Safeguarding Adults Executive Board

BI-BOROUGH SAFEGUARDING ADULTS EXECUTIVE BOARD: LESSONS LEARNT REVIEW

Joan

October 2021

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Independent Reviewer

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CONTEXT OF SAFEGUARDING ADULTS REVIEWS

a. Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) if:

   I. There is reasonable cause for concern about how the SAB, member of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adults dies (s44(2)); or
   II. If the adult is still alive and the SAB knows or suspects, that the adult has experienced serious abuse or neglect (44(3)).

b. In addition, SABs are free to commission a SAR in any other situation where it is thought there is valuable learning for the partnership (s44(4)). It is on this basis that the Bi-Borough Safeguarding Adults Executive Board (SAEB) commissioned this SAR on behalf of Kensington and Chelsea.

c. A key principle for completing a SAR, is to ensure there is a culture of continuous learning and improvement across the organisations that work together, and the approach taken to the reviews should be proportionate to the scale and the level of complexity of the issues examined. The process and the spirit of the review will emphasise the importance of learning to make a positive difference across the partnership. There is a no blame approach to learning as it is recognised that practitioners aim to do the best they can for adults and so their decisions and actions need to be understood in the context that they work within.

d. In line with a Making Safeguarding Personal approach, involvement of the people who are the subject of the reviews is recognised as an important aspect of the learning from the review. If the person who is the subject of the review is living, he or she will be approached to ascertain their wishes on involvement in the review and where indicated, assess capacity to consent to this.

e. The SAEB commissioned an independent author to provide the SAR report. Belinda Oates is a qualified social worker registered with Social Work England. She has over 25 years' experience of working in the field of social care. Belinda gained practice experience initially as a front-line social worker before progressing to management roles which included multi-agency team manager and safeguarding adults operational and strategic manager. Belinda has been working independently for the last 16 years. Her work as a consultant and trainer has focused primarily on safeguarding adults as legislated by the Care Act 2014 and mental capacity in line with Mental Capacity Act 2005. Belinda Oates was commissioned to start the SAR in September 2021.

f. A SAR is not designed to hold individuals or organisations to account. Other processes exist for that purpose. The SAR enables all information from partner agencies to be reviewed in one place enabling the author to identify key areas for development and learning to support SAEB partners to improve ongoing safeguarding practice.

g. The Care Act 2014 (s44(5)) states that, each partner must cooperate and contribute to the review, identifying lessons to be learnt and to apply the lessons to future practice.

h. The Department of Health and Social Care's six principles for adults safeguarding should be applied across all safeguarding activity.[1] The principles will be considered throughout the SAR as follows:

Empowerment	Understanding how adults were involved in their care, involving adults and/or their representatives in the review
Prevention	The learning will be used to consider how practice can be developed to prevent future harm to others
Proportionality	The learning of this case will be more effective in the learning lessons and considering the themes
Protection	The learning will be used to protect others from harm
Partnership	Partners will cooperate with the review, considering how partners are working together to safeguard adults across the Bi Borough
Accountability	Agencies will be transparent in the review with the SAEB holding individual agencies to account for agreed recommendations

i. The statutory guidance states 'The focus must be on what needs to happen to achieve understanding, remedial action and very often, answers for families and friends of people who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.'[2] Although the SAR process aspires to follow the guidance and includes families in the process, it is not always the case that the SAR outcome provides all the answers some families are searching for. Joan's family have been involved in the SAR process and met with the Independent Reviewer to share their experiences and views. The family have asked for Joan's real name to be used throughout the report.

SCOPE OF THE REVIEW

This review did not meet the mandatory criteria for a SAR. The SAEB commissioned the SAR on the basis that there are valuable lessons to learn from how partner agencies provided support and care to Joan who lived in the Royal Borough of Kensington and Chelsea (RBKC) and received statutory services. The concerns that triggered this SAR was the Local Authority Care Act Section 42 enquiry (August 2019) and the Local Government Ombudsman (LGO) Report (March 2020) which identified themes including poor communication, lack of multi-agency working and non-personalised care. The evidence considered as part of this SAR and the subsequent lessons learnt, validates the SAEB decision to commission a discretionary SAR in the form of a Lessons Learnt Review.

[1] Department of Health (2016 Care and Support Statutory Guidance issued under the Care Act 2014) s14.125

[2] Department of Health (2016) Care and Support Statutory Guidance issued under the Care Act 2014) s14.128

The SAR referral was made into the Safeguarding Adults Case Review Group (SACRG) where Joan's case was presented in July 2020. The Board agencies had an opportunity to contribute to the discussion and decision-making process. There were concerns about how professionals and services worked together to safeguard Joan. The discussion highlighted concerns over the discharge planning process, which did not initiate action to ensure that Joan had the required equipment delivered in situ at her home ready for discharge.

The SAR referral makes reference to:

- Poor hospital discharge planning
- Delayed responses by the District Nurses, Social Work and Occupational Therapy (OT) services
- Agencies did not communicate well together leading to inadequately managing safe discharge from hospital. Joan had care and support needs and because of those needs was unable to protect herself from harm.

Joan's family made a formal complaint in June 2019 regarding Joan's care to Adult Social Care (ASC) through the complaint's procedure. A reply was provided; however, the substance and tone of the response was found to be unacceptable by the family. As a consequence, the family approached the LGO for their support and oversight of the Council's practice. The LGO's final decision was published in March 2020 outlining a series of omissions in practice for which they found the Council at fault.

The SACRG agreed that whilst the case had already had much work completed and there was some evidence of learning, there was potential for further lessons to be drawn from a partnership perspective. A review in the form of a Lessons Learnt Review was agreed and endorsed by the SAEB Independent Chair.

