West Sussex Safeguarding Adults Board

Mrs Patricia Pelham: Learning Review

Author: Alison Cooke
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Contents

1. Foreword

1.1. The West Sussex Safeguarding Adults Board has today published this Multi-Agency Learning review in respect of the death of Mrs Patricia Pelham. Mrs Pelham was a 70-year-old woman who died following a period of physical illness in hospital. Family described her as an independent lady who felt that when she was facing difficulty towards the end of her life that "no one cared".

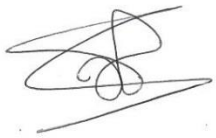
1.2. Her Husband feels very strongly that she would have liked to have made a difference in ensuring that the same situation does not happen to anyone else.

1.3. A multi-agency learning review is completed when there are complex themes of learning across different agencies, that may have been identified in previous reviews; whether locally or nationally, as a way of ensuring that systems are in place to reduce the likelihood of similar incidents recurring.

1.4. This specific case, in the context of a helps identify key actions to make a difference in West Sussex. It demonstrates the importance of sharing information effectively and working across all agencies engaged with people who use services, respecting their independence and assessing risk.

1.5. All agencies involved in this learning review have committed to making changes to improve services through better communication and working together more closely.

1.6. The West Sussex Safeguarding Adults Board and the Safeguarding Adults Review subgroup of the Board will monitor progress on implementation of recommendations, so the Board is assured services are improving overall.



Annie Callanan, Independent Chair

2. Introduction and background

2.1. Introduction

2.1.1. This multi-agency review is regarding a 70-year-old woman who died in August 2017, and who will be referred to as Mrs Pelham throughout this report. Mrs Patricia Pelham was an adult with care and support needs who died through neglect. Several agencies were involved, or had been recently involved, and the level of need appears not to have been recognised by individuals and agencies. There are implications for a variety of agencies and professionals.

2.2. Legal framework

2.2.1. The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.2.2. In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

- Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults;
- To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

2.2.3. The review will be conducted in accordance with the West Sussex Safeguarding Adults Board (WSSAB) SAR Policies and Procedures. The aim being to establish if there are any lessons to be learnt about the way in which local professionals and agencies worked together to prevent and reduce the abuse and neglect of adults.

2.3. Commissioning of the review

2.3.1. This multi-agency learning review is commissioned by WSSAB, and in accordance with the Sussex Safeguarding Adults Policy and Procedures (Edition 4: June 2018) and the Sussex SAR Protocol (v2.0: May 2018).

2.3.2. On 16/05/18 the WSSAB SAR subgroup agreed that the referral should be made for a multi-agency review, and the Chair of the subgroup made a recommendation to the SAB Independent Chair which was approved on 23/05/18.

2.3.3. The SAR subgroup made the decision that although the criteria for a SAR had not been met, there was a need for a multi-agency review process to consider the involvement of organisations with Mrs Pelham. A multi-agency review is one of the ways that the WSSAB can ensure that learning is identified from complex situations where a number of organisations have been working with an adult who has died.

2.3.4. This multi-agency learning review has been undertaken by Alison Cooke (Named Nurse: Adult Safeguarding Sussex Community NHS Foundation Trust), and Alison Cooke was appointed as the Lead Reviewer following the May meeting.

2.4. Purpose of the review

2.4.1. This SAR will be conducted using Individual Management Reviews, which will reflect on multi-agency work systemically and aims to answer the question; why did this happen?

2.4.2. The review will recognise good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. This review will be a proportionate, collaborative and an analytical process, which will actively engage all agencies involved in the multi-agency review process.

2.4.3. The information will be used to enable practice, policy and procedural developments for safeguarding people living in West Sussex.

2.5. Terms of reference

2.5.1. The specific terms of reference for the review to consider were:

- Consider what opportunities were taken, or could have been taken, by individual agencies to identify and address the risks to Mrs Pelham;
- Review decisions made in terms of Mental Capacity Assessments and Best Interest Decisions, and the recorded rationales if assessments were not considered to be appropriate;
- Consider whether the wishes and feelings of Mrs Pelham and/or her family and/or her representatives were ascertained, properly recorded and taken into account when decisions were made by agencies;
- Identify whether any other interventions or processes might have improved the outcomes for Mrs Pelham;
- Consider whether all single agency and multi-agency procedures were followed including factors around self-neglect and non-concordance. Did any factors impact on compliance with these, or the effectiveness of them?;
- Consider whether agencies worked together effectively, took action that was necessary and shared information appropriately;
- Identify the lessons to be learned from this case in relation to the way in which local agencies and professionals worked together to safeguard and promote the welfare of Mrs Pelham, both generally and specifically at time of physical health deterioration.

