Safeguarding Adults

Thematic Review

Of

The quality, safety and effectiveness of services for adults living in care settings in Sutton

Publication Date: 19th May 2021

Introduction:

This is a report on the findings from thematic safeguarding adults review of the care provision for adults living in care setting. This was commissioned by Sutton Safeguarding Adult Board following the identification of some common themes arising from several cases referred to the Board. It identifies the learning from two of those cases and from the wider context of how safeguarding partners work together effectively across what is, locally and nationally, an increasingly complex and fragmented system of care provision. It identifies 11 key learning points for the Board to consider and decide on how to apply the learning.

Background Context:

The review was commissioned in relation to two cases, both referred under S44. There was a recognition by the Sutton Safeguarding Adults Board that there were similar themes in the two cases despite the clear difference between them. Similar themes were also emerging in relation to several other cases known to the Board.

Nationally the context is one where the quality of care and the safety of residents in nursing and residential care, and in specialist care for adults with learning or physical disabilities continues to be a concern. A review undertaken by East Midlands Safeguarding Adults network in 2017[1] identified a number of key learning points; all of which have informed the terms of reference for this specific thematic review. (appendix 1). Other reviews have highlighted the key issues in terms of the relationship between the Care Quality Commission (CQC), local authorities and hospitals.

Case 1: The first case was considered following the death of a woman placed from one of the local NHS Hospital Trusts into nursing home accommodation following surgery after a fall at her home. The Coroner concluded a Narrative Verdict, finding this was contributed to by Neglect. Failure by the home to follow their own policies in relation to diabetic care was causative.

Case 2: The other referral related to abuse experienced by residents at a specific residential home (Home B) for adults with learning difficulties run by a large national provider with homes in Sutton. This was following the completion of an enquiry conducted in line with s42 Care Act 2015 that found young people and adults had been abused whilst resident. This provision had secured approval from CQC in December 2018 to change its status to provide specialist residential care to adults with learning disabilities and behavioural needs. By March 2019 a number of people had been placed into the accommodation. All of these were 'out of borough' placements, i.e. arranged by other local authorities moving their clients into Sutton. LBS' adult social care department were not responsible for these placements and were not

[1] Undertaken by the East Midlands Safeguarding Adults network and published by ADASS in November 2017 at: https://www.nottinghamshire.gov.uk/media/132275/emsanthematicreviewsars.pdf

informed that clients had been placed there.[2] In March 2019 LBS received a complaint which triggered a visit by commissioning staff who in turn raised concerns with the placing authority and CQC that 2 of the residents were under 18. When further concerns were raised in early April 2019 a full enquiry was undertaken in line with s42 Care Act 2019. A multi-agency action plan was put in place resulting in the prosecution of 4 members of staff accused of ill treatment of those in their care. Criminal proceedings have been delayed due to C-19. In addition, 5 further staff members were referred to the DBS

This thematic review did not undertake any detailed review of either of these cases and does not deal with the facts of what happened. In both cases this has already been done through other processes.

Terms of reference and methodology:

The review explores the following key questions:

1. Have the recommendations put forward by the complex abuse investigation at Home B led to improved practice, particularly in respect of interdepartmental and interagency communication so poor quality or care or concerns regarding culture/ organisational abuse are identified early? How is this reported to SSAB and the wider community?
2. Have recommendations regarding hospital discharge following the Individual A learning review been implemented locally? How could these be applied across the South West London CCG footprint? How will this be reported to SSAB and the wider community?
3. What role should family, friends and advocacy play in preventing a culture of poor care or institutional abuse? How do we ensure their voices are heard and concerns acted on?
4. How do agencies work together to identify new provisions opening in Sutton (including supported living placements)? How does this ensure provision is properly resourced and regulated to provide the care, particularly if this is commissioned on a 'spot purchase' arrangement, 'step down to assess' or other intermediate care basis?
5. Where there is a high degree of restraint anticipated or residents are placed by other local authorities or CCGs which are out of area, is the legal framework robust enough to ensure host authorities are aware of placements and can comply with their safeguarding and market management responsibilities? Would mandatory notification (proposed by the Atlas House report) assist and what can be done locally to reduce safeguarding risk whilst legislative changes are considered?
6. What worked well in these investigations? Particular focus to be given to securing both criminal and civil (DBS) remedies for the adults and children who experienced abuse. Did this comply with the 'making safeguarding personal' principles?

