SAR Sheila Hartman
Improvement briefing

Identifying and managing risks of aggression and violence between people living with dementia in residential care homes

What we have learnt about ordinary work across agencies/partners in Bedford Borough and Central Bedfordshire?

Commissioning SAB: Central Bedfordshire and Bedford Borough Safeguarding Adults Board

Independent reviewer: Dr Sheila Fish

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1 A legacy for two much loved mothers

This SAR is dedicated to two much loved mothers who were both living with advanced[1] dementia. [2]

1.1 REMEMBERING SHEILA HARTMAN

1.1.1 Sheila Hartman was a great-grandmother, who had been a keen walker and loved knitting and making things.

Her son, Richard Uridge said: "She was a loving mum, and we had an idyllic childhood, but practical would be the one single word I think I would use for her ... and that's why this review is so important. It identifies practical measures to keep people safe and improve care."

1.2 REMEMBERING BARBARA[3]

1.2.1 Barbara was born in St Kitts in the West Indies. She was a seamstress and then worked for Luton Borough Council. She was sociable and liked spending time with others and singing. She was a committed Christian, and prayer was important to her. At 92 years old she had been widowed and lived with her daughter who cared for her. Barbara had a brother and a close friend also both important to her.

[1] The phrase is used to refer to the later stages of dementia – **see** **Supporting a person in the later stages of dementia | Alzheimer's Society**

[2] Dementia is not a single disease but an umbrella term describing a collection of symptoms and caused by a range of underlying brain diseases. Therefore it is often more suitable to talk about to talking about 'a dementia' – see **'A' dementia — Dementia Services Development Centre**. However, for the purposes of this report we have used the generic formulation.

[3] This pseudonym has been chosen by the family.

1.3 TWO VICTIMS

1.3.1 Sheila and Barbara's lives had not crossed before they both came to live in a care home in Bedfordshire. They were both living with an advanced dementia. Sheila had been living there for three years, and Barbara for under half a year. Their rooms were next to each other, separated by an empty one. The two women were said to have got on well and had been seen sitting, holding hands and chatting.

1.3.2 But in confusion and distress caused by dementia, Barbara ended up in Sheila's room at night, where she violently assaulted her, causing serious head and facial injuries. Sheila died a few hours later.

1.3.3 Sheila and Barbara's families had both sought a place that could provide their respective mothers with the care and support they needed as their dementia progressed and where they would be kept safe. Both women became victims in a breakdown of these arrangements. Sheila lost her life in a brutal and traumatic way, a memory her family live with. Barbara's life and legacy were also changed irredeemably; her family carrying a double burden. This review aims to derive systems learning from this tragedy.

1.4 SYSTEMS LEARNING

1.4.1 This review focuses on arrangements for the provision of residential care for people living with advanced stages of dementia. The goal is to illuminate important areas where improvements are needed in order to create set-ups that are more reliable in keeping our loved ones safe and make it easier for practitioners, clinicians and managers to provide the quality of care they strive to provide for people living with advanced dementia in care homes.

1.4.2 This focus was, and continues to be, in line with the wishes of Sheila Hartman's son:

> "It's not about an individual who's attacked my mum. It's more about how we care for older people and whether we can do better to reduce the risk of this kind of thing happening."[4]

1.4.3 Central Bedfordshire and Bedford Borough Safeguarding Adults Board (SAB) and partner agencies are then responsible for supporting and holding partners to account for the actions they take in response to the learning, and reporting this in the SAB annual report.

1.4.4 As the independent reviewer, I hope this provides some assurance to both Sheila and Barbara's adult children.

[4] **Police investigate alleged killing of grandmother at care home - BBC News**

2 Introduction

2.1 DECISION TO UNDERTAKE A SAR

2.1.1 A SAR referral was received on 03 October 2022 from Bedfordshire Police

2.1.2 The SAR referral stated:

> 02/10/2022 Police have attended Ridgeway Lodge Care Home in Dunstable following a 999 call at 05:44 hrs. Call was from Care worker reporting a patient having a 'Dementia Outburst' had attacked another resident hitting them around the head 3 times with a walking stick." As a consequence of the incident Sheila passed away in hospital soon after the assault.

2.1.3 Barbara had first moved in to the Care Home in May 2022 whereas Sheila had lived there since December 2019.

2.2 LEGAL MANDATE

2.2.1 The referral was discussed during the SAR Subgroup meetings on 01 November 2022. A decision was made to conduct a SAR as Sheila was an adult at risk (as described by The Care Act 2014) and that condition 1a, 2a and b have been met.

Section 44 of The Care Act 2014 requires Safeguarding Adults Boards to undertake a Safeguarding Adult Review as follows[5]:

(1) "A SAB must arrange for there to be a review of a 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) 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.

(1) 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 or neglect before the adult died).

(2) 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.

(3) 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

[5] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

meeting any of those needs).

(4) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case and applying those lessons to future cases."

2.2.2 The review was commissioned to focus not only on Sheila as the victim of an assault but also on Barbara who assaulted her. Both women had care and support needs as defined under The Care Act and both were living with advanced dementia.

2.3 A SYSTEMS-BASED METHODOLOGY

2.3.1 Across multiple sectors, the evidence base suggests that a systems-based approach provides the most useful learning from practice, to drive improvements. This is reflected in the new Patient Safety Incident Response Framework (PSIRF) in the NHS.[6] It is also reflected in the work led by Dr. Sheila Fish over nearly two decades at the Social Care Institute for Excellence (SCIE) to support multi-agency safeguarding reviews in both child and adult safeguarding.[7]

2.3.2 A systems-based approach assumes that multi-agency work takes place in a complex, adaptive system. In such complexity, reviews of practice provide an invaluable opportunity to better understand ordinary practice in contemporary contexts. By this means, a systems approach uses a single case to give a 'window on the system'[8] revealing how social and organisational factors, and complex systems dynamics influence what practitioners and clinicians do in direct work with citizens.

2.3.3 This approach uses the specifics of what happened and why in the index case under review, to explore what is typical and usual. It moves from the 'case findings' of what went well and where engagement and outcomes were not optimum in terms of appropriateness, timeliness or quality, to draw out wider, generalizable learning about strengths and vulnerabilities in single and multi-partners social and organisational set-ups and ways of working. This wider learning can be distinguished with the terminology of 'systems findings', i.e. learning that identifies what is enabling good practice and what is getting in the way and making it harder to achieve.

2.3.4 Using this methodology usually involves:

- Meaningful engagement with the person, family members or equivalent
- Enabling collaboration with practitioners and managers involved at the time (Case group)
- Close working with strategic leads of involved agencies and services (Review team)

2.3.5 A concise, practical report then concludes with a focus on learning relevant to improvement activity across local, regional and national partners and individual and collective SAB assurance work.

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[6] See: **NHS England » Patient Safety Incident Response Framework**

[7] See: **SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews | The Learning Exchange (iriss.org.uk)**
SCIE SAR Quality Markers March 2022 (lbbd.gov.uk)

[8] Vincent, Charles ref

2.4 METHODS, TIMELINES AND PARTICIPANTS

CONTEXT FOLLOWING THE INCIDENT

2.4.1 Sheila died on 02 October 2022 shortly after the assault. A CQC inspection took place on 13 October 2022 and concluded the care home 'requires improvement' – the second such rating (previously March 2020) – and identified breaches in relation to safety management, staffing, person-centered care and leadership.

2.4.2 Press coverage of the CQC inspection report noted:

> "The report found issues with how the registered manager, provider, and staff supported people who lived with dementia and who expressed forms of distress. Staff training, knowledge and skills in this area were limited, and people did not have meaningful reviews of their care.
>
> There was also a lack of dementia expertise and a lack of stimulation and access to safe spaces outside.
>
> Meanwhile, staff did not have effective training and competency checks in place. Key training such as dementia training was not embedded into staff practice and people's social experience living at the home was not always personalised. Staff did not routinely chat and spend time with people – their interactions were task-focused.
>
> The report added that managers and the provider did not always investigate events when needed to learn lessons from these. Audits and reviews into people's social experiences at the home were limited.[9]

2.4.3 In addition, HC-One commissioned Niche Consultancy to conduct an independent review. This was very critical.

2.4.4 In a recent inspection (15 June 2023), Ridgeway Lodge Care Home, provided and run by HC-One, received 'good' across all areas (Report published: 8 July 2023).[10]

THE CORONIAL INQUEST

2.4.5 A Pre-Inquest Review on Sheila Hartman's death took place on 22 February 2024. The need for an Article 2 inquest was determined. This took place over two weeks, 8-17 October 2024. Her son Richard Uridge took part as a participant, representing Sheila's family. The Niche independent review commissioned by HC-One was incorporated in full, as part of the inquest.

2.4.6 Discussion with Richard Uridge (05 December 2024) about the inquest and a review of press-coverage of it, highlighted that the analysis of what happened and why in Sheila Hartman's case had to a great extent already been achieved. A rich picture had already been established of the care and support provided to Barbara, and of the social and organisational factors that influenced what practitioners and managers did and did not do, which left the risks Barbara posed due to her dementia, poorly understood and unmanaged.

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[9] **Damning report of care home where great-gran allegedly suffered fatal assault says it still requires improvement**

[10] **Ridgeway Lodge Care Home - Care Quality Commission**

2.4.7 It was important therefore to design the SAR process so as to avoid duplication. The SAR was an opportunity to build on the understanding gained to-date of the circumstances that led to incident and focus on the wider system of care provision for people with advanced dementia, and the wider learning that this case example indicates. Therefore this SAR was commissioned to explore the broader systemic weaknesses that may still exist in dementia care home provision, that leave people like Sheila Hartman living in places that are poorly able to make and manage care plans effectively, so increasing the chances of what is often described as 'resident- on resident' violence, and sometimes death.

SYSTEMS ORIENTED LINES OF ENQUIRY

2.4.8 This SAR has the potential to open a 'window' on to arrangements for the provision of residential care for people living with advanced stages of dementia and identify gaps and weaknesses in set ups, arrangements and working practices.

2.4.9 At the point of commissioning therefore, the following systems focused lines of enquiry were set for exploration:

What can we learn from Sheila and Barbara's experiences about: …

- **what is helping and hindering partners in working together to manage risk and achieve safety in the making and managing of care home placements for older people with dementia.**

PROPORTIONATE LEARNING TOGETHER APPROACH

2.4.10 This focus is well suited to the Learning Together approach originally proposed for the SAR. The Learning Together model (Fish et al. 2010)[11] is a proportionate, systems-based approach, designed specifically to move beyond 'case findings' about what went well and where were there practice problems in professional practice in the case, to draw out broader learning about strengths and vulnerabilities in single and multi-partners social and organisational set-ups and ways of working. The model calls this wider learning 'systems findings' that identify what is enabling good practice and what is getting in the way and making it harder to achieve.

2.4.11 Learning Together is compatible with the SAR Quality Markers (Fish 2022) that capture good practice in safeguarding adults reviews. Using this methodology involves:

- Meaningful engagement with family members
- Enabling collaboration with practitioners and managers involved at the time (Case group)
- Close working with strategic leads of involved agencies and services (Review team)
- A concise, practical report to inform improvement activity across partners and SAB assurance work

2.4.12 In this instance, however, it was agreed that the review did not need a 'case group' of operational practitioners and managers who had been directly engaged in Sheila and Barbara's care to be convened. These practitioners and managers have already contributed both to an independent review by Niche consultancy shortly after the incident, and more recently many have also been called to the coroner's inquest. The

[11] **Heading 1 (19 pt Arial no bold) (iriss.org.uk)**

chances of yielding any additional or different insights were deemed slim, and it seemed ethically inappropriate to do so.

2.4.13 Instead, the SAR process convened with a Review Team of senior leads from all relevant agencies and divisions, who worked collaboratively as the independent reviewer. Their role was to bring a diverse range of expertise and experience to the process of the review, and to test and evidence wider systems findings that can be extrapolated from the experiences of Sheila and Barbara.