The objective of this SAR is to consider the recommendations and lessons learnt from the:

- Care Act 2014 Section 42 safeguarding enquiry
- LGO final decision report dated 19 March 2020
- Effectiveness of the ASC action plan in evidencing lessons have been learnt
- And to ensure the partnership response has been fully taken into account in the previous findings and actions and that those actions have been fully implemented.

This SAR aims to be a proportionate response to the seriousness of the incident, and to the possibility of maximising learning, and preventing harm to other people who may find themselves in similar circumstances.

METHODOLOGY

This SAR adopted a systems approach to learning. Wherever relevant, the approach will be informed by available research to ensure that Joan's experience is also understood in a broader context.

All agencies involved in Joan's care were invited to participate in contributing to the review. The following agencies contributed:

- Imperial College Healthcare NHS Trust

- ASC and OT, RBKC
- Central London Community Healthcare (CLCH) NHS Trust
- North West London NHS Clinical Commissioning Group, representing primary care
- Central and North West London (CNWL) NHS Foundation Trust

Joan's family were invited to contribute to the review and their views are included in the report.

The methodology used in this SAR included:

a. Analysis of chronologies from key organisations which included any intervention or involvement with Joan from December 2018 – October 2019.

b. The independent reviewer identified key practice episodes from chronologies and supporting documents. Key practitioners were interviewed to contribute to identifying the episodes.

c. The independent reviewer facilitated a collaborative session with all relevant agencies. The aim of the session was to:

- Review key practice episodes
- Discuss findings
- Agree what further points need to and/or can be investigated to establish practice learning
- Establish learning points
- Make recommendations for each organisation based on lessons learnt.

In addition, the following documentation was reviewed:

- Section 44 referral
- ASC safeguarding case audit – Section 42 enquiry
- ASC action plan in response to LGO decision report
- ASC audit – complaint learning and action plan
- ASC LGO action tracker
- Local Authority customer care response to LGO final decision
- Care Act 2014 Section 42 enquiry documents concluded December 2019
- LGO final decision 19 March 2020
- Local Authority customer care responses to family complaint dated 24 June 2020 and 12 August 2021
- Joan's family's letter of complaint to ASC
- Joan's family's letter to LGO

JOAN'S LIVED EXPERIENCE

Joan lived in the same street in London for all of her life until the two years prior to her death. Joan was the last born of nine children and her mother had remarried. Joan did not attend school as education was not valued by her parents and she described school as a 'scary intimating place where they hit children'. Joan was not evacuated during the war as her mother valued her family and was concerned about where they would be placed during evacuation. Her mum was a fierce protector and local midwife who kept her family together and relied on no-one.

The community where Joan lived, was made up of large working-class families. They all knew each other well and were often related in a secondary way which created a unique and warm environment where people were safe and cared for. They looked out for each other, to an outside observer, which might have appeared in a 'rough and ready way'; front doors were left open, and everyone supported each other.

When Joan was 20 years old, she worked as a tailor before moving to work at a local school as a cleaner and dinner lady. Joan's family described her as hardworking and always being available to support her family. Joan enjoyed her job and retired at the age of 60 after being at the school for 27 years. Her husband passed away in 2004; he used to work for an electricity company.

Joan had two children and numerous grandchildren and great grandchildren. Joan was a matriarch figure who supported her family in every aspect of their lives, financially, through caring, running errands, cooking, clothes making and being a listening ear. She was always available devoting her time to her family was of paramount importance to her.

Joan's family remember her as a strong character and in their words 'a legend' in her own right. Joan lived on her own and was fiercely independent. She found growing old very difficult, especially the loss of her independence and the fact she was reliant on carers and her family. Throughout her life, she was fit and healthy until the last year of her life. Her family remembered fondly how much Joan used to enjoy shopping. She was very active, loved cooking and knitting until the pain prevented her from doing so any longer.

Joan was admitted to hospital five times in the last 10 months of her life. In May 2019 Joan was discharged home from hospital with a package of care but re-admitted in July 2019 with increased delirium, drowsiness and pain related with sacral ulcers. This was recorded as community acquired ulcers - grade three on her heel and an un-stageable ulcer on her sacrum. Joan's family were strong advocates for her, communicating with the statutory agencies as to what her care needs were, both during her hospital admissions and when she was in her own home in the community. Joan was discharged from the hospital to a care home in August 2019, where she passed away in October 2019 at the age of 88. An overview of the specific circumstances of Joan's hospital admissions is covered in more detail further within this report.

THE FAMILY VIEWS

The independent reviewer met with four of Joan's family members; her two grandchildren, her son in law and her granddaughter in law. All of the family participating in this SAR were actively involved in Joan's life, with her daughter and son in law being present on a day-to-day basis during the last year of Joan's life, providing care and support. Her granddaughter acted as her advocate in addressing concerns about quality of service provided by the statutory services. In addition to the meeting with the family, the family shared with the independent reviewer two letters of complaint: a complaint to RBKC in June 2019 and a complaint to the LGO in August 2019.

a. Joan's family's views of the care that Joan received from statutory services is described below. This is not a full account of the discussions had with the family but provides an overview from their perspective. The family emphasised that it was not poor practice from an individual professional, but that the system let Joan down. It was felt that some

professionals were unclear of their role and some social workers often did not follow up on procedures unless they were chased and/or under duress of a complaint. The family expressed that they wanted to ensure that their experience was listened to with the aim that other vulnerable people would not go through the same experience.

b. The family felt that they had no alternative but to make multiple complaints about the care Joan received. A lack of communication and apparent due regard for basic human rights from both hospital and community staff raised serious concerns for the family. For example, when Joan was discharged from hospital there was no equipment in place nor a referral for a community OT assessment and the social care team appeared unaware of the discharge. The family believe if they had not been persistent in requesting this and if had they not complained to a senior level within the Local Authority, the assessment would not have taken place.

