting restrictions but on 17th April 2020 his daughters received a call from staff at the care home stating that he was unexpectedly being discharged to his home. Within the hour, he arrived at his home address. Unable to walk and having taken his daughters an hour to get him into the house, he subsequently fell. One of his daughters described him as "grey, filthy, and skeletal". He was also wearing someone else's clothes. Referring to her father's appearance upon being discharged from the care home back to his own home she stated to the author that, "he looked half the man he was after he left Northampton General Hospital."

Involvement of families pre and during COVID-19

7.19 Prior to the home closing its doors to all visitors and families due to the Covid-19 pandemic, relatives reported that visiting was maintained.

7.20 On 11th March 2020, two weeks prior to the announcement of the first national lockdown, the care home closed to all family visitors. The families said they were unclear how this was communicated. Some reported arriving at the care home to find a note on the main door and others recall an email being sent to them. Amicura Limited stated that they had sent letters or emails to the residents' families but were unable to locate them for the review.

7.21 From that point onwards, relatives report that the only contact with the home was by telephone, with the hope of being able to speak to a member of staff. It became increasingly difficult for relatives to reach anyone as often the phone would go unanswered. Relatives reported that there seemed to be a stock answer from staff who always reported their relative was fit and well. They said there was no consideration of the use of other technologies in trying to keep the families in touch with loved ones.

7.22 One family who did visit their mother on an almost daily basis were able to stand outside the ground floor window of her room and hold up signs and see her through the window. They, along with other families sent in many cards and presents to their relatives. They were then later shocked to find that all of the cards and presents had been left unopened and were in a pile in their relative's rooms along with the wilted flowers. For families who experienced their relative being discharged from a hospital setting to the care home when lockdown had occurred, they report that they struggled to get any meaningful contact with the care home despite trying to call on numerous occasions. One relative stated that the care home just didn't seem to have the staff to manage.

7.23 The lack of contact and information shared with families was commented on in relation to both Northampton General Hospital and Kettering General Hospital. In one case, Northampton General Hospital did not inform a son (and only Next of Kin (NOK)) that his 99-year-old mother had been admitted following a fall at her home. He was also not informed when she was subsequently then discharged to the care home. He found it difficult to obtain any information about the health of his mother and said that no-one answered the phone at the care home. He recalled that on one occasion when he did manage to speak to someone, a porter had assisted in helping his mother speak to him on the phone. He said that she was "in pieces", she had no TV or radio in her room and despite asking for those items, they were never provided. His mother sadly died on 24th April 2020; three weeks short of her 100th birthday. The time of her death was reported as 4.00 am by the care home, but again communication was distinctly lacking, and he was informed by a local vicar that she had passed away some seven hours later.

7.24 Many families also reported difficulties obtaining their relative's belongings from the care home following their relative's death and in one case the staff appeared to show a total lack of empathy when they merely placed resident's belongings into black bags and put them outside of the front door as the relatives arrived. One relative said that the staff were laughing and joking as he saw them approach the door.

Discharges from hospital

7.25 In nearly all of the cases where relatives were discharged from an acute health care setting to the care home in the first few months of 2020 (January to March), the families' perception was that they had no choice in where their relative was sent. This was the experience from both Kettering General Hospital and Northampton General Hospital. Families and relatives received no explanation as to why the care home was chosen and how the home may have been able to meet their relative's needs. One example is where a relative was taken by a member of the discharge team on a pre-arranged appointment to Temple Court Care Home prior to her husband being admitted to the care home. She said that she was given no other choice of care home for her husband.

7.26 Relatives reported that they understood the need to free up beds in the acute hospitals and they were also told that there was a lack of community care providers to deliver care packages to support individuals in their own home.

7.27 Family members generally were not clear who they spoke to regarding the discharge process from the acute care setting, some believed it was a nurse and in other cases a social worker. None of the families were clear about why the care home was chosen to accommodate their relative.

The impact of Covid-19

7.28 In considering the impact of the pandemic, there are two different groups of residents to consider, the residents who were already at the home prior to the implementation of the National Discharge Requirement on 19th March 2020 and those that were discharged there from other health settings following this.

7.29 Families whose relatives were already resident at the care home were unaware of the increased activity within the home and the increase in new residents over a short period of time. One relative said that during telephone conversations with staff at the care home the staff maintained a "rosy picture" of what was happening and there were many assurances that the home was not experiencing any Covid-19 cases. In contrast, some relatives reported that they were aware that staff at the care home were becoming ill with suspected Covid-19 and were becoming increasingly reliant on agency staff whose knowledge of the residents was scant.

7.30 During one conversation sometime in April 2020 a member of staff at the care home is reported to have told one relative that they had one confirmed case of a resident with Covid-19 that they were managing. This relative found out via a local newspaper that one of the residents had already died at the end of March 2020, with suspected Covid-19 and this was shortly followed by another elderly gentleman passing away. Three weeks prior to the home permanently closing and residents being moved, the same relative reported receiving an email with a letter attached, from the care home informing him that the level of care being provided at the home had fallen due to a situation beyond their control. This relative rang both the author of the letter and then shortly afterwards a man he believed to be the Chief Executive of Amicura Limited. He states that he was told by this individual that it "had all gone wrong there [the care home] and was down to the hospital forcing them to take in 18 patients". He said he had to report bed availability daily and had no choice about taking in the patients if he had wanted to carry on receiving funding. The relative was unable to recall the names of either the letter author or the person he believed to be the Chief Executive.

7.31 At around the same time the same individual, desperate to find about the health of his father, contacted the care home and managed to speak to one of the staff. He asked about his father and said that he knew that at least four people had died. He reportedly heard the staff member speak to someone else in the room who told her to "say nothing."

7.32 Relatives of those residents who were transferred to the care home from other healthcare settings were also unclear as to whether their family member had been tested for Covid-19 prior to them arriving at the care home. There was some confusion with test results when they were undertaken, with one resident reportedly testing negative prior to return to the care home when in fact, they were positive. This relative reported that they believed there had been a mix up of swabs at the hospital,

although this is not confirmed. It should be noted that the routine testing of patients prior to discharge from hospital was not announced by the Government until 13th April 2020.

7.33 One gentleman arrived at the care home from hospital and his wife was informed that he had arrived at the care home with a cough but there was uncertainty as to whether he had been tested for Covid-19 or not.

7.34 In the case of the resident who was discharged from the care home to his home address, his daughters confirmed that when they spoke to staff at the care home on 17th April 2020 it was reported that there were no cases of Covid-19 within the home.

Duty of candour

7.35 Not only did families report difficulties in communicating with the care home but there was a distinct lack of candour with those relatives. There is both a statutory duty and a professional duty of candour for service providers with the aim of making sure that those providing care are open and transparent with the people who use their services, whether or not something has gone wrong and whether or not an incident has been identified as a "notifiable safety incident"[4]. From the information gathered it appears that families experienced significant downplaying of the true nature of their relative's health conditions and denial that the care home was struggling with the impact of the virus. One resident was transferred to Kettering General Hospital with reported "breathing difficulties" as described by the care home but actually arrived at hospital completely unresponsive and died later that day. Having looked further into these circumstances it was reported by EMAS that they were called to the resident at 0551 hours and a crew arrived at the care home at 0654. After assessment, they left with the resident at 0742 hours arriving at the hospital at 0748. It is recognised by the author that the resident's condition may have deteriorated during this time or on route to the hospital. The author has not been able to establish whether there were any delays in handover that may have exacerbated the situation.

7.36 From the information gathered, apparent errors in basic attention to detail have had an impact upon the families. For example, one family could not be contacted due to the recording of an incorrect phone number for them by the care home, and they were not notified that their relative was deteriorating. When he subsequently died there was then a significant delay in informing the family. Amicura Limited reported to the review that information provided to them from the acute hospitals was often incorrect or inadequate. NGH dispute this was the case and state that there is no evidence to support this position.

Concerns and complaints raised by families

7.37 Concerns were raised by the families to the Local Authority's safeguarding team during the period under review. This included one concern in relation to the fall of a resident in January 2020 and the apparent conflicting accounts, where no records were ever produced. Also following the death of one of the residents, complaints were raised as to the care of that individual who had only been placed at the care home for recuperation following an operation.

7.38 Complaints were also raised both verbally and via email to the Registered Manager of the care home from relatives in relation to the cleanliness of the home, care provided to their relatives and in several cases, belongings not being returned to relatives after the death of their family member, this included an expensive wristwatch, glasses and hearing aids.

7.39 Concerns were also raised by relatives to members of the care home staff in relation to the environment their relatives were kept in during the lockdown. At least two families asked for their relatives to have a TV or radio in their rooms as they were spending a considerable amount of time in them and whilst promises were made the items never materialised.

7.40 Families were also reported to be shocked to find the deterioration in their relative's physical conditions as a result of their time at the care home. In one particular case a relative told us that her husband was a very proud man who shaved every day, if not twice a day. At aged 90 he had specifically

[4] www.cqc.org.uk/sites/default/files/2022-12/20220722-duty-of-candour-pdf-version-FINAL-2_0.pdf

asked for a new electric razor for his birthday which he took into the care home with him. Upon his death his wife was extremely upset to see that he had a full beard.

Movement of residents and closure of the home

7.41 Following the decision to move residents and the subsequent closure of the care home again there appeared to be little in the way of information provided to families from either the care home, the Local Authority, CCG or CQC. A lack of choice was evident again and families were either told at short notice that their relative was moving, their destination being unclear, or they were informed that they had already moved to another home.

7.42 One family arrived at the care home to find a number of staff in their mother's room waiting for an ambulance to arrive to transfer her to another care home. She was on an end-of-life pathway, and they found her in a very poor physical state. They discovered a carrier bag of food left untouched in her room, which had been there for two weeks, packets of un-used incontinence pads they had previously provided and wilted/dead flowers. The family intervened in her transfer and insisted she be taken to a local hospice where they felt she could be treated with dignity during her final days. The family maintain that she had clearly not been fed properly or her basic personal needs met whilst at the care home and they too described her body condition as "skeletal".

7.43 One relative said that he had received a letter from the Local Authority around 1st May 2020 which informed him of the closure of the care home. It appeared to apportion blame elsewhere and made no mention of any issue linked to the pandemic. He said it felt like "job done", there was no choice for residents or families and the situation was desperate. His father was moved by ambulance to a new care home and despite suffering from Alzheimer's disease, even then he was allowed to wander into the new home without supervision. A joint letter from the Local Authority and CCG dated 14th May 2020 was sent to the relatives of all residents informing them that there was to be an immediate review of residents' safety, and that alternative arrangements were being made for their accommodation.

7.44 This relative also sought clarification from the CQC about what was happening and said that he felt he was essentially warned off by a member of CQC staff when he was told during a telephone conversation that he needed to "stop [asking questions] as it was not helpful". He states that the inspection carried out by the CQC in May 2020 was done too late as most of the residents had already been moved.

7.45 Another of the relatives stated that she was contacted by the care home at the beginning of May 2020 to say they were having difficulties and some of the residents would have to move out. However, it was unclear at that time who would be required to move. The following day she received another telephone call, and the caller began speaking about another resident, not her mother. Her sister went across to the care home to find many people dressed in PPE in the car park and it wasn't apparent at that time what was happening. The sisters then received a telephone call from a hospice saying that their mother had been moved to them. It was reported that she was very poorly, dehydrated and her condition had deteriorated.

Key points

7.46 The accounts and comments made through this report are those obtained directly from the families of residents. The families had no direct input to provide about the circumstances and situation apparent within the care home during the period of lockdown and their observations are based upon, in the main, telephone contact with the care home and their experiences outside of the care home and as it was closing. The main concerns experienced by families of residents at the care home included:

1. Poor planning prior to discharge from hospital about next stage in a resident's care journey with little or no prior discussions with families about choice of care home. It should be noted that the Covid 19 Hospital Discharge Requirement removed patient choice due to the emergency pandemic situation. Lack of patient choice was also a feature when residents were transferred from the care home.

2. Poor care standards generally. Some residents were left with little stimulation, poor nutrition and hydration to the extent that some residents experienced very significant weight loss. Staff seemed to pay little attention to the personal appearance of residents with reports of matted hair, residents generally looking unkempt and poor standards of room cleanliness. Medication management was also a challenge, with one resident having their medication reviewed and re-balanced completely on admission to a hospice when the care home ceased operations.

3. Management and staffing levels were identified as a challenge by one of the relatives of a longer-term resident dating back to when the care home opened anew in 2018. Recruitment and retention appear to have been a problem as staff changed very regularly and comments were made by several of the families regarding the frequent changes of registered manager. Towards the end of the care home's operations, the staff team seemed to consist mainly of agency staff who had very little knowledge of the residents.

4. Communications with the care home, particularly during the lockdown period of Covid-19, were very challenging. Standard and 'pat'/stock answers were given in response to enquiries by families, particularly about Covid-19 being in the home.

5. Visiting arrangements, whilst relatively satisfactory prior to Covid-19 lockdown, seemed to be very difficult during lockdown, even for end-of-life residents, and some families experienced difficulties when wanting to contact their relatives via telephone. There appears to have been a lack of opportunity offered to use technology to facilitate remote contact.

6. Families felt that the problems being experienced by the care home were self-evident and could not understand why the care home and the owners had not sought help a lot sooner with the challenges they were facing. Relatives also found it difficult to understand why statutory agencies had not acted sooner than they did.

8. Context and timeline

8.1 Whilst the period under review is January – May 2020, there is a need to understand the context in which the care home was operating, along with the quality and standard of its care to residents as reported on by the CQC following its inspection in May 2019.

8.2 As a result of the inspection the care home was required to complete action plans for the CQC and action plans were required by both the CCG and the Local Authority. The care home was subject to further quality assurance visits both in relation to the progress of the required improvements and in response to some whistleblowing and safeguarding concerns detailed later in the report.

8.3 There are also some key national dates and circumstances that feed directly into the situation within the care home, most notably in February 2020 the requirement for the discharge of all medically fit patients from local hospitals to free up bedspace, the beginning of the national lockdown on 23rd March 2020 and the commencement of local emergency procedures under the Civil Contingencies Act 2004 and the establishment of the Local Resilience forum[5] to manage the response to the pandemic.

8.4 The context in which all organisations were operating during the period under review became more extreme and unprecedented as time progressed. A significant amount of central Government policy and guidance was being disseminated to the Health Service, Social Care and providers, and as more was learned about the Covid 19 virus, guidance was also frequently changing. Vaccines were not available, PPE was in short supply early in the pandemic, and the testing of patients and professionals was extremely limited.

[5] Local Resilience Forum – multi-agency partnerships that plan and prepare for localised incidents and catastrophic emergencies.

8.5 The impact of the pandemic is discussed later in this report but it is acknowledged that there was a significant strain upon all agencies in respect of resourcing levels and the sheer emotional impact of delivering care in these circumstances. There are several national reports detailing the experiences of staff working within care homes suffering from burn out and extreme stress. Likewise, the impact upon the residents within care homes and their families was immense.

Key themes, analysis and learning

9. Quality monitoring, oversight, and regulation

9.1 Covering the first two points of the terms of reference, this theme examines:

1. Whether all agencies were clear about their roles and responsibilities with regard to the commissioning and delivery of the service and the necessary oversight and support when it was apparent the home was not achieving the required standards?
2. It also looks at how the system and framework which regulates the service and standards was applied locally and whether it was sufficiently robust and effective, if not, what barriers prevented it from being?

9.2 The regulation and registration of health and social care services is the responsibility of the CQC ensuring that services meet standards in respect of quality and safety. Their role also involves holding providers to account by taking regulatory action to ensure that providers rectify any shortfalls in their arrangements to safeguard children and adults.

9.3 Following their inspection of the care home on 3rd May 2019, the CQC inspectors met with the provider on 21st June 2019. The CQC graded the home overall as "Requires Improvement" and found the provider to be in breach of regulations 12 and 17. The inspection found that the provider had failed to keep people safe from unsafe care and treatment and the quality assurance systems used by the care home were ineffective.

9.4 The CQC imposed conditions on the provider's registration requiring them to provide detailed information and action plans demonstrating how they were ensuring compliance with the regulations.