[2] It should be noted that whilst it is good practice to notify 'host' authorities of a placement within their area, as they will be responsible to lead any safeguarding enquiry under s42 Care Act 2014, it isn't a legal requirement unless responsibility for funding on-going care will transfer to the new authority [see s37 Care Act 2014 and chapter 20-21 Care and Support Guidance.

7. Has the C-19 crisis built on the learning from the two cases, changed the context for Sutton and provided better opportunities to work together to address some of the issues, and if so, what can we learn from this for the future?

Scope and Methodology:

The Independent Author is required to:

1. Review and analyse:
   - Evidence collected in the course of the safeguarding investigation
   - Chronologies / IMRs / collated records
2. Identify and be provided with additional information
3. Liaise with the individuals' concerned families and frontline staff as appropriate

She is further required to:

1. Attend meetings with the SAR / One Panel and any other relevant meetings
2. Produce a written report, which provides an analysis of the evidence presented, consideration to Making Safeguarding Personal, findings and recommendations for agencies across the borough to implement.
3. Present the report to the Sutton Safeguarding Adults Board on completion.
4. Conduct a Learning Event across related partners.
5. To undertake any other tasks that the Panel or the Board identify.

The review involved on-line interviews with key personnel (appendix 2), and a number of on-line focus group interviews. Interviews with family members and residents in case 2 were not possible due to the ongoing court proceedings. Technical challenges affected the range of people interviewed and the CCG did not contribute as a consequence. C-19 constraints meant file audits could not be undertaken. Delays in progressing the review for a variety of reasons meant that a planned practitioner learning event/focus group did not take place, and interviews with other SAB Chairs were not held. The Reviewer was satisfied there was sufficient robust and very rich evidence to make proper conclusions without those specific elements.

The Metropolitan Police were not involved in the interviews. At the planning stage they were not included as they had limited involvement in case 1. Their role in case two was well documented and led to successful prosecutions. After the multi-agency learning event, when the absence of any prosecution in case 1 was discussed, conversations took place with the Police. Following this a new investigation began in relation to ongoing concerns about case one, as there were, in the Reviewer's opinion, questions to answer about why the failure to act appropriately in terms of treatment for Individual A had not been deemed to be neglectful at the time. This investigation will not be concluded until at least June 2021. Rather than wait until then the decision was made to note the action taken by the Metropolitan Police in response to learning from this review, and conclude the review process.

The family (for Individual A) gave very generously of their time and made a thoughtful and very balanced contribution to the reviewer's understanding of the family perspective. Everyone who was interviewed was constructive, open and reflective in their contributions.

It is striking that a significant number of those people interviewed were not in post at the time of both cases. The review was significantly enhanced by their "fresh eyes" and analysis of the organisational context they had moved into.

The Review was conducted by Jane Held, an independent safeguarding consultant.

Review Findings:

Key question 1: ***Have the recommendations put forward by the complex abuse investigation at Home B led to improved practice, particularly in respect of interdepartmental and interagency communication so poor quality or care or concerns regarding culture/ organisational abuse are identified early? How is this reported to SSAB and the wider community?***

The complex abuse investigation was, after a delayed start and limited recognition of what action was necessary, an exemplary investigation. There was no formal report at the conclusion of the investigation setting out what had been learnt and what needed to happen so there were no formal recommendations or a formal action plan. Individuals in adult services had very limited knowledge of both the issues involved or of any actions arising from it so there was little cross fertilization across different groups of services.

There is no doubt that despite this, the complex abuse investigation has led to some changes in interdepartmental and interagency communication in the services most involved with the provision of Learning Disability (LD) Services. Several examples of improvements were provided. Individual residents in LD settings involved in any investigation will at the conclusion of that process be supported through individual therapeutic intervention plans in recognition of the trauma caused to them. Providers involved in concerns about care, or safeguarding investigations can now be recorded on "mosaic" (the Local Authority Case system) in their own right. This means multiple incidents at the same setting can be recorded in one place as well as in individual case files, thereby improving the surveillance and monitoring capacity of the local authority as well as the response to new incidents (if practitioners actually use the capability). The commitment made to increasing commissioning capacity in the local authority was another response.

The strongest indicator of improvement and the application of learning was the speed and effectiveness of the multi-agency response to further concerns and a S42 investigation at the same unit. This is good practice but is, in itself, concerning as the undoubted personal commitment of the relevant senior staff within the provider organisation has not, as yet translated into effective change on the ground by the provider. However agencies responded effectively and well.