REVIEW TEAM

2.4.14 Roles/agencies that were represented in the strategic leadership group included.

Bedford & Central Bedfordshire Councils

- **Safeguarding Adults Board** Board Manager
- **Strategic commissioner**
- **Contracts & Brokerage CBC** Head of Service
- **Principal SW & Head of Safeguarding CBC**
- **Commissioning & Quality.** Head of Care, Quality, Support & Improvement

Care home providers

- **HC-One** Exec. Director Quality; Dir of Safety;
- **Bedford Care Group** Chair and provider rep on BSAB
- **Providers x3**

Care Quality Commission

- **East of England.** Deputy Director of Operations
- **Adult Social Care,** Dept. director
- **Safeguarding and Close cultures** Deputy Director

ELFT

- **Dementia Intensive Support Service DISS** Ops Manager
- **Memory Service** Clinical Lead
- **MH Service** Advanced Practitioner
- **Admiral nurse**
- **Bedford & Luton Dementia.** Assistant Director
- **CMHT**
- **Mental Health and Wellbeing services in Bedfordshire and Luton – Community.** Director
- **ELFT Safeguarding.** Head of

LUTON Council

- **Adult Social Care,** Head of Safeguarding, Quality & Professional Standards
- **Adult Social Care,** Quality Assurance and Care Placement Manager
- **LSAB/LSCP,** Joint Strategic Business Manager

Voluntary sector

- **TIBBS Dementia Support**
- **Alzheimer's Society Dementia Support Team Luton & Beds.** Service Manager

Health

- **ICB BLMK Bedford, Luton and Milton Keynes** Desig. Prof. Safeguarding Adults
- **Cambridge Community Services. AD**

Advocacy

- **VoiceAbility** Practice Lead
- **Healthwatch Central Bedfordshire** CEO

INVOLVEMENT OF BOTH FAMILIES

2.4.15 . Sheila Hartman's son Richard Uridge has been key in driving a focus on systemic learning.

2.4.16 He was an interested party in the Article 2 Inquest and has generously shared the analysis he conducted for that and his reflections from all the information shared at the inquest.

2.4.17 The draft report has also been shared with him for review and comment.

2.4.18 Barbara's adult daughter has also generously contributed and, likewise, been offered the opportunity to feedback on the review.

2.5 METHODOLOGICAL COMMENT AND LIMITATIONS

2.5.1 The review has benefited from notable commitment, openness, and engagement from all of the review team members. This included local providers; CQC: TIBBS Dementia Foundation (Experts by Experience) and members of both families which added significant value.

2.5.2 In order to be proportionate and prioritise findings, the role of some agencies has come less into focus including GPs and local authority safeguarding. We did not have representation from services providing a brokerage/matching service for carers, so there are also limitations to this aspect of the analysis.

2.5.3 Audio recordings but no transcripts are available of Coroners inquests, making engagement with the detail very time consuming. Though the safeguarding adults board found creative ways to create transcripts retrospectively, the quality made these challenging to use.

TIMELINES, TIMESPAN & CAPACITY

2.5.4 The start of the SAR was delayed in order for the Coroner's Inquest to be completed. It therefore began in December 2024, with the findings presented to the SAB in June 2025. The was then a delay in completing the write-up of the full report, with the first draft submitted at the end of February 2026.

2.6 OUTLINE OF THE REPORT

2.6.1 The report begins with a summary of what has already been identified regarding what went well and areas of poor practice, in the care and support provided to Barbara while at Ridgeway Lodge. This forms the foundation from which to draw out wider systems of learning. And the rest of the report presents the wider learning we have drawn out from Sheila and Barbara's experiences.

3 Case specific analysis

3.1.1 In this section, we start with a brief description of the care home, before provideing a summary of the incident that led to Sheila Hartman's death. Then an appraisal of practice synopsis captures the main judgements made of the care and support provided in Ridgeway Lodge as identified in the coroner's inquest into Sheila's death.

3.2 THE CARE HOME

3.2.1 Ridgeway Lodge is a registered care home in Dunstable, which provides residential and residential dementia care for up to 61 people.

3.2.2 It is arranged on two floors, with residential clients living on the ground floor and the first-floor reserved for residential clients with dementia and higher levels of need.

3.2.3 It is run by the HC-One Group, referred to as "HC-One" which is one of the largest care home providers in the UK. It provides residential, nursing and dementia care for older people across its family of c.280 care homes across Britain.

3.2.4 In October 2025, the US-based company Welltower completed the purchase of Barchester Healthcare and HC-One assets, in a massive double-deal worth more than £6 billion.[12] The Competition and Markets Authority (CMA) has decided to investigate the completed acquisitions by Welltower Inc. of multiple care homes managed by Barchester, HC-One, Aria Care and Danforth Care.[13]

3.3 THE INCIDENT IN BRIEF

3.3.1 Barbara had been living at Ridgeway Lodge for 20 weeks prior to this incident. Sheila longer since December 2019. Their rooms were on the same side of the building, next to each other bar an empty room in between.

3.3.2 Two members of staff were on duty on the first floor on the night of the incident. The additional member of staff, who should have been 'floating' between the two floors as needed, had called in sick. This had not been reported; no replacement was sought. The two members of staff would sit at opposite corners to each other, so that all four corridors of the floor were in eyesight.

3.3.3 The two staff were on the opposite side of the building to Sheila and Barbara's rooms, giving personal care to someone, that required them both, when they heard banging sounds and shouting. One of them left the room; the other stayed to first complete the person's care and lower the bed in order that they were safe.

3.3.4 They found Barbara outside, with a duvet over her shoulder and her walking stick covered in blood. Sheila was alert and awake but described as being in a bad way. Barbara kept trying to get back into the room, bashing the door from the outside with

[12] **Mega deal: Welltower acquires Barchester and HC-One assets in record £6.4 billion transaction**

[13] **Welltower / multiple care homes merger inquiries - GOV.UK**

her walking stick. There was no response from staff on the ground floor to the emergency button being pushed.

3.3.5 The staff member called the ambulance. When asked if the bleeding from Sheila's head wound has stopped. She said,

> 'Yes, it's stopped. It's just literally, it's not pouring out of the wound at all but it's like, … I don't know how to describe it. It's like a murder scene. It's shocking.'

3.3.6 When the paramedic arrived, they could not get to Sheila directly because Barbara was acting aggressively smacking her walking stick on the floor and walls, shouting and swearing in his statement. They had to take the long way round.

3.3.7 Sheila was taken to Luton and Dunstable Hospital where her condition deteriorated, and she died the same day.

3.3.8 The forensic pathologist confirmed Sheila's facial fractures were most likely at the severe end of the scale based on a three-point scale of mild moderate severe. Her death occurred as a consequence of the blood loss and stress caused by the assault, with a background of underlying heart disease.

3.4 APPRAISAL OF PRACTICE SYNOPSIS

3.4.1 The Inquest into the death of Sheila was summarized as follows.

3.4.2 There had been sufficient time for Ridgeway Lodge to develop appropriate dementia informed care plans for Barbara

3.4.3 Care plans could have included more details about the risks she presented.

3.4.4 Staffing levels were not reviewed considering acuity or changing demands and risks of residents.

3.4.5 Barbara was known to wander and be confused at night, but there was no indication in her Care Plan of the need for a sensor mat or increased staffing.

3.4.6 Barbara's experiences of wandering and confusion were more frequent than recorded.

3.4.7 In addition, the emergency system for Sheila was ineffective. The impact of her dementia meant that she would not have understood or physically been able to use the emergency call button.

4 Systems findings

4.1.1 Through this SAR, we have identified and prioritised five systems findings. These are issues that make it harder for practitioners and clinicians to do a good job providing timely, effective, rights-based, person-centered care and support for people living with advanced dementia.

4.1.2 In this section, we provide an overview of the systems findings, introduce the structure used to evidence them, and then present teaching findings in more detail.

4.2 OVERVIEW OF SYSTEMS LEARNING

4.2.1 The table below presents an overview of the total package of findings, presenting only the systemic headlines.

Systems findings – overview table

	Systemic issue
1	**NATIONAL STRATEGY, STANDARD & RESOURCING. An apparent inertia at national level around dementia, means England has no national dementia strategy, quality standards, staffing or skill requirements, even for what look like specialist dementia care homes or units. Therefore, the expectations on providers are not clear or mandatory, and CQC's inspection of their regulated activities are also weakened by the lack of clarity about what 'good' looks like for people living with dementia.**
2	**OVERSIGHT. CQC and local authority oversight mechanisms for care homes, are structured around a provider registration with CQC, and make no distinction between different services provided under the same registration. The global focus is also reflected in report formats. This lessens the effectiveness of these mechanisms for people most severely impacted by a dementia, living in locked, 'higher needs' buildings or units. Even where quality issues have been identified, they do not stand out clearly in reports.**
3	**SUPPORT FOR SELF FUNDERS. People who fund their own social care receive little help to navigate the system, increasing the risk of ending up without suitable care arrangements. This can result in their managing without social care, or with insufficient care and potentially putting the person, their carers or others at risk, or arranging more intense care than is required and potentially depriving someone of life in the place they call home.**
4	**ADMISSION PROCESSES FOR SELF-FUNDERS. Self-funders rarely benefit from a Section 9 Care Act care needs assessment conducted by a local authority, and their only assessment is therefore the one carried out by care providers under Regulation 9. This takes place at the point they are seeking admission, often at points of crisis, when the family can no longer cope at home. In these circumstances, care home providers rely exclusively on information from family members, and do not engage with any previous services to have provided home**

	care to the person. This increases the chances that self-funders' needs and risks, are inadequately understood, potentially also creating risks to others living in the same home.
5	**PERSONALISED DECISION MAKING ABOUT BEDROOM DOORS AT NIGHT** **A norm whereby people's bedroom doors remain physically open at night in residential- and nursing care homes, has benefits for staff and residents, but denies choice and best interest considerations for individuals, in what are key safety decisions. This is particularly so because people with dementia who wander cannot be locked into their rooms, on legal and humane grounds. This means tragic incidents of assault are experienced by families as if they come out of the blue because no discussion about potential risks and available mitigations has taken place beforehand.**

4.3 LEARNING TOGETHER STRUCTURE TO SYSTEMS FINDINGS

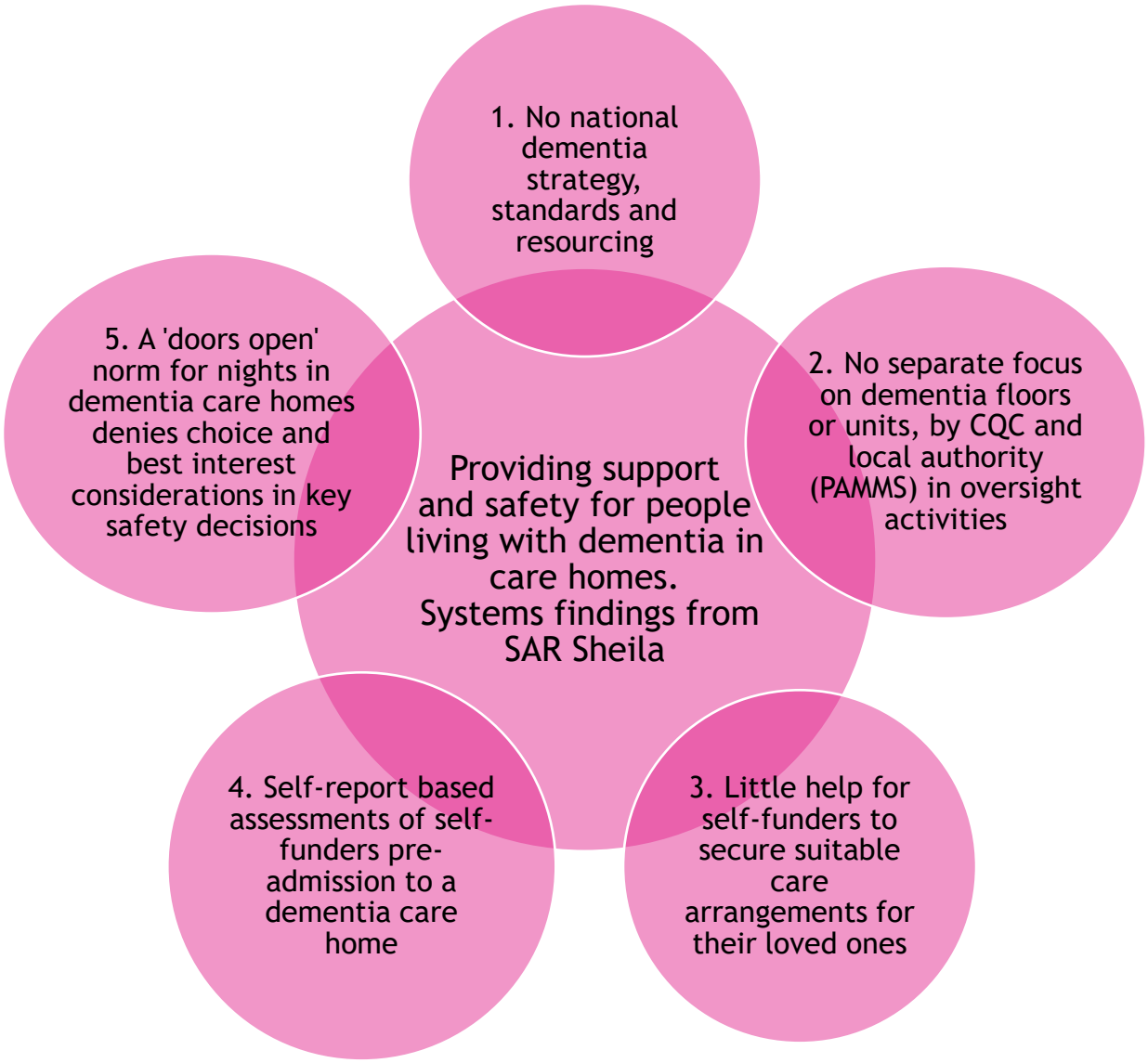
4.3.1 The Learning Together model uses a standardized structure to present and demonstrate systems findings. Each finding is presented using the following sections:

- **Systems finding headline** – this captures the systemic barrier/enabler or pattern that is increasing particular kinds of risks. The consequences are also captured albeit in a brief 'headline' format.
- **Background** this section gives some wider context to the practice area relevant to the particular systems findings. The intention is to make the finding accessible to those who are not necessarily active in the field but outlining some of the basic details necessary to make sense of the presentation of the finding that follows.
- **How did it manifest in the case?** In this section, an illustration is given to show how the particular systems finding showed in the cases of Sheila and Barbara, and what the impact was.
- **How we know it's underlying and not a one-off?** This section starts to describe the discussions or understanding that inform the view of the independent reviewer and review team that the particular issue was not a unique occurrence in the particular case, but something underlying that would impact on other cases, in the present and the future.
- **How widespread is the issue?** This section captures evidence gathered as part of the SAR, to demonstrate whether the systems finding is relevant only to the teams /providers involved in the case, or wider and if so, how widespread their existence is e.g. locally, regionally and/or nationally.
- **How many people are actually or potentially affected?** This section captures evidence gathered as part of the SAR to demonstrate what is known about how many people are or may be affected.
- **So what? Why should this be of concern to the Safeguarding Board and partners?** This section rounds up the presentation of the finding by summarising the organisational risks that the systems issue builds into set-ups, arrangements and ways of working, if left unaddressed.
- **Questions for the SAB to consider as it determines what action is needed.** The Learning Together methodology does not give recommendations for action. Instead, it leaves the SAB to decide who is best placed to make such decisions.

The SAR report gives some brief questions to prompt and support thinking and discussions to inform that decision making.

4.3.2 In using this structure, the aim is to support SAB members and other audiences of the report, to trust the systems findings presented and be confident of the need to act to address them. Often SAR reports identifying findings in a case and go straight to recommendations, without demonstrating the systemic nature of findings identified in the case under review. The Learning Together anatomy of a systems finding, bridges that gap.

Overview of systems findings



4.4 FINDING 1 - NATIONAL STRATEGY, STANDARDS AND RESOURCING

4.4.1 An apparent inertia at national level around dementia, means England has no national dementia strategy, quality standards, staffing or skill requirements, even for what look like specialist dementia care homes or units. Therefore, the expectations on providers are not clear or mandatory, and CQC's registration and inspection processes are also weakened by the lack of clarity about what 'good' looks like for people living with dementia.

ILLUSTRATION FROM RIDGEWAY LODGE

4.4.2 Sheila's son described being both surprised and disappointed at the extent of the failures at Ridgeway Lodge revealed through the Inquest.

> 'To say it was an accident waiting to happen would be wrong. It was no accident. It was the consequence of appallingly poor care'.[14]

4.4.3 Detail in the CQC inspection report that followed Sheila's death supports this view. The picture painted of the dementia care provided was devastating. The lack of specialism was striking. So much appeared perfunctory: tokenistic, meaningless, devastating. I quote the summary:

- We found there were issues with how the registered manager, the provider, and staff supported people who lived with dementia and who expressed forms of distress. Staff training, knowledge and skills in this area was limited. People did not have meaningful reviews of their care to try and find solutions to this distress.
- There was a lack of dementia expertise to promote a safe and personalised care experience for people. There was a lack of stimulation and access to the safe spaces outside, in the grounds of the home, for people living with dementia. Risks associated with dementia were not always explored and captured in risk assessments and care plans, to promote the individuals and others safety and mental well-being.
- When people needed sensor equipment to reduce the risks of falls, this equipment was not always working or positioned correctly.
- There were shortages of staff at night and poor processes to guide staff about what to do if there was reduced staffing, because of staff sickness for example. When evening shifts operated with less staff managers did not investigate these situations to look at what went wrong.
- Staff did not have effective training and competency checks in place. Key training such as dementia training was not embedded into staff practice.
- People's social experience living at the home was not always personalised to reflect their current interests and previous interests. Staff did not routinely chat and spend time with people; their interactions were task focused. Some people commented on how they had got to know the staff, but they also said they had had to work at these relationships. For people who could not do this, some people felt they had a more distant relationship with staff.

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[14] **Inquest jury highlights dementia care home failings in death of elderly woman attacked by another resident as she slept - The B'spoke(n) Word**

- Managers and the provider did not always investigate events when there was a need to, in order to see what had happened and learn lessons from these. Audits and reviews into people's social experiences at the home were limited.[15]

4.4.4 At the Coroner's Inquest, HC-One underlined that they had accepted all the findings of the independent investigation commissioned following Sheila's death. Equally devastating, however, is to know what sound like basic building blocks of care home provision for people living with dementia, were only at this stage being put into place, in the biggest care home provider in the country. They included, for example:

- Dementia skills and knowledge, particularly relating to experiences of stress and distress
- New dementia care manager role per region, to support staff and home managers with expertise, advice and coaching
- Pre-assessment and re-assessment tools, now with a whole section on behaviour challenges and behavioural changes
- A big refurbishment programme to create more dementia friendly built environments
- Values based recruitment
- Use of assistive technology (mat / door sensors) not only for people at risk of falls, but for monitoring if people are getting out of bed at night
- A digital case management and recording system to support daily records, analysis and oversight

4.4.5 The role of the SAR was to get underneath this scenario whereby what appear to be specialist provisions, can in fact be, sometimes fatally, amateur. We tried to understand how such a scenario is possible.

HOW DO WE KNOW IT'S UNDERLYING NOT A ONE OFF?

4.4.6 Getting behind this scenario, revealed what for many involved was a startling picture. It brought the analogy of the emperor's new clothes to mind; the notion that we have been conned when it comes to dementia care, ripped off, but no-one is calling it out. As the number of citizens living with and forecast to be diagnosed with dementia has increased, the policy focus on dementia has decreased. Between 2009 to 2015, the question of dementia care was centre-stage. The first national dementia strategy (2009), and two subsequent 'challenges on dementia' (2012, 2015) announced by the then Prime Minister, indicated a serious intent, at the highest level, to prioritise dementia and strive to make England the best country in the world for dementia care and support by 2020.

4.4.7 Since then, the policy context has been marked by a worrying inertia regarding provision for citizens impacted by dementia. A 10-year plan for dementia, announced by then Secretary of State for Health and Social Care (2022) was aborted and dementia was instead included (2023) in the Major Conditions Strategy. The Major Conditions strategy was then paused (2023), when the Labour government commissioned Lord Dazi to investigate the state of the NHS, to inform a new 10-year plan of reform. Publication of the NHS 10-Year Plan (2025) includes a Service Framework for frailty and dementia, promised by spring 2026. This is billed to set standards for care and

[15] **848c172d-6e92-455b-8b71-5f8d533b047d.pdf** Accessed 20.02.2026

identify the best types of support that health professionals should provide, presumably the result of considerations of how to incorporate the findings from the Major Conditions Strategy into the 10-year plan.

4.4.8 Feedback from the Local Government Association (LGA) to the Department of Health and Social Care (DHSC) on this proposal has raised many points related to whether Service Framework for frailty and dementia will be a clinically focused framework, or if it will be for all services, including social care, voluntary and community groups.[16] Meanwhile, it is unclear whether the Casey Commission and the National Care Service plans will include specific activity related to care for those living with dementia, or whether any other relevant activity is planned.

4.4.9 These changes of policy tack have both raised concerns that dementia is being given insufficient prominence and that more pro-active action on key challenges are needed - see All-Party Parliamentary Group (APPG) on Dementia, the Alzheimer's Society and Chief Medical Officer.[17]

4.4.10 In practical terms, it means that there are currently no clear national standards for what 'good' dementia support looks like, nor any mandated dementia training requirements for health and care staff broadly, or care home staff and managers in particular. NICE guidelines published 2018 and updated, are not considered broad enough for care homes or regulators.[18]

4.4.11 Recent research by the Nuffield Foundation (2024)[19] has recommended:

- Government and the regulator must take a more leading role in signalling what 'good' dementia care looks like
- Government and national workforce bodies should take leadership on equipping the workforce to provide a high standard of dementia care

4.4.12 The Care Quality Commission (CQC) has also recently recognised this need and is committed to co-producing a dementia strategy. Plans include the development and publication of statutory guidance that is co-produced with people with lived experience and key stakeholders, informed by research and evaluation.[20] For care providers, this would cover how do providers meet the requirements of the Health Social Care Act regulations with regards to people living with dementia. It would also be applied in practice in the way CQC assesses new registration applications and on-going monitoring/inspection activity.

4.4.13 CQC published an independent voice report on health and social care support for people with dementia (May 2025).[21] A literature review of good practice in dementia

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[16] **LGA feedback to the Department of Health and Social Care: The Development of the Modern Service Framework for Dementia and Frailty | Local Government Association**

[17] **Awaiting a 10-year dementia plan for England | Alzheimer's Society**

[18] **Overview | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE**

[19] **Nuffield Trust - Dementia and social care_WEB_0.pdf**

[20] **Board meeting: 25 September 2024 - Care Quality Commission**

[21] **Summary - Care Quality Commission**

care is due to be published immanently (March 2026). These two reports will be used to develop the statutory guidance on good dementia care which CQC will begin to coproduce from Autumn 2026. They are also keen to be a convener of other key stakeholders (DHSE, Skills for Care, NICE, SCIE, other regulators, commissioners, etc) to work collectively in this area with a joined-up voice and a shared view of dementia's level of priority.

4.4.14 This important initiative to establish good practice standards for dementia care is therefore still at an early stage and requires other national partners to collaborate.

4.4.15 In the meantime, therefore, registration with CQC of a new dementia care home or a care home newly catering for people living with dementia, can only take place without a robust benchmarking for requisite expertise and capability to assure quality and safety of environment and care.[22] There is no national specificity of what compliance with requirements of the Health Social Care Act regulations (regulated activity) means for people living with dementia. It becomes easier to see how dementia care is not necessarily the specialist care you might expect for yourself or your loved ones.

HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

Nationally

4.4.16 We are an ageing population in England and Wales. Census 2021 results show the population of England and Wales has continued to age since 2011. The number of people aged 65 years and over increased from 9.2 million in 2011 to over 11 million in 2021 and the proportion of people aged 65 years and over rose from 16.4% to 18.6%.[23]

4.4.17 Recent research has projected that the number of older people with dementia will more than double (108% increase) over the next 25 years. The Alzheimer's Society estimates that there are approximately 982,000 people living with dementia in the UK and this is projected to rise to 1.4 million in 2040.[24]

4.4.18 An especially sharp rise, almost doubling, is estimated in the number of older people with advanced or severe dementia. As a result, the number living in care homes is projected to rise by 166% over the 25-year period.[25]

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[22] CQC provider registration requires a statement of purpose, which includes the type of service i.e. residential or nursing home and the type of 'service user' they intend to provide the service for. These are called 'Service User Bands' and are selected from a drop-down menu of service specialisms which includes: dementia; caring for adults over 65 yrs; caring for adults under 65 yrs; physical disabilities etc. how many people potentially affected?

[23] **Profile of the older population living in England and Wales in 2021 and changes since 2011 - Office for National Statistics**

[24] **Local dementia statistics | Alzheimer's Society**

[25] **(PDF) Projections of care for older people with dementia in England: 2015 to 2040** Age and Ageing 2020;49:264–269 doi: 10.1093/ageing/afz154 Published electronically 6 December 2019

Locally

4.4.19 A recent Dementia Health Needs Assessment for Bedford Borough 2025[26] provides the following descriptive epidemiology:

> There were approximately 1,500 people registered as living with dementia in Bedford Borough in 2024. However, it is estimated that more than three in every one hundred people living with dementia are undiagnosed, meaning there may be almost 2,500 people truly living with dementia. • Dementia is the leading underlying cause of death in England and Wales. The rate of death from dementia is not significantly different in Bedford Borough when compared to the England average. • The number of people living with dementia in Bedford Borough is forecast to increase between 54% and 86% between 2023 and 2043, depending on the assumptions of the forecasting model. This is equivalent to approximately 1,500 additional people living with dementia.