9.5 Monthly reports were required from the care home to evidence that action was being taken and improvements made in specific areas, notably:

1. Records relating to "Accidents and Incidents" occurring at the care home had been reviewed by the Registered Manager, and action been taken to mitigate any future risks.
2. Contemporaneous and accurate Personal Emergency Evacuation Plans (PEEPs) had been completed for all service users.
3. Bed rail risk assessments had been completed for all service users, and any steps to mitigate risk undertaken.
4. Risk assessments had been completed for all service users.
5. Effective systems had been established and were being operated to assess, monitor and improve the quality and safety of services, and to mitigate risks to the health, safety and welfare of service users.
6. An audit covering bed rails and gaps between mattresses and bed frames had been carried out by a suitably competent individual and detailed any actions taken as a result of the audit.

9.6 Compliance with the improvements required was monitored by the CQC via the monthly reports that were submitted. Evidence provided reflects that the care home submitted reports on a monthly basis from August 2019 to March 2020.

9.7 There was no further follow up from the CQC until their inspection in May 2020. Amicura Limited consider that this indicated the CQC had accepted that their action plan would address all the areas where improvement was needed and were not concerned. They outlined that they had made significant investment in terms of staff and the environment at the care home, along with appointing a new manager in September 2019. The home had three managers from 21st June 2018 to its closure. Amicura Limited have provided dates for each of the managers they employed. The first manager was employed between 21st June 2018- 6th February 2019, the second from 8th November 2018 to 5th September 2019 and finally the third manager from 26th August 2019 to 4th September 2020.

9.8 The CQC responded to the review that where a regulated service fails to meet any of the required standards, they will require it to respond by way of a report and action plan identifying the action it will take in respect of the areas identified. The CQC must also act on any new concerns in relation to risks to individuals or on safeguarding concerns or whistle-blowing reports. The CQC utilise an Enforcement Policy[6] and Decision-Making Tree to ensure that all action taken is proportionate to the risk. The assertion by Amicura Limited that the CQC were unconcerned cannot be substantiated as CQC were following their documented policy and practice. Routine inspection of registered providers was suspended by the CQC on 16th March 2020.

9.9 The quality of care provided for patients at the care home on the Continuing Healthcare[7i] (CHC) pathway was also monitored by the CCG. There was no CCG contract with the care home but the monitoring team used CHC placements as a means to enable monitoring.

9.10 In January 2019, the care home was subject of an annual quality review by the CCG and the care home was graded as complying with 72% of their requirements but, following a full CCG quality monitoring inspection on 23rd January 2020, this figure had increased to 92%. It should be noted that the monitoring visit focused upon two individuals who were in receipt of CHC funding; it did not inspect the services provided to other residents, although it is understood that quality or safety issues would have been raised had they been identified during their walk around the care home. The care home only had three individuals in receipt of CHC funding at the beginning of January 2020. As a result of the monitoring review the CCG and the care home developed an action plan to address the outstanding issues.

9.11 There is evidence of a detailed action plan developed by Amicura Limited in response to the CQC inspection which identified areas that required immediate attention and others which were to be developed in a specific timescale. In relation to safeguarding concerns, two actions were immediately adopted which included the implementation of communication sheets between professionals, the resident's family, or next of kin. A safeguarding log was also introduced. Further actions included the development of workshops for staff to cover key areas around record keeping, personal care, dementia awareness, effective communication, fluid and nutrition, safeguarding and mental capacity assessments. Workshops were commenced during October 2019. Other practical actions were detailed to include the replacement of fluid and nutrition charts, repositioning charts, removal of bed rails not in use, plus actions in respect of wound care management and the safe administration of medication.

9.12 Amicura Limited stated as part of the review that the CCG monitoring report along with the CQC action plans demonstrated that the care home had made marked improvements and it was clearly on a journey with the appointment of the new manager. Amicura Limited also interprets the CCG quality monitoring review as identifying that the home was compliant in most of the areas examined. In particular they identify 100% compliance with infection prevention and control, staffing and staff training. They identify that a score of 83% was achieved for governance and management noting that it was the intention of the new manager to commence annual performance development and reviews with all staff, along with the identification of their training needs.

[6] https://www.cqc.org.uk/guidance-providers/adult-social-care/enforcement-adult-social-care-services

[7] NHS Continuing health care can be provided to people who have long-term and complex needs. An assessment of eligibility will be conducted to identify whether a person qualifies for free social care which is funded solely by the NHS

9.13 The Local Authority and the CCG did not have a framework contract with the care home but residents were accommodated in the care home under a spot arrangement[8]. Information provided for the review by the CCG indicates that as a consequence of how funding is allocated, there would be more residents within the care home funded by the Local Authority than those meeting the criteria for the CHC pathway. The Local Authority process for monitoring the quality of standards and care provided at the time of the review has not changed. The monitoring of the quality of care provided under a spot contract replicates the arrangements for providers who are contracted under a framework agreement. Individuals placed into a care setting under a spot arrangement would be subject of a review. Where a provider is failing to deliver care to the required standard, it is the action that could be taken by the Local Authority in the case of a spot contract that differs and it could only be taken in respect of that particular arrangement and not in relation to the organisation as a whole.

Following a visit to the home on 28th January 2019 by the CCG concerns around the quality and standards of care were shared with the Local Authority Quality Team. They decided not to place any further residents through spot contract agreements in the care home. At that time the Local Authority had 15 residents placed at the care home. There was information shared between the CCG and the Local Authority that the concerns at this time related to the manager and deputy manager leaving, lack of care plans for residents, poor wound care, no accurate documentation around repositioning, food and fluid intake, action plans not completed and staff not competent at using the electronic care planning system. The care home provided the CCG with an action plan on 15th February 2019 and the CCG conducted a supplementary visit to the care home on 21st March 2019 to review progress against the action plan.

9.14 The Local Authority Quality Team were notified of the outcome of the CQC Inspection on 21st May 2019 and in conjunction with the CCG an improvement plan was put into place. A monitoring visit was carried out by a Local Authority Contract Monitoring Officer (CMO) on 12th August 2019 following the CQC report and the Local Authority reported that an overall co-ordinated action plan was being developed to include all the improvements required from both the CQC inspection and CCG monitoring visits. A further visit was made to the care home by the CMO on 27th September 2019 and on 17th January 2020 to review the action plan.

9.15 At that time the Local Authority Quality Team and CCG held regular monthly information sharing meetings detailing concerns around local providers and agreeing the action required.

9.16 Information provided for the review suggests that there had been issues of concern in relation to the care home prior to the CQC Inspection in May 2019 and that, whilst some improvements had been made, in June 2019 things had begun to deteriorate again with a lack of patient risk assessments, poor fluid charts, lack of fortification information and re-positioning charts. A meeting was held between the Local Authority, CCG and Minster Care senior managers on 16th August 2019 to discuss the situation. The meeting also addressed similar issues which were occurring in three of Minster Care Groups other care homes.

9.17 Minutes of meetings evidence that the care home was discussed at the joint Local Authority/CCG information sharing meetings in August and September 2019 and again in January 2020. In August 2019, the main concerns focused on the high turnover of managers, recruitment of staff and lack of governance and oversight.

9.18 An anonymous safeguarding referral was made on 2nd January 2020 and detailed in the CCG questionnaire which raised several issues around the care being provided at the care home including concerns that beds were not safe, there was a shortage of staff, tablets had been found in residents beds, falls were not being reported and there was a lack of activities for residents to access. A further report from a whistle-blower was made to the CQC on 26th February 2020 stating that the care home was constantly understaffed, putting people at risk and stating that the provider had put additional staff on duty at the time of the CCG quality monitoring visit.

[8] A spot purchase contract is an arrangement under which a Local Authority procures care and support services for a specific individual. The contract is between the Local Authority and the service provider.

Analysis

9.19 The recent history of the care home appears to indicate a care home that had experienced reoccurring issues particularly in relation to its patient care, retention of staff and the oversight and governance provided by its senior management.

9.20 The author has seen five different action plans which are dated 15th February 2019, 22nd July 2019, 12th August 2019, 30th January 2020 and 3rd May 2020. It is not apparent through these that the documents have been consolidated into one overarching plan and therefore it may have been difficult to follow through the process of improvement. At the managers' learning event, this situation was described as an anomaly, in that the care home had too many action plans resulting in a chaotic approach to progress monitoring.

9.21 Information from the managers learning event suggested that the information sharing meetings between the Local Authority, CCG and CQC had been developed following a review in 2009 and worked well. However, quality monitoring was carried out by telephone contact with care homes once the first wave of the pandemic lockdown commenced, essentially creating closed environments due to the national restrictions. The CCG's Quality Improvement Nurses (QINs) did continue to visit care homes as necessary, but with a limited resource of only two nurses for Northamptonshire their ability to cover the large number of premises within the County was clearly stretched.

9.22 In response to the pandemic an interim quality review process was introduced at the end of March 2020 by the Local Authority and in unison with the CCG Quality Team. It set out key indicators which would be monitored including staffing and safeguarding concerns. This was designed to prevent poor practice, offer support and guidance and provide any necessary support for the resilience of the service. A review was not conducted for the care home during the period under review.

9.23 The CQC also suspended all its inspection activity following the national lockdown.

9.24 It was recognised by managers having responsibility for the monitoring of safety and quality that to have effective oversight they needed to be in receipt of all information available, including any low level or soft intelligence. What is apparent is that the information received from the two whistleblowing reports in January and February 2020 do not appear to have been considered in connection with any overall monitoring of the provider. Thorough safeguarding enquiries were conducted into both and the Registered Manager was deemed to be transparent and proactive, dealing with issues arising from the relevant action plans. Once the enquiries were completed by the Local Authority safeguarding team there was no further focus upon the care home.

9.25 The turnover of staff, and more importantly the changes of registered manager, features within the discussions between the care home and those monitoring their performance. The formal role of registered manager is critical to the running of any care home, and it was highlighted at the managers learning event that there is a requirement[ii] for care homes to notify CQC when changes of managers occur. Participants also said that in some areas the Local Authority also require care providers to notify them at the same time. Adopting this approach may be useful soft intelligence for commissioners and contract managers and assist them in understanding the wider picture and potential level of risk.

9.26 As the national restrictions were implemented, the effect of isolation upon care homes was apparent. Isolation presents a greater risk of harm and institutional abuse occurring within such settings as there are fewer people visiting the home in a personal or professional capacity. In terms of the residents themselves, many were frail and suffering from dementia and therefore unable to provide feedback or information themselves. Contact with the care home staff was also reduced due to restrictions, again reducing the opportunity for the Local Authority and the CCG to obtain valuable feedback and information to triangulate any concerns.

9.27 A useful document[9] developed by ADASS[10] during the first wave of the pandemic and published in May 2020 sets out clearly the areas which identify that a service is at a higher risk of causing harm/abuse to patients/residents:

1. Past risk is the best indicator of future risk
2. High levels of staff or resident turnover
3. Fragmented care provision and governance
4. Little contact with the outside world
5. Lack of candour
6. Weak system of communications
7. Blanket restrictions

9.28 All of the above points are reflected within this scenario as it developed within the care home. There was a pattern of reoccurring issues, high turnover of staff and a reliance on agency care. Governance of the service had also been highlighted as a previous concern and the information provided to families was extremely limited and sometimes inaccurate. The indicators of risk highlighted in the ADASS guidance should be included in any future risk assessment process considering these points as triggers to potential further exploration.

Learning

9.29 The quality monitoring system in operation during the review period was not as co-ordinated as it could have been, not all information was considered, and evidence provided would suggest that action plans were not consolidated. It was articulated at the practitioners' learning event that the focus had been taken away from the care home and more attention was paid to the other care homes within the Minster Care Group. This suggestion is disputed by Amicura Limited who also state that Amicura Limited was the provider and not Minster Care Group.

9.30 The quality monitoring process has been in place since 2009 with monthly information sharing meetings being chaired by the CCG (now ICB) and attended by the CQC, NHFT, CHC, and the local authorities. It has developed further since the beginning of 2020 and provides a range of opportunities for the commissioning and regulatory agencies to develop an overall picture of care provided. It now involves three information sharing meetings each month, the original meeting chaired by the CCG, along with two additional meetings led by the two local authorities, NNC and WNC. The CCG also reported that during the period of the pandemic, there were weekly meetings with the CQC and together with the Local Authority a joint risk assessment process and a joint quality monitoring form were developed. The risk assessment process was provided to the author for information but a risk assessment of the care home was not undertaken during the period under review.

9.31 To have an effective quality monitoring system in place is vital to ensure the safety of residents and to ensure they receive appropriate care. To achieve this there must be co-ordination between the commissioners and regulators of services which uses all available information from professionals, residents and families to shape that understanding. Safeguarding reports and whistle blowing must feature in that overall picture providing an early warning system that standards, quality and safety may be at risk.

9.32 Providers that are graded as "Requires Improvement" or "Inadequate" should receive regular monitoring and risk assessment with a 'turn-round' improvement plan with external support, as necessary, to achieve acceptable standards of care and wellbeing.

9.33 With the development of the Integrated Care System[11], between health and social care organisations imminent, there is potentially an opportunity for a more co-ordinated approach to the quality monitoring system. A new care model developed within Cambridgeshire and Peterborough[12] has increased the number of CCG Quality Improvement Nurses and created a joint Care Home Support.

[9] https://www.derbyshiresab.org.uk

[10] ADASS – Association of Directors of Adult Social Services

[11] Integrated care systems (ICS) are new partnerships which will be established in law, between the organisations that meet health and care needs across an area to co-ordinate services.

[12] Cambridgeshire and Peterborough CCG – Model of support to Care Homes

10. Hospital Discharges and admissions

10.1 This theme examines how the national requirement to move medically fit patients from acute hospitals was managed and addresses the impact it had on all organisations. It correlates to the terms of reference examining:

1. The impact of the Covid-19 pandemic upon partner agencies and whether they were able to manage the risk to service users and keep residents and staff safe
2. Whether there were any processes or systems that affected the ability of agencies to do so – this should be considered against the backdrop of national Government guidance and its local application
3. Whether partner agencies had sufficient information about the individuals/residents concerned to be able to meet their individual needs effectively, if not what barriers stopped this from occurring?

10.2 Evidence has been provided for this review by the CCG, Local Authority and acute hospitals that outlines the initial phases of the emergency response to the pandemic.

10.3 Local Resilience Forums (LRF's) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, NHS and others. Their aim is to plan and prepare for localised incidents and catastrophic emergencies. In the event of such an incident the LRF establishes a Strategic Co-ordinating Group (SCG) in order to respond effectively and provide strategic leadership throughout the emergency.

10.4 The evidence is that a SCG was first convened by teleconference on 3rd March 2020, and identified that at the time there was one positive Covid 19 case within Northamptonshire. There is evidence of discussions and preparations being made at this early stage of the pandemic and prior to the Government's request to discharge all medically fit patients from hospital settings. The meeting identified some of the key risks, including the loss of health care workers through illness, the importance of business continuity plans in relation to providers and the development of escalation plans. The SCG agreed to convene weekly meetings from 3rd March 2020.

10.5 A second SCG meeting held on 10th March 2020 recorded that there were five positive Covid 19 cases within Northamptonshire and that nationally, the emerging situation had taken on a major incident footing. Plans were being developed in response to the escalation and for seven day/24 hour incident management. A daily situation report (sit-rep) was being developed and it was recognised that there was no capacity within the acute hospitals for additional patients, therefore other alternatives were being explored.

10.6 The SCG met more frequently from 17th March 2020 and began to develop its response to the discharge plan issued by Simon Stevens (then Chief Executive of the NHS). The SCG set out its strategic aims and objectives for response and directed the development of a tactical plan and the creation of relevant cells to support it. Teams within each organisation were also deployed to support the process including the CCGs Quality Team, Continuing Healthcare and CHS teams.

10.7 The tactical plan was developed jointly by the Emergency Preparedness Resilience and Response group which is a multi-agency team. Its aim was to create capacity by freeing hospital beds and established a "Hospital Transfer Cell" (HTC) to managed the process. On 17th March 2020, the aim of the HTC was to create 200 additional beds within the acute hospitals.