Key question 2: ***Have recommendations regarding hospital discharge following the Individual A learning review been implemented locally? How could these be applied across***

the South West London CCG footprint? How will this be reported to SSAB and the wider community?

As with the other case there was no final report following the learning review which took place, but which was not clearly documented. There appears to have been no action plan associated with the learning. The Hospital Trust did not commission a Serious Incident Review (although retrospectively it is clear this should have been properly considered at the time). Surprisingly and of some concern, there was no immediate referral under S44 (Care Act 2014)[3] for consideration of whether the Safeguarding Adults Board should undertake a Safeguarding Adults Review even though the s42 investigations indicated the criteria for such a review were met. If it had been, there may have been a more effective process of learning from what had happened, as well as a multi-agency approach to the case.

The provider concerned did commission an internal investigation and an action plan was drawn up. It is clear from the inquest that action was taken to address the concerns identified by the provider. This included clear recommendations that an admissions checklist should be properly completed on receipt of residents from hospital and all aspects of the resident's care plans, treatment requirements and medical needs established before admission and cross checked on admission.

This action whilst appropriate for the provider does not address a range of issues highlighted about hospital discharges during the safeguarding investigations. The safeguarding team at the Hospital were clear that action has been taken to improve four areas of concern within the hospital; the approach to discharge planning processes on a multi-disciplinary basis when the patient and family are taking personal responsibility for the post discharge arrangements (especially with self-funders) transfer of information at hand-offs between one part of the hospital and another as well as at discharge; the identification and review of all cases of so-called "unsafe or failed discharges" and repeat admissions and full and proper engagement with S42 requirements and processes.

Whilst individual parts of the system have taken action, it is clear that there has not been a multi-agency and multi-disciplinary approach to further exploring what can be done to improve discharge planning across the system.

Key Question 3: ***What role should family, friends and advocacy play in preventing a culture of poor care or institutional abuse? How do we ensure their voices are heard and concerns acted on?***

[3] **S44: Safeguarding adults reviews**

(1)An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
(a)there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,

There were some clear views expressed by professionals involved in the Individual A case and Home B case about the role family, friends and advocates play in preventing a culture of institutional abuse, and some exceptionally constructive reflections from the family in Individual A. It is clear that when discharge or placement planning takes place and the individual and their family are pro-active, involved and prepared to make arrangements themselves, hard pressed professionals are less likely to fully engage in what is required. It is undoubtedly the case that self-funded placements are approached differently.

It is also clear from the interviews that families tend to be unclear about what to do if concerns do arise, and to feel disempowered by the professional staff involved. In the Individual A case the family took great care to choose a home that they felt met acceptable to good standards of care. They trusted the fact that trained and registered nurses were employed by the provider and assumed (rightly) the same standards of nursing care applied as in a hospital setting. In the Home B case all the families lived some distance away and some felt that the setting provided good care even after the investigation. Families trust the system far more than perhaps they should.

The evidence in the review was that advocacy services were not really considered for older people, and rarely used in learning disability services although they were employed to good effect during the investigation. There was a universal view (including from providers) that ways to engage and involve advocates and better inform families about what to look out for and how to raise concerns needed to be found if real change was to take place.

Key question 4: ***How do agencies work together to identify new provisions opening in Sutton (including supported living placements)? How does this ensure provision is properly resourced and regulated to provide the care, particularly if this is commissioned on a 'spot purchase'***

The Borough is a "net importer" of individuals living in residential and care settings and there is an oversupply of residential and nursing care provision, much of which is for self-funded residents. At the time of interview there were 39 care homes, 29 nursing homes and 50 settings registered for mental health service use. Out of 1350 registered care setting places only 200 are commissioned by Sutton. This was the subject of much discussion but there was an acceptance that it is not easily solved. Respondents were unsure about how to best improve the current complex circumstances within which new residential settings and independent living or supported living provision is established. There are also differences in the degree to which new settings are quickly identified depends on both their legal or registration status and care group.