c. According to Joan's family she responded better to consistency in her care provision. In March 2019 following a hospital admission, Joan was discharged with reablement care. The family described the reablement carers as 'brilliant'. This was because they were employed by the Local Authority, properly trained, and their caseload was scheduled with realistic timing to support Joan effectively. Joan liked the carers as they were the same people coming into her home daily, so she was able to build a rapport with them. The carers provided from external organisations, were less consistent and the family raised a number of concerns about the quality of care. This led to the family raising questions as to who is accountable for monitoring the care provided by private care agencies.

d. The family explained that the hospital staff did not take time to communicate with Joan, because she could not see the person talking or hear them properly without her hearing aids or glasses, which had gone missing. There was a long delay in replacing the hearing aid and glasses and when they were replaced the family felt they were ineffective and of substandard. In the end, the family arranged for Joan to have them replaced privately.

e. This was a particular concern when staff made the decision that on discharge from hospital in May 2019, Joan would not be in receipt of reablement as she had not demonstrated willingness to engage with rehabilitation services such as physiotherapy or OT whilst in hospital. Joan would often answer 'no' to questions asked. The family have argued that if the reasonable adjustments Joan needed to be able to see and hear staff had been made, and that staff spent time with Joan to build rapport and explain what they were asking, it is likely she would have engaged with rehabilitation more effectively.

f. Joan was admitted to hospital on five different occasions from December 2018 – July 2019. On each admission, the family felt there was a lack of coordination in the hospital and on discharge into the community. The family gave an example of attempting to speak to Joan's doctor in the hospital, but they were never available. The family stated that nurses were unable to provide them with updated information. The family felt that the system did not offer a consistent or personalised approach to Joan. This caused undue distress for both the family and Joan and resulted in the care provision being disjointed. It is the family's opinion that Joan would have benefited from having an allocated care manager who could have

coordinated the care and acted as link for the family and Joan to navigate between the agencies involved.

g. The family emphasised that Joan was a much-loved family member and Joan's experience over the last 10 months of her life has caused the family a great deal of distress. It is the family view, that if Joan had received an appropriate level of personalised care without delays, spending time to encourage and motivate her, that Joan would not have deteriorated as quickly as she did and may still be with the family today.

KEY EPISODES IN JOAN'S LIFE DECEMBER 2018 – OCTOBER 2019

Joan was admitted to hospital on five separate occasions between December 2018 and her death on 4 October 2019. For ease of reference the key events are captured under each admission as this will enable the reader to follow Joan's experience across a number of different services/organisations. It is noteworthy that in the summary of key events below, the detail regarding medical intervention is excluded. It is not the purpose of this review to analyse whether the medical interventions were appropriate.

The chronology of events has been gathered from the chronologies submitted to the independent reviewer from each organisation. The chronology below does not include the full chronologies submitted from each organisation but highlights salient points linked to the analysis.

Joan admitted to hospital on 30 December 2018 following a fall at home.

1. 14 February 2019 - Joan was discharged from hospital with a reablement care package.
2. The family raised concerns with the hospital duty social worker about poor discharge and reported that the ambulance left Joan on a chair for a couple of hours by herself before the carers attended. The family were advised to report their concerns to the Patient Advice and Liaison Service (PALS).
3. The family requested additional equipment from ASC, to support Joan's independence at home. There is no evidence within the records as to whether this was responded to or not.
4. 22 February 2019 - the family raised concerns with ASC about carers leaving Joan sitting in a high-backed chair, not arriving on time or completing all of the allocated tasks. There is no evidence that the concerns were addressed by the Local Authority or communicated to the care provider.
5. 1 March 2019 - a physiotherapist from the GP Practice visited Joan at home and assessed her as being safe with the assistance of two carers, four times daily.
6. 1 March 2019 – An initial therapy assessment was completed. The aim is for this assessment to be completed within two working days but in this instance the assessment took place 12 days after the referral. The rehabilitation therapist was concerned about Joan's reduced mobility and that she was drowsy. The situation was escalated to the Rapid Response service.
7. 1 March 2019 – the Rapid Response service visited Joan as it was suspected she had a suspected urinary tract infection. An initial assessment was undertaken, and the team liaised with the GP for a prescription to be issued for antibiotics.

8. The Rapid Response service completed a follow up visit to review observations and medication. They also communicated with the out of hours GP to review blood results which indicated altered liver function.
9. 4 March 2019 - a physiotherapist from the Rapid Response service visited Joan. The chronology evidences the record of a discussion with the care agency of the need to prompt Joan to take her medication. A further follow up visit was planned for next day but not completed due to Joan being admitted to hospital.

***Significance of episode**: Poor co-ordination between key agencies leads to discharge which is below standard of practice expected in terms of co-ordination. Period in question demonstrates number of different organisations involved in care leading to possible confusion for family as to the role of the different organisations in supporting Joan and who was the lead agency.*

Joan admitted to hospital on 5 March 2019 after falling out of bed.

10. 14 March 2019 - the hospital social work team assessed Joan as having capacity to decide about her care and support plan and discharge arrangements were discussed with the family. The family raised concerns with the hospital team about the quality of the care provided to Joan within her home environment, including concerns regarding inconsistency with different carers and carers not spending enough time motivating and encouraging Joan to be independent. The family's preference was to try reablement initially before putting in a long-term care package. Whilst a formal multi-disciplinary meeting did not take place, the hospital social work team implemented a referral for a reablement service in line with the family's wishes.
11. 19 March 2019 - reablement assessment completed of which the outcome was to recommend visits four times a day from two carers. It was planned for the OT to review the care package once Joan returned home.
12. 20 March 2019 – Joan was discharged home from hospital.
13. 20 March 2019 – An initial assessment completed by a physiotherapist identified that equipment was needed to aid transfers to/from a chair. However, there is no evidence this was followed up. The Rapid Response service have accepted their records were misleading and ambiguous, but outlined that whilst at an initial assessment, an adult may have difficulty transferring, but this can change as the adult becomes more used to the height of their chair/s at home. Subsequent visits would assess if transfers were still a concern and if necessary appropriate equipment would then be ordered.
14. 21 March 2019 - District Nurses visited and noted that Joan's pressure areas were intact.
15. 22 March 2019 – an OT visited but could not gain access to the property. The visit was rearranged for 27 March 2019, but this did not go ahead as Joan was admitted to hospital 25 March 2019.

