REPORT NO: 179/2015

PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL

1 October 2015

Manton Hall

Report of the Director for People

Strategic Aim:	Meeting the health & wellbeing needs of the community.	
Exempt Information	No.	
Cabinet Member(s) Responsible:	Councillor Richard Clifton, Portfolio Holder for Adult Social Care	
Contact Officer(s):	Dr Tim O'Neill, Director for People	Tel: 01572 758402 Email: toneill@rutland.gov.uk
	John Morley, Head of Adult Social Care	Tel: 01572 758127 Email: jnmorley@rutland.gov.uk
Ward Councillors	*n/a*	

DECISION RECOMMENDATIONS
It is recommended that the Panel: 1. Notes the partnership approach being taken to support Manton Hall. 2. That our safeguarding and quality monitoring service is a developing service

1. PURPOSE OF THE REPORT

1.1 This report outlines the support or interventions given to Manton Hall Residential Home by officers of the council over the last 12 months of the homes' operation.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The report should be considered alongside the report entitled "Early Warning System". This will ensure the members understand the relationships and powers of the respective statutory bodies. The multi-agency safeguarding network is a complex area as each agency has its own statutory function and therefore responsibility. The Care Quality Commission monitors, inspects and regulates services to ensure they meet fundamental standards of quality and safety. The local authority and respective health agencies ensure services provide people

with a safe, effective and compassionate environment specifically in relation to safeguarding from abuse.

2.2 Officers from Adult Social Care and the Commissioning team meet every two weeks to share intelligence gathered on all of the residential homes in Rutland which includes Manton Hall. The officers consider findings of visits which have taken place in their day to day business or specific issues raised by other professionals such as district nurses or general practitioners. Included in these meetings are any safeguarding alerts received into the duty team through to falls being reported or complaints received about any of the regulated companies discussed. A safeguarding Social worker is always in attendance and will progress any issues to a safeguarding enquiry if thresholds are met triggering a multi-agency strategy meeting if warranted. If a serious wider concern is recognised such as suspecting institutional abuse, the meeting will escalate the concern to senior managers as they continue to follow the established LLR multi-agency safeguarding procedures adopted by RCC.

2.3 Officers meet with the Care Quality Commission and other placing agencies and authorities every two months to discuss all residential homes across Leicestershire, Leicester City and Rutland including Manton Hall to share information across those agencies. This gives a wider intelligence base and more importantly ensures all agencies are aware of possible problems and can work together to support any of the homes raised by the group and any other regulated service.

2.4 Our commissioning department receives bulletins identifying homes outside of Rutland that other authorities are notifying of institutional safeguarding concerns or placement suspension if such action has been warranted. Some Rutland residents are placed or place themselves in surrounding authority borders within which we have no statutory powers over. This is all part of the multi-agency approach RCC is committed too. In the case of action taken against a Rutland residential home like Manton Hall RCC officers inform those same authorities and agencies in like manner.

2.5 Over the last 12 months Manton Hall has maintained a consistent informal contact with RCC duty and safeguarding team. This has further improved since the recruitment of a new registered manager to Manton Hall who has been very willing to work with us. It is pleasing to say we are building such relationships with the Rutland private regulated providers. Information can be regards staff changes through to HR issues which is information not normally volunteered to councils by independent providers. The home also has been very transparent in its safeguarding alerting, sending in all incidences whether or not they think it will meet our threshold and this is good practice.

2.6 There have been a number of visits to Manton Hall from our staff by way of contracts monitoring or social worker review. These are discussed in the information sharing meeting above with all of the other Rutland residential homes or regulated providers visited if appropriate to do so. In such reviews family are always invited to attend and give their opinion on the care of the home, this is true of all reviews in all regulated services if the person being reviewed wants their family or friends present. Other placing agencies such as the Clinical

Commissioning Group also review their clients and invite family. If they have concerns abuse may be occurring that agency will inform RCC or a relative for example. It may be the case the reviewer is unhappy with quality of recording for example in which case they may notify CQC as the regulating body.

2.7 As an example of RCC officers working proactively with multiple agencies a recent safeguarding incident is a good indicator which took place at Manton Hall. A multi-agency strategy meeting was called attended by Appropriate RCC officers, Care Quality Commission, Leicestershire Partnership and the Clinical Commissioning Group. At such a meeting all agencies will share histories, decide how to react proportionately and will supported the plan they put forward. In this case it was agreed to suspend any further placement to the home. On top of this, Manton agreed not to admit any self-funding clients which neither the council nor other placing authorities have power over. All placing agencies agreed to review their clients and the result is that no concerns have been raised except for those of a compliance nature such as care plan content or updating.

2.8 Other agencies and placing authorities who were unable to attend were informed of the outcome. Police at that time were already involved although it is our understanding that no criminal activity was suspected and so no Police investigation has taken place.

2.9 The Care Quality Commission (CQC) will revisit the home and it is our understanding the Police have indicated an officer will attend with CQC to review security and the home has welcomed this. It is CQC who are responsible for monitoring the 11 care standards not council officers, council officers coordinate enquiry into suspected abuse all actions having to be proportionate and seeking to attain the outcome the affected adult wants which is not always what the professional would want.

2.10 CQC last visited Manton Hall in February of this year when there was no registered manager in place, the report published this July 6 months after the inspection and a few months after the appointment of its new manager. Manton was not identified as an inadequate home but one needing some improvement to attain “good” from “requires improvement” in its care standards compliance. In areas where they required improvement many of the concerns had been addressed although there are still issues for the home to address to be judges as good. The following table outlines the findings from the April 14 inspection compared with the February 15 inspection.