10.8 The first meeting of the HTC occurred on 18th March 2020 . Two discharge hubs were implemented one at each of the acute hospitals to manage the process and an initial process plan was developed. On 19th March 2020, the HTC made a recommendation to the SCG that all patients in acute hospitals awaiting either domiciliary care or packages of care to be discharged home (Pathway 1) should instead be transferred to alternative beds, which were to be identified. This recommendation was approved by the SCG on that date, however the SCG chair reported to the author that this recommendation did not lead to a blanket approach and other options to support a patient returning home were to be pursued in each case. The author has not been able to validate this comment either way.

10.9 On 19th March 2020 the Government published the Covid-19 Hospital Discharge Service Requirement[13].

10.10 On 25th March 2020 all Midlands acute and community trusts received an email from NHS England which increased the requests to health services that it was critically important to progress the discharge of medically fit inpatients and there was a requirement that they should have no medically fit patients awaiting discharge by 26th March 2020. In response to this the SCG increased their requirement to discharge 200 patients up to a figure of 350.

10.11 On 18th March 2020 the care home had 33 residents. Between 19th March and 3rd April 2020, the care home received an additional 23 residents from both the acute and community hospitals in line with the national requirement to free up hospital bed spaces. 15 new residents were discharged from NGH, six from KGH and two were discharged from community hospitals. Nationally, routine testing for Covid-19 pre-discharge was not in place at this time.

10.12 Care Home Selection Healthcare (CHS) have been commissioned by the CCG since 2016 as a brokerage service to facilitate the discharge of patients from acute hospital settings – Northampton and Kettering General Hospitals.

10.13 CHS stated that on 12th March 2020 that they were requested to support with the discharge planning of a large cohort of patients who were classed as medically fit for discharge but requiring assessment for their on-going needs. CHS stated that there were discussions between the two acute hospitals, the CCG and Local Authority developing the process.

10.14 Their original brief was to facilitate the discharge of 100 patients in a two-week period commencing on 15th March 2020.

10.15 CHS stated that concerns were raised by the Local Authority about the potential locations of patients who needed to be assessed and did not want them to be spread all over the County. It was therefore agreed that they would use as small a number of care/nursing homes as possible. This would then enable social workers to conduct the necessary assessments at the care homes.

10.16 CHS provided information for the review that following the National Covid 19 Hospital Discharge Service Requirement, all cases of discharge from an acute hospital followed a "discharge to assess" process. This involved people being moved quickly to temporary support and an assessment of long-term needs being conducted after discharge. The document also directed members of the hospital discharge team, including Adult Social Care to work in this model and hence remove Adult Social Care presence from hospital wards to the community. The process involved the ward identifying the patient needs, the referral was looked at by a member of the hospital discharge team alongside a Principal Social Worker and a decision was recorded alongside what the original discharge destination would have been if Covid-19 were not a factor. If the person could go immediately home, they were discharged home. If the person needed any element of support, they were passed to CHS for them to find a placement for them to reside whilst awaiting an assessment outside of the hospital.

10.17 CHS would initiate a telephone call with prospective placements and then the care home would be sent a Patient Discharge Needs Assessment (PDNA) form which had been completed by the multi-disciplinary teams and discharge teams within the hospital discharge hubs. The CCG Head of Quality and two QINs were deployed to the two acute hospitals between 17th March and 26th March 2020 to support the discharge process using their local knowledge and experience. The care home Manager would assess whether they could support the patient and confirm an admission date.

10.18 The HTC was responsible for the oversight of this process and was located within the Local Resilience Forum (LRF)[14] emergency structure. The information was retained by CHS and was available within the

[13] COVID-19: Hospital discharge service requirements (publishing.service.gov.uk)

[14] Local Resilience Forums are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are Category 1 Responders as identified under the Civil Contingencies Act 2004

HTC and to both CCG and the Local Authority on a daily basis. This spreadsheet has been provided for the review.

10.19 The Local Authority stated to the review that moving patients to care homes should have been considered as a last resort. All efforts encouraging relatives to care for patients at home were to be pursued. The Local Authority state that there was no formal agreement between themselves and the CCG in relation to using CHS to facilitate the discharge process, however the CCG had been using CHS for this process since 2016 and therefore prior to the pandemic. Once the strategic decision had been made the Local Authority had to put in place different processes to ensure that the specific things they were still responsible for, happened. This included the following up and assessment of the patients moved and the payment to providers of these placements.

10.20 There was no 'pooled' budget between the CCG and the Local Authority for discharging patients and the initial funding for the discharge process was made through the national Covid fund and held by the CCG. The Local Authority stated that there were approximately 14 homes across the County where there were concerns about the quality of care at that time. CHS told the review that they were not made aware of care homes where there were any concerns only if placements had been suspended.

Analysis

10.21 The Covid-19 Hospital Discharge Service Requirement came into effect on 19th March 2020 and was relevant to both Health and Social Care Commissioners.

10.22 The Government's aim was to free up 150,000 beds nationally by 27th March 2020. The Hospital Discharge requirement introduced a "Discharge to Assess" model which had four clear pathways:

Pathway 0 - 50% of all patients would be discharged to their home address requiring no ongoing support

Pathway 1 - 45% of all patients would be discharged to recover at home but with some support

Pathway 2 - 4% of patients would require rehabilitation in a bedded setting

Pathway 3 - 1% of patients would have experienced a life changing occurrence and discharge home would not be an option

10.23 The Covid-19 Hospital Discharge Service Requirement is clear that for the model to operate effectively there should be collaboration and co-ordination of all partners involved in health and social care. Social care colleagues were to be involved within the daily ward rounds to identify early the requirements of patients for support, type pf placement and housing. Evidence provided to the review from both the SCG, Health Tactical group and HTC support that there was strategic leadership with representation from the CCG, Local Authority, KGH, NGH, NHFT and Public Health leading the response to the pandemic. Within the cell structure there was also a multi-disciplinary approach. The Local Authority advised that at the initial stages of the HTC development Adult Social Care were not involved in the cell and neither had they agreed the discharge process. Meeting notes from the HTC on 20th March 2020 reflect that the cell was led by a CCG representative and that the deputy chair of the group was from the Local Authority therefore indicating that the cell did have Local Authority representation. The HTC developed the hospital discharge plan as had been directed by the SCG, however, this initial process was not tabled at any future SCG meetings for approval and therefore there was no strategic oversight on this process in its early stages. It was approximately two to three weeks later that the discharge process was revisited and amended and agreed at a strategic level.

10.24 The responsibility for each pathway is also defined in the Covid 19 Hospital Discharge Service Requirement document with the acute trusts responsible for pathway 0 and the community health service responsible for the co-ordination of pathways 1-3. This guidance is reflected within an email sent from the SCG chair to the chair of the Health Tactical Co-ordinating Group and the chair of the HTC on 20th March 2020, which required clear identification of the leads for each pathway as per national guidance.

10.25 The Government directive also removed any patient choice in where patients may be accommodated but does provide suggested information leaflets for both patients and families/carers to explain why they were being discharged. This information was utilised by the SCG and an example of communication circulated from the SCG to the public has been provided for the review author.

10.26 At the Managers' learning event, it was reported that at the time of the review, there were a lot of beds available through the different providers. There was also an accepted norm that there were also many care homes which had been graded as "requires improvement" by the CQC. Information provided to the review by the CCG also states that whilst there were beds available, many other care home providers refused admissions due to staffing constraints and also to ensure quality and the safety of existing residents.

10.27 The financial incentive to admit new residents was attractive and there was a good level of funding to care homes that received the patients. However, where agency staff were relied upon to supplement employed staff, as is the case at the care home, this additional level of funding is not significant.

10.28 In terms of how care homes were selected to receive patients from the acute hospitals, CHS have told the review that up until March 2020 the only criteria they were asked to meet was that care homes that were suspended from accepting new residents, should not be used. After this time, the criteria changed and they did not place any patient into a care home with a CQC grading of "Inadequate". CHS informed the review that they did not receive any information or soft intelligence which would indicate there were possible concerns or safeguarding issues with any of the care homes.

10.29 The LRF HTC was responsible for over-seeing the process and national guidance was localised. A bed tracker was introduced and all discharges and their onward admissions to care homes were captured by CHS in a spreadsheet provided for the review author. However, what this does not provide is evidence as to what pathway each patient was on.

10.30 The author has requested information from the relevant partners involved in the review, specifically involved in the SCG, to provide the number of patients who were discharged from the acute hospitals along each pathway during the months of March and April 2020. The only information that has been provided shows that during the two months a total of 6014 patients were discharged from the two acute hospitals and 233 (3.9%) of those patients went to care homes along pathway three. Information in relation to those discharged under the "discharge to assess" model has not been provided. Without the specific data it cannot be ascertained whether the Northamptonshire process discharged more patients in to care home settings than it needed to or whether it was in line with the nationally suggested percentages.

10.31 The impact of this particular national policy was significant and whilst successfully achieving the overall aim of freeing up bed space the impact upon other parts of the health and social care service was not monitored sufficiently by the local emergency response structure or the senior management within the care home.

10.32 Practitioners attending the learning event told the review that there were limited options for patients leaving acute hospitals in that they could either return home with family support or be put on the "Discharge to Assess" pathway into a care home setting for further assessment. It was suggested that up to 95% of all patients' discharges went to care homes when not all should have done. A number of families spoken to as part of the review were also expecting their relative to be discharged home. It was felt by practitioners, that the process developed was not the safest but had been designed at a time of panic.

10.33 Whilst the national guidance set out the available pathways the use of percentages against each may not have been as helpful. There is a need for local systems monitoring and an understanding of the level of need within a community and a degree of flexibility required to achieve the right balance of pathways utilised[15].

[15] A report of people's experiences leaving hospital | Healthwatch

10.34 Practitioners felt that the care services generally were frightened to receive the patients, as were the families of residents and the reablement services and private care packages simply were not available.

10.35 The acute hospitals stated that they informed relatives of the situation and explained their lack of choice, however early on in the process it is accepted that this wasn't recorded and there was clearly some confusion. A log recording telephone calls and relevant details was ultimately implemented by the acute hospitals.

10.36 The PDNA forms were not as informative as they could have been and when assessments by social care commenced in the third week of April 2020 not all information was available and made assessments inaccurate. Social workers were not able to visit the patients at the care home and had to conduct their assessments via the telephone.

10.37 The rate of discharge to the care home is significant and it has been acknowledged by Amicura Limited with the benefit of hindsight, that 23 new residents admitted into the home in 16 days (between 19th March to 3rd April 2020) was inappropriate. Some of the patients who found themselves at the care home had significant needs and they required nursing care and specific monitoring. According to information supplied to the author by a manager within Amicura Limited, the normal rate of admission would be in the region of only one or two new residents per week. Amicura Limited have advised that the care home only accepted the number of residents it did because it was trying to help the national response to ensure that acute hospitals had the capacity to deal with a potential surge in patients requiring intensive care support.

10.38 The decision to accommodate residents within a limited geographical area cannot be evidenced within any particular meeting, but it has been explained by the Local Authority that the initial plan had been to condense the area into which residents were placed in order to make the subsequent assessments easier to manage rather than spreading residents across a geographically very large county. Whilst appearing to be a sensible approach, this could have inadvertently placed care homes under pressure to accept more residents than they otherwise might have. However, from documentary evidence provided by CHS it is apparent that due to the volume of people requiring to be placed into residential care, this plan did not succeed and residents were in fact placed throughout the county.

10.39 There was no evidence that either the HTC or the Provider Hub followed up with the care homes and in particular where significant numbers of patients were discharged into one location. From the information provided, the care home received one of the highest number of new residents in the county in an extremely short time period.

10.40 The responsibility for accepting new residents rests with the registered manager of a care home, however there is no evidence to identify how she was supported in this role and what oversight senior management within Amicura Limited or Minster Care Group had of the overall admissions policy within the care home. The overall rates of admission were not monitored by the senior management team. From the CHS data available a comparison with another of Minster Care Groups homes suggests that during the same time period (19th March – 3rd April 2020) this home took only seven new admissions. This difference could of course be explained due to differences in bed availability at that time.

10.41 In line with national Government policy there was no routine Covid-19 testing of patients leaving acute hospitals at that time unless they were symptomatic. It is also understood by the author that there was a national problem with inaccurate test results when they were carried out with test results providing false positives. The theme of infection prevention and control is discussed further within this report.

Learning

10.42 The overall system adopted to discharge patients quickly and in large numbers was developed at a time of national emergency. However, the system that operated locally within Northamptonshire to facilitate that requirement would have benefitted from greater oversight from both the LRF HTC , Provider Hub and the senior management of Amicura Limited / Minster Care.

10.43 In any similar scenario where there is either a need to move a significant number of patients into a care home setting or another emergency situation, there must be multi-agency agreement relating to the selection of care homes. Placements must be subject of a risk assessment based on all available information to ensure that the care home can meet the needs of residents and are safe, and in particular, where a care home has a grading of "requires improvement" there should be multi-disciplinary discussion on whether enhanced support is required and what form this would take. Information provided to the author by the CCG reports that local intelligence gathered from information sharing and monitoring processes is used when commissioning placements and closer monitoring is given to care homes that are rated as 'Requires Improvement' with supplementary visits taking place at regular intervals.

10.44 The speed of discharge also meant that the initial information provided from the hospitals about a ~~of~~ patients' needs was suboptimal in many cases, and it took several weeks for social care assessments to commence once the resident was moved to the care home. Amicura Limited have informed the author that it is their usual practice to attend hospital and carry out their own assessments prior to accepting someone into their care. This could not happen due to Covid and so they were reliant upon information from other professionals. Amicura Limited reported that they were frequently given incorrect, incomplete or no information upon a patients discharge from the hospital to the care home and it was therefore difficult for residents to receive personalised care and for their needs to be appropriately met when admitted. NGH state that there is no evidence to support Amicura Limited's position about being given incorrect, incomplete or no information about a patient. However, once the care home got to know the residents, there should have been opportunity for their needs to be reviewed.

10.45 The discharge to assess model could be extremely beneficial in terms of patients being able to leave hospital sooner provided that the placement they are discharged to is the right setting and care is personalised to their needs.

11. High Court Judgment

11.1 On 27th April 2022, the High Court issued a Judgment following a claim brought by the daughters of two fathers who had sadly died from Covid whilst they were resident in care homes during the first wave of the pandemic. The SAR review panel considered the Judgment in detail and its potential implications in respect of this review.

11.2 The claim was made against the Secretary of State for Health and Social Care, the NHS Commissioning Board (NHS England) and Public Health England (the Defendants) and stated that certain policy documents issued by the Defendants and policy decisions recorded in those documents constituted breaches of their fathers' rights under the European Convention on Human Rights, or alternatively, were unlawful and susceptible to judicial review on common law principles.

The Judgment relates to four key policies but essentially focuses upon two:

1. "March Discharge Policy" which is made up of two documents namely "Next steps on the NHS response to Covid 19" (Published on 17th March 2020) and "Covid 19 Hospital Discharge Requirement" (published on 19th March 2020).
2. Admission and care of patients during Covid 19 including in a care home (Published on 2nd April 2020)[16].

11.3 The Judgment found that the Claimants partially succeeded in their claims against the Secretary of State for Health and Social Care (Matt Hancock) and Public Health England in relation to the two policies above. The Judgment stated –

> "298. The common law claim succeeds against the Secretary of State and Public Health England in respect of both the March Discharge Policy and April Admissions Guidance documents to this extent: the policy set out in each document was irrational in failing to advise that where an asymptomatic patient (other than one who had tested negative) was admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for 14 days".

[16] [Withdrawn] [Withdrawn] Admission and care of residents in a care home during COVID-19 - GOV.UK (www.gov.uk)

Analysis

11.4 The SAR is not a review of Government policy, however, the review panel considered how Government policy and guidance was implemented within Northamptonshire and the care home at the relevant times.