2.6. Agencies involved

2.6.1. Agencies involved in Health and Social Care delivery:

- South East Coast Ambulance Service NHS Foundation Trust (SECAMB)
- West Sussex County Council (WSCC)
- Western Sussex Hospitals NHS Trust (WSHT)
- Sussex Community NHS Foundation Trust (SCFT)
- Medical Practice (GP)
- Guy's and St Thomas' NHS Foundation Trust (GSTFT)

2.6.2. Learning Review Panel:

- South East Coast Ambulance Service NHS Foundation Trust: Nurse Consultant for Safeguarding
- West Sussex County Council: Social Worker Senior Practitioner
- Western Sussex Hospitals NHS Trust: Trust Senior Lead for Safeguarding Adults
- Sussex Community NHS Foundation Trust: Proactive Care Team/Community Nursing Clinical Nurse Lead
- Medical Practice: GP
- Guy's and St Thomas' NHS Foundation Trust: Head of Safeguarding Adults

2.7. Confidentiality and information sharing

2.7.1. The findings of the review will be reported to the WSSAB who will have responsibility for decision making regarding the sharing of this report.

2.8. Involvement of family

2.8.1. A vital part of this process is to engage with the family members, giving them the opportunity to be involved in the review process and share their experiences and concerns with the learning review author and a representative of the SAB. Opportunities will be built into the process by a representative of the SAB to ensure family members are updated on the progress made with the overview report and feedback on the final report.

2.8.2. The husband of Mrs Pelham was contacted via letter on 10/10/18 but no reply was received. An additional letter was sent on completion of the draft report.

2.8.3. The learning review author and a representative of the SAB met with the husband of Mrs Pelham on 01/10/19.

2.8.4. Mr Pelham stated that his wife had told him that she felt "no one cares". He feels very strongly that she would have liked to have made a difference in ensuring that the same situation does not happen to anyone else, and it is his expressed wish that the learning review refers to his wife as Mrs Patricia Pelham.

3. Multi-agency review

3.1. Introduction

3.1.1. This report is drawn from the information and facts provided by the agencies listed above within the scoping period of the year before her death in August 2017 to look at how agencies involved worked together in the period before her death.

3.1.2. Each agency was asked to provide a Summary of Involvement (SOI) and Internal Management Report (IMR) detailing their involvement with Mrs Pelham, and considering the points listed above in the Terms of Reference (TOR).

3.1.3. There followed a series of meetings of the panel members where the reports were discussed, further questions identified, and actions and learning identified.

3.2. Outline of the case

3.2.1. Mrs Pelham was living at home with her husband who was her main carer.

3.2.2. On 01/08/17 South East Cost Ambulance Service (SECAMB) attended and found the following;

3.2.3. *Pt's legs were severely necrotic with open wounds which were clearly infected with dying skin. The smell was strong from the legs when the crew removed the blanket that was covering them. The husband stated he had been dressing them himself. He said that the district nurses had not visited them in over a month. He was using the dressing that the nurses had left along with baby nappies which was evident on the patient's right leg. We found the patient to be critically unwell. Observations and findings suggested septic shock. We noticed that both legs below the knee were necrotic and severely infected.*

3.2.4. Mrs Pelham was deemed by the paramedic crew to potentially have sepsis[1] and was transported to hospital where she subsequently died.

3.2.5. Prior to this concern, an initial WSCC assessment was undertaken with Mrs Pelham herself, needs were identified, and referrals were made to OT and Telecare. Mrs Pelham was very clear that her husband was able and willing to support her with personal care and this was what she wanted also. A later request to assess for support was made to Adult Services by the Proactive Care Team.

3.2.6. There appears to have been a withdrawal of service by nursing staff who had been attending Mrs Pelham's legs although the legs were still not healed.

3.2.7. Mrs Pelham's husband stated that he had tried a number of times to contact her GP for help with her general deteriorating condition and legs. Her husband stated that he had shown the Out of Hours Health Care Professional the legs during a visit 12 hours previous to the ambulance crew attending. He said her legs "had not changed in these 12 hours."

