Written evidence from Anonymous (HCS0012)

The Role of the CQC and its partner agencies in the regulation of health and care services in England.

Introduction.

The opinions expressed below are mine and are based on my experiences when I was POA for my friend. The information is taken from my notes, emails, correspondence and other documentation including some acquired by Subject Access Requests.

Background.

Between 2016 and 2021, I held Power of Attorney for my friend who had a number of health conditions which could be treated but not cured.

In July 2017 he suffered a Stroke which left him partly blind and he spent 2 months in hospital on a specialist stroke ward. I found him one day in a state of collapse in his hospital bed not having been fed for the best part of a day. For the last 3 weeks of his hospital stay I took food in for him almost daily just to make sure he was given something to eat. I am still remonstrating with the hospital about this matter and also the information revealed by a Subject Access Request which confirms that missing meals had been a regular occurrence - which has been concealed for some time. At the time, I twice wrote to Matt Hancock MP and SoS for H&SC about this but received no helpful reply and to Sajid Javid but received no reply. At the time of writing I just been able to meet the Chief Executive of the hospital Trust. Whilst this document is mainly aimed at the CQC and its partner agencies I also firmly believe there needs to be a change of attitude others in positions of leadership in our health and care provision.

In September 2017 my friend, assisted by our NHS, moved to the first of what would turn out to be 3 nursing homes supported by Continued Health Care Funding.

He was at this first home for 3 months during which period, the staff admitted later, he fell 10 times. The last fall in late December 2017 left him hospitalized with a life changing injury - a broken hip and as a result he never walked again for the rest of his life. I will say not an insignificant event then for someone in such poor health to start with; in the full time care of the State; suffering the pain of a broken hip; undergoing the risks associated with an operation which should not have been necessary; having a further enforced stay in hospital due to him being effectively homeless whilst a replacement nursing home was located - also with assistance from our NHS -and, having to manage the confusion of it all and cope with the after effects of a life changing injury.

This was reported by me to the CQC as a Safeguarding matter in early 2018 and I will return to this point later.

In the second nursing home, located in a different local authority, at the time and currently rated good overall. Due to his high risk of malnutrition, he was prescribed a food supplement which was not given by the nursing home staff for a period of 7 months - April to November 2018. I calculate he missed the equivalent of one meal a day every day over this period which corresponded with him being misdiagnosed with organ failure and being given possibly days to live in September 2018. In fact, he had a urine infection and there had been a delay in the delivery of anti biotics. All concealed by the nursing home including, incidentally, from the GP who conducted his examination. There were two Safeguarding matters raised with the local council and I will return to this later also.

There were other matters in this particular nursing home including but not limited to intermittently failing to administer medication properly; colluding with the mental health team staff to withdraw him from the waiting list for an assessment without consulting him or me (finally conducted months later after a formal complaint); one instance of dog excrement on the dining room floor; allowing a continued health assessment to take place without him or me being present resulting in the recording of inaccurate information into his records (the assessment was repeated after a formal complaint) reviewing a DNACPR without consulting him or me (removed after discovery) .

I looked for other accommodation for my friend and was on the point of finalizing the move when he fell ill again in early 2020. Notwithstanding 3 phone calls I made over that weekend when I was assured he was not so ill he needed a GP and specifically was not dehydrated, he was rushed to hospital on the Monday morning due to an untreated infection and acute dehydration. His Triage notes say he was taken straight to resuscitation and was in a coma at the time of admission. I spent the day with him at Casualty and the night on the floor of his room back at the nursing home.

I managed to secure the move to the 3rd Nursing home a few days later which cost him over £100 by private ambulance. The move was chaotic. No one told me he was moving that day I just happened to be visiting anyway. I located him on his own in the dining room slumped forward with his head on the table. The staff had "packed" his belongings by stuffing them randomly in black bin bags. His wheelchair stank of rotted fish due to something having been spilt on the seat and not properly cleaned, if at all.

I refused to make a Safeguarding complaint to the Local Council on the premise that earlier experiences proved it to be a waste of time and, due to the seriousness of the event I made a

complaint of neglect to the Police, who made their own Safeguarding referral. I am, and have been for some months challenging the Police on their conduct. My solicitor has reviewed their response to my complaint and confirmed they failed to pursue all reasonable lines of enquiry and, the Local Authorities' Safeguarding response is based on the bare minimum they could do.