***Significance of episode:** Family are involved in discussions regarding discharge planning arrangements, although it appears a formal multi-disciplinary meeting did not take place. This lack of a more effective multi-disciplinary approach may have contributed to a further breakdown in communication between family and organisations involved in Joan's care.*

Joan was re-admitted to hospital on 25 March 2019

16. 25 March 2019 – the family raised concerns about the quality of care. An OT attempted to contact the family to discuss but were not able to contact them. It appears that further attempts to contact the family were not progressed.
17. The chronologies reflect that the family were included in discharge planning. Joan was discharged on 29 March 2019 and reablement care was resumed. The same care agency was providing the care as that prior to Joan's admission despite the concerns raised by the family.
18. 29 March 2019 - District Nurses received a referral from the hospital and visited Joan on the same day. All pressures areas were assessed to be intact. Weekly visits were scheduled with Joan's family to check Joan's pressure areas.
19. 29 March 2019 – a hospital OT requested support from an OT in the community to avoid hospital readmission.
20. 29 March 2019 – Joan refused a comprehensive mobility assessment due to fatigue. A slide sheet was ordered.
21. 29 March 2019 – a community OT visited to review care package. The outcome of this visit was that the OT planned to carry out joint visit with carers to review transfers and quality of care.
22. 1 April 2019 – further to the visit undertaken on 29 March, Joan received a joint visit from the GP and the Rapid Response service. Family members were present. It was agreed that hospital admission was not in Joan's best interest as it would be too distressing.
23. 3 April 2019 – the carers made a referral to the District Nurses as were concerned Joan had developed pressure sores. However, when District Nurses visited on the 5 April 2019, they found Joan's pressure areas to be intact.
24. 12 April 2019 – family requested a GP home visit. The GP found no cause for concern and felt that Joan did not require hospital admission. The GP records commented that there was no Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) instruction. The family was updated following the visit. Family reported they felt 'Joan had given up'.
25. 15 April 2019 – My Care My Way (MCMW)[3] became actively involved and contacted Joan's family. The family wanted Joan to be considered for a care home placement in view of her ongoing deterioration. A referral was made for a review by ASC. DNACPR was discussed with the family, but no decision made.
26. 18 April 2019 - an OT visit took place. The carers asked for a hoist as Joan had only left her bed once since leaving hospital. However, the OT declined with the rationale that it would not be safe to introduce new equipment. Bed rails were requested by carers but there is no evidence that this request was considered.
27. 8 April 2019 –the Local Authority started a social care assessment which was completed on 20 April. This assessment recorded that the family were happy with the current care provision. The assessment identified risk of pressure sores but recorded that at that stage there were no concerns of skin breakdown.

***Significance of episode**: Good practice would be to have asked if family wanted to change agency, given it had not been possible to resolve ongoing concerns. It is unclear if this happened despite review of package. The social care assessment completed by ASC appears to contradict what we know about the family's feelings about the care provision.*

[3] My Care My Way is a multi-agency service led by the North West London Clinical Commissioning Group bringing together GP surgeries, NHS hospitals, local community and social care services to deliver integrated care interventions.

Joan was admitted to hospital on 21 April 2019

28. Family reported concerns about quality of care to the Local Authority, stating that carers were not always attending at the same time. There is no evidence this concern was responded to.
29. 9 May 2019 – the hospital social work team completed an assessment of Joan's care and support needs, and a care and support plan was agreed on the 22 May 2019. A decision was made that Joan needed a full package of care on discharge as she was now bedbound. It was agreed the community OT would complete a home visit to assess Joan for the use of a hoist. Discharge planning was discussed with Joan's family.
30. 21 May 2019 - Joan's discharge was planned for this date, but then delayed until 23 May 2019 as family had not been informed of the earlier discharge date.
31. 24 May 2019 - the family raised a concern that Joan was not eating and was depressed. Joan's daughter was advised to contact Joan's GP, which they agreed to do.
32. 28 May 2019 - the District Nurses received a referral from the hospital regarding Joan's pressure sores, outlining that she had two grade one pressure sores. The District Nurses visited the same day. A referral was made to MCMW raising concerns that Joan not coping at home.
33. 31 May 2019 - District Nurses visited and redressed her wounds.
34. 5 June 2019 - the family raised further concerns with District Nurses about the quality of care provided by ASC.
35. 5 June 2019 - Joan's family raised a concern with ASC requesting that a review of the care and support plan be brought forward. However, there is no evidence that this took place.
36. 7 June 2019 - District Nurses visited to monitor pressure areas. The family raised concerns with them again about poor quality of care.
37. 14 June 2019 – District Nurses contacted ASC to report current concerns.
38. 17 June 2019 - District Nurses records state that the family had requested respite care, but there is no record of this being followed up and communicated to ASC by the District Nurses.
39. 6 June 2019 - a community OT assessment was requested by the hospital social work team, two weeks after Joan was discharged from hospital.
40. 21 June 2019 – the GP visited Joan at home and saw her alone. Records indicate that Joan's cognition was poor, but that the GP recorded no acute medical needs were identified.
41. 24 June 2019 – the GP had telephone contact with Joan's family, in which it was discussed that hospital staff had lost Joan's hearing aid and glasses. The GP made a referral to the audiology clinic and confirmed to the family that new glasses had been provided.
42. 25 June 2019 - District Nurses visited to provide Joan with wound care. The District Nurses recorded that Joan had been incontinent and as a result they completed personal care while visiting. The records lack detail as to the time of the visit and whether this was after the care workers had attended. If there was concern that the carers had just visited or had not visited at the scheduled time, this should have been reported to the Local Authority. However, as the record does not include the time or the circumstances, it is not clear whether this was an indicator of omission of care by the care agency or an isolated accident Joan had.
43. 26 June 2019 – GP visited Joan at home and agreed to refer to ASC in response to the family requesting a nursing home placement for Joan. There was no evidence from the chronology that this referral to ASC was made.
44. 27 June 2019 – assessment completed by community OT, over four weeks after discharge from hospital. Following this assessment, a hoist was ordered.