3.2.8. Key points, with a focus of leg wound care, have been determined from the SOIs provided by the agencies involved in health and social care provision for Mrs Pelham.

[1] Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death https://www.sepsis.org/sepsis/definition/

3.3. Summary of findings

3.3.1. What opportunities were taken, or could have been taken, by agencies to identify and address the risks to Mrs Pelham?

3.3.2. The first admission to WSHT on 26/02/17 indicated ongoing liaison with other hospitals and multidisciplinary team working.

3.3.3. As Mrs Pelham was an older adult on 06/03/17 she was seen by the GSTFT older person's specialist team that provides comprehensive assessment and advice to the care of older people undergoing surgery. Part of their assessment is a cognitive assessment and where appropriate they will advise on capacity issues. They followed the patient throughout her stay and did not identify any issues with decision making. They did not identify an impairment of the brain or mind. The patient recovered without issues related to delirium. An Occupational Therapist was also involved who assess the functional ability of the patient. There were no concerns of issues with cognition or capacity raised at the time for the patient's admissions.

3.3.4. On 07/03/17 GSTFT referred Mrs Pelham to WSCC Adults' Services and were subsequently contacted on several occasions by members of the Social Work Team at WSHT, regarding possible needs on discharge and to provide information about local services. Staff GSTFT suggested that Mrs Pelham would likely need some support with personal care on discharge but would prefer her husband to undertake this. They agreed to contact the WSHT Social Work Team in the event this was not viable, but no contact was made, and the author suggests that this may have been a missed opportunity by GSTFT to identify health and social care needs.

3.3.5. Following a referral on 15/03/17 from the Proactive Care Team, Mrs Pelham was telephoned on 17/03/17 and an Initial Assessment was undertaken by a member of staff at WSCC Care Point 2. The outcome of this was that Mrs Pelham declined any assistance with personal care as her husband was supporting her, and this was later corroborated by her husband who was spoken to independently on 31/03/17 and who reported they were managing well. A further outcome of the Initial Assessment was that it was arranged for a lifeline alarm and a keysafe to be installed, to enable Mrs Pelham to call for assistance in an emergency and to facilitate access to her home by emergency services if necessary. The author is unaware of the planned installation date but suggests that this may have supported more immediate access to support. Contact was attempted with the referrer and a message left as to the outcome of the assessment.

3.3.6. At the no access visit on 21.06.17, the SCFT community nurse did not document if they contacted the patient or her husband by phone, but they have stated they now have a process in place where the nurse will attempt contact by phone and leave a card explaining how the patient can contact the community nurses to rebook visits. There is a process in place so when the community phlebotomist identifies a risk to a patient, they would ask a registered nurse for an assessment: this did not occur as the phlebotomist saw no risk to Mrs Pelham at the time of the domiciliary visit.

3.3.7. Within the IMR process, the SCFT Clinical Nurse Lead has recognised that they could have had improved communication with the Proactive Care Team and GP that Mrs Pelham was registered with. The community nurses regularly asked for dressing prescriptions from the registered GP Surgery, but as Mrs Pelham was out of area there were delays with the pharmacy which meant not enough appropriate dressings were delivered.

3.3.8. The GP has also acknowledged that care could have been better coordinated if Mrs Pelham had registered with the local practice sooner.

3.3.9. A subsequent referral to WSCC Adults' Services was made by SCFT Proactive Care on 10/07/17 suggesting similar needs as in the previous referral and that Mrs Pelham and her husband were now requesting support. Mrs Pelham was admitted to WSHT the following day where she remained for several days; however, there is no record of any referral being made to the Hospital Social Work Team prior to her discharge.

3.3.10. The second admission to WSHT on 11/07/17 indicates that the presenting problem was the Acute Kidney Injury (AKI[2]); one learning point recognised by WSHT within the IMR process was that on discharge there should have been a request for community nursing follow-up to ensure that the community nurses were going to resume dressings.

3.3.11. There was need for further home assessment by WSCC Occupational Therapy service to address issues of access to bathing facilities and use of stairs was identified during their initial assessment. Mrs Pelham was added to the waiting list for such assessment and informed of this in writing, suggesting she make contact if the situation became more urgent. She was subsequently contacted on 31/07/17 to arrange a visit. Mrs Pelham requested that she be phoned again in a week's time as she was due to attend hospital the following day and this would likely result in a brief stay.