11.5 At the time of the publication and dissemination of the two documents referenced in the Judgment it was a fast-moving emergency situation with changes to legislation and to guidance occurring on a daily basis. There was extreme concern that the numbers of seriously ill patients requiring intensive care would rise so rapidly that it would overwhelm the capacity of the NHS. Vaccinations were a long way off in the future and the testing capability was limited to approximately 5000 per day by 18th March 2020.

11.6 The understanding of the transmission of Covid 19 was also developing and whilst there was information in existence about how individuals could have the virus without exhibiting symptoms, it was not until 15th April 2020 that the Department for Health and Social Care (DHSC) directed that new care home residents should be tested for Covid and isolated for 14 days on admission.

11.7 Media reporting in respect of the Judgment suggests that the overall Government policy of discharging patients into care homes was unlawful, however the detail within the Judgment states that there was nothing unlawful in the policy, subject to the point relating to asymptomatic patients (as mentioned at paragraph 11.3 above), as the Government were being advised by experts, there was a real risk of the NHS being overwhelmed and they could not afford to wait.

11.8 Paragraph 285 of the Judgment states "The fact that discharge was necessary to preserve the capacity of the NHS to provide in-patient care to those seriously affected by Covid did not eliminate the need to consider the best way to manage those discharged". It is the author's opinion that this paragraph highlights the need for all those involved in the discharge process, for example, the Government decision makers, CCGs, Local Authorities and providers, to consider carefully how to manage the process and to keep people safe.

11.9 There is a difference of opinion between the agencies involved in the review panel in relation to their overall roles and responsibilities. All agencies reference the difficulties with constantly changing guidance and policy, but Amicura Limited have maintained throughout the review that they felt under pressure to accept the number of residents that they did, and that they were attempting to assist and do their best in the national emergency. The review panel have been clear that despite the uniquely challenging circumstances, the responsibility for all organisations including providers was to safeguard the individuals they were caring for.

11.10 The "March Discharge Policy" is clearly referenced within this review and evidence provided has shown how the information was disseminated from the Local Resilience Forum, Strategic Co-ordinating Group, through specific cells and onto providers.

11.11 It is less clear how the guidance relating to admissions and care of patients published on 2nd April 2022 was disseminated and implemented locally. The purpose of the admissions guidance states that it is designed to ensure that care homes had the right information to safely admit and care for patients. The guidance states that some of the patients may have Covid and may be symptomatic or asymptomatic, and it outlines that where a newly admitted resident is not displaying any symptoms, they could be cared for in the normal way. The guidance provided for symptomatic individuals was that they were to be isolated for 14 days. Where more than one case was evident there is also guidance and suggestions around the cohorting of various groups to prevent the spread of the virus. The cohorting suggestion relates to both residents and staff.

11.12 Amicura Limited state that all guidance received by the company was dealt with by the Directors who then circulated it to the area managers and the care home managers to implement. They relied upon the oversight of the individual care home managers to ensure that guidance was appropriately adhered to and senior managers state that as far as they were aware, patients arriving at the care homes were being isolated.

11.13 The question of whether the inclusion of guidance, from the Government and national health bodies in relation to asymptomatic patients would have made a difference to the implementation of the admission process and to the overall care of individuals is important. Clearer advice around the potential for implementing quarantine arrangements for new residents may well have made a difference to how the virus was transmitted between existing residents, new residents and staff.

11.14 However, what also has to be acknowledged is that this route of transmission is not the only way in which the virus was spread. A recent study published in May 2022 "Consensus statement on the association between the discharge of patients from hospital and Covid in care homes"[17] suggests that the discharge of patients from hospital to care homes was not the dominant way in which the virus was spread. It outlines other routes such as core staff within the care home, visiting professionals, new community admissions and other visitors as suggested routes of infection.

11.15 The final decision on whether to admit new residents to a care home lies with the registered manager and their assessment of whether the care home can meet the needs of that individual. The Registered Manager could have refused to take new residents at any stage and further evidence provided by CHS does detail that the care home refused to admit four patients following assessment of their PDNA. It has been unfortunate that the Registered Manager has not engaged with this review as it would have been beneficial to understand her decision making in respect of the number of new residents the home did admit. The Judgment specifically states "We have therefore had to keep in mind that the Defendants had the power of persuasion and guidance in relation to care homes, but not of compulsion. In particular they had no power in law to require care homes to admit patients nor to require them to remain open" (Paragraph 146) indicating that there was no pressure put onto care homes to accept patients being discharged from hospitals but Amicura Limited suggest this was not the case.

11.16 Despite a failure of guidance and advice being provided by the Government in relation to the asymptomatic transmission of the virus, the underpinning principles contained within the Care Act 2014, and the CQC Framework meant there was no change to what was required of providers. The well-being and safety of individuals who clearly needed care and support should have remained central to the service being provided. Likewise, there is also a responsibility on the provider, registered manager and the wider system to seek the necessary support when it is required.

11.17 In addition, Amicura Limited stated that they understand that all new admissions were isolated upon admission so the issue around difference in approach concerning asymptomatic patients doesn't appear to be relevant to the care home. However, from the practitioners' event it is clear that there is a discrepancy around whether isolation did in fact take place. Amicura Limited highlight that newly discharged patients to the care home were clearly also exposed to the same members of staff as existing residents at a time when obtaining PPE was problematic and barrier nursing difficult.

Learning

11.18 The impact of new policies and guidance should be considered by both strategic leaders and practitioners alike, to ensure as far as possible, that likely consequences are identified and therefore mitigating actions can be taken. Whilst achieving the aim of increasing the available bed space within hospitals, the impact placed on providers was significant and was not recognised sufficiently.

11.19 Registered managers of care homes should feel confident and be supported in their decision-making by both their own organisation and commissioning bodies to be able to make appropriate decisions relating to the admission of residents and also to seek assistance from other organisations when the care home needs support.

11.20 Senior managers within Amicura Limited relied upon their registered managers and area managers to implement relevant policies and guidance. It is important that the implementation of any new policy or guidance is monitored and there is an appropriate procedure in place to ensure that it is being adhered to.

[17] Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes - GOV.UK (www.gov.uk)

12. Infection prevention control arrangements

12.1 The role of Public Health in respect of the Covid pandemic is at the heart of the national response. Local Public Health teams ensured sufficient Personal Protective Equipment (PPE) was received by care homes, that specific advice and guidance was available and that essential services were reconfigured to remain operational.

12.2 The responsibility for infection protection control within care homes falls to the registered manager.

12.3 In terms of guidance and policy developed by Amicura Limited a number of documents have been provided which relate to the response to the pandemic including a coronavirus contingency plan, a detailed risk assessment dated 17th March 2020, a Covid management policy for care homes and a recovery plan.

12.4 Within the Covid contingency plan and risk assessment from Amicura Limited there is a clear direction that "Service users being discharged from hospital should be assessed and treated as an isolation case for 14 days to ensure no symptoms appear". Amicura Limited's response for this review also specifically stated that quarantine and isolation was implemented in line with Government advice. A specific example is provided within their response indicating that a newly admitted resident became symptomatic on 20th March 2020, advice from a GP was sought and the patient was isolated, however sadly passed away on 27th March 2020.

12.5 In the associated risk assessment, information details the required action should a resident develop symptoms including reporting to the Local Authority, reporting to the 111 number and informing CQC.

12.6 Amicura Limited state that on 18th March 2020 they received an email from the Local Authority providing offers of support, asking homes to work together and stating they were looking to source additional PPE. The information also indicated that care home staff did not need to wear PPE if the resident was not showing symptoms of Covid-19 which was in line with the national policy at that time.

12.7 They also reported that on 27th March 2020 they received information from the Local Authority and the CCG that indicated that routine testing of patients upon discharge from hospital was not required, again this was the national guidance.

12.8 Information gathered from the practitioners' learning event is contrary to that provided in Amicura Limited's response and suggests that the basic foundations of effective Infection Prevention Control (IPC) at the care home were not in place and this was exacerbated by the additional new residents. Agency staff who attended the practitioners event said that they were very anxious at this time and whilst it was not identified who had told them, they understood that all new residents being admitted to the care home would have been tested for Covid-19 prior to leaving hospital.

12.9 Despite Amicura Limited reporting that they implemented a policy of isolating new admissions practitioners reported that this was not the case and due to the health conditions of some of the residents they were unable to prevent residents "wandering" and moving from room to room within the care home. It is the view of the practitioners who attended the learning event, that there simply were not enough staff to be able to manage this situation and that this aspect was not pursued by managers.

12.10 Agency staff who attended the practitioners learning event also reported that as well as poor IPC there was a lack of basic equipment, and they gave examples of a lack of thermometers and blood sugar monitors. Specifically on 24th March 2020 a safeguarding report was made following attendance at the care home by EMAS in relation to a resident who was unwell and hypoglycaemic. The report stated that the blood sugar monitor was broken. Evidence from the safeguarding report indicates that enquiries by the Registered Manager revealed that the monitor only required its batteries changing and another monitor was available within the home. The agency nurse did not seek assistance at the time. On 17th April 2020, a safeguarding report was again made in respect of EMAS attendance at the care home and related to a patient with a blocked catheter. The report stated that there were no other catheters available in the home and that a PAT slide (patient transfer slide) was broken. The CQC made contact with the Registered Manager to discuss these and she was able to provide an update.

12.11 According to the agency staff, PPE within the home was also limited and they reported having only one face mask per shift along with an apron and gloves. A request for more face masks was made via email to the Local Authority by the care home's Registered Manager on 6th April 2020.

12.12 During the early stages of the pandemic guidance was issued by the Government on 25th February 2020[18], informing the social and community care sector that in general terms the use of PPE was not required and good hygiene would suffice. Facemasks were only recommended to be worn by infected individuals when advised by a healthcare worker to reduce the risk of transmitting the infection to other people. It continued to say that "it remains very unlikely that people receiving care in a care home or the community will become infected". This guidance was withdrawn on 13th March 2020. It is recognised that at this time guidance was at points being updated, and there were some shortages of PPE nationally.

12.13 Amicura Limited state that once guidance was updated around the use of PPE the management sourced their own PPE and that there were no shortages.

12.14 Public Health Northamptonshire, in conjunction with the CCG, the Local Authority and CQC, held regular multi-disciplinary team meetings to discuss outbreaks of Covid-19 within Northamptonshire. They commenced visiting care homes to provide training in "donning and doffing" PPE in the correct manner and to assist in developing the testing regime once implemented. It was acknowledged however, that there was a gap in the support given by Public Health Northamptonshire in the early weeks of the pandemic which is reflected in the timeline associated with the care home.

12.15 The CCG state that on 3rd April 2020 the care home contacted them to request further face masks. The record states that the care home did not require anything further and did not require any IPC advice. There is a further email exchange between the care home's Registered Manager and a member of the Local Authority Quality Team on 6th April 2020 where more face masks were requested and the manager reported that they had one confirmed case of Covid-19 and a number of residents who were symptomatic.

12.16 IPC training was not delivered to staff within the care home until 29th April 2020 following intervention from the QINs on 20th April 2020 and the support of a deputy manager from another of Minster Group care homes.

Analysis

12.17 It is accepted that guidance around the wearing and use of PPE was constantly changing, and public health staff regularly disseminated the updated information through the LRF system to providers. They were also heavily involved in sourcing and delivering PPE to many locations and providing necessary training. Whilst there was a reported shortage of PPE in January/February 2020, Public Health in Northamptonshire spent £2 million on purchasing necessary equipment.

12.18 Access to PPE was available through an on-line portal, a help line and through a generic email address within the LRF.

12.19 Amicura Limited told the review that there was difficulty in obtaining PPE and whilst they were aware of how to make requests for more supplies, they also sourced their own equipment too.

12.20 Guidance around effective IPC has been in existence for a substantial amount of time and there are a multitude of documents and guidance for care homes and staff to use. However, clearly the understanding of the spread of Covid 19 was developing all the time.

12.21 Routine testing for care home staff and patients leaving hospital was not in place until 20th April 2020, but Northamptonshire was one of the first areas to commence the testing.

[18] [Withdrawn] Guidance for social or community care and residential settings on COVID-19 - GOV.UK (www.gov.uk)

12.22 Guidance was issued by the British Geriatrics Society[19] on 25th March 2020 in relation to managing the pandemic in care homes for older people and provides a wealth of information relating to infection control, admissions, testing, visiting etc. The original guidance suggests that care home staff become trained to monitor residents' vital signs and provides advice that the symptoms of Covid 19 may present atypically in older residents. The guidance advised around developing standard operating procedures for residents who "wander" and also the cohorting of residents in the event of an outbreak.

12.23 Managing isolation with patients suffering from dementia is a difficult task and was again an area which saw developing guidance as the response to the pandemic continued. People with dementia may well have found the change of situation extremely frightening and difficult to understand. The challenge for care home settings was to develop a range of strategies for helping to minimise the risk. The type of risk also differs depending upon the Covid-19 status of the resident and clearly social interaction and "wandering" increases the risk of spreading infection. The consideration for care homes was to understand that their establishment is also the resident's home. The legality of any hard, physical restraint was also a difficult balancing act for providers to consider.

12.24 Information from practitioners was clear that the IPC measures were not sufficiently embedded and that despite guidance issued by senior management and their assertion that appropriate measures were in place this was clearly not adhered to. With a lack of oversight and checking from senior managers that their directions had been implemented the evidence suggests that there was no control over the spread of infection within the care home. Steps to rectify this were taken when the care home was supported by additional staff and a manager towards the end of April 2020.

Learning

12.25 Multi-disciplinary meetings in relation to notifiable outbreaks of Covid-19 were good practice and delivered the necessary responses to assist in many locations not just care home settings. Learning from outbreaks and appropriate responses should be disseminated to all health and care settings.

12.26 Effective IPC must form part of embedding a culture of safety throughout care homes in general with appropriate training for staff and regular updating of current practice. Familiarising all staff (including agency staff) with correct procedures and use of PPE is essential.

12.27 Current and relevant risk assessments are needed to ensure the safety of residents, staff and visitor and effective communication with families and residents about IPC measures is also important.

12.28 However, policy and guidance forms only part of the response to ensuring IPC is embedded, and the operational delivery is a key area for the senior management of providers to ensure it is actually happening.

12.29 Sound IPC measures are not only relevant to a pandemic such as Covid-19 but can be necessary in relation to many other transmittable diseases. Building the requirement to have effective IPC measures in place into all contracts and ensuring an annual compliance test could help raise the importance of such measures.

12.30 Care homes would also be wise to ensure within their contingency planning that they have an effective outbreak planning assessment to ensure that measures are put into place quickly and staff are clear about roles and responsibilities. The CQC Guidance for providers gives a detailed list of questions that can be used to assess whether the providers IPC arrangements are effective.

13. Guidance, support, management oversight and grip

13.1 The first Strategic Co-ordinating Group[20] of the LRF met by teleconference on 3rd March 2020 and during the initial weeks the Local Authority set up a "Provider Hub" which was resourced on a daily basis for 12 hours. Its purpose was to support and provide guidance to all care providers and had representatives from the Local Authority, CCG, GPs and IPC. In addition, a care home cell with similar representation met twice weekly.

[19] COVID-19: Managing the COVID-19 pandemic in care homes | British Geriatrics Society (bgs.org.uk) Published June 2020 – for the March guidance please contact the NSAB office for document

[20] A Strategic Co-ordinating Group takes overall responsibility for the multi-agency management of the emergency and establishes the policy and strategic framework within which lower levels of command will operate.

13.2 On 18th March 2020, the Local Authority sent out a communication to all providers requesting that care homes develop collaborative relationships to support each other where necessary and providing clear information about how providers could contact the Local Authority Adult Social Services. They updated providers about the Provider Hub and requested that all social care providers should immediately contact the Provider Hub with any business-critical issues that impacted upon their ability to maintain care delivery.

13.3 Providers were also asked to send their business continuity plans into the Provider Hub which would then be assessed by the Local Authority Quality Team. The Provider Hub did not receive a business continuity plan from the care home but did receive one from the other three Minster Care Group care homes within the county. The document sent out by the Local Authority on 18th March 2020 gave information about what providers should do if residents or staff displayed symptoms of Covid 19 and referred them to the latest Government guidance.