The legal framework was seen as unhelpful and at times a barrier. Similarly there was a degree of unanimity in the view that mandatory notification to the local authority, both of the intent to set up a home and of the placement of non Sutton residents by other local authorities and

NHS bodies would assist but, as one person pointed out, mandatory reporting of placements for children exists and local authorities do not all follow it. Care providers felt the solution rested with their own willingness to notify and report locally. Those providers involved in the review felt that the expectation arising from C19 they notify the local authority of all new placements regularly was a good one, and that the imperative to keep people safe overrode the previous resistance to voluntarily reporting anything that might damage their reputation

The care home and nursing home market is well known, well understood and new provision is usually notified to commissioners and/or the Care Support Team quickly. There was less confidence that information is received effectively or quickly about new homes in the learning disability and mental health sector. The Home where the abuse took place had been registered by CQC at the time of the investigations but had not had its first inspection. Because the planning application was for change of use rather than new provision the usual notifications between the Sutton Planning Department and Commissioners had not taken place. The usual system of notification by the planning service to Social Care was also not seen as robust or consistent. This is actively being addressed.

Overall, the impact of an urgent need to work far more closely together to respond to C-19 has made a very significant difference on several counts, which bodes well for a stronger system to be developed:

- The C-19 imperative has really improved communication links between commissioners, providers, service managers, and quality providers
- A focus on keeping individuals safe and their wellbeing enhanced has resulted in changed cultural norms in the provider sector, increased openness and transparency and has taken down the artificial barriers arising from a competitive market.
- The demand for places has dropped significantly so providers are keen to cooperate with commissioners in a way they were not when the market was more buoyant.
- Data and intelligence sharing has significantly increased and regular communication is improving relationships significantly
- The need for sharper approaches to the identification of and assessment of risk has significantly increased liaison between provider, especially home managers, practitioners in the CCG, operational social care services and commissioners across the system

Key question 5: ***Where there is a high degree of restraint anticipated or residents are placed by other local authorities or CCGs which are out of area, is the legal framework robust enough to ensure host authorities are aware of placements and can comply with their safeguarding and market management responsibilities? Would mandatory notification (proposed by the Atlas House report) assist and what can be done locally to reduce safeguarding risk whilst legislative changes are considered?***

At present there is no local framework of practice expectations or good practice guide for providers or NHS and Care practitioners in relation to restraint and managing challenging

behaviour. In addition the incidence of restraint in specific settings, and/or its compliance with good practice requirements and standards is not monitored at all with the exception of incidences of repeat S42 investigations. The only "route in" into provider settings legally remains the Deprivation of Liberty Safeguarding legislation.

The recommendations from the Devon SAR (Atlas House) in relation to mandatory reporting and proper oversight[4]could equally still apply locally in Sutton. The legal framework does not provide rigorous enough requirements to ensure the host authority is both aware of and able to monitor the well-being of those individuals placed in learning disability, autism or mental health settings in particular, although it applies too for adults with physical disabilities and older people (both placed and self-funded). This is exacerbated for authorities such as Sutton, who have an oversupply of provision (and potential housing stock) and are therefore very well used by placing authorities from a considerable distance away. The pressure on the Sutton system is well rehearsed, but significant.

In addition, those settings that are owned and run by big national providers (as was the setting in Home B) present additional challenges, the impact of which can minimise local engagement in the care provided. They provide specialist therapeutic services and their own quality assurance, training and support systems which limits "eyes on" contact from local professionals. If local care support and commissioning services are unaware of the needs of residents and/or the needs for training of staff, they are also likely to be unaware of care practice or the regime within a setting. The degree of actual knowledge of care practice held by placing authority social workers or NHS Commissioners is limited so it is entirely possible for residents to be "hidden from view" except to their families.

Mandatory reporting of placements alone would not solve the problem. It was clear from the review participants that what is needed as well as data, intelligence sharing and good support links are strong active relationships, openness and transparency, and voluntary but well publicised agreements between the CCG, Local Authority and Providers about their oversight and quality assurance roles and contributions as well as their safeguarding responsibilities to all Sutton residents, including those living in those settings. A voluntary agreement by

- [4] Incentivise commissioners to engage in 'close to home' arrangements for adults with learning disabilities, autism and mental health problems.
- Make mandatory notifications by commissioning authorities of prospective placements to a host authority.
- Assert a requirement for specific funding for monitoring, reviewing and safeguarding as necessary, and for residents' access to local health services.
- Assert a requirement that placements be discontinued should they 'take anyone', or would not be registered by the CQC in line with its Registering the Right Support policy for services for people with learning disabilities and/or autism.

providers about notifications could go some way to mitigate the problems but is only as good as the providers that are involved.