45. Joan's family made a formal complaint to the Council regarding the poor communication, delay in OT assessment and the lack of appropriate equipment following Joan's discharge on 24 May 2019.

***Significance of Episode**: Demonstrates the disconnect between family and ASC around care being provided. Episode queries whether health practitioners such as District Nurses are confident in how to raise quality assurance concerns which may not reach the threshold of a safeguarding concern. Co-ordination of health and social care systems appear to be lacking to support better complex health and social care needs of people like Joan.*

Joan was admitted to hospital on 3 July 2019

46. 4 July 2019 - the hospital raised a safeguarding concern relating to the pressures sores that Joan had on admission to hospital.
47. 9 July 2019 - the Council responded to the family's complaint and offered to meet with them. However, there is no record of this meeting ever taking place.
48. 15 July 2019 - family attended a discharge planning meeting at the hospital.
49. 2 August 2019 - a CHC checklist was completed and sent to the CHC team requesting an assessment, with a request for funding of a nursing home placement for three months for pressure sore management.

Joan moved to into a Care Home on 14 August 2019

50. 16 August 2019 - ASC contacted the family to update them, stating that the pressures ulcers were not due to an unsatisfactory discharge but instead, as a result of poor care in the community and that as such a safeguarding concern would be raised.
51. 19 August 2019 - a safeguarding concern was raised by the hospital in relation community acquired pressure ulcers.

Joan died on 4 October 2019

***Significance of Episode:** Good practice ought to dictate that the safeguarding pathway supports Making Safeguarding Personal, and Joan's wishes with support from her family are central to the process. What we know is that this did not happen in a timely manner and may have been a contributory factor to the family making a complaint.*

SECTION 42 SAFEGUARDING ENQUIRY

The safeguarding concern

A safeguarding concern raised by the hospital came into the Local Authority on the 9 July 2019. The safeguarding incident occurred on 3 July 2019. The details of the concern were:

- Joan was admitted to hospital with community acquired unstageable sacral sore and a grade three sore on her right heel. An unstageable pressure sore is defined as, "full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed'[4]
- The allegation was neglect by the community care provider.

ASC decision

[4] National Pressure Ulcer Advisory Panel (NPUAP)

The three statutory criteria for safeguarding were applied:

I. adult with care and support needs,
II. at risk of abuse or neglect and
III. as a result of their care and support needs are unable to protect themselves from abuse or neglect.

The safeguarding enquiry was scheduled to proceed on 27 August 2019 but not started until 19 December 2019.

Outcome of enquiry

It was apparent that there was poor discharge planning and that Joan was discharged home without the relevant support in place. It was identified that there were lapses in the discharge planning process. Necessary services needed to maintain Joan's health and wellbeing was not made available soon enough. She deteriorated whilst she was in the community.

The delay to the safeguarding enquiry was not acceptable and the Local Authority extended apologies to the family for the failures that happened in the care and support that was required from both health and social care.

The conclusion of the enquiry noted that lessons would be learned, and relevant managers would be informed about the outcome of the safeguarding procedure. It was also noted that a referral for a SAR under Section 44 would be made.

Internal audit

RBKC carried out an internal audit on the safeguarding process given a number of concerns raised by the family and delays in commencing the safeguarding enquiry.

The key findings were:

- The safeguarding enquiry was not completed in a timely manner. There was a delay in commencing the enquiry and then additional delays in progressing.
- There was limited management oversight, in both the planning and coordination of the enquiry.
- There was no clear plan or scope of the enquiry and clarity as to what actions needed to be undertaken by whom or which organisation.
- There was a lack of evidence of partnership actions planned or progressed to undertake a comprehensive the enquiry gathering the key facts.
- There was no evidence of the risk assessment and interim safety planning.
- There was no consideration of follow up actions that may be needed regarding the organisation or individuals responsible for the alleged neglect.
- There was no record of Joan's mental capacity regarding her care and support needs.
- There was a lack of a Making Safeguarding Personal approach and no record of Joan being included in the safeguarding enquiry, or her views and wishes having been sought.
- The record of the enquiry meetings is difficult to understand and navigate because the perimeters of the enquiry were not established at the planning stage. The record is in parts verbatim and simply a collection of statements by individuals with no analysis.

Internal audit outcome:

- ASC staff involved in the enquiry into Joan's care were supported to reflect on the learning. They have been supported to develop their knowledge and skill on safeguarding practice and processes.
- Joan's case was referred to the SACRG for consideration of a Care Act 2014 section 44 SAR which led to this review being commissioned.

ADULT SOCIAL CARE (ASC) COMPLAINTS PROCESS

Following the review of the families concerns about the quality of the response, the learning and actions agreed by the ASC complaints team are:

a. At the time of the complaint, there was a lack of management oversight of the complaints process and the final draft letter was sent without authorisation. The council recognises this as a fault in practice.
b. As a result, a process has been implemented, all members' enquiries and complaints responses will be scrutinised by a Head of Service before being finalised.
c. Responses to complaints must be completed within 10 days unless there is a valid reason and an extension with the complainant has been agreed.

LOCAL GOVERNMENT AND SOCIAL CARE OMBUDSMAN (LGO) FINDINGS

The outcome of the LGO investigation completed in March 2020 found the Council at fault in its provision of care to Joan.