13.4 "Bite-sized" briefings were developed by the Provider Hub commencing on 30th March 2020 and circulated all up-to-date information that was available. The first briefing clearly outlined the requirement for the notification of Covid-19 where two or more cases were suspected and provided the telephone number to use. Briefings were circulated on average three times per week.

13.5 Contact with the care homes directly has been more difficult to evidence and whilst it was suggested that weekly telephone calls were made to all homes, this cannot be verified for the care home.

13.6 All the GP practices local to the care home continued to support their registered patients within the care home as the first wave of the pandemic commenced and on 22nd April 2020 the practice with the largest number of patients at the home assessed 19 of its patients via a virtual ward round. The practice stated that it maintained medicine management process, oversight of patient care, gave the home a direct telephone number to contact and continued to carry out face to face visits when required.

13.7 On 5th March 2020 Amicura Limited circulated their own contingency plan and guidance for staff. They also provided further information over subsequent days to their staff via email including guidance around non-essential visitors, employee fact sheet, risk assessment for exposure to Covid-19, a separate recovery plan, policy and procedure, and the Government Covid action plan. The care home began the process of restricting all non-essential visitors from 11th March 2020.

13.8 Within the separate Covid-19 recovery plan Amicura Limited set out a number of procedures that should be activated during a pandemic and detail that a Coronavirus Pandemic Crisis management team would be deployed which would include representatives from throughout the company who would be expected to demonstrate leadership and make operational and business decisions.

13.9 Contact was made with the care home on 28th March 2020 by one of the CCG QINs to check that the home had the information to report suspected Covid cases. It was reported to the QIN that there was one resident with symptoms but none of the staff. All residents were reported to be self-isolating. They reported no problems with access to PPE at that time.

13.10 On 3rd April 2020 the Registered Manager emailed the CCG's Covid 19 email address and reported that one resident had been transferred to KGH with suspected Covid 19 and that two other residents had increased temperatures. She also informed them that the home were down to five face masks and she had requested more. This email was actioned by the Strategic Co-ordinating Centre and a call was made to the care home on the same day to provide the care home with additional face masks .

13.11 On the morning of 6th April 2020 the Registered Manager emailed the Local Authority to inform them that a resident admitted to KGH had tested positive for Covid 19, three other residents had been admitted to hospital over the weekend and sadly one had passed away. The Local Authority responded the same day to say that Public Health were responsible for the Covid 19 notifications but did not provide any direction as to whose responsibility it was to provide them with that information. In the afternoon of the same day the Registered Manager emailed the CCG's Covid 19 email address and provided similar information stating that the resident admitted previously to KGH had tested positive for Covid 19 and that there were a "number" of other residents who were symptomatic.

13.12 Between 6th and 9th April 2020, it is known that a number of staff from the care home became symptomatic with Covid-19 and began to isolate. On 9th April 2020, the Registered Manager became ill and also began isolating. She informed Care Home Selection that the care home would not accept any new residents.

13.13 There is no evidenced contact between the care home and either the Provider Hub, the Local Authority or CCG from 6th April to 20th April 2020.

13.14 There is also no evidence of contact between the Area Manager, Operations Manager or other senior staff from Amicura Limited with the care home or the Registered Manager during this period of time.

13.15 On 20th April 2020 the deteriorating situation within the home was identified following a call to the home by one of the QINs. She was informed that the manager was off sick, the clinical lead shielding and other senior staff absent. The QIN escalated concerns to Amicura Limited's area manager and operations manager. She was informed that nursing support was awaited from one of the other care homes. Arrangements were put in place for a deputy manager to attend the care home on a daily, which commenced on 22nd April 2020. Amicura Limited state that the deputy manager began supporting the care home from 17th April 2020 and that the Operations Manager had visited the care home on 9th April 2020. Between those dates Amicura Limited say that there was regular contact with the home including by phone with the area manager, as well as email contact with various managers. No specific evidence has been provided to demonstrate direct contact with the care home in this period.

13.16 Amicura Limited reported that management cover, agency cover, and a clinical lead nurse were all in place at the home from 27th April 2020.

13.17 Training for the care home staff in IPC was arranged and delivered by the Health Protection Team on 29th April 2020.

13.18 On 30th April 2020 a QIN visited the care home and met with the deputy manager who was providing management cover for the care home. The care home at that time had 39 residents and had experienced 13 deaths, not all had been notified to the CQC as required. It was also found that not all of the residents had been registered with a GP. The QIN found that there were residents without care plans and risk assessments, residents with Covid-19 symptoms and the requirement to inform public health had not been complied with. The deputy manager's role was to provide the necessary leadership and she focused upon reviewing the needs of the residents with a clinical lead nurse.

13.19 Amicura Limited state that it was on 30th April 2020 that they sought assistance from statutory services as it was clear that the care home could not cope due to the implications of Covid-19 and admissions to the care home had been suspended on 9th April 2020 by the Registered Manager.

13.20 A shared risk management meeting took place the following day involving the CCG, the Local Authority and the care home confirmed to the CQC on 2nd May 2020 that it would voluntarily suspend any new admissions.

13.21 Between 1st May to 12th May 2020 the Local Authority, CCG and the CQC worked collectively to develop a clear action plan to drive improvement with the care home however it became apparent that the improvements were not being made and advice was not being acted upon. The CCG had developed the concept of a Health Tactical Team, and this was deployed into the care home on 3rd May 2020 as it was apparent that there was a need for clinical oversight to increase quality and safety. The individuals forming the team stated that their role was one of support to the care home and not to take over the day-to-day management of the service. An initial movement of ten residents from the care home was made due to the individuals being clinically unwell and following a decision on 11th May 2020 the remaining residents were also moved to other accommodation.

Analysis

13.22 In terms of support and guidance provided to the care home at the commencement of the pandemic and as the emergency structures developed under the LRF, there was clear guidance available in respect of contact with the Provider Hub, regular updates and information. It is accepted that guidance provided centrally from the Government departments was frequently changing as understanding of the virus grew and the guidance developed. The provider hub reported that it was a huge task to deal with the influx of emails on a daily basis and disseminate the information out to providers.

13.23 The terms of reference for the Provider Hub identify that the overall aim of the cell was to provide a tactical response to and on behalf of the Local Authority and CCG to Adult Community Providers, including the provision and commissioning of care services due to Service Disruption and to enable the continued service delivery by Care Providers to vulnerable adults.

13.24 The membership of the cell included representatives from the Local Authority's Quality and Commissioning Team and the CCG Quality Team. What is not evident is the role played by care providers or their care association within the LRF emergency response structure. Identified within a rapid SAR into similar circumstances within another Local Authority area it was commented upon that it was unclear what role care providers had in an emergency situation and suggested that theirs was a somewhat passive role where they could not influence decisions. The membership of the Provider Hub supports this view with only statutory partners input to the local decision making or consideration of the impact of national and local policies.

13.25 The Provider Hub requested that service providers shared their business continuity plans with them and whilst they received some documents, the care home plan was not one of them. The Provider Hub recognised that the maintenance of a risk register and acting as a central point of contact for the risk assessment of providers was a key part of their role, enabling them to make appropriate interventions when necessary. However, this cannot be achieved effectively without the best information available, and this was not helped by the under-reporting of suspected Covid-19 cases and deaths from the care home.

13.26 Whether the business continuity plans in relation to care homes were robust enough, whether they were sufficiently prepared and whether there were areas that were not sufficiently covered would be difficult to ascertain across such a large number of services and in a short space of time.

13.27 Weekly calls from the Provider Hub to care homes cannot be evidenced.

13.28 Email exchanges provided for the review by Amicura Limited indicate that the Registered Manager requested additional face masks on 3rd April 2020 and again on 6th April 2020. Between 3rd and 6th April 2020, she notified the CCG and Local Authority that the home had one confirmed case of Covid-19, and three further residents had been admitted to hospital. There is no evidence that the Registered Manager requested any other support. She contacted CHS on 9th April to report that she would not accept any new residents.

13.29 There were missed opportunities between 3rd and 9th April 2020 to identify that the home may have been experiencing some difficulties and for the Covid 19 emergency response system to take supportive action sooner. After 9th April 2020 there was no further contact from statutory partners with the care home until 20th April 2020 and no suspected cases or deaths reported. The definition of a Covid 19 "outbreak" required two confirmed cases within a 14 day period and whilst the care home did not say they had this level of cases, the status of the three residents transferred to hospital was unknown. An enquiry with the care home could have triggered a response or at least clarified the situation.

13.30 Support from a community health perspective involved the use of technology over time involving video consultation and virtual ward rounds carried out by one GP surgery commencing on 22nd April 2020. Contact during the first few weeks following the commencement of the national lockdown was mainly via the telephone, face to face contact was maintained where necessary.

13.31 A virtual community health model was developed and a draft document outlining its aims has been provided for the review. However, this was not developed until sometime after 20th April 2020.

13.32 As part of the NHS Long Term Plan the "Enhanced Health in Care Homes"[21] (EHCH) framework sets the minimum standards expected and is a detailed guide for registered managers ensuring they are aware of all the arrangements that should be in place. This framework is being rolled out between 2020-2024 and whilst not implemented in Northamptonshire at the time of this review it is currently being developed within Northamptonshire. It aims to provide a much more co-ordinated and personalised approach to caring for residents in care homes. The residents within the care home were registered with a number of different GP surgeries and some were simply not registered at all when they were initially admitted. The responsibility for registering residents with local GPs lies with the care home.

13.33 In brief the EHCH framework to support care homes includes:

1. Care homes being aligned to a Primary Care Network
2. Having a named clinical lead
3. Weekly "home rounds" for prioritised residents
4. Within 7 days of admission/re-admission residents should have a person-centred holistic health assessment
5. Within 7 days pf admission/re-admission residents should have a personalised care and support plan in place
6. Prioritisation of care home residents who would benefit from structured medication reviews

13.34 The senior management team responsible for the delivery of service through Minster Care Group and Amicura Limited had a vital role in ensuring that even under emergency pressures they were able to manage an appropriate and safe service for their residents. In particular the "nominated individual" who is a senior representative within the organisation must oversee all regulated activity, ensure the service is run well and safely, that it is compliant with all standards and is managed and has the right resources.

13.35 Part of any effective organisation will involve business continuity planning that outlines how it will continue to provide a service and will continue to operate during any unplanned disruption. Amicura Limited have provided the review with a detailed contingency plan which covers a number of different scenarios but as important as developing plans is the opportunity to test those plans and to identify any specific weaknesses. It is clear from the circumstances that developed that the contingency plan did not operate effectively in the care home, particularly in terms of IPC, resourcing and senior oversight.

13.36 The senior management team were not aware of the support available through the Provider Hub and were surprised that the Registered Manager had not sought assistance or help sooner.

13.37 The structure of management support within Minster Care Group and Amicura Limited was lean, with two senior managers (Director & Operations Manager) responsible for oversight of approximately 80 services. They were supported by 10-12 area managers, a governance manager, business development director and other Head Office staff, but it is the author's opinion that as the effects of the pandemic took hold, the ability of the senior director and operations manager to maintain a high-level view of services was compromised. It is acknowledged that senior managers found themselves providing hands on nursing care within other care homes in the group, whilst also trying to maintain that strategic oversight to deliver a safe service. The learning for all provider organisations must be to ensure a management structure that is able to flex and adapt even in emergency situations. Many organisations re-organised staffing structures ensuring their critical business areas were protected, however effective business continuity also requires senior management and oversight.

13.38 Ultimately it is the provider's responsibility to ensure that through appropriate planning and testing their service can remain operating safely. They did not have the appropriate level of oversight and management of this deteriorating situation.

[21] NHS England » Enhanced Health in Care Homes Framework

Learning

13.39 The health and social care providers, which includes residential care homes, in the County were key stakeholders in the development of the response to the Covid-19 pandemic in Northamptonshire. They had no direct input to the LRF or opportunity to influence local policy decisions or flag potential issues.

13.40 In reviewing the County emergency procedures consideration should be given to involving care providers as key partners in the LRF structure with provider representation at tactical and strategic level. Whilst there were weekly provider forums, there was no evidence of a care association representative or other nominated representative within the LRF arrangements which could lead to more effective communications, a better early warning system and identification of risk

13.41 Good practice identified in various areas throughout the country would suggest that proactive and regular telephone calls/video calls to care homes is essential and in some Local Authority areas calls were made on a daily basis. The CCG's Chief Nurse and Quality Officer held twice weekly Teams forums during the pandemic for all care home and domiciliary providers to support them and offer an opportunity to discuss issues and help with process, however there is no evidence to show that the care home accessed these sessions. Monitoring the uptake of this support may also provide a useful indicator and prompt further action and reach out from the statutory partners.

13.42 Proactive senior management within care homes is essential to the safety and quality for residents. It should be a key area for all providers to update their business continuity plans and processes through learning from the pandemic and from reviews such as this.

13.43 The overall governance and structure of a provider should form part of the assessment criteria, regulatory oversight and contract management processes to identify whether a management structure is too lean to be effective.

13.44 Inspection of providers business continuity plans and processes should form part of the regulatory and quality monitoring system to ensure that providers understand their obligations and are as prepared as possible to meet foreseeable challenges.

13.45 Developing the provision of health care through the "Enhanced Health in Care Homes" framework will provide a more person-centred approach to the needs of all residents, together with clinical support to Care Home Managers, nursing and care staff and a more proactive service if care homes are aligned with Primary Care Networks.

14. Quality of care and culture

14.1 The CQC set out clearly what individuals should expect from a good care home and use this as a basis for their inspection. Included in their safety standard are a number of points including that the care home and any equipment are well maintained, there are always enough staff on duty with the skills needed to make sure residents feel safe, residents are regularly asked about choices and views and that the staff have the right knowledge, qualifications and skills to carry out their role so that you have a good quality of life[22].

14.2 This theme examines:

1. Whether partner agencies had sufficient information about the individuals/residents concerned to be able to meet their individual needs effectively, if not what barriers stopped this from occurring?
2. Were there any barriers between or within agencies that affected the care provided to residents?

14.3 When the deteriorating situation within the care home came to light many of the aspects identified within the CQCs standards appear to have been absent.

[22] The fundamental standards | Care Quality Commission (cqc.org.uk)

14.4 Prior to the pandemic the experiences of families indicated a perceived change in approach within the care home and the feeling that it had become more of a business than a home. Concerns were also voiced around the lack of activities for residents, and the apparent lack of choice in food preferences.

14.5 A lack of attention to basic personal care and poor standards of hygiene within residents' rooms and bathrooms was reported to the author by several of the residents' families and these issues were apparent prior to the pandemic. The author has not looked into specific complaints from the residents or relatives nor sought evidence to substantiate this or otherwise.

14.6 The review benefitted significantly from the input of several agency staff and employed staff who had first-hand experience of having worked for a significant period of time within the care home.

14.7 The agency staff who attended the practitioners' learning event reported that they had not been allowed access to residents' care plans which were locked away in the (manager's) office. They relied heavily on daily notes to be able to care as best as possible for their residents. The agency staff said that they had challenged this situation with "management" informing them that they would be in breach of regulations if ever they were inspected and the plans were not readily available. They stated that they reported this to the deputy manager who covered the home during the Registered Manager's absence and also to their own agency.

14.8 In their inspection report of 12th May 2020, the CQC made comment about access to residents' records. They stated "*At this inspection people were at risk of harm as the systems to manage people's risks was ineffective. People's care plans and risk assessments were not always available for staff to refer to and the information in their care plans did not always reflect their current needs. Staff did not have up to date information about people's risk of falls, how to manage moving and handling, use of bed rails, pressure relieving equipment and people's current health status*[23]*.*

14.9 The regulations and guidance that accompany Regulation 17 state that records relating to people's treatment and care are accessible to authorised people as necessary in order to deliver care and treatment in a way that meets their needs and keeps them safe.

14.10 They also state that they highlighted issues where some of the residents were running out of medication and they had taken it upon themselves to contact the residents' GP to obtain more. It was reported by the agency staff (employed to work in the care home by Amicura Ltd) attending the learning event, that they were reprimanded as a result, but it cannot be ascertained by whom. It has been established that on 24th April 2020, an agency nurse did make contact with Out of hours emergency care) to request medication for five of the care home residents as their medication had run out.