	24 April 2014 Summary	**6 February 2015 Summary**
Is the service safe?	There were times when there were no staff in attendance in the lounge area. Some people were dependent on staff to meet their needs and ensure their safety because of physical of cognitive disability. There was an annual programme of audits to monitor the quality of service provision. Staff were not involved with or aware of the audits undertaken. There was limited evidence available to	There were enough staff to keep people safe and meet people’s individual needs. Staff understood how to protect people from abuse and avoidable harm, but arrangements for the safe management of medicines were not in place.

	24 April 2014 Summary	6 February 2015 Summary
	demonstrate that learning from incidents / investigations took place and appropriate changes were implemented. This increases the risk of harm to people and fails to ensure that lessons are learned from mistakes. People were not always cared for in a clean and hygienic environment. There were not enough domestic staff on duty to clean all areas of the home on a daily basis. We found significant breaches to the expected standard for infection prevention and control. Staffing numbers were not always sufficient to meet people's needs or keep them safe. One person told us they had to wait for staff to attend to them at certain times of the day. The actions staff should take to manage the deprivation in the least restrictive way were not recorded in one person's care plan. People were not fully protected from the risks of receiving care that was inappropriate or unsafe. Staff had not carried out risk assessments for three people who had recently moved in.	
Is the service effective?	People's health and care needs were assessed before they moved in, but care plans for three people who had recently moved in had not been completed. Some care plans had not been reviewed regularly. Care plans were therefore not able to support staff consistently to meet people's needs. Staff had not received all the appropriate training they required to meet people's needs or to keep them safe.	Staff had received the training and support they required to meet people's needs and keep them safe. Mental capacity assessments were completed for some people who lacked mental capacity to make decisions about their care and treatment. However these did not fully meet the requirements of the MCA legislation. The quality of food and choice of meals was good and people's health needs were met.
Is the service caring?	People were supported by kind and attentive staff. We saw that care staff showed patience and gave encouragement when supporting people. Some staff members told us that they did not always have the time to spend with people because they were so busy. People's preferences, interests, aspirations and diverse needs had not always been recorded. Because of this care and support could not always be provided in accordance with people's	People told us they liked the staff and had positive relationships with them, but they were not always actively involved in making decisions about their care and support. Privacy and dignity was maintained and people were mostly treated with respect and kindness.

	24 April 2014 Summary	6 February 2015 Summary
	wishes.	
Is the service responsive?	People had been supported to maintain relationships with their friends and relatives. People knew how to make a complaint if they were unhappy. People told us that staff would listen to them and take appropriate action. An activities organiser had recently been appointed. We were told that the activities organiser would be responsible for arranging monthly residents meetings so that people could provide feedback about their experience of care, treatment and support.	People said they received care and support in the way they preferred. Opportunities for people to follow their hobbies and interests were limited. Complaints were used as an opportunity for learning and improvement.
Is the service well-led?	The service had a quality assurance system, records seen by us showed that not all of the shortfalls identified had been addressed. The system did not systematically ensure that staff were able to provide feedback to their managers, so their knowledge and experience was not being properly taken into account.	People and care staff said that the management team maintained a visible presence and engaged with them to seek their feedback on the service. The provider had systems in place to monitor the quality and safety of the service.

2.11 On a daily basis many people go in and out of a care home each one being a potential whistle-blower/alerter. Health professionals go in on a daily basis and this includes Manton Hall and they are duty bound to report any suspected abuse. Relatives are usually around at varying points of the day all of them watching out for their loved ones who again would report in if they were concerned. In the case of Manton, historically it has been staff who have informed us of any concerns via the registered manager. Sometimes people will complain to CQC who in turn will inform the local authority if they think the issue reported falls into the realm of suspected abuse in which case the local authority will decide how to proceed.

2.12 **Very recently Manton met with the residents and their relatives to discuss recent events and only one complaint was put forward from that group and that was not in relation to care of their own loved one. The clients and their families reported being happy with the homes facilities and services.**

2.13 That said Officers at the present time are monitoring Manton's ability to adapt to changing needs of vulnerable people as they get older and as their condition deteriorates. Similarly officers are monitoring the level of complexity of new residents the home assesses as a suitable resident.

3. ALTERNATIVE OPTIONS

3.1 None

4. IMPLICATIONS

5. FINANCIAL IMPLICATIONS

5.1 Developing the Service to enable it to safeguard vulnerable individuals

6. EQUALITY IMPACT ASSESSMENT

6.1 N/A

7. COMMUNITY SAFETY IMPLICATIONS

7.1 None

8. HEALTH AND WELLBEING IMPLICATIONS

8.1 The Care Quality Commission will continue to monitor the fundamental standards in the case of Manton Hall the 4 requiring improvement to enable the service to be judged as good.

9. ORGANISATIONAL IMPLICATIONS

9.1 Given the very small number of available specialist social workers a registered provider such as Manton Hall requiring sustained intervention takes a relatively large proportion of the available resource. This is mitigated through the multi-agency approached outlined as occurring within the report.

10. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 To prevent abuse

11. BACKGROUND PAPERS

11.1 None.

12. APPENDICES

12.1 None

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

(If requested Large Print Version should be printed in Arial 16 to 22 pt)