4.4.20 The equivalent for central Bedfordshire 2025[27] states:

> There were approximately 2,000 people registered as living with dementia in Central Bedfordshire in 2024. However, it is estimated that almost 4 in every 10 people living with dementia are undiagnosed, meaning there may be closer to 4,000 people truly living with dementia. • Dementia is the leading underlying cause of death in England and Wales. The rate of death from dementia is lower in Central Bedfordshire when compared to the England average. • The number of people living with dementia in Central Bedfordshire is forecast to increase between 57% and 93% between 2023 and 2043, depending on the assumptions of the forecasting model. This is equivalent to approximately 2,000 additional people living with dementia.

4.4.21 The CQC website lists over 80 care homes in the local authority areas of Bedford and Central Bedfordshire that are registered with the specialism of dementia.

WHAT IS THE GEOGRAPHIC SPREAD OF THE ISSUE?

This is a national finding, so it impacts across the country.

SO WHAT? WHY SHOULD IT MATTER?

4.4.22 Local Health Needs Assessments identify that:

- one in every 71 people in the entire UK population lives with dementia
- one person in every 14 aged 65 or older in the UK, who live with dementia.

4.4.23 Dementia care will touch all of us, directly and indirectly through loved ones, often both. Yet England is the only UK nation without a specific dementia care plan and dedicated funding.

4.4.24 Critical gerontology alerts us to the way that explicit and implicit agism risks impacting in particular, approaches to people impacted by more advanced dementia, who fall short of the independent 'third age' ideal – productive, cognitively intact, self-managing,

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[26] **Bedford Borough Dementia HNA 2025 | Bedford JSNA**

[27] **Health Needs Assessments | Central Bedfordshire JSNA**

or autonomous and independent.[28] As care is consolidated as a financial asset, the need for a national strategy held within a democratic framework becomes even more pressing.[29]

Finding 1: An apparent inertia at national level around dementia, means England has no national dementia strategy, quality standards, staffing or skill requirements, even for what look like specialist dementia care homes or units. Therefore, the expectations on providers are not clear or mandatory, and CQC's registration and inspection processes are also weakened by the lack of clarity about what 'good' looks like for people living with dementia

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- Is this a national finding that the SAB would want to escalate through the National Chairs Network?
- What can the National Chairs network do to promote and support the CQC's dementia strategy?
- How might this finding be fed into the Cassey Commission on adult social care?
- Are there other forums the SAB can use to raise this issue?
- How would the SAB know if things had improved?

Link back to table of findings

4.5 FINDING 2 DEMENTIA CARE HOME OVERSIGHT

CQC and local authority oversight mechanisms for care homes, are structured around a provider registration with CQC, and make no distinction between different services provided under the same registration. The global focus is also reflected in report formats. This lessens the effectiveness of these mechanisms for people most severely impacted by dementia, living in locked, 'higher needs' buildings or units. Even where quality issues have been identified, they do not stand out clearly in reports.

ILLUSTRATION FROM RIDGEWAY LODGE

4.5.1 Ridgeway Lodge is a registered care home, providing residential care for people with dementia. It is arranged on two floors, with the ground floor catering for residential clients and the first floor catering for residential clients with dementia and higher needs. The two units ran with separate staff allocations, and there was no movement of people between the floors. The first floor was locked.

[28] (7) A 'modern services framework' on frailty and dementia must be bold about the future of geriatrics and gerontology | LinkedIn

[29] When £6.4 Billion Buys Silence: Who Really Owns Our Care Homes Now? | Jackson Bollocks

4.5.2 The CQC website shows that in total, Ridgeway Lodge has had six inspections over seven years. These summarised in the table below:

CQC inspections – summary table

Owner/run by	CQC visit	Report	Type of inspection	Number of inspectors	Overall rating	Ratings
BUPA Care Homes LTD	Oct 2016	Jan 2017	Unannounced – triggered by concerns	one	Inadequate	
BUPA Care Homes LTD	20-21 June 2017	July 2017	Follow-up	One inspector and 2 experts by experience. And specialist in medication management	All	
HC-One Oval Ltd	Jan 2020	Mar 2020	Unannounced (in full report) Planned (in summary) inspection based on previous rating (good published July 2017)	One inspector; one Expert by Experience;	Breaches in staffing and QA systems. Action plan and re-inspection	
HC-One Oval Ltd	Aug 2020	Sept 2020	Announced. Targeted inspection linked to Covid-19 to look only at Infection Control Measures		Not rated but 'were assured' throughout	
CH-One No.1 Ltd	13, 18, 27 Oct 2022	Dec 2022	Triggered by death of Sheila H. Last rating Mar 2020 was Required Improvement. Provider completed an action plan of what by when. Now still in breach	3 inspectors; 1 specialist advisor nurse with knowledge of dementia care and x2 Experts by experience	Requires Improvement overall and across the board	
HC-One No.1 Ltd	15, 20 June 2023	July 2023	To review breaches in regulation found at last inspection	2 Inspectors and x1 Expert by Experience.	Good	

4.5.3 Each report begins with a section titled 'about the service', but the arrangement over two floors is only described in one of the six reports. In the same report (Jan/March 2020), the issue of insufficient staff to support people safely is detailed as especially pressing on the first floor, where people had higher support needs. Otherwise, it is mentioned in only two of the other reports, and then only as part of illustrations of wider points e.g. responsiveness of the service to preference, with the example of accommodation of a family's wishes for someone moved downstairs (June/July 2017); e.g. people going out into the garden more, with the example of 'even' someone from the first floor having gone out recently (June/July 2023).

4.5.4 Reference to distress, agitation or aggression, that one would expect to occur more often for people living on the first floor, was also notable in its absence. It was only referenced in the inspection triggered by Sheila's death, and the most recent, where clarifications were made with use of the sentence: 'This included people living with dementia who may show behaviour indicating distress'.

4.5.5 However, these elements relating specifically to the first-floor service are dispersed throughout the different sections of the report and therefore not easy to find. There is no summary box, for example, detailing highlights of the inspection relevant to the service to people living on the first floor.

4.5.6 PAMMs (Provider Assessment Management system) is well established in the Eastern Region, where it has been used as the basis for local authority quality assurance and oversight of care providers. This includes Bedford Borough and Central Bedfordshire. It provides a structured focus across five domains and 16 regulatory standards. Like CQC inspections, its focus is on the provider as a whole and therefore, like CQC reports, PAMMs reports do not differentiate between different units either.

HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE OFF?

4.5.7 Input from the review team, including CQC and people in local authority quality assurance roles, confirmed that the approach described above for Ridgeway Lodge, as standard. Inspections and reports focus on the provider as an entity, incorporating all different buildings, services or units. Report structures do not present findings separately for different aspects or client groups of the registration.

HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

4.5.8 See Finding 1.

WHAT IS THE GEOGRAPHIC SPREAD?

4.5.9 Finding 1 indicates that across Bedford Borough and Central Bedfordshire there are approximately 80 care homes offering services for people with dementia. It is not possible to identify how many of these run separate units or floors, for people with higher needs linked, among possibly other things, to more advanced dementia.

SO WHAT? WHY IS IT IMPORTANT TO ADDRESS?

4.5.10 Finding 1 highlighted a significant systemic weakness in that England is unique in the UK, in not having a dementia strategy, standards or linked funding which means standards of 'good' care are not prescribed for dementia care specifically, and there is no mandatory level of training for staff in dementia care. This impacts the registration process, and the expectations against which any care home can be inspected. Here, with Finding 2, we detail an additional factor that exacerbates and compounds Finding 1. The available mechanisms of quality assurance and oversight provided by CQC and local authorities, do not distinguish in their approaches, particular buildings or units that are explicitly designed to support people living with dementia who have the highest support needs. This means key mechanisms to assure quality and identify problems, work least well for the most dependent and vulnerable people living in residential dementia care.

Finding 2: CQC and local authority oversight mechanisms for care homes, are structured around a provider CQC registration, and make no distinction between different services provided under the same registration. The global focus is also reflected in report formats. This lessens the effectiveness of these mechanisms for people most severely impacted by a dementia, living in locked, 'higher needs' buildings or units. Even where quality issues have been identified, they do not stand out clearly in reports.

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- Can CQC assessment report design be adapted to include a new heading or summary box related to any dementia specialist floor/unit, as a quick win from this SAR?
- How might PAMMs be adapted to do the same?
- What other options are there for tackling this finding locally?
- How would the SAB know if things had improved?

Link back to table of findings

4.6 FINDING 3 – SUPPORT FOR SELF-FUNDERS

People who fund their own social care receive little help to navigate the system, increasing the risk of ending up without suitable care arrangements. This can result in their managing without social care, or with insufficient care and potentially putting the person, their carers or others at risk, or arranging more intense care than is required and potentially depriving someone of life in the place they call home.

ILLUSTRATION FROM BARBARA'S EXPERIENCE

4.6.1 Barbara's daughter's experiences in trying to arrange the best care for her mother as her dementia progressed, are a powerful illustration of how the care system currently works for people who fund their own social care – or 'self-funders' - and how little help is available to navigate it. It also illustrates the risks that can unintentionally result, for everyone involved.

4.6.2 Barbara's daughter first went to visit Ridgeway Lodge in November 2021, with a view to her mother moving in. The care home was only six minutes from her own house, and she had friends whose grandparents had been there. She did not look at CQC's website but went on what people she trusted said: it was a good home, clean.

4.6.3 Her mother had first been diagnosed with vascular dementia when she was 84. Even after four years, Barbara was living well and the impact of dementia was minimal. At that point, her daughter had no idea how the disease would develop for her mother; 'You don't realise what it does to a person'.

4.6.4 After diagnosis, Barbara's care was passed back to her GP, as is standard. The GP conducted an annual dementia review. Otherwise, Barbara's daughter occasionally rang Age Concern if she had a query. Barbara was a Luton Borough Council resident. She had had a Care Act needs assessment at some point, resulting in a bath lift and stair rail.

4.6.5 As Barbara's dementia progressed, her daughter described her as becoming nocturnal. She had also started opening the front door, to check that she had locked it, raising safety concerns. She would also ring her daughter constantly, day and night. Then behavioural changes also began. Barbara became verbally aggressive and also unkind toward her daughter, when she tried to support her with daily needs. Her daughter, who also needed to continue her full-time job, was totally exhausted.

4.6.6 When her GP asked how she was, she would just cry. The GP encouraged her to have a conversation with Barbara about moving into a care home. She tried but Barbara said she would not go. She said very clearly 'No!'.

4.6.7 Barbara did not have a social worker, and her daughter did not know she could approach the local authority again as her mother's needs increased, for a s.9 needs assessment.

4.6.8 Her daughter then tried live-in carers for three weeks. She used Elder Care locater,[30] an online service that allows clients to source carers local to them. Clients choose from available carers' profiles, that meet their specified needs. Barbara's daughter selected a carer on the basis that she had the most experienced according to the website. What

[30] **Elder Care | Home**

was not clear at the point of selection was that her experience was within a care home environment and not as a live in carer at that time.

4.6.9 The carer gave evidence at Sheila's Inquest. She described how different Barbara's presentation was to that described in the care plan. Barbara did not understand that she (the carer) was there to care for her, and thought she was an intruder. She was very distressed and aggressive toward the carer. She would take her walking stick and go to attack the carer. When the carer took the walking stick away and hid it in the garden, she described that Barbara would instead go to get pots from the kitchen to use as a weapon. After the first day, when Barbara's daughter returned from work, the carer told her to call the GP and ask for Lorazepam – a sedative for short-term use for anxiety.

4.6.10 The carer described that she did not leave the job immediately because she understood that having someone new in her house was a major change for Barbara, and understandably disconcerting. She hoped therefore that with time Barbara would get used to her and feel less distressed, and the situation would calm down.

4.6.11 The lorazepam did help; Barbara was calmer after taking it. But as soon as the effects wore off, she would get agitated and aggressive again. The carer described how she had barricaded the door to the room where she slept, to keep herself safe.

4.6.12 Finally, she told the office that she needed to stop the job because Barbara was too aggressive. It was at this point that Barbara's daughter re-approached Ridgeway Lodge – the admission process is addressed in the next finding. Barbara initially went into the care home for respite.

HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE OFF?

Research

4.6.13 Research (2021)[31] that reviewed the scientific literature to find out what skills are required for arranging social care, highlighted the following requirements:

- the ability to search for and manage information about their options
- objective decision-making between options
- the ability to manage money and budgets
- administrative skills to manage paperwork
- skills in employing care workers – for example writing job descriptions, advertising for carers, dealing with contracts and sorting out salaries, national insurance and legal issues
- negotiation skills to decide on payment rates
- people management skills.