It is against this background of abuse by neglect that I had to in effect abandon him to his fate in the third nursing home when lock down started in March 2020 and try and maintain contact mostly be 30 minutes Skype per week with some socially distanced garden visits over the Summer also limited to 30 minutes per week.

The role of the CQC and its partners in Adult Social Care.

I have a letter from the CQC dated 27/2/2020 [redacted] which says this:

"We monitor, inspect and rate the quality of care of providers and tell them where they need to make improvements in their standards of care. If they don't meet the legal requirements, known as Fundamental Standards, we take action to make sure they improve"

"The CQC receives information all the time in respect of the services we regulate. Should we receive information which is deemed to be a safeguarding concern, then we will refer that concern to the relevant Local Authority. Where CQC is the first statutory agency to receive information of the kind, we call this a 'safeguarding alert'. We will make a safeguarding referral to the Local Authority as soon as possible and in any case with a 24 hour period."

" Should that information on its own, or in conjunction with other information we hold, cause us to have concern for the safety of people who use the service then our inspection methodology allows us to inspect a service at any time we choose. This may be by way of a focused/responsive inspection to look at a specific issue of safety or a full comprehensive inspection."

So my interpretation of this that there is a professional relationship between the CQC and the relevant Local Authority. The latter conduct Safeguarding Investigations and report the results to the former which in turn uses the information to inform its future actions. According to the CQC's website there are a number of actions they may take including;-

"Hold the care provider to account for their failings by:

issuing simple cautions

issuing fines

prosecuting cases where people are harmed or placed in danger of harm."

The CQC is then heavily reliant on the quality of the Safeguarding investigation conducted by the Local Authority and, if that investigation fails in any way the CQC will be ill informed, possibly to the extent that abuse or abuse by neglect is left unchallenged which of course has implications for the aggrieved and does nothing to protect others. It is in everyone's best interest then that there are service level agreements or similar in place between the CQC and its partners and, on the basis of responses I have had from the CQC to my letters of complaint on this matter there appear to be none. I ask why this is?

I will go so far as to say that if the CQC and its partners are not able, jointly and/or severally, to conduct Safeguarding investigations in a professional manner and come to an evidence led conclusion they are colluding with the abuse of some of the most at risk members of our society. And by way of illustration please look at this:-

The Safeguarding investigation into my friend's fall in December 2017 was conducted by a Social Worker visiting him when he was alone in hospital recovering from his operation. Deciding that he lacked capacity at the time, this particular attempt at an investigation was concluded by a telephone call to the manager of the nursing home (who had the potential to be a perpetrator of abuse) and written off as an accident. Pursing a complaint on the basis that this was heavily biased in favour of the nursing home, discriminatory, institutionally abusive, lacking diligence and negligent in itself. It took me 12 months of attrition with the Local Council and a trip to the ombudsman to get any attempt at an investigation started which incidentally when it was eventually officially signed off, revealed this to me and the CQC but as late as July 2019:-

"Examination of the records... revealed that appropriate care plans and risk assessments were in place. Whether those plans and actions were being followed is disputable.... Staff were aware that Mr. (name redacted by me) could move unsupervised, at speed and without the aid of this frame and yet they were stretched to meet the needs of all residents."

"I have also spoken with a CQC inspection officer and made a retrospective report. I am advised that whilst an inspection took place in June 2018 published in August 2018 with the overall rating being good, the retrospective information will be considered and that if deemed necessary further investigation may be made."

I will return to this later also.

The Safeguarding investigations into the delays in administration of antibiotics was again conducted by attempting to interview my friend alone and, having decided he lacked capacity at

the time, concluded without him being represented whilst simultaneously attempting to brush off the complaint about the food supplement without any investigation at all. When I obtained the reports there were references to a third party in them and, among other things, I had to question who the report was about. Again these had to be repeated. The conclusion into the investigation about the significant delay in providing the food supplement concludes:-

"There was a significant delay in Mr. (name redacted by me) receiving supplement Food link which had been recommended to MR (name redacted by me) by the Dietician Service on: 12/4/2018.