Findings:

a. Repeated concerns about the quality of care provided to Joan with no evidence the Council properly considered these concerns or responded adequately.
b. Delay in undertaking the initial OT assessment led to a subsequent delay in the provision of equipment that could have ensured greater safety at home.
c. Further delay in the OT assessment following discharge where imminent risks were identified in relation to pressure sores.
d. Neglect in its care of Joan due to poor communication, delay in assessments and delay in overall care and support.

ASC have responded to the report and accepted the findings within remedial actions completed.

ANALYSIS AND KEY THEMES

This section considers analysis and key themes of both, areas of learning for future development, and where good practice was identified.

Communication and coordination

Inconsistent communication between organisations and the family is a key theme throughout Joan's experience. In addition, the SAR has identified gaps in the communication and coordination between partner organisations which impacted on the quality of care Joan received.

a. When an adult has complex needs has a number of different services involved, it can be difficult to determine who is accountable for what. This was clear in Joan's case that the concerns raised were either not responded to, or family were signposted to raise their concerns to different teams for resolution. Although records reflect numerous conversations with the family, responses were often limited, and it appears that the family's views at times were not adequately heard.

b. The family communicated the stress they were under to numerous professionals across different services. The Care Act 2014[5] states, Local Authorities have a duty to offer informal/ unpaid carers an assessment. Whilst the family were offered a carers assessment in June 2019, the evidence reviewed indicates that communication with them regarding the purpose of a carers assessment was insufficient. The family were offered a carers assessment again in October 2019, but by this time Joan had moved into a care home. In view of the high level of support Joan's family provided, a carers assessment should have been offered in line with legislative requirements.

c. Joan's family were actively questioning professionals' decisions about Joan's care, both from a clinical and social care perspective. The chronologies provide evidence of ongoing

[5] Care Act 2014 section 10

communication with the family but reflect a lack of coordination from different professionals both in the hospital and the community. It is acknowledged that it can be difficult for professionals when a number of different family members are actively challenging decisions. The professionals' interactions with family are clearly documented with records evidencing that family members were at times angry and verbally aggressive towards professionals, likely to be born out of frustration of the circumstances. Professionals need to be supported and offered opportunities to develop skills to effectively listen to concerns raised by family members and understand behaviours that can present as anger or frustration. A coordinated approach from all agencies would certainly have improved the communication with the family in Joan's case.

d. Joan had a number of readmissions to hospital, which involved various professionals across health and social care meeting with family separately. This resulted in family members being given different messages at times which lead to frustration on their part. Insufficient action was taken to address these concerns. It would have been beneficial to have coordinated a professionals meeting with the family (such as considering Family Group Conferencing), giving them an opportunity to ask questions and understand the rationale why certain decisions were being made.

e. The hospital found on review of Joan's case that the timeliness of response to requests and expert opinions and liaising with external agencies (e.g. referring to therapies, specialty teams and their responsiveness) was positive overall.

f. There was poor communication between the hospital and Joan's family on her last discharge regarding where she was being moved to. Whilst responsibility for this rested primarily with hospital staff, equally there was a role for the CHC team to have liaised with family members, given they identified the placement and funded the care.

g. Consistent with the LGO report, the review has found poor communication as inadequate from the Local Authority to the family. The communication lacked a person-centred approach. It is possible that the poor communication with the family added to the overall distress they experienced.

h. Although the communication between the family and GP was good with a proportionate response to concerns, there is no record of the GP practice referring Joan to ASC for a nursing placement as requested by the family in June 2019. The family had previously requested ASC source a nursing placement that same month, but there was no evidence of action being taken to progress matters before Joan was readmitted to hospital in July 2019. More effective communication and coordination between the GP and ASC would have likely ensured a more holistic risk assessment and possibly resulted in escalating the assessment process for Joan to move into a care home at an earlier stage.

i. Joan was on the MCMW, caseload from December 2016, but her case was inactive between August 2018 and April 2019 as she was deemed not to be in need of the service. However, from reviewing Joan's journey, it is clear Joan would have benefited from a case worker following her discharge from hospital in February 2019. However, MCMW were not informed at the point of the change in Joan's level of need from any of the other professionals

involved. Joan was referred back to MCMW by the District Nurse in April 2019. This is another example of how coordination between services needs improving.

Continuity of care

j. Not allocating a lead professional to Joan from ASC until June 2021, resulted in a lack of continuity in the care provision. This approach resulted in Joan's family being passed between different professionals, without anyone taking accountability to resolve the concerns they were raising about the substandard quality of care, delays in assessments and impact this was having on Joan.

Person-centred care

k. Throughout records and chronologies reviewed from the statutory organisations, there is extensive evidence of communication with the family but no evidence of Joan's voice being heard. The records do not provide evidence of Joan's views regarding how she wanted to have her care provided. There are questions about Joan's capacity, however the family are clear that Joan was able to have a voice if she was listened to. A risk of only communicating with the family and not hearing the person receiving care leaves one asking the question did the professional who worked with Joan really know what Joan wanted? While it is a great strength for the adults who have supportive families, the voice of the individual should not be lost. The provision of care should be personalised and the records should have reflected Joan's wishes.

Mental capacity

l. Records across the organisations refer to 'best interest' decisions. There is no record of an assessment of capacity or that this was considered, despite Joan having a formal diagnosis of dementia.

m. Information through the chronologies is contradictory in clarifying whether Joan had capacity to make decisions about both health and social care interventions. Joan's family believe that she had capacity to make decisions about what she wanted but that communication with professionals was hindered due to the missing hearing aids and glasses. As directed by the Mental Capacity Act 2005[6]; all practicable steps should be taken to help someone make a decision. In Joan's case time should have been taken to enable Joan to understand the information she was being asked to discuss; including providing her with glasses and working hearing aids to support communication.

n. The GP Practice completed home visits on a regular basis between December 2018 until Joan's last hospital admission in July 2019. She was not seen by the practice once she moved into the care home. The practice records highlight a timely response to the families concerns and home visits were being initiated following family concerns. The GP identified that Joan did not have a DNACPR in April 2019 and although it was recorded as an action to address, no action was taken.