3.3.12. Mrs Pelham was readmitted to WSHT for a third time on 01/08/17. An IMR detail evidences complex discussions with her husband who was informed of severity of condition.

3.4. How did agencies consider Mental Capacity, and Best Interests in line with agency procedures and the Mental Capacity Act? How were recommendations and rationales recorded and could this have been improved?

3.4.1. WSCC have determined that in none of the referrals or communications between health professionals and Adults' Services was the issue raised of (the possible lack of) mental capacity in relation to the ability of Mrs Pelham to make decisions about her care and wellbeing. Likewise, in their initial assessment with Mrs Pelham the Assessment Officer did not identify any possible behaviour or circumstances

[2] Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness https://www.nhs.uk/conditions/acute-kidney-injury/

which gave rise to concerns about capacity, and nor were these raised by her husband therefore there was no indication that a Mental Capacity Assessment was warranted.

3.4.2. From the documentation available to GSTFT there were no issues raised about the patient's cognition or inability to make any decisions about her care and treatment, and their referral to WSCC indicated that Mrs Pelham had capacity to consent to the referral.

3.4.3. WSHT also stated that nursing assessment documentation indicates no concerns re mental state or cognition. There was no past medical history to suggest any impairment of, or disturbance in, the functioning of mind or brain and there is no evidence that there was any reason to question capacity: the first principle, assume capacity, was therefore applied (MCA 2005 2(1)[3]). As Mrs Pelham was assumed to have capacity to make decisions around her care and treatment Best Interest did not apply as Mrs Pelham was able to make decisions herself. This was also reflected by SCFT who stated that on all community nursing visits Mrs Pelham was deemed to have capacity, and by the GP who stated Mrs Pelham was assessed as having capacity.

3.4.4. However, the clinical picture presented to SECAMB on 01/08/17 indicated Mrs Pelham was unresponsive, severely septic and critically unwell and although the clinical record doesn't explicitly record mental capacity it is recognised that SECAMB acted in the patient's best interest in conveying to hospital.

3.4.5. This clinical picture is reflected within the third admission to WSHT on 01/08/17 when a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR[4]) was completed, and Mrs Pelham was deemed not to have capacity to make the decision about being resuscitated due to severe sepsis. No capacity assessment was undertaken as it would have been inappropriate as the patient was so unwell: DNACPR was discussed with the husband who was in agreement with the decision.

3.5. Were the wishes of Mrs Pelham and/or family/representatives, identified, properly recorded and taken into account when decisions were made by agencies?

3.5.1. Within discussions by GSTFT Mrs Pelham wanted to continue to have her care and support provided by her husband instead of being referred to the Reablement Team. The patient's husband was contacted and he agreed that he will continue to provide support with all household tasks and supporting his wife and Mrs Pelham was clear that if she and her husband required any help post discharge they would get in touch with social services, and she was provided with the contact details.

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[3] MCA (2005) S2(1): Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise https://www.legislation.gov.uk/ukpga/2005/9/section/2

[4] The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly https://www.resus.org.uk/dnacpr/

3.5.2. The wishes of Mrs Pelham were identified during the WSCC Initial Assessment undertaken on 15/03/17 when Mrs Pelham stated clearly that she did not wish any assistance with personal care and that her husband was supporting her. In a subsequent discussion with her husband on 17/03/17, he confirmed that they were managing well and did not want any such assistance. As previously noted, it was identified that Mrs Pelham would benefit from a home assessment by a member of the Occupational Therapy service, as well as the installation of a lifeline and keysafe. Mrs Pelham was in agreement that the further assessment should take place and also that the lifeline and keysafe be installed. In all of these instances the wishes of Mrs Pelham and her husband were identified, properly recorded and taken into account when decisions were made.

3.5.3. The GP states that the wishes of Mrs Pelham and her family were identified and respected. In between SCFT community nursing visits Mrs Pelham was changing dressing pads when they became wet and following a discussion with a community nurse on the 26/05/17 it was agreed to carry this arrangement on, and the community nurses would monitor weekly. SCFT encourages patients to self-care, and a further two monitoring visits, a week apart assessed this plan as satisfactory. When SCFT were unable to gain entry a nurse telephoned Mrs Pelham at the next visit and was told the legs were drier, and that Mrs Pelham would carry on managing this herself. The nurse ensured that Mrs Pelham was in agreement with this arrangement and was aware how to make contact if required, and it is of note that it is normal practice for Community Nursing Teams to support patients by phone as well as in person.