4.6.14 The list of skills required to successfully navigate the system to arrange social care is described as 'daunting':

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[31] **People who fund their own social care receive little help to navigate the system** or Kate Baxter, Mark Wilberforce, Yvonne Birks, What Skills Do Older Self-Funders in England Need to Arrange and Manage Social Care? Findings from a Scoping Review of the Literature, *The British Journal of Social Work*, Volume 51, Issue 7, October 2021, Pages 2703–2721, **https://doi.org/10.1093/bjsw/bcaa102**

'They are more like the tasks carried out by a senior manager, than something older people or their families, with no experience of social care, can do on their own.'

4.6.15 The same research found that self-funders generally receive little help to navigate the system.[32] There are also many challenges on receiving financial advice.[33]

4.6.16 The study highlighted the implications for the suitability of decision making about care arrangements:

- People without these skills trying to arrange care may end up without suitable arrangements. They might try to manage without social care, or with insufficient care, and put their health at risk.
- Alternatively, they might arrange more intense care than is required. For example, people might enter residential care when with more advice, they could have remained in their own home with personal care and support. This could mean they run out of money to fund the care sooner than they otherwise would have done. In that case, they might need to fall back on council-funded support.

4.6.17 The study reported that while a network of friends or family could help or make recommendations, not everyone was able to rely on this.

4.6.18 In addition, they found that, as with Barbara's experiences, decisions were often made at a point of crisis, when people were emotional and less able to take objective decisions. Previous research had also shown that people who self-fund want better access to information about funding social care.[34]

4.6.19 The research described above addresses all care scenarios. There is also research specifically on planning for future care related to dementia (2025).[35] Here findings highlight that the challenges in accessing support included:

- Participants sought to feel secure by following recommended practices, manage uncertainty, avoid crises, share burdens within families, and avoid poor end-of-life experiences. However, support was often lacking.
- Many were unable to speak with specialists and described limited conversations with GPs, leaving them with unaddressed questions. Some described feelings of abandonment.
- Disease progression was commonly poorly explained, with some participants later encountering information they found confronting.

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[32] **People who fund their own social care receive little help to navigate the system** or Kate Baxter, Mark Wilberforce, Yvonne Birks, What Skills Do Older Self-Funders in England Need to Arrange and Manage Social Care? Findings from a Scoping Review of the Literature, *The British Journal of Social Work*, Volume 51, Issue 7, October 2021, Pages 2703–2721, **https://doi.org/10.1093/bjsw/bcaa102**

[33] **109.-SSCR-research-findings_RF109.pdf**

[34] See **Independent financial advice about funding social care in later life Research 109.-SSCR-research-findings_RF109.pdf**

[35] **"You like to be in control of your own destiny to a degree, don't you?": conscientious autonomy and planning for future care with dementia | BMC Palliative Care | Springer Nature Link**

- Carers who continued researching the condition felt responsible but under-resourced for discussing disease progression with their relative and believed this should be undertaken by a professional.
- Formal processes—e.g. Lasting Power of Attorney (LPAs), advance care planning, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) could prompt informal discussions but gaining an overview was difficult, with confusion about how they would be utilised, what information to include an apparent overlap between processes.
- Misunderstandings about medical and end-of-life decision-making were commonplace.

4.6.20 Pertinently, participants were those who had done some planning for future care, leading the authors to emphasis: 'If even those who are most conscientious about planning for future care struggle to access adequate support, others are likely to face greater challenges.'

Locally

4.6.21 The recent Health Needs Assessments[36] on dementia, for both Bedford Borough Council and Central Bedfordshire identified that organisations which are commissioned to provide support for people living with dementia across the two authorities include, but are not limited to, Tibbs Dementia Foundation, Carers in Bedfordshire and the Dementia Intensive Support Service. These provide a range of different resources and services – detailed thoroughly in the respective reports.

4.6.22 While locally across Bedford Borough and Central Bedfordshire through the commissioned services, many useful resources are available, the SAR did not access any evaluation to ascertain how well known and accessed these are locally, nor how useful self-funding families find them to be.

4.6.23 **TIBBs** contributed generously to this SAR. Tibbs Dementia Foundation, formed in 2013 and granted charitable status in 2016, aims to enrich the lives of individuals living with dementia and their carers, through a range of groups and activities offered in face-to-face and online settings. As of November 2024, Tibbs had approximately 75 volunteers and 9 full-time staff members, with many volunteers having used Tibbs services in the past. The service is funded through a contract to deliver dementia post-diagnosis support services and is jointly commissioned by BBC, CBC and BLMK ICB; along with charitable grants and community fundraising.

4.6.24 TIBBs confirmed that the question about what would have been helpful for people during the dementia journey, in when and how to find and access a suitable care home and wider social care whilst at home is a key question. Their experience indicates that this is a difficult transition for many families, and while there has been a lot of focus on the pathway of care around diagnosis, there has not been the equivalent focus on this later phase.

HOW MANY PEOPLE POTENTIALLY AFFECTED?

4.6.25 **'Self-funders'** Social care in England is funded through a combination of state funding and individuals' private resources. Eligibility for state-funded social care involves a needs test (more below) and a means test. This means that the majority of people pay

[36] **Bedford Borough Dementia HNA 2025 | Bedford JSNA**; [36] **Health Needs Assessments | Central Bedfordshire JSNA**

a contribution or all of the costs themselves, depending on their savings and assets, as follows:

- **Self-funding:** If your assets exceed £23,250, you pay all costs.
- **Partial Funding:** If you have between £14,250 and £23,250, you receive some council support but contribute to your fees.
- **Full Funding:** If your assets are below £14,250, the council may pay, but you still contribute from your income.[37]

4.6.26 Nuffield Trust estimated that fewer than half of older people with care needs were receiving publicly funded support (including support from unpaid carers).[38] Long-running cuts to local authority budgets have meant that funding has failed to keep pace with demographic pressures. Currently, nearly one-third of requests for local government funding result in no support. Unmet need puts pressure on the five million self-identified unpaid carers in England and Wales to provide support for their families and friends, and demand is unlikely to be met without significant funding increases.[39]

4.6.27 According to ONS data from 2022/23,[40] nationally people in CQC registered care homes who are state funded (63%) outnumber those self-funding (37%). Of a total of 372,035 people, 137.480 are self-funded.

4.6.28 Comparing regions, the East of England region has the highest proportion of self-funded care home residents. Central Bedfordshire stands at 42.1% and Bedford Borough at 35.4%.

4.6.29 The Eastern region also has the highest proportion of self-funded residents in care homes for older people and/or providing dementia care at 44.7% of a total of 37,445 people.

WHAT IS THE GEOGRAPHIC SPREAD OF THE ISSUE?

4.6.30 Available research suggests that a lack of accessible and practical support for self-funders is a national issue.

4.6.31 Within the capacity of the SAR, no data has been identified to distinguish between Bedford Borough and Central Bedfordshire, or between regions of the country.

SO WHAT? WHY IS IT IMPORTANT TO ADDRESS?

4.6.32 The potential of new disease modifying drugs for dementia attracts much media and political attention. This is despite the declining productivity of the biomedical sector, and to the detriment of attention to how people and their carers, can live well with dementia, for as long as possible. A brilliant Think Local Act Personal (TLAP) report is an important contribution to re-energise this discussion around living well.[41]

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[37] **Social care - charging for care and support 2026 to 2027: local authority circular - GOV.UK**

[38] **The decline of publicly funded social care for older adults | Nuffield Trust**

[39] **Adult Social Care: Key facts And figures | The King's Fund**

[40] **Care homes and estimating the self-funding population, England - Office for National Statistics**

[41] **'I just want to be able to dance' - TLAP**

4.6.33 Leading charities have also been criticised recently for appearing, through their public communications, to be:

> 'Now focused only on the 'late stages' and portrayed the experience of living with dementia as one defined solely by the underlying condition. This left little scope to imagine people living with dementia as active agents in their own lives or as people with gifts and talents to contribute to their families and communities. Moreover, such narratives say nothing about the social conditions or supports that could offer the potential for people to live a good quality of life and maintain their health and wellbeing despite living with dementia.' [42]

4.6.34 This finding highlights the importance of avoiding polarization in this debate.

4.6.35 This finding indicates that on the ground, support families, especially self-funders, at the later stages of the disease is missing. Without this, and despite the very best intentions, paid and unpaid carers can be put at risk of physical and emotional harm, while loved ones are left suffering high levels of distress.

4.6.36 DHSC has recognised this gap. At the time of writing, DHSC is currently looking at the self-funder care journey to better support people and families when they're arranging care for themselves or someone else. They have launched a short survey (around 10 minutes) to hear directly from people with lived experience of finding and paying for care. The insights will help identify where information, advice, and policy could better meet people's needs. They are particularly interested in:

- What support helped identify the right care package
- What information/advice supported decision-making
- What influenced choice of provider
- What support would improve the overall experience

4.6.37 The results will be directly relevant to this finding.[43]

Finding 3: People who fund their own social care receive little help to navigate the system, increasing the risk of ending up without suitable care arrangements. This can result in their managing without social care, or with insufficient care and potentially putting the person, their carers or others at risk, or arranging more intense care than is required and potentially depriving someone of life in the place they call home.

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- What do the SAB and partners know about how well known or accessed the available local resources to support local self-funders are?
- How sufficient is this provision relative to the numbers of people locally living with dementia?
- What do the SAB and partners know about the range of online services matching people with potential carers locally, the information they provide, including safeguarding procedures?

[42] **What needs to improve for social care to better support people with dementia? | Nuffield Trust**

[43] The contact provided for the survey is: ***william.blanc@dhsc.gov.uk***

- What do the SAB and partners know about the guidance and support provided by GPs once the behaviour of someone living with dementia becomes agitated and aggressive, and how this might be strengthened?
- What more should be done to support people with dementia to navigate all the services they use?
- How might the SAB and partners engage with the DHSC work in this area?
- Is this an issue to escalate to the National Chairs Forum for consideration of national recommendations such as a national role akin to the Independent Mental Health/Mental Capacity Advocates, with a remit to support self-funders with admission and later oversight/review of care packages?

Link back to table of findings

4.7 FINDING 4 – CARE HOME ADMISSION PROCESSES FOR SELF-FUNDERS

Self-funders rarely benefit from a Section 9 Care Act of care needs assessment conducted by a local authority, and their only assessment is therefore the one carried out by care providers under Regulation 9. This takes place at the point they are seeking admission, often at points of crisis, when the family can no longer cope at home. In these circumstances, care home providers rely exclusively on information from family members, and do not engage with any previous services to have provided home care to the person. This increases the chances that self-funders' needs and risks are inadequately understood, potentially also creating risks for others living in the same home.

ESSENTIAL BACKGROUND

4.7.1 **Local authority Needs assessments** Section 9 of the Care Act 2014 states that local authorities have a duty to assess need for anyone where there is the appearance of need, regardless of who later pays to address those needs. This means that everyone is entitled to a needs assessment by the local authority ahead of any discussion of their financial situation.[44] This is intended to describe the amount of help an individual needs, regardless of who pays. The legislation is shown in the box below.

[44] Care Act 2014

Assessing needs

Assessment of an adult's needs for care and support

(1) Where it appears to a local authority that an adult may have needs for care and support, the authority must assess—

(a) whether the adult does have needs for care and support, and

(b) if the adult does, what those needs are.

(2) An assessment under subsection (1) is referred to in this Part as a "needs assessment".

(3) The duty to carry out a needs assessment applies regardless of the authority's view of—

(a) the level of the adult's needs for care and support, or

(b) the level of the adult's financial resources.

(4) A needs assessment must include an assessment of—

(a) the impact of the adult's needs for care and support on the matters specified in section 1(2),

(b) the outcomes that the adult wishes to achieve in day-to-day life, and

(c) whether, and if so to what extent, the provision of care and support could contribute to the achievement of those outcomes.

4.7.2 The Care and Support Statutory Guidance (2025)[45]emphasizes that an assessment much always be appropriate and proportionate. This includes:

> The severity and overall extent of the person's needs. For example, an individual with more complex needs will require a more detailed assessment, potentially involving a number of professionals. A person with lower needs may require a less intensive response (para 6.4.2b).

4.7.3 Input from other agencies and professionals is supported when it is required:

> People may approach a local authority for an assessment, or be referred by a third party, for a number of reasons. The 'assessment' which they receive must follow the core statutory obligations, but the process is flexible and can be adapted to best fit with the person's needs, wishes and goals. The nature of the assessment will not always be the same for all people, and depending on the circumstances, it could range from an initial contact or triage process which helps a person with lower needs to access support in their local community, to a more intensive, ongoing process which requires the input of a number of professionals over a longer period of time (para 6.4).