[6] Mental Capacity Act 2005, principle 2

o. Within Imperial College Healthcare NHS Trust assessments, reference to Joan's mental capacity and her wishes is largely absent from hospital records. Whilst her cognition was regularly assessed and documented by numerous staff members, these do not reflect decision specific capacity assessments, especially in relation to what medical intervention and social care support Joan wanted.

Safeguarding adults at risk

Safeguarding is a multi-agency responsibility. This review highlighted a number of organisations were aware of the concerns the family had about the quality of care being provided by the care provider but, with the exception of the referral from the hospital in July 2019, these were not communicated to ASC. On the occasions that the family communicated directly with ASC about the concerns of quality of care, ASC did not recognise the need to consider addressing the concerns through the safeguarding pathway.

The family raised concerns about the quality of care being provided by the care agency to the ASC on six occasions. Under Section 42 of the Care Act 2014, Local Authorities have a statutory duty to undertake or ensure others do, a safeguarding enquiry if the following three criteria are met.

- the adult has needs for care and support,
- the adult is experiencing or at risk of, abuse or neglect,
- as a result of those needs are unable to protect themselves from the experience of, or risk of, abuse or neglect.[7]

There is no evidence that on any of the occasions, that the concerns were looked into via safeguarding procedures until the hospital raised a concern in July 2019. The subsequent enquiry was limited, to investigating the cause of Joan's pressures sores. At no point has the Local Authority conducted a safeguarding enquiry into the concerns the family had raised about the quality of care provided by the independent care agency while Joan was at home.

A lack of response to the quality concerns were a missed opportunity for ASC to address the poor quality of care and work with the agency and relevant regulatory bodies such as the Care Quality Commission to improve services and ultimately achieve a better quality of care.

j. The internal audit of the safeguarding enquiry by ASC highlighted that the enquiry was not undertaken in accordance with the London Multi-Agency Safeguarding Adults Policy and Procedures. The enquiry reflected a lack of professional curiosity from the organisations involved. The lack of in-depth enquiry was a lost opportunity to learn lessons about where the gaps in Joan's care were. The outcome of in-depth enquiry based on factual evidence can be used to influence changes to improve the quality of service to the adult who is the subject of the enquiry. In Joan's case, she sadly passed away prior to the enquiry conclusion but the lessons learnt should improve the quality of service to others.

k. The District Nursing Service was providing support to Joan in the community from January 2019 to July 2019. The responses were timely and efficient in relation to referrals and interventions. However, in June 2019 when the family communicated with the District Nursing service their concerns about the inadequate care and the lack of response from the Local Authority, the District Nurses did not share this information with ASC. Whilst it is appropriate to signpost families to have direct contact with ASC regarding safeguarding

[7] Care Act 2014 section 42

concerns, good practice would have been for the District Nurses to have shared the family's concerns with other relevant professionals, and certainly the Local Authority.

The SAR Process

l. It is the policy of the SAEB to send a registered letter to family members or representatives informing them a SAR is commencing, what this means in practice and how to get involved. It is always difficult to know how this type of letter may be accepted by any family. The family found this very distressing and felt that the SAEB representative should have made a phone call informing them and pre warning them that the SAR was commencing.

m. The ASC action plan dated June 2020, in response to the LGO final decision recommends referral for a SAR. The SACRG agreed a learning review (discretionary SAR) in July 2020. It is acknowledged that the unprecedented pressures caused by the COVID pandemic contributed to a delay in this SAR being initiated.

n. The easement of Local Authority duties during the COVID pandemic did not extend to SARs. Due to unprecedented pressure on services responding to the pandemic, Joan's SAR was delayed. While it is recognized that the delay was unavoidable, the delay and rationale for the delay should have been communicated to the family at an earlier stage. The SAR process was not seamless. This SAR considered two parallel processes, i.e. the LGO findings and the partnership lessons to learn from Joan's journey. The two separate processes caused confusion for both professionals and the family as to who is accountable for what. Early learning from the SAR ensured that the LGO findings and subsequent actions were addressed and progressed by the agency to whom they applied i.e. in this case ASC. This allowed the SAR to focus on lessons learnt across the partnership as a whole.

ASC ACTION PLAN IN RESPONSE TO LGO

ASC published a complaint learning and action plan in June 2020, in response to the LGO final decision.

The independent reviewer considered the action plan in relation to the LGO findings in the context of this SAR. The action plan is comprehensive and addresses the key faults identified by the LGO by ASC. However, the action plan would have benefited from a more partnership focus with clear evidence of measures around compliance. Although the actions in progress are proportionate and linked to the lessons learnt, there was a lack of accountability for ensuring they progress and timescales in which they are to be achieved. Early learning coming from this SAR has ensured that actions are being reviewed and is described at the end of this section.

This subsequent review and the previous section 42 enquiry have highlighted how the gaps in effective co–ordination and communication between organisations contributed to the inadequate care Joan received.

ASC has started to implement internal audits to ensure lessons have been learnt but this is at an early stage of implementation and further consideration is needed by the SAEB as to what mechanisms are required to provide the Board with sufficient assurance that the learning

from the LGO process, ASC action plan and this review leads to organisational change and has an impact on practice across the safeguarding partnership.

The narrative provided to the reviewer by the ASC about the themes from the 20 cases which have been audited to date include:

- The preliminary findings show that case management and team interface working is inconsistent across the key discharging hospitals for the Bi-borough. There are incidents of good practice and person-centred planning, smooth and timely transitions of cases between teams and effective communication. However, there are also examples where practice standards need improving to ensure that there is effective planning coordination and communication with internal and external partners so that discharges can be expedited safely.