3.5.4. During the third admission to WSHT on 01/08/17 the Doctor discussed the condition of Mrs Pelham with husband and son. Her husband had concerns over delay with GSTFT seeing Mrs Pelham and with being able to contact the district nurses to help with dressings: the doctor agreed to help address these issues at a later time because at that point Mrs Pelham was very ill and this was the doctor's focus of care.

3.6. What other interventions or processes might have improved the outcomes for Mrs Pelham?

3.6.1. It is not immediately evident to WSCC that other interventions or processes relating to the work of Adults' Services might have improved the outcomes for Mrs Pelham.

3.6.2. In addition, there were no indications that other interventions from GSTFT would have benefited or improved the outcome for the patient: Mrs Pelham passed away approximately two months post discharge from hospital, she was contacted two weeks post discharge to inform her of a further admission date in August 2017 and the GP was written to in July about her new admission date.

3.6.3. At the time of this event, SCFT Community Nursing Team had access to SystmOne (SCFT electronic records system) but because Mrs Pelham's GP was based out of area, the record sharing functions within SystmOne were not automatic or arranged. This is reflected by the GP practice who have highlighted that Mrs Pelham moved address but did not register with the local Medical Practice and chose to remain with her original practice. SCFT have stated that improved communication between the local Community Nursing Team and the registered GP

Surgery and Proactive Care Team would have ensured more holistic care for Mrs Pelham.

3.6.4. From a WSHT perspective, given the reasons for admission it is difficult to determine what other interventions may have improved the outcome as the underlying issue that was being treated was poor kidney function. Treatment of the leg ulcers were of a secondary concern; the primary concern being the renal failure and associated complications, but an intervention that might have improved the outcomes would include a referral to the community nurses following the second admission.

3.7. How were single agency and multi-agency procedures followed including factors around self-neglect and non-concordance. Did any factors impact on compliance with these, or the effectiveness of them? How were these addressed?

3.7.1. All responses indicated a similar theme. On transfer from WSHT to GSTFT there was no information handed over to suggest that there were issues with self-neglect or non-concordance. Mrs Pelham was compliant with all care and treatment, and where there were deficits, she would be supported by the husband which he had agreed to do. There were no doubts about decision making capacity of Mrs Pelham regarding her discharge home arrangements.

3.7.2. Issues of self-neglect and non-concordance were not raised in the referrals to WSCC Adults' Services by the professionals making those referrals. Nor were any such issues identified in the subsequent contacts between WSCC Adults' Services and those professionals, or with Mrs Pelham and her husband.

3.7.3. SCFT community nurses did not identify any areas of self-neglect, or non-concordance. This was also reflected by WSHT who stated that there were no indications that there were any issues around self-neglect identified, and Mrs Pelham appeared willing to engage with staff and her husband was supporting her.

3.7.4. Factors that impacted on single agency and multi-agency procedures were unknown to the GP and the author recognises that this may be due to Mrs Pelham not being registered with them.

3.8. How did agencies work together effectively to take action that was necessary and shared information appropriately? Were there barriers to this and how were they addressed?

3.8.1. Mrs Pelham was registered with a GP that was out of area and this caused difficulties with SCFT multi-disciplinary communication; discussions were had with Mrs Pelham about changing surgeries, but she refused. The Proactive Care Team were also out of area, and with limited SystmOne sharing there was little communication between SCFT community nursing teams, and the local community nursing team were unaware that Mrs Pelham and her husband had previously refused social service support.

3.8.2. This is reflected by the GP who stated that it is unknown if agencies worked together effectively as Mrs Pelham was not registered with them, and therefore was not their patient. It is unknown if the practitioner who visited Mrs Pelham on

the 31/07/17 reviewed patient held community nursing notes, or if these were available.

3.8.3. There is evidence of ongoing hospital discussions with both the vascular and renal consultants, and also communication with GSTFT who highlighted that the need to involve other agencies was not obvious from the documentation available.

3.9. Lessons identified in relation to the way in which local agencies and professionals worked together to safeguard and promote the welfare of Mrs Pelham, both generally and specifically at time of physical health deterioration.