[45] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#first-contact-and-identifying-needs

4.7.4 **Care Home pre-assessments**. Under Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,[46] providers must undertake a pre-admission assessment in collaboration with the person. The purpose is to ensure they have the skills, staff and facilities to meet the specific care, health, emotional and social needs of the person, and manage any risks assessed.

4.7.5 The principle of person-centred care is the rationale for this requirement of a direct assessment, rather than relying on a third-party report. Providers are expected to review and draw on assessments from other professionals e.g. hospitals, local authorities, or other agencies, but must not rely on these as a substitute for their own assessment.

ILLUSTRATION FROM BARBARA'S EXPERIENCE

4.7.6 The nature of the assessment process undertaken prior to Barbara moving to Ridgeway Lodge care home, illustrates a common pattern for self-funders.

4.7.7 When Barbara's daughter contacted Ridgeway Lodge for the second time, she recalls a conversation with the team leader, where she explained that her mother was now getting much more aggressive, mainly toward her daughter. She recalls the member of staff saying that there were other people who are agitated currently living at Ridgeway Lodge, so she would need a team meeting to see if the staffing levels were sufficient to accommodate Barbara as well. We have found no reference to any record of this decision making, but it was later agreed that Barbara could move in.

4.7.8 As described in Finding 3, Barbara had not had a recent Section 9 Care Act needs assessment by Luton Borough Council. She had not come from hospital, so there were no professional assessments for Ridgeway Lodge to review, in the conduct of their own Regulation 9 assessment.

4.7.9 The independent investigation conducted after Sheila's death provided detailed information about the Moving in Assessment conducted on Barbara. It notes that at the time HC-One had a comprehensive Care Planning Procedure (reference PRO-CAP-01, v 4.4). After the incident it was in the process of being reviewed and improved – as described in **Finding 1**. The procedure stated that the 'Moving in Assessment', baseline observations, seven-day care plan and resident profile must be completed within 24 hours of admission, and these had been completed for Barbara at that time. The initial assessment completed for Barbara was the HC-One 'Moving in Assessment'. This was recorded as completed on 22 April 2022. We understand that this was the date the Barbara was originally intended to arrive, but she did not in fact arrive until 11 May 2022.

4.7.10 The moving in assessment is described as a generic 14-page assessment tool which is then used to form the basis of the 'outcome-based care plan' and provided initial guidance on Barbara's needs.

4.7.11 The investigation concluded that the documentation in place at the time of Barbara's moving in, did not lend itself sufficiently to form a basis for a dementia informed care plan. In particular, the questions and space related specifically to dementia and behaviours as a consequence of dementia were insufficient.

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[46] **Regulation 9: Person-centred care - Care Quality Commission**

4.7.12 Despite this, the investigation confirms that the information provided by Barbara's daughter (as above) was all noted:

> 'Under the section on 'Mood' the assessment notes "Barbara may occasionally become stress[ed] and distress[ed] when left alone for long time, or when she does not know what is going on around her or if it a day or night-time." Also, that "not knowing what is happening" could cause her distress, but that one-to-one chats, a cup of tea and reassurance would ameliorate this distress.
>
> Under the section 'Reason for moving in' it is recorded that "Barbara's daughter stated that Barbara requires 24 hours support to ensure her safety… [and] to ensure that her personal care needs are met, to ensure adequate food and fluid intake, medicines management, as without support mum would be at risk of malnutrition, self-neglect, deterioration in health."'

4.7.13 There appears to be a later handwritten entry which includes

> 'DC has stated that Barbara is very verbally challenging towards her now when she is supporting or trying arrange things for her, she said she will shout and swear at her and be very unkind towards her.'

4.7.14 Barbara's daughter also gave all of her mother's medication to Ridgeway Lodge, including the Lorazepam prescribed by the GP following the incident of agitation and aggression towards the live-in carer, as described in **Finding 3**. This was not, however, listed in the admission forms.

4.7.15 A key focus of question in the Coroner's Inquest was on whether Barbara's daughter had directly informed Ridgeway Lodge about those incidents of physical aggression and the reason for the Lorazepam.

4.7.16 Here we suggest that it is more pertinent to highlight that the assessments completed by the care home within the first 24 hours, relied exclusively on information from Barbara's daughter and the care home's own observations. There was no request for information from any other service, including the previous home care provider. This made them wholly reliant on Barbara's daughter for relevant information.

HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE-OFF?

4.7.17 Discussion with the review team during this SAR indicated that anecdotally the right to a s.9 care needs assessment by the local authority is not well known. The assumption therefore is that few self-funders approach their local authority for one.

4.7.18 Even if they did, nationally, waiting lists in social care across country are significant. Some 245,820 adults were waiting for an assessment as of August 2022. Waiting times for a social care assessment are lengthy, with an estimated 33% of adults waiting over 6 months in August 2022, up from 20% in November 2021. Nuffield research indicates that part of the reason for this bottleneck could be pent-up demand due to a decline in social care activity during the pandemic, alongside a decline in local authority staff giving advice and information or carrying out assessments combined with a lack of

capacity within providers to take on new clients.[47] We can assume therefore that most self-funders are assessed only by the provider, at the point of admission.

4.7.19 While care home providers are mandated to carry out this assessment, how they do it is not prescribed. We understand, however, that it is common for the assessment process to rely on information from the family.

4.7.20 There are other Safeguarding Adult Review reports that have highlighted that the assessment of needs and risks undergone by a person seeking admission to residential care differs greatly depending on if they are funding their own care or not, because the latter will have received a thorough, holistic local authority assessment while the former will usually not. Calderdale SAR highlighted the risks created, that information about individuals that could affect safety for other residents goes undisclosed.[48] See also Finding 3 in a Suffolk SAR on the death of May Miler.[49] The failed efforts of the care home where May Miller was staying, to gain relevant information from a GP related to a potential new resident, was a key concern in the Prevention of Future Deaths report by the Suffolk Coroner.[50]

HOW MANY PEOPLE POTENTIALLY AFFECTED?

4.7.21 The figures around self-funders are the same as for the previous finding.

4.7.22 According to ONS data from 2022/23,[51] nationally people in CQC registered care homes who are state funded (63%) outnumber those self-funding (37%). Of a total of 372,035 people, 137.480 are self-funded.

4.7.23 Comparing regions, the East of England region has the highest proportion of self-funded care home residents. Central Bedfordshire stands at 42.1% and Bedford Borough at 35.4%.

4.7.24 The East region also has the highest proportion of self-funded residents in care homes for older people and/or providing dementia care at 44.7% of a total of 37,445 people.

WHAT IS THE GEOGRAPHIC SPREAD?

4.7.25 Within the capacity of the SAR, we have not found any research that speaks to regional variation in the matter of pre-admission assessments for self-funders by care home providers.

SO WHAT? WHY IS IT IMPORTANT TO ADDRESS?

4.7.26 Social care is means-tested and seems likely to remain so. By the nature of congregate settings, any single person's safety is as dependent on the understanding and management of risks of others, as it is of the quality of their own care and support. This finding highlights key vulnerabilities in current arrangements at initial points of admission, by preferencing robust professional, independent assessments only for

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[47] **The decline of publicly funded social care for older adults | Nuffield Trust**

[48] **SAR-In-Rapid-Time-Systems-Findings-Report.pdf**

[49] **nf_SAR-in-Rapid-Time-Systems-finding-report-FINAL.pdf**

[50] **May Miller - Courts and Tribunals Judiciary**

[51] **Care homes and estimating the self-funding population, England - Office for National Statistics**

those whose levels of savings are low enough to allow them state funding, and not for those who need to self-fund their own care.

Finding 4: **Self-funders rarely benefit from a Section 9 Care Act of care needs assessment conducted by a local authority, and their only assessment is therefore the one carried out by care providers under Regulation 9. This takes place at the point they are seeking admission, often at points of crisis, when the family can no longer cope at home. In these circumstances, care home providers rely exclusively on information from family members, and do not engage with any previous services to have provided home care to the person. This increases the chances that self-funders' needs and risks are inadequately understood, potentially also creating risks for others living in the same home.**

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- What potential is there for the Board to address the disparity between assessments for self-funders and local authority-funded residents by encouraging higher standards in pre-admission assessments by providers across the board?
- Is there a role for the SAB to develop and promote quality standards around this issue?
- What might be done to enable or require multi-agency input, including previous carers, to inform good decision making at pre-assessment to care home admissions for self-funders?
- How can the Board be assured of the robustness of providers' assessments of need and risk, at the point of admission of self-funders and assessments adequately consider risks to others?

Link back to table of findings

4.8 FINDING 5 – PERSONALISED DECISION MAKING ABOUT BEDROOM DOORS AT NIGHT

A norm whereby people's bedroom doors remain physically open at night in residential- and nursing care homes, has benefits for staff and residents, but denies choice and best interest considerations for individuals, in what are key safety decisions. This is particularly so because people with dementia who wander cannot be locked into their rooms, on legal and humane grounds. This means tragic incidents of assault are experienced by families as if they come out of the blue because no discussion about potential risks and available mitigations has taken place beforehand.

ILLUSTRATION FROM SHEILA & BARBARA'S EXPERIENCES

4.8.1 This illustration starts by outlining what was identified after Sheila's death, about the extent of Barbara's wandering, distress and outbursts of aggression, before presenting what we have learnt about safeguards regarding people with dementia who wander as well as regards other people in care homes at night.

The extent of Barbara's wandering and disorientation

4.8.2 Barbara, after being moved into Ridgeway Lodge, experienced time shifts and delusions linked to the progression of her dementia. She thought the floor where she was living was her own home and with that, she saw all the other residents as intruders.

4.8.3 Niche independent review stated:

> Throughout her stay it is noted that Barbara was generally settled in the daytime. However, there are several notes made that Barbara was often unsettled at night, both before midnight and in the early hours of the morning and was often found wandering in the corridors. On occasions she was found shouting and was also reported to be in other people's rooms asking them why they were in her house. Her condition meant she believed she was in her own home and other people around her were intruding. This became particularly acute at night.
>
> 3.17 This was particularly the case shortly after she had moved into Ridgeway Lodge (first recorded on 13 May 2022), and it is reported that later in her stay she became more settled. Records concerning her being unsettled at night appear to be less frequent in August and September.
>
> 3.18 The number and frequency of Barbara being unsettled reduces over time in the records. Staff told us that sometimes-loud noises could unsettle Barbara, and, on other occasions, she would wake confused as if from a bad dream. Staff told us they frequently talked to each other about Barbara and her behaviour, but this was not recorded in the notes.
>
> 3.19 Records throughout the summer convey a picture of someone given some support with their personal care needs (washing and dressing), who needed staff to serve and prepare food, but who could eat independently. There are very many notes concerning Barbara having had a good diet that day and describing what she had eaten. Staff commented on Barbara being a very engaging 'people' person with a strong sense of humour.
>
> 3.20 Staff also told us that Barbara could occasionally become forgetful and confused at times but would be calmed and reassured by staff sitting and talking or singing with her. Many staff reported that Barbara liked to sing, particularly gospel songs, and often sang "Amen" or "Hallelujah!"
>
> 3.21 Although there are records of several occasions when Barbara shouted and went into other residents' rooms, there are no records of Barbara being physically aggressive to staff or other residents and the staff we interviewed also confirmed they could not recollect Barbara having been violent.
>
> 3.22 On the night of 1 October 2022 and the morning of 2 October, Barbara was reported to have been in a "happy mood, singing and settled into bed". She went to bed at around 09:00pm and was reported to have been very calm.
>
> 3.23 Barbara's last hourly check was at 05:00am when she was recorded as asleep.

4.8.4 For the Article 2 Inquest, Sheila Hartman's son reviewed all daily records related to Barbara and created a chronology of times when it is noted that Barbara was distressed, confused, walking around, night walking, aggressive, in other resident's rooms and given the medication lorazepam to calm her down. This work gave a more detailed picture of Barbara's experiences than the previous report.