Key Question 6: ***What worked well in these investigations? Particular focus to be given to securing both criminal and civil (DBS) remedies for the adults and children who experienced abuse. Did this comply with the 'making safeguarding personal' principles?***

The investigation in the Individual A case was limited and not particularly clear or well managed by agencies. The Social Worker involved worked hard to ensure the investigations were properly conducted but there was limited cooperation from the NHS at the time, (as a result of the absence of a properly resourced safeguarding team) and a lack of coordination between partner agencies. Several processes ran in parallel but were not pulled together. The inquest focussed on a narrow set of issues and concerns and did not explore in-depth practice issues relating to transfer of information, hand-offs from one part of the system to another or discharge processes and practices. There was a police investigation as part of the initial process, but the decision was that the death was of natural causes so no case to investigate further. This was reviewed as part of the outcome of the learning event held by this thematic review and the case is now being investigated by the Metropolitan Police which is positive.

Following the inquest, the staff involved were properly referred by the local authority to the relevant regulatory body, but they were allowed to continue in their profession by that body. This was overall a less robust approach than should have been taken given the circumstances, where the death resulted from natural causes but where neglect was a contributory factor.

The new Safeguarding Team at the Hospital has taken action robustly and with tenacity to start to address a range of concerns identified by them when researching the case and are to be commended for the work that is now underway.

The second case was handled exceptionally well once the fact that there needed to be a complex abuse investigation was recognised. As well as timely, well managed, well attended and clear multi-agency meetings at regular intervals, the various strands of the investigation were constantly pulled together and coordinated. The process was exemplary in its focus on the welfare, well-being, voice and needs of the victims of the abuse, and uncompromising in seeking to pursue legal justice for them. The dismissal of staff and the pending legal proceedings are an indicator of the thoroughness and tenacity of those involved to ensure the alleged perpetrators are properly brought to justice. If written up and published as a suitably anonymised case study for how to handle complex abuse investigations well, the learning from it would be valuable.

The development of a Provider Concerns Protocol, arising out of a recognition that intelligence about what was happening in case 2 was held in a range of places, and a recognition about how fragmented and inconsistent the response to concerns was, and still is, was another positive piece of work as a consequence of what took place. It is still in

development but has the potential to create a far more coherent approach to provider concerns, at every level of concern.

Key question 7: ***Has the C-19 crisis built on the learning from the two cases, changed the context for Sutton and provided better opportunities to work together to address some of the issues, and if so, what can we learn from this for the future?***

The review has identified that the C19 crisis has created new and strong relationships between people in different parts of the system, as well as a sense of shared endeavour and purpose. Regular communication processes, crisis support as well as risk and infection management support, and the coordination and provision of supplies etc. has built up a shared understanding of roles and responsibilities, interdependence and responsibility for the well-being of residents, staff and families.

The need for intelligence and good data at both meta and granular level has resulted in a far better understanding of the sector, and of the nature, type and needs of residents. The Joint Intelligence Group (JIG) and the Pre-Jig or pre-meeting have developed rapidly, building on an established but reasonably limited role very rapidly.

It is clearly a valued and significant multi-agency forum for properly understanding not just the activity across the sector, but also the quality of care. This is informed by a range of sources, and clearly pulls together intelligence and data from a range of sources allowing aggregated data to be provided. Regular reporting of different metrics on a daily basis, coupled with daily analysis of returns has created a responsive informed system, where concerns are quickly identified, risk assessed discussed and individual action plans for those settings put in place are significant system improvements that at the very least help identify concerns quickly

Themes arising from the Review

There are a number of clear themes arising from this review, some of which emerged strongly in all the interviews, and which together provide considerable learning for the multi-agency safeguarding system in Sutton.

<u>Safeguarding Practice</u>:

A consistent view expressed by all the professionals interviewed and by providers was that the locality restructure in adult social care had undermined confidence in safeguarding practice. The move from a centralised team of “experts” to a generic locality model had a significant impact initially. It was widely seen as leading to inconsistency in terms of the knowledge and skills of social workers, their expertise in safeguarding practice, the quality of assessments, decision making, recording and communication. The evidence from records supports these concerns.

The restructure also had a significant initial impact on intelligence gathering and the aggregation of small issues and concerns which together signify more serious underlying concerns. In addition, the restructure disrupted clear links between safeguarding services and commissioners, and established communication processes were lost, leading to increased risk and decreased knowledge of what was happening in relation to care settings. This issue has been recognised and work to address it has taken place. Safeguarding champions in each locality provide some expertise and support to their locality colleagues and meet together monthly.