Mr. (name redacted by me) did not receive the supplement Food link until: 21/11/2018.

The (name redacted by me) Nursing home manager explained staff experienced difficulties obtaining the supplement from Mr. (name redacted by me) GP surgery as GP surgeries do not automatically prescribe supplements recommended by the Dietician Service. The (name redacted by me) manager accepts that there was a significant delay.

The (name redacted by me) Nursing Home are now fully aware of the system that the GP practice use and that the (name redacted by me) are required to follow up any Dietitian recommendations with a letter to the GP practice to request the supplements are prescribed by the GP practice"

So no investigation then as to why the nursing home staff ignored several written and verbal reminders from the dietitian (I have the paperwork), no investigation why the whole thing was concealed leaving me to find out by chance in January 2019 and, no investigation as to why it takes qualified nursing staff 7 months to work out they need to follow the instructions they had been given and send a letter to the GP. They did however report the matter to the CQC so what did they do?

Once again conduct by a partner of the CQC which was heavily biased in favour of the nursing home, discriminatory, institutionally abusive, lacking diligence and negligent in itself.

The CQC

I am returning now to my complaint to the CQC made in January 2018 following my friend's fall and their own actions in response to my original complaint and the information they finally received from the Local Authority in March 2019.

Initially, I was informed by email that the CQC would look at my complaint of neglect following my friend's broken hip when they next did a routine inspection. Presumably then, the CQC is

happy to take the risk that other residents may fall in the meantime but I was not and pressed the matter. This resulted in the CQC ringing the manager or the nursing home and accepting assurances that it was an accident. I assume from this then, that the CQC are content to undertake focused inspections without conducting a visit or looking at any records but by having only a telephone conversation with a potential abuser. I was not and pressed the issue again and was told, the CQC would look if the situation met the criteria for a referral to the Local Council as a Safeguarding matter. According to the CQC quoted above this should happen within 24 hours but not in this case apparently.

I have looked at the CQC's recorded inspections of this particular nursing home since I reported the Safeguarding complaint in early January 2018 and there are two recorded which are significant as follows:-

On 19th June 2018, five months after the safeguarding alert no specific mention of any investigation into the alleged neglect related to the fall although the CQC were well aware of it and confirmed (on the 25/4/2019) that they had examined my friend's records at the time. Merely this:-

"Where safeguarding concerns or incidents had occurred, these had been reported to the local authority and commissioners and we saw records of the actions that had been taken by the home to protect people"

18th June 2019, 17 months after the safeguarding alert and, after the Local Council reported the failures they found there is this:-

"We received concerns in relation to people not receiving their evening medications as prescribed, there not being sufficient staff for evening routines, people's falls risks not being managed and people's bedtime routines not being at times of their choice. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

"The overall rating for the service has remained the same. This is based on the findings at this inspection. We found no evidence during this inspection that people were at risk of harm from the concerns"

Really? Well this is at odds with the consequences for my friend and the findings of the Local Authority so how do the CQC explain this?

Conclusion

The CQC and its partners have obligations under Human Rights Legislation and CQC's has its

own stated objectives. Regardless of what is written on their website, the real test is what do they actually deliver and do their methods of working alone or with partners allow those obligations and objectives to be met? Based on my experiences I will say they do not.

Even without the additional pressure of the pandemic, there is very little offered by way of choice of a nursing home in circumstances where there are time pressures involved and there is not the luxury of testing the market. Mainly the choice relates to who has a vacancy and who will accept the resident based on the nursing home's own assessment. The only real assessment the prospective resident can make is a visit to the home and the CQC's published rating. It is vital then at least that the rating has credibility and if it is based on flawed Safeguarding investigations then it has not. In this context the CQC is not fit for purpose.

I will say the CQC needs to urgently review its own working practice relating to inspection and to the investigation of complaints; its relationship with all partner agencies in this same respect and, produce an effective system of regulation which identifies and challenges poor and unsafe practice rather than condone it and, is then a reliable indicator of the standards of care offered. Eventually this will drive up standards and protect vulnerable residents.

I would like you please, as part of the review of adult social care to urgently look at the way Safeguarding matters relating to vulnerable people are being investigated.

31/10/2021