14.11 They said that they felt that they were not listened to by the management within the care home and one stated that the Registered Manager had said to her that she had been recruited "to fill up the home".

14.12 Training of staff featured within at least one of the care home's action plans and the new manager was reported as being committed to ensuring that a training needs analysis was completed and that a new personal development/reporting process should be introduced.

14.13 Following the intervention of the CCG QIN on 30th April 2020 activity to support the home was increased. However, the issues found within the home indicate a failure to provide basic care to residents.

14.14 At that time the care home had 39 residents but a low number of staff. There had been 13 deaths of residents and nine had not been notified to the CQC and neither had notification of the Covid outbreaks been notified to Public Health Northamptonshire. In terms of the residents' care on 30th April 2020 the QIN reported there was again a lack of risk assessments, either no care plans or care plans not updated, food and fluid charts not completed, gaps in repositioning charts, no records of catheter changes, pressure wounds not appropriately treated and no mental capacity assessments or best interest decisions records.

[23] https://www.cqc.org.uk/location/1-8163675835/reports

14.15 There is a requirement in law for the providers of care services to notify the CQC of the death of a person accessing their service. The data is used by the Office for National Statistics[24] and from that information is it apparent that since 2016 the number of deaths of people in general terms has remained consistent until 2020. Between 2016 and 2019 the number of deaths overall has been recorded at around 45,000 people each year across the East Midlands. Residents of care homes made up 16.5% (male) and 26.2% (female) of that total number. However, in 2020 the total number of deaths recorded rose to 52,056 but the percentage of those deaths which occurred within a care home setting remained very similar – 16.8% male and 28.3% female.

14.16 Excess deaths in care home residents are obtained by comparing the number of deaths from all causes with the average number of deaths over five years and gives a clear understanding nationally of the impact of the pandemic on care homes. Nationally there were 35,067 excess deaths in March and April 2020 and 6331 in the week ending 24 April 2020. Comparison of data locally to Northamptonshire is complicated by the realignment of the Local Authority areas, however basic data would suggest a significant increase in the deaths of care home residents in 2020 but that Northamptonshire is not an outlier nationally.

14.17 On 2nd May 2020 it was further highlighted that four of the residents had become hypothermic, which had not been discovered as their temperatures were not being regularly checked by staff.

14.18 Personal accounts from staff who went into the care home as a Health tactical team shortly after this are distressing and harrowing. They recounted that some residents were found in wet beds within minimal clothing. Even those who could manage to drink for themselves had no access to fluids.

14.19 Amicura Limited's senior staff who had taken over the management of the care home said that the intervention by the Health tactical team was chaotic and their purpose poorly communicated. Care Home staff attempting to rectify the situation within the care home perceived that they were not given sufficient time to make any improvement and there was a sense that they were not encouraged to succeed.

14.20 One of the nurses from the Health tactical team explained that this was the first time the team had been deployed into a very challenging situation. She said that the compassion and care had gone out of the building and an example she provided was that on VE Day there were no celebrations, and the residents were fed with chicken nuggets.

Analysis

14.21 What stopped the residents at the care home from receiving the best of care, maintaining their dignity and feeling safe?

14.22 Many of the existing residents at the care home were frail and suffered from dementia, therefore doubling the capacity at the home in around two weeks appears to have put a significant strain on the existing staff resulting in their inability to provide basic care. However, the basic provision of nutrition, hydration and personal care had all featured in action plans prior to the pandemic hence there is likely to be a pre-disposition to similar issues re-occurring.

14.23 Amicura Limited state that when the Registered Manager began self-isolating due to her own illness and the senior staff from the home also began isolating the situation deteriorated. There was no structure in the care home and help wasn't requested. However, there are a number of factors in the author's opinion that led to residents suffering harm.

14.24 The registered manager's role within a care home is significant in terms of setting culture, standards and expectations. Without the benefit of her input, it cannot be established how well she was supported within this role and what was in reality a relatively new role to her. There are indications from agency staff that certain aspects of the care home's management made doing their job extremely difficult and they felt unable to raise issues with the more senior staff.

[24] Excess deaths in England and Wales, 2020: Final - Office for National Statistics (ons.gov.uk)

14.25 Having an adequate number of appropriately trained staff on duty to deliver a high level of care is not defined by regulation. The CQC guidance states "Providers must deploy sufficiently qualified, competent, skilled and experienced staff to make sure that they can meet peoples care and treatment needs and therefore meet the requirements of Section 2 of these regulations".

14.26 The resourcing of the care home was considered in some detail as part of the review to identify the levels of staff available against new admissions. The information provided by Amicura Limited covered a period of time between 1st March 2020 to when the home closed on 12th May 2020.

14.27 On average the number of agency staff on duty represented approximately 30% of the total workforce, which does not correlate with the recollections of the agency staff themselves. They believe that agency staff fulfilled a greater capacity than that actually reported.

14.28 The numbers of staff on duty at any one time varies from as low as 6 members of staff to 16 during a day shift and on night shifts from 3 to 7 members of staff. These numbers include a mix of skills and experience with nurses and carers.

14.29 The care home had its greatest number of residents on 4th April 2020, with 52 residents recorded as being present. 14 staff were on duty during the daytime and 5 overnight. Information would suggest that in pre-pandemic times a ratio of 5/6 residents to one member of staff during the daytime would be standard and dropping to 5/6 staff on duty overnight.

14.30 Most providers will use an approach of matching staffing levels according to the levels of dependency of the residents within their care home and a systematic approach to identifying each resident's level of need e.g., in terms of personal care, eating, changing positions, moving and handling etc.

14.31 Amicura Limited told the review that their staffing levels were maintained to care for the full 54 bed capacity of the home and they used a predictive tool to help assess residents' needs, but did not provide it for the purposes of this review.

14.32 The training of employed staff and agency staff is also key to ensuring that the most appropriate level of care is provided. Details of the care home's staff induction were provided for the review which is a comprehensive document and sets out clearly all mandatory training. Examples of the agency staff competency framework were also provided and again clearly sets out the training the staff members has completed prior to them being employed within the home.

14.33 The information available suggests that there was an overreliance on the use of agency staff and an inconsistency of staffing that made meaningful communications with families very difficult to achieve, along with a lack of awareness of resident's needs.

14.34 The reliance upon agency staff within the care home belies a more fundamental and national issue which this review highlights. The ability to recruit and retain quality staff within the sector is increasingly difficult and is clearly linked to the standard and quality of care being provided. A national Unison[25] report details the results of a survey of their members carried out late in 2021 which reported 31% of care staff saying that staffing levels were dangerously low, with 97% of care workers reporting that their employer was experiencing staff shortages with burnout, overwork and low pay. Two thirds of respondents said they were thinking of leaving the sector.

14.35 Amicura Limited accept that their communications with relatives was poor and there simply were no staff available to deal with the family contact. They have since reviewed this aspect and incorporated it into their pandemic response plans.

14.36 The Code of Conduct[26] for Healthcare support workers and adults social care workers (Skills for Care) is not a legal requirement, but it does promote best practice. It outlines how workers should behave and the associated Care Certificate describes the minimum things workers must know and be able to do. The Code contains seven standards including the accountability of workers and promoting and upholding the privacy, dignity, rights, health and well-being of people under their care.

[25] Care sector pushed to brink by staffing catastrophe | Press release | News | UNISON National

[26] Code of Conduct (skillsforcare.org.uk)

Learning

14.37 It is a provider's responsibility to ensure a good level of safe care for their residents and the culture is set by senior management and registered managers within homes. An active Registered Managers network, provider forums and the influence of local care associations can all have a significant impact upon the quality of care and gives commissioners an opportunity to engage and influence.

14.38 The NICE guidelines[27] published in 2021 identify that it is the responsibility of the registered manager to ensure that agency staff have completed the necessary training for their role and understand the local multi-agency safeguarding policy and procedure[28].

14.39 Training for agency staff should replicate that of employed staff. Care homes should assure themselves that agency staff are as well trained as their own staff and provide any additional local input, as necessary. It is a requirement under Regulation 18 from CQC that providers ensure their staff are appropriately trained, supervised and received Continuous Professional Development[29].

14.40 Adoption of the Code of Conduct for Healthcare Support Workers provides a framework for the conduct and professionalism of care workers including their accountability.

14.41 The culture within the care home as described by practitioners indicates that despite raising issues with senior staff, no action appeared to be taken. A more open, transparent and responsive culture needs to be a priority.

14.42 Amicura Limited detail within their Coronavirus contingency plan that relatives of residents could be asked to assist the care home in times of emergency. This was also suggested by one of the contributing families and could have been a very effective way of providing some basic care. However, it should be acknowledged that the Government guidance published shortly after the commencement of the first national lockdown advised that family and friends should not visit care homes except the next of kin, and in exceptional circumstances such as end of life.

14.43 Communication to relatives from the care home could and should have been better. An individual dedicated to maintaining contact with the families during the closure process would have helped their understanding significantly.

15. Safeguarding, Whistleblowing and intervention

15.1 The terms of reference specifically asked:

* *Did agencies identify safeguarding issues; did they have the appropriate safeguarding policies and procedures in place, and did they ensure effective safeguarding activity formed part of their service delivery – was it seen as 'everyone's business'?*

15.2 During the period under review there were two anonymous whistle-blowing reports made in January and February 2020 as already outlined.

15.3 On 8th January 2020 following a discussion with one of the QINs the Registered Manager at the care home made a safeguarding report after the suspension of the deputy manager who had failed to follow correct procedures in relation to the management of medication.

15.4 There were two further reports made anonymously to the CQC on 13th April and 15th April 2020. The first stated that there was a lack of continence care for residents, call bells had been removed by staff, the home was understaffed and people were leaving. Residents had unexplained bruising to their bodies and staff were not ensuring that residents were taking their medication. There were also concerns about the food and fluids being provided and a lack of utensils for eating. The CQC emailed the Registered Manager about this but received no response.

[27] Safeguarding adults in care homes (nice.org.uk)

[28] These multi-agency policies and procedures are the local adult safeguarding policy which all organisations are required to follow. Each agency and organisation operating in the area should develop their own arrangements for safeguarding to complement but not over-ride the multi-agency policy

[29] Continuing Professional Development or CPD is a self-tracker of an employee to improve professionally continuously

15.5 The second report made to the CQC on 15th April 2020 reported that staff were leaving and the home was being predominantly run by agency staff. There was concern that residents may be suffering from abuse due to the unexplained bruising seen.

15.6 Two safeguarding reports were also made by EMAS. On 3rd March 2020 EMAS made a safeguarding referral after they had experienced a resident at the care home whose behaviour was putting other residents at risk and the police had been required to attend. The referral stated that the staff at the care home were not sufficiently trained to deal with the individual.

15.7 The second referral made by EMAS was on 26th March 2020 and related to concerns they had about the knowledge and skills of staff at the care home in dealing with a resident who had a "Do Not Resuscitate" notification[30] in place.

15.8 A further safeguarding report was made by an NHS 111 member of staff on 24th March 2020 when an emergency call had been made from the care home relating to a resident who was unwell and had diabetes. The blood sugar monitor was broken and the patient hypoglycaemic. The staff were unable to check the residents blood sugar levels and the resident was not eating or drinking.

15.9 The CQC alerted the Local Authority safeguarding team to the anonymous reports received on 13th and 15th April 2020 and as further information came to light, including reports from Kettering General Hospital and from families of residents, the focus of the safeguarding investigation became an institutional safeguarding enquiry as opposed to individual cases.

15.10 Following the discovery of the deteriorating situation at the care home and the concerns raised to the CQC and Local Authority, a significant number of meetings were held between professionals involving the Local Authority (including Public Health), the CCG, the CQC and the care home's senior managers in an attempt to support the home and to assess the needs of all of the residents. The care home voluntarily suspended further admissions from 1st May 2020. The Health tactical team began to support the home from 2nd May 2020.

15.11 Two further whistleblowing reports were received by the CQC on 4th May 2020 and again related to concerns over medication, staffing levels, manual handling and equipment.

15.12 Both the CCG and CQC became concerned that despite the support being provided to the care home there was no progress being made in particular relating to clinical oversight and maintaining residents' dignity. On 6th May 2020, a decision was made to move a number of residents to alternative accommodation. The following day Amicura Limited's operations manager was asked to notify the residents families of the situation.

15.13 On 11th May 2020 a meeting of all professionals was held, and the ongoing concerns outlined and captured within the minutes of the meeting. In brief these were that the Registered Manager was not leaving her office, staff had been discovered asleep and there was an overall lack of cleanliness. It was agreed to move all residents out of the care home.

Analysis

15.14 All agencies involved in the review are required to have safeguarding and whistleblowing policies in place.

15.15 In considering the situation that staff found themselves in within the care home there are a number of barriers outlined within the NICE guidelines[31] that are relevant to this review and can prevent abuse being identified:

1. The culture within a care setting
2. Levels of transparency
3. Fear of repercussions
4. Residents' inability to communicate

[30] A do-not-resuscitate order, or DNR, is a formal medical order that a patient can establish with their doctor. A DNR dictates that the patient does not wish to receive CPR or have their heart restarted in the event that their heart stops.

[31] Safeguarding adults in care homes (nice.org.uk)

15.16 The safeguarding adult's policy provided by Amicura Limited is a generic policy which is clearly designed to have additional information included within it to provide the relevant contact details, link to multi-agency procedures and identification of the safeguarding lead. However, the document is out of date and appears to have been developed shortly after the implementation of the Care Act 2014 as it refers to the setting up of Safeguarding Adults Boards and also uses the term "vulnerable adults" which has been changed to "adults at risk".

15.17 All organisations need to have a clear safeguarding policy setting out what constitutes abuse and harm, how to respond and who to inform. This should form an essential part of staff training and needs to be clear and accessible to all members of staff, residents and their families. Amicura Limited were able to provide a policy dated 2014 relating to the induction of staff which sets out clearly the structured induction plan covering Principles of Safeguarding in health and social care and provided evidence that 30 out of 41 members of staff had completed safeguarding training in 2018 and 2019. However, it is the view of the author that the lack of a current safeguarding policy arguably indicates a lack of importance attached to the wellbeing and safety of residents.

15.18 During the period under review safeguarding referrals were made by the care home on 7th January 2020, 14th January 2020, 15th January 2020 and 20th January 2020. Amicura Limited also stated to the review that a safeguarding concern was raised by them on 3rd March 2020 in relation to a resident, although evidence from the CQC indicates this referral came from EMAS. As previously described, a safeguarding concern in relation to the apparent lack of a blood sugar monitor was raised on 24th March 2020. Amicura Limited indicate that this was also raised by the care home. Evidence provided to the author states this safeguarding concern was made by NHS staff. No further safeguarding concerns were raised until the beginning of May 2020, when the deputy manager from Cheney House had assumed responsibility for the care home.

15.19 It is the author's opinion that it is not possible to demonstrate that safeguarding was understood and embedded within the care home. Of concern is that the condition of some of the residents suggest an indifference and lack of empathy and care exhibited by those trusted to look after them.

15.20 In relation to the culture within the care home, as identified from the practitioner learning event, agency staff felt that they were not listened to and whilst they did make some reports about lack of equipment and medication, they felt nothing was done and no action taken. They also described feeling fearful that they would be seen as troublemakers and would not be employed in the future.

15.21 Amicura Limited had a whistle blowing policy, but concerns were articulated by agency staff who attended the practitioners' learning event, that they were not confident in using the provider's own process. They could also have reported concerns through their own agency but none did although some reports were made through the CQC process. All care workers have a duty to report safeguarding concerns.

15.22 In general research suggests (NICE consultation – evidence review[32]) that there is only a limited amount of confidence in whistle-blowing processes, and it was often observed that concerns raised often became stuck with a manager due to their inability or reluctance to respond. It is vital that all staff know about how to raise concerns but also that they have options. Support to individuals who do raise concerns through the whistle-blowing process should also be available. A consideration for providers would be to utilise an external whistle-blowing service or at least promote the use of other routes which include the CQC, CCG and Local Authority. These routes are signposted in Amicura Limited's policy.