The appointment of a Head of Safeguarding and Principle Social Worker has led to management oversight of practice in all three localities, the identification of what is needed to improve practice and the introduction of new expectations. However, investing in just one person to provide the source of specialist oversight and expertise to three localities is insufficient.

Any organisational model has merits and weaknesses, along the spectrum from highly centralised and specialist to fully dispersed and generic. The issue is the same, i.e. that social workers need to have the right knowledge and skills to exercise sophisticated judgements about safeguarding, be properly supported, managed and supervised, and work within clear frameworks, using effective processes. There remains a lack of confidence in Sutton that these requirements are sufficiently well embedded.

Learning point 1: The Sutton Safeguarding Board may want to seek assurance about how these concerns (which are clearly articulated and understood) are being addressed by the local authority and what is being done to improve multi-agency confidence in social work and to monitor the progress being made to improve practice.

Learning point 2: They may also want to establish whether capacity and capability are being managed to best effect by the local authority in balancing sufficient specialist expertise alongside a locality-based model of service delivery. The merits of a model which provides specific safeguarding practitioners equipped to give locality-based consultancy and advice to practitioners and team managers should be considered by the local authority.

Providers and some managers highlighted the need for the development of a simple guide to raising safeguarding concerns, to help them make judgements about when, where, who and how to make safeguarding referrals to social workers. They noted that Sutton to the best of their knowledge does not have a professionals' helpline for them to use in arriving at judgements nor does it have a clear levels of concern, or a simple local safeguarding matrix tool.

Learning Point 3: Sutton Safeguarding Adults Board, working with Adult Social Care and Health partners and providers should consider developing some locally relevant and simple guides and tools to aid providers, other professionals and (and families) to know when to

raise safeguarding concerns locally and how, similar to the tools developed in Suffolk and Milton Keynes for example.

The provider concerns protocol being developed by a number of managers will make a significant difference to how the complicated relationship between poor care, provider failure and safeguarding is identified and addressed. It should lead to a common approach to provider concerns and safeguarding practice as well as transparency about how decisions are made. However, it has been slow to develop and will require significant multi-agency senior buy-in and Director level leadership to ensure it is introduced effectively. A significant level of investment in ensuring the protocol is properly implemented with appropriate single and multi-agency familiarisation and training will be needed. If this is not done the protocol will be limited in its impact in addressing current system problems.

Learning point 4: The Sutton Safeguarding Adults Board may want to consider how best to endorse the final protocol and assure itself of the impact of implementation on practice.

Relationships:

The second strong theme to emerge is the importance of strong relationships between professionals. The care sector is complicated as is the overall relationship between the various partner organisations involved in the adult care system. The responsibilities of a long list of organisations overlap but are also distinct and different. What was universally recognised as the most positive thing about the C19 crisis was the development of relationships between the different people in the different parts of the system who together had a shared goal and common purpose.

Commissioners and quality assurance staff in the NHS and Local Authority already had a good relationship but the engagement with home managers has significantly increased and improved, and a degree of mutual trust has been fostered. Heads of Service and Social workers necessarily worked very closely with their equivalents in the health economy leading to significant improvements in shared understanding about what was happening in a specific home. This in turn impacted significantly on the early identification of provider concerns and swifter more coherent safeguarding investigations when concerns were raised.

It is clear there is a desire amongst providers and commissioners to move from a market management model to a relational and collaborative approach to working together in the best interests of those who live in care settings.

The challenge is two-fold. Firstly, partners need to consider how to ensure the gains in better care and better awareness of concerns are not lost. Secondly thought should be given to how to build this into practice as well as future service planning, and developments. There are a range of ways this could be achieved.

Learning Point 5: The Safeguarding Board may want to consider how best to build on what has been learned from C19 in terms of new ways of working together that enhance the degree of inter-professional relationships and local knowledge and understanding and sharpen a focus on providing high quality safe care.

Learning point 6: A range of models to facilitate this, such as for example, a quality and safeguarding forum across Sutton and or locality care partnership groups where social work managers, community health care staff, GP's, local providers and commissioners meet regularly to share knowledge and support improvement could be explored by partners

Family and friends:

The third strong theme to emerge is the central importance of the voice of residents, and the role of their family and friends. For this to be fully effective in terms of safeguarding their family members they need to know what good care should look like, be encouraged to be curious about their relative's care, and empowered to challenge professionals. This should apply regardless of who funds the care placement. As one professional said, the nature of the funding source should not influence the way professionals work with families. This applies as much to discharge planning as it does to admissions, and to the quality of the care being given at any point in time.