3.9.1. On discharge from GSTFT Mrs Pelham was physically stable and during both admissions the patient was treated appropriately and made good recovery. Her social circumstances where explored and options to maximise her health and independence were offered to the patient. With her agreement she had community physiotherapy arranged for ongoing rehabilitation. She had equipment given to her to make her transfers safe, her bed mobility and transfers were limited and Re-ablement was offered which the patient declined, she had been sleeping on a recliner chair and stated that she would continue to do this. Follow-up surgery and arterial scan was arranged for her; the surgery was delayed for reasons unknown but when this was realised a date was sent for the patient to attend the surgery.

3.9.2. During the time SCFT attended they identified no signs of deterioration or self-neglect. However SCFT recognise that they could have explained, and documented, the difficulties more clearly with Mrs Pelham about having an out of area GP: Proactive Care and her GP were the leads in managing her overall health care in the community and better communication between the three teams could have improved Mrs Pelham's outcome. As previously highlighted, Mrs Pelham was not registered with her closest Medical Practice therefore she was not their patient. Care could have been better coordinated if Mrs Pelham had registered with the practice sooner. SCFT state that they were informed that Mrs Pelham had registered with the local GP Surgery on 01/08/17, which is the date of the third and final admission to WSHT.

3.9.3. On the second admission to WSHT on 11/07/17, at the point of discharge on 14/07/17 there was no indication that community nursing were already involved in the care of Mrs Pelham. This was potentially a missed opportunity for a referral to the Community Nursing Team to monitor and/or review her healthcare needs: Mrs Pelham was known to Proactive Care, but this was not documented in the WSHT nursing notes.

3.9.4. GSTFT state that when dealing with patients who do not demonstrate that they may have issues with cognition and capacity when making decisions about their care and treatment, they will continue to be consulted and involved in their care. Mrs Pelham made an unremarkable recovery following her procedures and was seen by a specialist older person's team who undertook a full assessment of Mrs Pelham, including cognition and capacity issues when making decisions about their care and treatment, and from this they have not identified any lessons to be learnt from this case.

3.9.5. It is noted that given the limited exposure by SECAMB to Mrs Pelham there were no obvious learning points for SECAMB.

3.10. What have agencies already done to improve practice/review systems in response to the incident surrounding Mrs Pelham?

3.10.1. No changes have been made by WSCC in terms of practice and review systems as a direct response to the incident surrounding Mrs Pelham, however WSCC identified the following to be lessons; due to the volume of cases awaiting assessment there was a delay of four months between receiving the referral and allocating the case to a worker: there was no indication on the referral from CP2 that there was greater urgency, therefore it was treated with standard priority. A letter was sent to advise Mrs Pelham and her husband of the waiting time, but WSCC only received information from her husband. If there had been better liaison with other professionals involved with Mrs Pelham, and more information provided about how her husband was managing to care for his wife, it would have been possible to have assessed her needs earlier and referred to appropriate agencies.

3.10.2. SCFT has ongoing operational work to streamline the process for electronic sharing and accessing systems for out of area patients, and the additional following lessons have been identified: The responding to no reply, missed or deferred visits policy was only partially followed. When Mrs Pelham declined wound dressing and dressed wound herself, self-management care plans were not evident. Clinical assessments were recorded on 07/04/17 and then 14/06/17, which indicates there were no clinical assessments for a period of approximately eight weeks, and due to geographical location between the registered GP and the home of Mrs Pelham, there was an inappropriate delay in accessing the appropriate wound care dressings.

3.10.3. WSHT has not identified urgent areas requiring improvement but has recognised ongoing lessons. As part of this review WSHT contacted SCFT One Call who reported they had not received a referral from WSHT for community nurse input for the leg dressings, and that Mrs Pelham was known to Proactive Care; however, this was not documented in either the WSHT clerking or the nursing assessment. On exploring their internal electronic records system, details on Proactive Care were logged, and at the point of admission the flags would have been evident to the staff caring for Mrs Pelham. On discharge there could have been a request for community nursing follow-up to ensure that they were going to resume dressings.

4. Recommendations

4.1. Guys and St Thomas' NHS Foundation Trust

4.1.1. There are no identified lessons but GSTFT will continue to raise the awareness of the MCA.

4.2. Medical Practice

4.2.1. Whilst the author recognises that this is a wider national issue, access to a central patient database and detailed patient held community nursing notes would support information sharing.

4.3. South East Coast Ambulance NHS Foundation Trust

4.3.1. It is noted that given the limited exposure by SECAMB to Mrs Pelham there are no obvious learning points for the trust.