15.23 The fact that care homes became a closed environment during the first wave of the pandemic meant that the standards and the quality of care within a care home were not being observed by others, including families and other visiting professionals. The fact that two whistleblowing reports made within the space of three days did lead professionals to enquiring further and with the intervention of the QIN there followed a significant period of intervention, support and safeguarding.

[32] Recommendations | Safeguarding adults in care homes | Guidance | NICE

15.24 The support and intervention provided by the CCGs Health tactical team, Community Nurses and the Local Authority was a timely and well-intentioned intervention once the problems were identified within the home. The intervention was designed to risk assess all residents and support the home in improving the standard of care. The intervention was not considered by the care home staff as always supportive.

15.25 At the time of the intervention, contact with the residents' families was lacking in detail and information. Some families said that they found out about the situation and the movement of their relative only after it had occurred and again the lack of choice was evident. There is evidence that a letter was agreed between Amicura Limited Operations Manager and Chief Nurse from the CCG which was sent out to all of the residents' families (dated 14th May 2020) The Amicura Limited Operations Manager has also stated that he personally followed up this letter with a telephone call to all of the relatives to discuss their loved one's experience and to offer apologies and condolences where appropriate. A clear, organised communications strategy could have helped this situation and begun to rebuild the trust of families.

Learning

15.26 A current safeguarding policy that is available to all staff, residents and families must be maintained by providers. Ensuring staff understand what constitutes harm and abuse and the action they must take must feature significantly in their mandatory training and be supplemented by support from statutory agencies and the safeguarding board. A useful guide for registered managers is available from SCIE.[33]

15.27 Amicura Limited are encouraged to make a commitment to update and disseminate their safeguarding policy to staff. Publishing the policy on their group website would also allow residents, families and other interested parties to have an understanding of safeguarding.

15.28 The safeguarding process should be seen as a supportive process and not adversarial. Providers should supply relevant information to safeguard adults at risk and then drive necessary improvements. The quality monitoring process used by commissioners of service should be used to identify whether the learning from safeguarding enquiries has been embedded.

15.29 Staff did use the anonymous whistle-blowing route to raise a number of concerns to CQC, which indicates a lack of confidence in the management of the home and their ability and willingness to deal with issues. Providers need to ensure they have an effective policy, which is well understood by employees and agency staff and that they place importance on developing an open and learning culture to ensure standards of care are maintained.

15.30 Information provided to the families and their involvement during the movement of residents from the care home following the intervention of the Health tactical team could have been managed in a more sympathetic way by allocating individuals from Amicura Limited and the Health tactical team to carry out this communication role.

15.31 The deployment of the Health tactical team into the care home was a new process but during the review it became apparent that there was a difference in opinion about the roles and responsibilities of the parties involved, with Amicura Limited stating that the Health tactical team was responsible for the running of the care home. This was not the understanding of the Health tactical team and the CCG have stated to the review that the tactical team strayed beyond their original remit due to residents being at risk and an emergency response was required for patient safety. They had a duty of care to the residents, professional accountability and responsibility to safeguard them. The CQC have stated to the review that the deployment of the community nurses into the care home was to implement clinical oversight, monitor people's safety and to safeguard people. The CQC state that the registered provider remains legally accountable for the running of the care home. It would be beneficial if this arrangement was documented and roles and responsibilities clearly articulated at the start of the deployment.

[33] Creating-a-safeguarding-culture.pdf (nice.org.uk)

16. What has changed?

16.1 Amicura Limited

Amicura Limited have engaged with this SAR and have completed a lessons learnt exercise themselves. They advise that the following actions have been implemented:

1. The company took immediate action to revamp its reporting structure to identify failings. A KPI structure was implemented giving better oversight of all homes. It was recognised that there was a requirement for more Head Office oversight and this led to the employment of additional staff to increase surveillance of homes and their monitoring.
2. The company is to identify "crisis managers" that can be re-located to support other homes that may be facing a significant Covid-19 outbreak (or other serious event requiring support).
3. All managers will receive training in "admissions in crisis" in future Covid-19 outbreaks and are trained how to say 'no' and work with the pressures that they may come under. Managers now report any Covid-19 outbreaks to senior management, are contacted daily and offered support including discussions on potential admissions and staffing levels.
4. Homes to identify staff that can and will move into a home to ensure its safe running during a pandemic situation. Staff from other local homes will also be put on an alert list to be contacted. The provider has identified significant agency provision to ensure that in the event of an outbreak, enough staff can be obtained.
5. The company has invested significantly in its IT network in order to ensure it remains fit for the current climate of remote working, Zoom and Teams calling. All homes have had their Wi-Fi upgraded and this now allows families to remain in contact when visiting is restricted.
6. A more robust admissions procedure developed to ensure that part of the process is making contact with the family, ensuring that any failure to do so is logged and handed over to the next shift.
7. Any resident admitted to the service is now tested prior to admission to obtain negative Covid-19 test. When admitted, residents are isolated for a period of 14 days.
8. The company has invested in better training and developed partnerships with the Local Authorities to ensure that better training of all staff is apparent. There has also been more robust management of cleaning tasks and enhanced cleaning procedures put into place. The company has invested significant sums of money on better and easier to clean / less hazardous infection control items such as vinyl flooring and furnishings.
9. The company now follows Government and local Government testing regimes. These were not available at the time of outbreak of Covid-19.
10. The company has arranged a central stock of PPE should such an outbreak arise again. However, the current support from Government and local authorities allows for the commission of such items from central and local Government. The company must be prepared for if / when that facility comes to an end.
11. Amicura Limited further advised that in terms of more general improvements they have improved IT systems – these include electronic care planning, electronic medication systems which are visible remotely by Head office. The introduction of an online policy portal to reflect up to minute information.
12. Secured the services of new providers who provide high quality training.
13. Engaged more operational staff across fewer services.
14. Employed internal quality and compliance staff as part of its internal structure. This means that the compliance role is supportive at home level to the care home manager.
15. In terms of its changes to its quality monitoring systems Amicura Limited reported that they have a monthly Key Performance Indicator monitoring system which analyses a range of indicators reported by each home at the end of each month, which is then scrutinised by the area managers and operations directors.
16. Increased staffing levels were required.
17. Developed a robust online auditing process which provides greater transparency. In addition, there is also a master action log from any audit / inspection that takes place. This enables these actions to be reported upon so that progress can be monitored across the homes.

16.2 Northamptonshire County Council (now North and West Northamptonshire Councils)

1. NCC reported that CHS were not commissioned to undertake the discharge of patients in the same way for the second wave of Covid-19.
2. During the second wave of Covid-19 the Local Authority were involved in the discharge process from the point of referral. All assessments, placements and reviews were done by the Local Authority and CHS were responsible for the placements of patients who were the responsibility of the CCG e.g. non-weight bearing patients or those under Continuing Health Care funding.
3. Joint quality boards have been strengthened to ensure that information is shared across agencies so that decisions regarding quality and safeguarding are shared and taken into account when placing people.
4. Restructure of the Commissioning, Quality and Brokerage elements of the service has drawn all these roles under one Service Manager to make sure that the quality of service is always considered at the point of sourcing care.

16.3 NHS Northamptonshire Clinical Commissioning Group (Now Northamptonshire Integrated Care Board)

1. The development of a joint risk assessment process with the local authorities, along with a strengthening of the quality monitoring meetings to include a monthly quality board, information sharing meetings and a strategic CQC meeting. Joint quality monitoring boards have been in place since 2009 but are reported to have been expanded to have a more analytical and data driven focus.
2. The recruitment of a practice facilitator to work with Northamptonshire University in arranging placements for new student nurses to experience nursing within social care.

16.4 Northampton General Hospital

1. Covid infection control guidance is more robust in terms of the testing of emergency admission patients, elective patients and in respect of regular re-testing. Training of all staff in correct PPE use, physical improvements e.g., plastic curtains between bed spaces, lateral flow testing for staff and enhanced cleaning. Inspections and audits to ensure compliance with these measures.

16.5 Care Home Selection Healthcare

1. CHS report that they are now included in the information sharing from the CCG and Local Authorities in relation to concerns around care homes and where the suspension of admissions has been commenced.
2. All patients are now tested for Covid prior to discharge as per Government guidelines issued on 15th April 2020 and the patient's Covid status has to be included in discharge papers.
3. A robust assessment plan and timescale has been developed should the need arise for a significant number of discharges being required.

16.6 Kettering General Hospital

1. Strengthened Covid testing both at point of attendance and discharge, following government guidance for testing whilst an in- patient**.**
2. Patients being discharged from KGH to a care placement have Covid testing 48 hours prior to discharge.
3. Covid results are mandatory in the discharge summary, ensuring appropriate information sharing.
4. Discharge after service, call back system for patients and care homes where the experience of discharge is monitored; one area of feedback asks if people were given their Covid status on discharge and was it accurate information.
5. Beds removed to increase the ability to social distance.

17. Conclusions

17.1 This review has examined the systems and processes in place across a number of organisations and their impact upon the safety and care of a large number of vulnerable residents, some of whom sadly died. This also took place during a time of unprecedented demand and unique events.

17.2 There was room for improvement in terms of the quality monitoring of the service provided by Amicura Limited and the care home, by the Local Authority and CCG which could have been achieved in a more joined up approach in relation to collation of all available information. This should include safeguarding concerns and soft intelligence.

17.3 Concerns in relation to the care home had been in evidence since 2019 and whilst improvements had been evidenced, there was still some inconsistency. The foundations of the service were not sufficiently established and robust when the national requirement to receive additional residents was made. The care home had a reliance on agency staff and there was a lack of effective management oversight and governance.

17.4 In respect of the care home it appears to the author that the admission of large numbers of patients in a short period of time in pursuance of the national approach to free up bed space created additional pressures for the care home. There was a lack of oversight of this process from the senior managers within Amicura Limited and within the LRF arrangements. The number and speed of discharges into the care home was inappropriate and there does not appear to have been any consideration given to the previous CQC inspection grading of "Requires Improvement" when determining the volume and specific needs or patients being discharged to the care home.

17.5 Whilst accepting that information and guidance was constantly changing, it appears to the author that the IPC arrangements within the care home were ineffectual and the Health Protection team were unaware of the numbers of infections due to a lack of reporting from the care home itself.

17.6 There was a significant amount of information and support available for care homes but their involvement in the decision-making process of the emergency response was missing. A more proactive approach from the LRF, Provider hub or Hospital Transfer cell to contact care homes on a more frequent basis may have identified the deteriorating situation earlier.

17.7 The quality of care provided to the residents was variable prior to the Covid-19 pandemic. Its significant deterioration during April/May 2020 was truly shocking and despite intervention and support from health colleagues it failed to respond and recover. Again, the oversight, governance and control by the service provider were absent. Residents within the care home were neglected and suffered significant harm as a result.

17.8 Many of the issues identified have led to change already but there is a significant national issue played out within this scenario in relation to the value of our care workers. In particular their remuneration, training and career progression. Attracting and retaining quality nurses and care workers to the industry is a significant challenge and more needs to be done to ensure that our most vulnerable people receive the care they deserve and are safe.

18. Recommendations

1. The local authorities and ICB, who are members of the Quality Monitoring Board, should provide assurance to NSAB that there is an effective system in place to identify where enhanced support and increased monitoring is required for providers that are graded as "requires improvement", "inadequate", or where there are other early warning signs or indicators poor quality and/or safety.

2. NSAB should engage with the Chair of the Local Resilience Forum and the members forming the strategic co-ordinating group, to disseminate the learning from the review to ensure that within the emergency procedures risk management process the impact of any national policy is examined against the local context and consequences are understood and closely monitored – Links to Recommendation 5.

3. The ICB and the local authorities should provide assurance to NSAB that they have arrangements within their commissioning and contract monitoring processes to ensure providers engage with the process, under any type of contract, including spot purchase provision and have effective IPC arrangements in place, not only through effective contingency planning policies but that it can be practically demonstrated by the provider.

4. Learning from the review should be disseminated to all Northamptonshire care providers and they should demonstrate learning from the pandemic and other relevant reviews by updating contingency plans. This should be monitored by the ICB and local authorities during quality and contract monitoring.

5. NSAB to seek assurance from the LRF Chair as to how the points of learning from this review will be incorporated in the development of emergency response procedures to ensure that health and social care providers are recognised as key stakeholders and included within the LRF structure.

6. The ICB, working with the local authorities, should commission a plan for introducing effective & timely EHCH arrangements and provide assurance to NSAB on the implementation within the county.

7. The CQC to consider that when a service provider is registered and inspected that the management structure of a service is assessed in relation to whether the senior management structure is appropriately resilient to ensure it is sufficiently robust to provide the necessary oversight and governance on a practical level.

8. The local authorities and the ICB should assure NSAB of their support and influence to assist care homes in developing the quality-of-service provision through engagement in any registered manager forum, provider forums, training events, or care association network.

9. NSAB will use the agreed National Network of Safeguarding Adult Board Chairs' Escalation Policy, when necessary, to raise issues through the network to the Department of Health and Social Care with specific focus upon the challenges in the recruitment and retention of quality staff, the over-reliance on agency staff to fill vacancies, and the national problem of the remuneration and working conditions of care workers leading to overall poor quality care.

10. NSAB should seek assurance through the local authorities and the ICB that commissioned service providers have current safeguarding policies in place, that are accessible to residents, staff and families and that the policy is understood and implemented.

19. Additional comment concerning Amicura Limited

Each agency involved with the review was asked to agree the report before the final report was sent to NSAB.

Amicura Limited have written to the author to express that they consider that they were not able to agree the report due to their concerns as to the approach and lack of impartiality of the review. Specifically, they have expressed the view that throughout the various drafts the presence of confirmation bias has unfortunately been increasingly obvious in responses to the comments raised by them. In addition, Amicura Limited stated that the draft retains a scepticism of the concerns reported regarding pressure being brought to accept discharges but that such scepticism is not found in relation to reported quotes in the report that are critical of the service.

The author has carefully considered all of Amicura Limited's comments throughout the review and is content that the review has been appropriately conducted.

The CQC brought a prosecution against Amicura Limited and on 23rd May 2023 Amicura Limited pleaded guilty to four charges relating to a failure to provide safe care and treatment to residents. A copy of the CQC press release in respect of this case be found here: Amicura Limited ordered to pay £200,181 after failing to provide safe care and treatment - Care Quality Commission (cqc.org.uk)

APPENDIX A

Agencies contributing to the review

Amicura Limited	Amicura Limited is a group of care homes operating in various locations within the UK and delivering services in eight care homes. Amicura Limited is a part of the Minster Care Group that own and run 68 care homes predominantly within the East Midlands, North of England and also in Wales and Cornwall. Temple Court Care Home provided nursing and care for up to 54 residents suffering from dementia, and physical disabilities for adult residents of any age.
Care Home Selection Healthcare	CHS Healthcare are commissioned by Northamptonshire CCG to provide hospital discharge support at both Northampton General, Kettering General and the counties community Hospitals. CHS have been commissioned by the CCG since December 2016 and manage specific patient cohorts and discharge pathways. Since commissioning CHS the CCG have requested CHS support different pathways and patients to aid the flow of discharges from the hospital. The discharge pathways have been both for health and social care. Temple Court was one of the local care homes that CHS have facilitated patient discharges to via the hospitals. Patients discharged to Temple Court were funded via health, social care or privately funded placements.
Care Quality Commission	The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care. It was established in 2009 and its role is to regulate and inspect health and social care services. The CQC conducted an inspection at Temple Court Care Home on 3rd May 2019 rating the service as Requires Improvement. The CQC also received whistle-blowing reports in 2020 and re-inspected the care home on 12th May 2020 resulting in a rating of Inadequate. The CQC are also currently conducting an investigation into the care received by residents at the care home.
East Midlands Ambulance Service	East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care services across the East Midlands Region. EMAS also provides Patient Transport Services for people who have routine (non-urgent) clinical appointments in Derbyshire and Northamptonshire. When a member of public calls or professional calls 999 in the East Midlands, they are first assessed by an Emergency Medical Dispatcher (EMD) in EMAS using the Advanced Medical Priority Dispatch System (AMPDS) to determine the most appropriate response for them based on clinical need. East Midlands Ambulance Service (EMAS) provided emergency 999 and urgent care services to residents at Temple Court Care home. Between 01/01/2020 and 30/05/2020 EMAS crews attended Temple Court Care home on 82 occasions following 999 calls made by staff caring for residents.
Kettering General Hospital	Kettering General Hospital provides acute care to patients within the Kettering/Northampton catchment area. The hospital has a substantial footprint in Kettering Town including an Accident and Emergency Department. Kettering General Hospital has no formal or contractual links with Temple Court Care Home other than that within the formal discharge processes and the Integrated Discharge Team. The discharges team worked with the home to facilitate discharges and support for these patients.