At present there is information by care settings provided to relatives and residents about how to report safeguarding concerns and about how to make complaints. In most settings they get no information about what good care should be like or how/with whom they can explore their worries and concerns about anything they observe, or experience, other than through the line management procedures in the care setting. As the family in the Individual A case said "worries and gut feelings are not the same as concerns or complaints but there is nowhere to go with those worries if you don't want to speak to home staff and there is no one to consult".

Providers noted that the linear nature of making complaints can be a disadvantage for residents and families, who may lack confidence their concerns will be fairly or properly dealt with. The expectation that if the family are unhappy concerns should be reported to CQC also means that there is always the possibility that the local authority and or the NHS commissioners are not fully informed about concerns and complaints in a setting and vice versa.

Learning point 7: Commissioners and Providers working with CQC and the Sutton Safeguarding Adults Board should consider running a "Poor Care – Where to Go" public information campaign. They should also consider whether to develop joint information packs for families and residents to be given on admission that help them know who to go to for what

Advocacy:

The family in the Individual A case also commented that whilst publicly funded placements are reviewed and monitored by the relevant social workers privately funded people have "no external protective factors built in".

This links to the absence of advocacy services for adults in care settings. The complex abuse investigation was exemplary in terms of the attention paid to ensuring residents had good independent advocacy during and after the investigations. However, the majority of adults placed in care settings do not have advocates. The assumption is that the family is expected to act as their advocate.

In children's care settings a legal independent visitor system was introduced to ensure young people have access to someone who is there for them and is independent of those adults with specific roles to play in the child's life. There is no equivalent for adults, including young adults. Where an individual has been placed a long way from family or their social worker no one has "eyes on" what is happening for that individual in a setting. Given that many of the individuals placed a long way from home are particularly challenging, and likely to require high levels of intervention and at times restraint this is a real safeguarding concern. It is not just an issue for Sutton. Ideally the placing authority with the host authority and the provider should collaborate to ensure an independent advocate is always appointed in those circumstances.

Learning point 8: Sutton Safeguarding Adults Board should consider whether to work with commissioners, Healthwatch, local advocacy organisations and any local "experts by experience groups" to explore what local opportunities there might be to introduce voluntary local advocacy and independent visiting services for residents of care settings.

<u>Intelligence gathering and sharing – application to understanding of risk and needs</u>

At the time of the two cases information was fragmented, held in many places and could not be used intelligently to identify specific instances where major safeguarding concerns were occurring or settings where concerns about the quality and safety of care were growing. Significant improvements have been made, and C19 has enhanced this improvement significantly. The JIG is valued and is making a very positive contribution to ensuring everything is known that could be. The challenges for it now are its size, and the quality of data it holds and can usefully analyse.

In addition, the JIG needs to decide how to maintain a clear strategic oversight of care provision, whilst balancing the degree of knowledge about varied different care types and care groups and facilitating much more granular deep dives, issue based analysis, and localised understanding. As yet the degree to which JIG intelligence links to strategic safeguarding knowledge, and how the understanding of local risk and need, informs local action and improvement plans, enhances shared risk management and influences strategic and organisational planning priorities is relatively limited. How the JIG intelligence informs

the Safeguarding Board's understanding and level of assurance about the quality of multi-agency safeguarding practice in the borough needs exploration and how it can positively contribute to a system wide, and systemic virtuous cycle of improvement in safeguarding practice is also worthy of discussion.

Legal constraints, procedural challenges and barriers

It is clear that the situation in the Home B case reflects a broader national set of issues in relation to how well a local authority area can safeguarding and protect its citizens properly if it does not know where the most vulnerable are living or what degree of need there might be for specific forms of service (such as specialist autism support). The argument for mandatory reporting has been made before but it remains valid as does the arguments made in the Devon SAR (Atlas Homes)

A setting like Home B, that has not been inspected, that has a new and relatively untrained staff team and not only takes several new and very challenging individuals in one go and also ignores the fact that two were underage on placement, can still "fly under the radar" quite easily. Placing authorities are frequently a distance away, and staff do not always perform sufficient due diligence when making placements especially when spot purchasing in a crisis. This ongoing situation is not acceptable. Whether mandatory placement reporting is a requirement laid on the placing authority or on the provider of the care setting is less important than the expectation all placements are reported to the host authority.