4.8.5 There are 249 entries from the day Barbara first moved in, to the assault on Sheila – far more than had been recorded or reported. It is upsetting to read as you get a sense of Barbara's disorientation and distress:

- Walking the corridor shouting and hitting the ground with her walking stick
- Barbara is very confused walking around another resident's bedroom
- Shouting non-stop
- Still anxious about her keys
- Walking the corridors 'lost'
- Threatening another resident (Rita) with a stick because she thinks she's stolen her glasses
- Barbara upset as she said someone had taken her keys
- Barbara upset and wandering around unit as she says people have stolen her clothes.
- Barbara confused again thinking XXX is her house. Again
- Barbara upset again because she says she hasn't got anything to feed her husband when he gets back from work. Barbara confused again thinking Ridgeway Lodge is her house.
- Barbara shouting in the corridor crying she doesn't know where she is.
- Walking around…expressed she would like to go home reassured…returned to room
- Barbara was very aggressive all thorough the night. She was agitated and tried to hot "yell" (staff) with her walking stick
- Out of room looking for handbag…also complaining of her hip calm.
- Asking why people are in her home
- ? went into Sheila's room. She ripped off all the foam in her bed. She needs a new bed.
- Barbara enters Elisabeth's room shouting at her and threw tables on the floor
- Barbara becomes very vocal shouting wants to go home
- Kept coming to front door looking for keys
- awake…walking in and out of bedroom
- Night walking
- Barbara shouting can't find money. Been calmed down.

4.8.6 There are 12 entries where it is stated specifically that Barbara was in other people's rooms. There are four references to Barbara hitting wall or ground with her walking stick or threatening with it.

What risk management measures might have been used for Barbara?

4.8.7 The HC-One report details numerous gaps and inadequacies in the risk assessments and care plans created for Barbara at the time, including that there is an absence of any discussion about her night-time wandering, and how she can become more agitated and shout, and what steps Ridgeway Lodge could take to mitigate any distress. It highlighted overall that: the assessments of mental capacity, actions to be taken as a consequence and ensuing care planning would be better informed by a more thorough understanding of dementia and the loss of mental capacity with a stronger focus on the psychological and behavioural aspects of how to care for a person.

4.8.8 During the inquest, Sheila's son also asked the provider whether they had considered using physical barriers on bedroom doors, as he had heard they were in use in some other care homes, like a 'stable door' arrangement, so that care staff could look in but it was not easy for a person to leave and wander around. The provider said they had

not. Their current focus was on the use of assistive technology, such as sensor mats or door sensors i.e. in order for care home staff to be able to be aware if someone known to wander, has left their room. At the time of Sheila's death, they had only been using these tools for people at risk of falls, and not to monitor people wandering. At the time of Barbara's assault on Sheila, Ridgeway Lodge had relied on the staff on duty physically seeing Barbara come out of her room. HC-One representatives at the coroners inquest also described how they are currently in discussions with companies about lighting that indicates when someone is up and moving around in their room.

4.8.9 The approach described in the preceding paragraph reflect the norms of good practice, which requires practitioners to seek the least restrictive options for the person known to wander. To be effective, they still require sufficient staffing levels to be able to respond immediately to the person who has left their room. Ridgeway Lodge increased the staffing levels at night after Sheila's death. Previously, there had been only two members of staff on shift and an additional person who 'floated' between the ground and first floors. On the night of Sheila's death, the floating member of staff had called in sick and no replacement was sought. Even with a floating member, whether they would have been or would ever be, immediately available would involve a high element of chance, given they work across two floors. The high levels of need of people on the first floor means that it is not uncommon that providing personal care to someone requires two staff members.

Why were no safeguards in place for Sheila?

4.8.10 For all the investigation and inquiry time that has been focused on Sheila and Barbara's experiences leading up to the assault that led to Sheila's death, including CQC inspection, HC-One independent review and the Article 2 Coroner's inquest, the circumstances that meant that Barbara had such ease of access to Sheila's room, remain unclear. None of these investigations have clarified whether Sheila's door was open or closed on the night she was attacked. Evidently it was not locked, or Barbara would not have been able to walk in from the corridor outside. It seems likely that the lack of clarity reflects how unproblematised this aspect of care home life and practice is: decision making about bedroom doors and whether they are open, closed and/or locked.

4.8.11 Sheila's son raised the question at the Inquest, stating he assumed that his mother's door was closed on the night of the attack, for reasons of privacy and dignity. He moved on swiftly however, to ask the more general question of HC-One representatives, whether residents' doors were <u>standardly</u> left open or closed at night. In the reply, HC-One stated that there was no blanket policy and decision-making was on a case-by-case person. So, it would vary depending on the preferences of the person and be captured in the care plan.

4.8.12 However, this does not seem to have happened for Sheila. Her son has no recollection of bedroom doors ever being raised as a subject for discussion either by Ridgeway Lodge staff or by the Best Interests Assessor. Sheila had been assessed as not having mental capacity to make decisions about her health and care. It seems likely therefore that the decision had more to do with taken-for granted ways of working, than with careful consideration of what was in Sheila's best interests. Sheila was on hourly monitoring through the night, as standard for people who were not able to get up ('mobilise') on their own. So having her door open would be typical, making it easier for staff to peek in on passing, and less likely that they would wake her up in the process.

Only it did not consider that she was also sleeping next door but one to Barbara. The room in between was not occupied and therefore presumably locked.

4.8.13 In terms of the potential for a person not only to close but also to lock their bedroom door at night, Sheila's son also asked at the inquest whether this was possible in the care home. The Inquest was told that rooms at Ridgeway Lodge can be locked from the inside using a lever/dial, meaning that staff could nonetheless also open the door from the outside, using a key. However, there was and remains no option available that is effective for people with marked cognitive decline who would not be able to use such a dial.[52]

4.8.14 Nothing is available equivalent to a hotel-style door locking system, whereby, when activated:

- from the outside, someone's bedroom door would open automatically for them while remaining locked to anyone else trying to enter
- from the inside, the door would remain open

4.8.15 The means practically, for people with significant cognitive decline, decisions could be made in their best interests to have their bedroom door closed at night, but it is unlikely that it would ever be deemed in their best interests to sleep behind a locked door.

4.8.16 In sum, we have illustrated how within Ridgeway Lodge it was and appears to remain the case that sleeping with bedroom doors open would not be subject of best interest processes for someone without mental capacity to make decisions about their health and care, leaving them reliant on immediate availability of staff to intervene if someone who wanders at night, intrudes into their room.

HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE-OFF?

4.8.17 There seems to be very little research about social care practice regarding bedroom doors in care homes. This finding was also identified late in the day of the SAR, so has benefited from less research and input form the Review Team than the other findings.

4.8.18 General principles of good practice indicate that care home residents who choose, can have their bedroom door closed or locked, as long as they have the mental capacity to make this decision. The care home must ensure that the person is able to let themselves out again, using a key or equivalent such as the dial that was described as available in Ridgeway Lodge. The person must be able to understand how they would call for help, if they needed to, using the emergency buzzer for example.

4.8.19 Anecdotally, however, it seems usual for residents' doors normally to be left open both day and at night. The benefits of this are presented such as reducing isolation and making it easy for staff to conduct their checks on individuals swiftly as they pass and without disturbing them, so that any fall or medical emergency can be quickly noticed and tended to.

4.8.20 Where a person is deemed not to have mental capacity regarding decisions about their health and care, the principles of the Mental Capacity Act (2005) come into play, namely

[52] Other staff witnesses who had been working on the first floor a the time of the incident, indicated that not everyone would carry keys, suggesting residents on the first floor with more advanced dementia, were rarely in a position to use this facility. On the few occasions that Barbara locked her door, it was noted in the daily record.

- **Best Interests:** Any action taken or decision made on behalf of someone lacking capacity must be in their best interests. This includes considering their past and present wishes, feelings, and beliefs.
- **Least Restrictive Option:** Before a decision is made or action taken, it must be considered whether it can be as effectively achieved in a way that is less restrictive of the person's rights and freedoms[53]

4.8.21 However in practice, there appears to be much more concern to-date about locking someone into their room, than there is with leaving someone's door open or unlocked. [54]

4.8.22 What research is available focuses on people with dementia who wander in care homes, least strictive option and their safety.[55] There is no equivalent focus on the best interests of people potentially impacted by the wandering of others in the same care home or what part decision-making about bedroom doors might play as regards their safety or other potentially competing priorities.

4.8.23 This appears to be reflected in the anecdotal evidence, for example seen in web chats of relatives of people in care homes, that indicates that people wandering uninvited in and out of other people's rooms, is something of an accepted part of care home life.

4.8.24 Technology has long existed that allows bedroom doors in congregate settings to be locked by default when closed, so that no-one can enter, while remaining open from the inside so the person is not locked in. These are typical for example in hotels. This technology, as far as we have ascertained through this SAR, has never been piloted in care homes.

4.8.25 Another local authority in the same region is in the preparation stages for piloting the installation and use of this technology in a new local authority owned care home, with the explicit aim of improving safety for residents. Due to the stage the early stage of the project, no further information is yet available.

HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

4.8.26 Continuing the theme of the lack of evidence, a SCIE report (2021)[56] on resident-on-resident abuse in care homes highlighted how very little UK literature on this issue exists, including prevalence data.

4.8.27 The summary highlights:

- Types of resident-to-resident abuse included: verbal (yelling, screaming), physical (hitting, kicking, pushing, throwing things), sexual (inappropriate touch, exposing themselves), violation of privacy and taking/damaging another's belongings. Linked to this was bullying, mainly highlighted in 'senior living facilities.
- Abusive behaviour was rarely documented or reported in some settings, with evidence that some care managers consider it an inevitable or predictable part of

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[53] **Mental Capacity Act 2005 at a glance - SCIE**

[54] See for example: **Care Ideals | Providing the balance between good business and exceptional care**

[55] See for example **Strategies to support safe wandering in care homes for older adults – what works, for whom, and in which circumstances?: A realist synthesis - ScienceDirect**

[56] **Resident-to-resident harm in care homes and residential settings - SCIE**

living in a residential setting. Some services allow harmful behaviours to be accepted and unchallenged.

- Research regarding the prevalence of resident-to-resident abuse is limited, yet information from a variety of sources suggests it occurs fairly frequently.
- Resident characteristics that are a risk factor for resident-to-resident abuse include dementia, mental illness, behavioural symptoms that may disrupt others and a history of aggressive or negative interactions with others.
- Environmental characteristics that are risk factors for resident-to-resident harm include a crowded environment, inadequate staffing levels, lack of staff training, high numbers of residents with dementia, a lack of meaningful activities, crowded common areas and excessive noise.
- Many incidents of resident-to-resident harm are not witnessed by staff.

4.8.28 A subsequent SCIE briefing focused specifically on sexual abuse incidents within adult social care settings (2022)[57]. This indicated that nearly 60% of incidents were alleged to be carried out by people who use services. There were:

- 1.23 incidents per 1,000 people living in care homes
- Between 1,300 and 1,405 incidents in the year reviewed

4.8.29 The literature studies conducted both in the UK and internationally suggest widespread underreporting within care settings.

4.8.30 Within the population of older adults, being a woman, increasing age and limited mental capacity were key risk factors for those at risk of being affected by sexual incidents both within the UK and in international studies

4.8.31 More recent CQC analysis (May 2025)[58] has also highlighted a number of relevant trends related to dementia care homes. Firstly, the analysis of notifications of serious incidents found that care homes that support more people with dementia have a higher rate of adverse events: Care homes where a majority of people have dementia submitted more than twice the number of notifications of serious injuries per person compared with care homes that do not support people with dementia. Care homes where everyone is aged 65 and above, and most people have dementia, submitted 75% more notifications of abuse or allegations of abuse per person than care homes where people over 65 with dementia are in the minority.

4.8.32 Further analysis showed that large care homes supporting people with dementia are associated with a larger number of notifications per person. For example: among care homes where more than half the people have dementia, large care homes (supporting 50 or more people) reported 54% more notifications of serious injuries per person (as many as 1 for every 5 people) than small care homes (supporting 10 or fewer people).

4.8.33 The CQC work also contextualized the higher rates of incidents, against patterns in staffing levels. They found that care homes where more people had dementia were more likely to report staffing issues, which can prevent people from receiving high-quality care:

In the care homes we looked at, as the proportion of people with dementia

[57] **Sexual Incidents in Adults Social Care; Evidence Review Briefing - SCIE**

[58] **Summary - Care Quality Commission**

increases, staff-to-person ratios decrease, staff turnover increases, there are fewer qualified staff, and fewer staff have named supervisors. For example, there are 20% more staff per person in care homes where fewer than half of people have dementia than in those where most have dementia.

4.8.34 The 2nd national analysis of SARs, over the period April 2019 and March 2023, showed that there were 37 SARs featuring resident on resident abuse in care homes; 6% of SAR report.[59]

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
n resident on resident abuse	6	4	3	1	5	11	1	2	4	37
Percentage of SARs	13%	12%	2%	6%	5%	8%	2%	4%	7%	6%

4.8.35 No further detail is provided so we do not know how many of these involved assaults that took place in a person's bedroom, or at night. For this level of detail, we need to turn to the detailed SAR reports themselves.