- The audit sample has highlighted there was a positive outcome for the adults when the following practice was applied:
  a. A clear transfer summary highlighting the needs of the adult and what care package was required.

  b. Where communication was clear and positive the outcome for the patient in their rehabilitation was far more successful, over those where the transfer was brief and lacked details. This is an area to be addressed through the audit and the pathways from hospital service to community service will be strengthened through a programme of training and developing the discharge pathways to the community.

  c. In those cases, where the adult and their families were consulted and listened to, the adult's journey was more stable, successful and they were less likely to need readmission to hospital.

  Actions in Progress:
  a. An external audit of hospital discharge practice has been commissioned by ASC to commence in November 2021. The audit will focus on hospital discharge cases into the community and looking at issues of best practice to include mental capacity, safeguarding, timely case transfers and the robust application of the Care Act 2014.

  b. A cycle of internal three-monthly audits will be embedded across the operational teams, focusing on the adult's journey from hospital to the community. The focus of all audits will be thematic, from complaint and practice issues. As stated above this will be the focus over the coming months. The independent auditor will review the findings and cross-reference with her own findings and make further recommendations about practice standards and processes. Her focus initially will be hospital discharge and the Discharge to Assess (D2A)[8] process.

  c. The hospital service is to be reviewed and redesigned to meet the emerging challenges of communication and coordination. The hospital social workers will proactively case

[8] The Discharge to Assess (D2A) is a NHS model of care which supports people to leave hospital, when it is safe and appropriate to do so, but continuing with the provision of care and assessment out of the hospital. This includes providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home.

manage post discharge thus allowing continuity of worker and take ownership and respond as issues arise.

IMPROVEMENTS AND LESSONS LEARNT ACROSS THE PARTNERSHIPS SINCE JANUARY 2020

Since Joan's death, organisations across the Bi-Borough partnership have had to develop and adapt in response to the Covid pandemic. The information below highlights some of the initiatives and improvements in practice as an outcome to the learning from Joan's experiences.

a. Partnership insights from the pandemic taken from the SAEB's 2020-2021 Annual Report

1. The SAEB were impressed by the collaborative working for example social care and other health colleagues in supporting and protecting care homes. Despite the difficulties the pandemic also brought new opportunities. There are many examples of good teamwork and strengths of true partnership working that became a feature of tackling the pandemic.

Social isolation is an increasing factor to include carer stress with more people initially asked to socially isolate as a result of Covid. In response:

2. There is a project being undertaken by Healthwatch, which is an independent organisation. They make sure that health and social care services listen to local people's views and feedback so that the services can be made better and easier to use. The project asked people with recent experience of safeguarding how well the process had worked for them. Interview responses were analysed and made recommendations have been made for improvements to the safeguarding process.

b. Hospital Discharges

CLCH were tasked with setting up the Covid hubs in March 2020 across all hospital sites, this has improved multi-disciplinary oversight on discharges. This is a health led process and includes ASC and OT as key partners.

In May 2021 the Trusts created the Integrated Discharge Teams which include ASC.
ASC are currently redesigning their Hospital Discharge Service to set up a (D2A Team – so although social workers will move out of the hospital, an adult will have an allocated worker visit them at home within 2- 24 hours after discharge. This is a critical point when returning home as the adult adjusts.

As part of the hospital redesign ASC are aiming to develop the hub model with NHS partners included in the D2A model focusing on the adults' outcomes and to improve their journey from hospital to home.

As part of the redesign ASC are recommending:

- A lead professional for each individual discharge. This professional will be a member of the newly created Integrated Discharge Team.

- ASC check and challenge screening process, on the D2A assessment, in a multi-disciplinary team context, at the point of discharge and before any care is set up.
- A review of training needs in relation to safeguarding and pressure ulcer care and management
- As part of the case transfer between teams, ASC will continue with the six-weekly meetings between hospital and D2A team (as it will become) and community teams. The hospital and reablement service have embedded the meetings in practice, and they have proved to be effective in improving communication between agencies.

RECOMMENDATIONS

a. The SAEB to develop a process to ensure the learning from Section 44 SARs is disseminated effectively throughout SAEB partner agencies and supports organisational change. This will incorporate principles of the revised Pan-London SAR Protocol and include the following key area of practice:
    - Ensuring a Making Safeguarding Personal approach to SARs, including consideration of involving the adult and their family from the outset of the review and ensuring their views are included within reviews.
    - Ensuring a consistent approach to the process and practice of SARs, including in relation to ensuring robust terms of reference for reviews, and that good quality, comprehensive chronology / Individual Management Review reports are produced.

b. The SAEB to consider developing multi-agency guidance and develop bespoke training sessions to raise awareness of the national protocol of pressure ulcers referral procedure, specifically regarding risk assessment and application of checklist to ensure that the agreed pathways are followed across the partnership. Awareness raising needs to include a strategic response to ensuring professionals not only have knowledge of the protocol but appropriate skills to implement the protocol in practice.

c. The SAEB to build upon the work already undertaken by ASC to introduce an ongoing programme of audits of safeguarding practice and decision making, by developing a multi-agency quality assurance and performance framework. The audit mechanisms developed should be used as a tool to measure how the lessons from SARs are learnt and effect changes in practice.

d. The operational model of the MCMW should be reviewed in the light of the implementation of Integrated Care Systems in terms of effectiveness and longer-term options to ensure optimal service delivery.

e. A Bi-Borough systems approach should be developed to ensure a more coordinated approach across acute hospital trusts and ASC, to ensure effective complex case management. This should draw upon the benefits identified from the integrated discharge hub response to the pandemic and consider the role of a lead professional and ensuring a team around the person response.