NHS Northamptonshire Clinical Commissioning Group (now Northamptonshire Integrated Care Board)	NHS Northamptonshire CCG fund continuing health care and therefore monitor the quality of any provider that is delivering care to a health funded client, this is inclusive of independent providers, hospitals, OOH (out of hours), urgent care centres, community provision. Temple Court had continuing health care funded clients and therefore sat within the CCG portfolio of providers. At the time of this SAR there were two Quality Improvement Nurses, reporting to the Head of Quality Improvement and onwards to the Chief Nurse and Quality Officer. The teams work closely with the Local Authority commissioning, safeguarding and quality teams; sharing provider information following review visits as well as at the monthly information meetings that are chaired by the CCG with minutes taken. The quality team provide reports with recommendations (where required) on all visits. The team will raise safeguarding notifications and where requested we will assist the Local Authority to investigate institutional clinical safeguarding within care homes. The quality team will also assist reviews, (with Local Authority agreement) of clients who have a Funded Nursing Care payment (FNC). Social care 'lead' on this particular client group given the major part of funding is from social care however there remains elements of nursing care. This is conducted under a memorandum of understanding.
North Northamptonshire Council	From the period of time covered by the SAR, Northamptonshire County Council (NCC) was the Local Authority that had statutory responsibility for safeguarding in the town where the care home was located. During this review period the Council had a contract in place with the home and would have undertaken regular reviews and monitoring visits. The information provided during this review period on behalf of the Local Authority has been split between North Northants and West Northants because NCC is now 2 separate councils.
Northampton General Hospital	Northampton General Hospital provides acute care. The Discharge Team at Northampton General Hospital assist in completing referrals following assessments with patients by Therapists and Nursing staff. Following these assessments, if a patient was identified as requiring a residential care home, this could be sourced by Care Home Select if self-funding or Adult social care and Social brokerage to source a home that could meet the individuals care needs. Northampton General Hospital would facilitate ensuring the discharge letter, tablets and transport was arranged for every Patient being discharged to any care home on the day of discharge.
Northamptonshire Healthcare Foundation Trust	Northamptonshire Healthcare Foundation Trust delivers many of the NHS services people in Northamptonshire receive in the community, at home, work, or in schools. NHFT has over 100 services including mental health, community nursing, sexual health, offender care and many other services. NHFT has approximately 4500 staff committed to delivering care as close to home as possible for patients, service users, and carers. NHFT District Nursing Team were requested to give all aspects of clinical support to Temple Court Care Home residents.

Northamptonshire Police	The local police force covering the County of Northamptonshire became involved at the request of the Local Authority following a number of deaths linked to Temple Court Care Home. The force undertook an investigation to consider whether there was any criminality or criminal culpability by any person or organisation linked to the deaths. The conclusion of this investigation was that the criminal burden for police led prosecution was not met and primacy for the investigation was then passed to the Care Quality Commission who in turn undertook to consider the matter in line with their protocols.
Public Health Northamptonshire (Part of the Local Authority, NCC)	The Public Health team of the Director of Public Health, acting on behalf of the Local Authority has an overarching duty to ensure the local health protection system works effectively. The Health Protection team plays a crucial role in leading the local response to Covid-19 incidents and outbreaks. It has been responsible for a wide range of health protection activities from ensuring adequate infection prevention and control (IPC) measures are in place to protect its population, testing in the community, to facilitating the uptake of the vaccine, to planning for the availability of wider support for local population and supporting local system with specialist public health advice. Advising on IPC, testing and vaccination support to the care homes within the county was to deliver delegated statutory responsibilities on behalf of the Local Authority.
West Northamptonshire Council	From the period of time covered by the SAR, Northamptonshire County Council (NCC) was the Local Authority that had statutory responsibility for safeguarding in the town where the care home was located. NCC had a contract with the care home for the delivery of residential care. As part of this they had at least annual quality monitoring visits and a contractual monitoring visit. The dates and detail of the interaction during the period has formed part of the information provided for the review.

APPENDIX B

Glossary

ADASS	Association of the Directors of Adult Social Services
CHC	Continuing Healthcare Funding
CHS	Care Home Selection Healthcare
CQC	Care Quality Commission
EHCH	Enhanced Healthcare for Care Homes
EMAS	East Midlands Ambulance Service
FNC	Funded Nursing Care Payment
GP	General Practitioner
HTC	Hospital Transfer Cell
ICS	Integrated Care System
IPC	Infection Prevention Control
KGH	Kettering General Hospital
KPI	Key Performance Indicator
LRF	Local Resilience Forum
NCC	Northamptonshire County Council
NGH	Northampton General Hospital
NHFT	Northamptonshire Health Foundation Trust
NICE	National Institute for Health and Care Excellence
NHSNCCG	National Health Service Northamptonshire Clinical Commissioning Group
NHSPH	National Health Service Public Health
NNC	Northamptonshire County Council
NNC	North Northamptonshire Council
NSAB	Northamptonshire Safeguarding Adults Board
ONS	Office for National Statistics
OOH	Out of Hours
PDNA	Patient Discharge Needs Assessment
PEEPS	Personal Emergency Evacuation Plan
PPE	Personal Protective Equipment
QIN	Quality Improvement Nurse
SAR	Safeguarding Adults Review
SCG	Strategic Co-ordinating Group

APPENDIX C

CHRONOLOGY INCLUDING GARDNER & HARRIS JUDGMENT		
DATE	**Event / Information**	**Source**
3 March 2020	First executive meeting - NCC set up a Provider Hub in response to the pandemic. Hub staffed with members of the Quality Team and CCG 8am-8pm 7 days per week. Available for support and guidance to all care providers. Hub linked with Public Health, CCG resilience and all other emergency services – infection control, testing and PPE.	WNC Questionnaire
5 March 2020	Amicura Ltd send email and attachments to all managers. Attachments include contingency plan for Covid 19 and guidance for information of staff. Contingency plan (undated) is from Minster Care and sets out the government response of Contain, Delay, Research and Mitigate – highlighted some people may not show symptoms. Contains a risk assessment document dated 4/3/20 – setting out basic hygiene measures.	Amicura Ltd Questionnaire
11 March 2020	The care home begins process of lockdown – reported to be Covid free at this point.	Amicura Ltd Questionnaire
12 March 2020	Amicura Ltd circulate an email and poster to all care home managers regarding visiting regarding all non-essential visitors to cease.	Amicura Ltd Questionnaire
	NGH requested CHS support with discharge planning for a large cohort of patients – classed as medically fit and requiring assessment for ongoing needs. Discussions then with NGH/KGH/CCG/NCC for CHS to support whole system.	Care Home Selection (CHS) Questionnaire
	Testing capacity UK wide 3000 per day.	Gardner & Harris Judgment
13 March 2020	COVID 19 Guidance for residential care providers PHE Policy – to LAs, CCGs, Registered providers of accommodation for people who need personal or nursing care – to support the planning and preparation in the event of an outbreak or widespread transmission. Guidance – not expected to have dedicated isolation facilities but should do so if symptomatic.	Gardner & Harris Judgment
	Joint NCC/CCG letter sent to care providers as above with advice and links to government guidance – COVID 19 Guidance for care providers. Asked providers to review and update their contingency plans specifically around staffing and those service users deemed to be at most risk. Provided links to the latest government advice and IPC advice. Noting that NCC/CCG can be the escalation point in the event that continuity resilience is severely compromised and people's needs cannot be met – however this will be confirmed.	Amicura Ltd Questionnaire
	Guidance for IPC in Healthcare settings – stated further study required regarding asymptomatic transmission.	Gardner & Harris Judgment
	Amicura Ltd send an email to care home managers containing a checklist regarding enhanced cleaning to homes.	Amicura Ltd Questionnaire
	General public told to isolate if they had symptoms.	Gardner & Harris Judgment
15 March 2020	Amicura Limited's Operations Manager circulates an email to all care home managers – Provides link to PHE Policy Covid 19 Guidance for supported living and home care in the event of a Covid 19 outbreak published 13th March 2020. Care homes not expected to have a dedicated isolation facility but should isolate residents if symptomatic. No PPE requirements. Email details some key points including not using agency staff due to risk of transmission, encouraging self- isolation of residents, use of emails/skype for relatives, Operations Manager advises he should be informed immediately of an outbreak, no visiting.	Amicura Ltd Questionnaire
	CHS to facilitate the discharge of 100 patients from this date within 2 weeks	CHS Questionnaire

DATE	Event / Information	Source
16 March 2020	SAGE modelling predicts hospital critical care capacity could be overwhelmed. Government agrees to rapid expansion of hospital and step-down capacity.	Gardner & Harris Judgment
17 March 2020	Government advice to stop all non-essential contact and travel. First death recorded in a care home setting. Document – Next step on NHS response to Covid 19 – which made up the national discharge policy.	Gardner &Harris Judgment
	Email and letter from Minster Group Operations Manager to all care home managers re Covid guidance for staff asking them to follow WHO guidance.	Amicura Ltd Questionnaire
	Email providing advice from industry group sent to care home managers within the Minster Group by Operations Manager– relating to the reporting of Covid outbreaks to CQC within 24 hours.	Amicura Ltd Questionnaire
	Covid 19 contingency plan and risk assessment developed – Links to government guidance of 13th March 2020. Note – this document has a contact number for the reporting of Covid 19 cases as a Peterborough telephone number which is incorrect.	Amicura Ltd Questionnaire
	Letter from NHSE/I to discharge fit patients from hospitals.	Amicura Ltd Questionnaire
	First Strategic Co-ordinating Group meeting held. Phase 1 of the discharge plan commenced following letter from head of NHS England	Executive meeting
18 March 2020	Email from CCG sent to providers requesting an extension of admission times in the evenings and weekends.	Amicura Ltd Questionnaire
	Email from NCC containing letter outlining current situation and requesting providers contact each other within the local community to discuss support providers can offer each other. Providers should contact Provider Hub to manage business critical capacity and continuity issues and inform NCC of additional offers of support, Business Continuity Plans requested from providers, links to government guidance reiterating no PPE if patient is not symptomatic.	Amicura Ltd Questionnaire File 8a
	First meeting of the Hospital Transfer Cell	Executive meeting
19 March 2020	Covid 19 Hospital Discharge Service Requirements published by Government. Modelling suggests that ICU capacity would be overrun by the end of March in London followed by other regions 1-2 weeks later.	Government Document Gardner & Harris Judgment
	3 patients discharged to TCCH from NGH	CHS Spreadsheet
	Email from CCG to Care Providers (Care Homes) providing death notification form.	Amicura Limited Questionnaire
	Email and letter sent by John Aflatt Minster Care Group to all care home managers and admins containing a letter from DHSC regarding facemasks. Letter states all care homes should receive an initial 300 masks and provides a national contact in case of concerns over availability.	Amicura Limited Questionnaire
	Recommendation made and accepted by SCG that patients awaiting discharge who required additional support (Pathway 1) should be transferred to other accommodation to be identified.	Executive meeting
20 March 2020	3 patients discharged to the care home from NGH	CHS Spreadsheet
21 March 2020	1 patient discharged to the care home from KGH	CHS Spreadsheet
22 March 2020	1 patient discharged to the care home from KGH	CHS Spreadsheet
23 March 2020	1 patient discharged to the care home from KGH	CHS Spreadsheet
	Tel call to the care home by QINs to check they had the Covid inbox info. Reported one resident with symptoms, no staff with Covid but one isolating. All residents self-isolating. 2 empty beds. Asked to update bed tracker. No problems with PPE. Advised regarding covid discharge plan and that assessments would be done over the phone between 8am – 8pm.	CCG Questionnaire

DATE	Event / Information	Source
	National Lockdown announced. UK Senior Clinicians Group agreed that only "absolutely necessary" visitors allowed into care homes.	Gardner & Harris Judgment
24 March 2020	3 patients discharged to the care home. One from KGH Two from NGH	CHS Spreadsheet
	Email from CCG to providers giving details of the updated death notification process.	Amicura Ltd Questionnaire
25 March 2020	4 patients discharged to the care home - 3 from NGH and 1 from KGH	CHS Spreadsheet
	Email from NHSE to all midlands acute and community trusts – requiring zero medically fit patients remaining in hospitals by 26th March 2020	Executive meeting
27 March 2020	Letter to providers from CCG/NCC/PHN refers back to the COVID 19 Guidance (13 March). Reiterates that there is no requirement to routinely test on discharge. States that if a home suffers an outbreak PHN will conduct a risk assessment and look at potential swabbing. Identifies that care homes are vulnerable to infection and suggests a number of steps to take – limiting visitors etc. Identifies strict IPC required and to remain vigilant for symptoms.	Amicura Limited Questionnaire
	2 patients discharged to the care home - 1 from KGH, and 1 from NGH	CHS Spreadsheet
30 March 2020	Email from NCC to all providers containing the first Provider Hub briefing. Reminders to report notifiable disease and specifies an outbreak as 2 or more suspected cases which should be reported to Public Health East Midlands (telephone number provided). Advises to inform NCC if facing significant operational difficulties including shortages of staff as "all mitigating actions "had been explored. Within the briefing document is a letter from the Secretary of State Matt Hancock that the briefing asks providers to share with their staff. Letter thanks all staff for their commitment etc. Second document attached is a guide for care workers on the correct use of PPE.	Amicura Limited Questionnaire
30 March 2020	2 patients discharged to the care home from NGH	CHS Spreadsheet
2 April 2020	2 patients discharged to the care home - 1 from Isebrook Community Hospital and 1 from NGH	CHS Spreadsheet
	Government publishes Admission and Care of Residents during Covid 19 incident in a care home. Key points – "Some of these patients may have Covid 19 whether symptomatic or asymptomatic All can be safely cared for if the guidance is followed".	Government Document Gardner & Harris Judgment
3 April 2020	1 patient discharged to the care home from Danetre Community Hospital in Daventry.	CHS Spreadsheet
4 April 2020	Covid 19 – management of exposed staff and patients in health and social care settings – Guidance published.	Gardner & Harris Judgment
6 April 2020	Home manager notifies CQC and NCC confirmed case of Covid 19 – male resident in KGH. 3 further residents admitted to hospital over weekend and one passed away. Awaiting results.	Amicura Limited Questionnaire and CCG
	NCC informs the home manager that PHE will require Notifications of Covid. Requests manager keeps NCC in the loop for testing, symptoms etc and to notify relatives of confirmed cases.	Amicura Limited Questionnaire and NCC
	Senior staff at Care Home become symptomatic.	Amicura Limited Questionnaire
7 April 2020	Symptomatic staff begin to isolate.	Amicura Limited Questionnaire
9 April 2020	The Care Home Manager reports sick and notifies the Community Health Services that the home would not accept any new residents due to people being discharged with Covid. Manager was informed she would be reported.	Amicura Limited Questionnaire
	PHE published guidance on IPC.	Gardner & Harris Judgment

DATE	Event / Information	Source
10 April 2020	National PPE plan published. DHSC – Social Care Strategy. Recommendations made to government around testing for discharges and quarantine.	Gardner & Harris Judgment
12 April 2020	PPE to be used for all episodes of care.	Gardner & Harris Judgment
13 April 2020	Government agrees to test all patients being discharged from hospitals to care homes.	Gardner & Harris Judgment
15 April 2020	April action plan published – mandatory testing on discharge.	Gardner & Harris Judgment

[ii] Regulation 15 CQC (Registration) Regulations 2009