Incidents of assault in a person's bedroom in care home settings

4.8.36 Ten of these SAR reports can be found in the national SAR library, and one further will be published shortly. Analysis of these available SAR reports featuring resident-on-resident violence, as part of this SAR, shows that five involve incidents of assault, two physical and three sexual assault. Three are incidents that took place after the perpetrator entered the victim's room, at night – in circumstances very similar to the assault leading to Sheila's death. In the other two, the reports do not provide the detail but it seems likely the assaults took place in the victim's rooms, though the time of day is not evident. In two of the assaults that took place at night, in the victim's bedroom, the person committing the assaults was staying in the next door room. In all but one, the perpetrator had a diagnosis or was suspected to have a dementia affecting their behaviour.

4.8.37 These recent SARs, suggest there may be approximately one such assault per year that results in a SAR. It is not known how many equivalent incidents occurred that did not result in a Safeguarding Adults Review.

4.8.38 None of the reports gave any indication that discussions had been had with the victim or their families about whether their bedroom door's should be open, closed and/or locked. In some cases this gap is especially pertinent. The family of May Miller who had been moved into the care home after a fall where she broke her hip, with no cognitive difficulties, said

> "Another resident arrived the day before in the next room and kept popping in to see my nan. She had told us she wasn't happy with that and felt frightened."

4.8.39 Does it not seem likely that May would have chosen to lock her bedroom door, had she been asked?

[59] **Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association**

SARs featuring physical and sexual assaults on people living in a care home by someone else also living in the same care home

	SAR and commissioner	Publication year	Victim and assault	Time and place	Perpetrator
1.	SAR **Violet**, Hertfordshire SAB	Forth-coming	In a care home, Violet (98) was sexually assaulted in her bedroom at night. She died shortly afterwards.	In her bedroom at night	A man (80) with a dementia diagnosis.
2.	SAR **Sheila**, Bedfordshire & Central Beds SAB	2026	In a dementia floor of the residential care home, Sheila (88) was violently assaulted with a wooden walking stick, causing serious head and facial injuries. Sheila died a few hours later.	In her bedroom at night	A woman (90) with a dementia diagnosis Bedroom next door but one to victim's.
3.	SAR Calderdale SAB	2023	In a residential care home, there were three victims of sexual assault. The victim of the last assault was on end-of-life care, and died shortly afterwards.	Assume in bedroom. Time not specified	Elderly man (no age provided) with dementia but no type specified at the time.
4.	SAR **Eileen Dean**, Lewisham SAB	2022	In a residential are home, Eileen (93) was beaten repeatedly with a metal walking stick causing severe injuries to her face, head and upper body. She died in hospital later that day	In her bedroom at night	A man (62) with Korsakoff's Bedroom next door to victim's.
5.	SAR Southend SAB	2022	In a residential care home, the victim who was bedbound and non-verbal, was sexually assaulted.	Assume in bedroom. Time not specified	A man (age not given). On the Violent and Sex Offender Register.
6.	SAR **May Miller**, Suffolk SAB	2021	In a residential are home, May (90) was attacked with a walking stick, beaten around the head and face, with defensive injuries to her arms and legs. May subsequently died in hosptial.	In her bedroom at night	A man (89) thought dementia but no diagnosis. Bedroom next to victim's.

WHAT IS THE GEOGRAPHIC SPREAD?

4.8.40 The second national analysis of SARs reported for the first time on resident-on-resident abuse in care homes. This showed that there were no regions without instances reported.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
n resident on resident abuse	6	4	3	1	5	11	1	2	4	37
Percentage of SARs	13%	12%	2%	6%	5%	8%	2%	4%	7%	6%

SO WHAT? WHY IS IT IMPORTANT TO ADDRESS?

4.8.41 Incidents of violent physical or sexual assault in care homes thankfully remain low frequency events, but their impact is of the highest order. Sheila died following an assault of significant violence. After the assault, Barbara was treated 'like a leper'; no homes wanted to take her. What appears to have become a cultural blind spot, is that the preventive measure we take for granted in any other setting, is denied to our loved ones at their most vulnerable: the option of a locked door.

4.8.42 This finding is not suggesting a blanket policy that all bedroom doors in care homes should be locked. Instead, it highlights the current lack of choice or best interests decision making currently for the people who would be sleeping behind those doors.

4.8.43 This finding is delicate. There is an understandable reluctance to talk about potential risks that people living with later stage dementia can pose to others, in part for fear of stigmatising the far greater numbers of people living with dementia who may never go on to be violent, in part for fear of undermining public trust in care homes.

4.8.44 Yet if this sensitivity leads to denial and reluctance to intervene, and from there to tragedies like Sheila, May, Eileen and Violent? Perhaps public confidence might be better supported through the funding of pilots of hotel-type technology, in order that more effective choices were available.

Finding 5. A norm whereby people's bedroom doors remain physically open at night in residential- and nursing care homes, has benefits for staff and residents, but denies choice and best interest considerations for individuals, in what are key safety decisions. This is particularly so because people with dementia who wander cannot be locked into their rooms, on legal and humane grounds. This means tragic incidents of assault are experienced by families as if they come out of the blue because no discussion about potential risks and available mitigations has taken place beforehand.

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- Is there a role for the SAB in enabling a discussion locally about this issue across commissioners, providers, families, advocates and voluntary sector dementia support organisations?
- Would it help for the SAB to find out more about the care home pilot to use new technology to allow safe locking of doors in care homes to prevent intruders?
- Is this a finding to be shared with the newly announced national Safegaurding Adults Board?
- How would the SAB know if this had improved?

5 Further areas for SAB exploration

5.1.1 This SAR has identified an area of potential systemic weakness, that has not been fully explored within the remit of the SAR. In part this is because it does not tie directly to evidence in the index cases of Sheila and Barbara. This is not uncommon in SARs. It means the issue cannot yet be evidenced to be a systems finding or indeed disproved as one. It is therefore presented briefly here, for safeguarding partners to consider whether further research is needed to better understand the issue.

5.2 WORKING TOGETHER WHEN A PERSON'S NEEDS AND RISKS ESCALATE IN A CARE HOME SETTING

5.2.1 Have social care budget constraints undermined the culture of working together between local authorities and care home providers, that is essential when a person is identified as needing a higher support package in order that the risks they pose to others and/or they themselves face, can be managed?

BACKGROUND

5.2.2 The government has recently established a commission, led by Baroness Louise Casey, to set out recommendations for a 'fair and affordable' social care system. This is long overdue. Long-term underfunding of local authority costs of social care has created what the Kings Fund described as a 'doom loop' where by higher wages, and increased fees mean that to balance the books, local authorities have had to reduce the numbers of people they support, despite increasing demands for social care services.[60] Meanwhile, costs for providers of social care services, mainly private companies, have also been risking steeply, leading to concerns about provider viability and imbalances in the market, as proivders focus business on self-funded clients who pay more than council-funded ones.[61]

HOW DOES THIS PLAY OUT RELATING TO MANAGING RISKS OF RESIDENT-ON-RESIDENT ABUSE IN CARE HOMES?

5.2.3 During the course of this SAR, the input of local care home providers was invaluable and informs the findings presented in the main body of the report. There was also another key issue that providers highlighted as having a critical influence on the effective identification and managing of risks potentially associated with the progression of a person's dementia.

5.2.4 They described a stark difference between the culture of working together across local authorities and care homes that existed ten years ago, with what they experience today. Previously, if they flagged that where a person's needs and presentations had changed and the provider could no longer manage the risk, they were confident they would receive a swift response, and willingness to work together to identify the best solutions. More recently, in contrast, responses are often not timely, and they are left holding the risk alone. Examples were shared where providers had to make the decision to fund

[60] The Government Must Avoid Return To Social Care 'Doom Loop' | The King's Fund

[61] Fixing Social Care: The Six Key Problems And How To Tackle Them | The King's Fund

1:1 care in order not to expose other residents to unmanaged risk, without any indication whether this would be repaid.

5.2.5 The system and process of funding panels was described as completely opaque. Providers do not have the opportunity to present their 'case' or be part of the dialogue and decision making process. Nor is there any information available for how to escalate concerns, where you may disagree with the decision.

5.2.6 From a providers perspective, without this collaboration and dialogue, in these situations, the only option is to terminate an agreement. This has benefits in terms of keeping other residents in the care home safe, but creates risks for the person themselves, who may end up in a less competent care home under financial pressure to fill their beds.

HOW DO WE KNOW IT IS UNDERLYING NOT A ONE OFF, HOW WIDESPREAD OR HOW MANY PEOPLE MIGHT BE AFFECTED?

5.2.7 Within the remit of this SAR, there was not capacity to explore these issues in more detail. so what? what should it matter?

5.2.8 Of the SARs featuring resident-on-resident abuse (considered as part of this SAR), at least one gives an example of equivalent experiences of providers:

> This raised the care homes' past experience of the difficulty of removing a resident from the care home if their placement was breaking down, or there were risks, including aggression, which could not be managed. The care home received reassurance from the social worker that full support would be provided if this happened with The Adult (SAR Eileen, Lewisham SAB).

Area for further research: Have social care budget constraints changed the culture of working together between local authorities and care home providers, when a person is identified as needing a higher support package to manage the risks they pose to others and/or they themselves face?

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

- Does the SAB or partners already have any data or insights on this issue?
- How might the SAB help bring the right people together about this finding?
- Is there a way of sharing the good practice identified locally?

6 Appendix

Timeline of key policy announcements relevant to dementia care[62]

- 2009
  - **First National Dementia Strategy – 'Living Well with Dementia'**
  - Aimed for better public awareness of dementia, earlier diagnosis and high-quality treatment across stages of the illness and settings
  - Following a report that found an overuse of anti-psychotic medication for people with dementia
- 2012
  - **Prime Minister's Challenge on Dementia**
  - Acknowledged progress following the first national strategy
  - Stated aims of improvements in health and care, the creation of dementia-friendly communities and better research
- 2014
  - **Care Act**
  - Set out how care and support for adults should be provided, including the personalisation of services, as well as how they should be funded
  - Placed a new emphasis on carers, including giving them the right to a carer's assessmen
- 2015
  - **Prime Minister's Challenge on Dementia 2020**
  - Built on the first Challenge on Dementia
  - aimed to make England the best country in the world in which to receive and provide dementia care and support, as well as the world leader in dementia research
- 2015
  - **Dementia Training Standards Framework released**
  - Department of Health and Social Care commissioned and funded
- 2019
  - **Conservative manifesto pledges on dementia**
  - Alongside commitments on funding and reform for social care, identifed funding a cure for dementia as one of the government's 'biggest collective priorities'
  - Often referred to as the dementia 'moonshot', it pledged double research funding and the speeding up of new trials for treatments
- 2021
  - **People at the Heart of Care: Adult social care reform white paper**
  - A 10-year vision for social care, acknowledging the importance of social care reform for people living with dementia and their carers
  - Set out aims for increased freedom of choice and outstanding quality, and equitable access to care and support
- 2022
  - **Secretary of State announces that a 10-year plan for dementia will be created**

[62] Building on Figure one in Nuffield Foundation Report **Nuffield Trust - Dementia and social care_WEB_0.pdf**

    - Secretary of State for Health and Social Care, Sajid Javid, pledged increased funding for dementia and other neurodegenerative diseases
    - Intended to help harness innovation to improve outcomes for people with dementia and to support people living with dementia with their speci c health and care needs
- 2023
    - **Dementia is named among six conditions to be included in the Major Conditions Strategy**
    - Strategy recognised dementia as one of the most important conditions for society and health and care services today
    - But also signalled a shift away from the dementia-specifc plan promised the previous year. Strategy still unpublished at time . UK the only nation without a specific dementia strategy and dedicated funding
- 2024
    - **Work on Major Conditions strategy paused**
    - Labour government commission Lord Dazi to investigate the state of the NHS, to inform a new 10 year plan of reform
    - Explanation given of aim to consider how to incorporate the findings from the Major Conditions Strategy into the 10-year plan
- 2024
    - **CQC being work on a dementia strategy**
    - Focus is on using CQC's regulatory work to influence and drive improvement in the provision of services, models of care and the quality of health and care services for people living with dementia.
    - ***Includes plan to*** *co-produce evidence based statutory guidance for what good dementia care looks like*
    - **NHSEngland publish Right Care Dementia Scenario**
- 2025
    - **NHS Ten Year plan, includes idea of Service Framework for frailty and dementia**
    - Promised by spring 2026, this is billed to set standards for carre and identify the best types of support that health professionals should provide
- 2025
    - **Casey Commission launched to provide the groundwaork for a new National Care Service**
    - The Terms of Reference do not explicitly mention demenia