4.4. Sussex Community NHS Foundation Trust

4.4.1. The Community Nursing Team should deliver care in accordance to 'The responding to no reply, missed or deferred visits protocol' SCFT Adult Services Policy.

4.4.2. When a patient declines or refuses treatment, the Community Nursing Team should formally document the patient's decision and consider implementing the SCFT Non-Concordance with Advised Treatment Policy for Adults. Care plans should be written in partnership with the patient, to appropriately capture expectations of care delivery.

4.4.3. Clinical assessments should be recorded based on care planning to meet the health needs of patient and reviewed if clinically indicated: Staff may require updating on their responsibilities of completing documentation including core care plans, MUST, Purpose T, wound assessment and description of wound appearance.

4.4.4. The Community Nursing Team should consider a review of their current process of accessing wound dressings from the GP and the delivery route to a patient's home. Consideration should also be given to who is responsible for collecting dressings from the dispensing pharmacy.

4.4.5. To support continuity of care, the Community Nursing Team should consider a review of the current process of sharing community nursing records between teams within SystmOne.

4.5. West Sussex County Council

4.5.1. Independent Living Services should consider a review of current process to enable reducing the waiting times for standard priority assessments.

4.5.2. WSCC should consider if alterations to the triage processes could support identifying whether a referral is standard or priority and allocated accordingly.

4.5.3. WSCC should ensure that social care information is sought from the named customer, as well as from people that are involved in their care.

4.6. Western Sussex Hospital NHS Trust

4.6.1. A more robust method of sharing information between partner agencies needs to be considered. In WSHFT currently, the fact that a patient is known to Proactive Care is highlighted by an alert on the electronic records system (PAS system). However, this does not provide up to date information on the patient and current status of treatment plans and a more visible method, and the sharing of this information by the GP, should be considered.

4.6.2. On discharge staff should consider contacting the community nursing team to ensure that dressing regime will continue: A named key contact person in the Community Nursing Team to whom hospital staff can direct queries, should also be considered.

5. Conclusion

1.1. This multi-agency learning review has considered the involvement of agencies with Mrs Pelham during the year before she died, and in particular whether those professionals and agencies worked together to safeguard and promote the health and social care needs of Mrs Pelham. As stated in the above narrative, for the majority of the last year of her life Mrs Pelham was viewed as a person with capacity to make choices regarding her care and treatment and this view informed the way in which professionals acted.

1.2. However, in response to the initial Adult Safeguarding Concern raised by SECAMB (as stated in the initial information above), at the point of discharge from the second WSHT admission there was no indication that community nursing were already involved in Mrs Pelham's care. This was potentially a missed opportunity for a referral to the Community Nursing Team at this point to monitor and or review the leg wounds. In addition, Mrs Pelham was known to Proactive Care, but this was not documented in the hospital nursing notes: the most likely reason for this is that the hospital staff had been informed that Mrs Pelham did not receive any community support.

1.3. The SCFT Clinical Lead has clarified that there was no proactive care planning to enable Mrs Pelham or her husband contacting the community team for rapid support in the event of wound deterioration and this was a missed opportunity to provide timely and effective wound care management.

1.4. Care delivery, both in the terms of accessing GP medical support and wound care dressing prescriptions, was also impacted on by Mrs Pelham choosing to remain with her original GP Medical Practice which was not local to her address. GP practices in England are free to register new patients who live outside their practice boundary area[5]. This means that patients can register with a GP practice somewhere that's more convenient for them, gives greater choice and aims to improve the quality of access to GP services. These arrangements are voluntary

[5] Patient choice of GP practices https://www.nhs.uk/using-the-nhs/nhs-services/gps/patient-choice-of-gp-practices/

for GP practices: if the practice feels it is not clinically appropriate or practical for the person to be registered so far away from home, they can still refuse registration and should explain their reason for refusing the registration.

1.5. The review has recognised good practice and strengths that can be built on as well as things that need to be done differently to encourage improvements. The information shows that single agency procedures were followed and that there was a reasonable amount of information sharing across agencies; however, it is the author's view that many of the responses from the agencies involved with Mrs Pelham were in relation to the presenting concern only. There appeared to be a lack of a clear, robust multi-agency assessment which considered the longer-term health related concerns, the social care provision that may have further supported her care needs, and the multi-agency communication to support addressing these. Recommendations have been identified above to address this, and multi-agency consideration of the recommendations will support ensuring that this situation is not repeated for another individual.

1.6. END OF REPORT