The Board might wish to use the case (once proceedings are concluded) to add its voice to the growing pressure to introduce requirements in relation to placement reporting and placement notification processes.

Learning point 9: In the absence of mandatory reporting or any other actions to improve local knowledge, the Sutton Safeguarding Board should consider through the commissioners how best to harness the benefit of a far better understanding about the local care sector as a result of C19. This should aim to identify how to engage with providers to agree a voluntary placement reporting scheme which brings benefits to the provider in terms of enhanced local support, advice and training and significant benefits to residents because of the active knowledge of and monitoring of their needs, care, and treatment

A serious procedural issue arises from this review in that it is unclear why in the Individual A case, where the criteria for a S44 referral was met, a decision was not made to refer the case to the Board. The dislocation between a S42 investigation, a criminal investigation, and an inquest meant all three dealt with partial information at times. In addition, undertaking a S44 review would have led to quicker whole system learning. It is clear that the criminal investigation process in safeguarding cases is necessarily not very collaborative, but could be far better linked in.

Another barrier was the absence of clear post investigative learning. In both cases, because they were not referred to the Board for a S44 SAR, there was no clear post investigation learning process, and with recommendations and action plans for improvement. The fact that forward progress has been made is largely based on individual professional's commitments to improve the way people are cared for. However progress is not coordinated, nor is it monitored and assured.

Learning Point 10: The Sutton Safeguarding Board must seek assurance from front line services that if S42 investigations are underway, accompanied by criminal investigations it then becomes clear that the criteria for a S44 Review are also met, a referral to the Board should be made immediately, and investigative processes aligned and coordinated from that point onwards in a coherent manner.

Public Health

Finally there was a small but important piece of learning from the case, which is that diabetes is not a mild illness but a potentially fatal one, especially volatile uncontrolled diabetes. The knowledge needed to recognise serious concerns relating to hyper or hypoglycemia should be part of anyone who cares for others' understanding and skill base.

Learning point 11: The Board may wish to ask the public health service to run a major public information campaign in relation to diabetes.

Learning Points

Learning point 1: The Safeguarding Board may want to seek assurance about how concerns about the quality of and skills held by social workers undertaking safeguarding investigations (which are clearly articulated and understood) are being addressed by the local authority and what is being done to improve multi-agency confidence in social work and to monitor the progress being made to improve practice.

Learning point 2: They may also want to establish whether capacity and capability are being managed to best effect by the local authority in balancing sufficient specialist expertise alongside a locality based model of service delivery. The merits of a model which provides specific safeguarding practitioners equipped to give locality-based consultancy and advice to practitioners and team managers should be considered by the local authority.

Learning Point 3: Sutton Safeguarding Adults Board, working with Adult Social Care and Health partners and providers should consider developing some locally relevant and simple guides and tools to aid providers, other professionals and (and families) to know when to raise safeguarding concerns locally and how

Learning point 4: The Sutton Safeguarding Adults Board may want to consider how best to endorse the final Provider Concerns protocol and assure itself of the impact of implementation on practice.

Learning Point 5: The Sutton Safeguarding Adults Board may want to consider how best to build on what has been learned from C19 in terms of new ways of working together that enhance the degree of inter-professional relationships and local knowledge and understanding and sharpen a focus on providing high quality safe care.

Learning point 6: A range of models to facilitate this, such as for example, a quality and safeguarding forum across Sutton and or locality partnership groups where social work teams, community health care staff, GPs , local providers and commissioners meet regularly to share knowledge could be explored by partners.

Learning point 7: Commissioners and Providers working with CQC and the Sutton Safeguarding Adults Board should consider running a "Poor Care – Where to Go" public information campaign. They should also consider whether to develop joint information packs for families and residents to be given on admission that help them know who to go to for what

Learning point 8: Sutton Safeguarding Adults Board should consider whether to work with commissioners, Healthwatch, local advocacy organisations and any local "experts by experience groups" to explore what local opportunities there might be to introduce voluntary local advocacy and independent visiting services for residents of care settings

Learning point 9: In the absence of mandatory reporting or any other actions to improve local knowledge, the Sutton Safeguarding Board through the commissioners should consider how best to harness the benefit of a far better understanding about the local care sector as a result of C19. This should aim to identify how to engage with providers to agree a voluntary placement reporting scheme which brings benefits to the provider in terms of enhanced local support, advice and training and significant benefits to residents because of the active knowledge of and monitoring of their needs, care, and treatment

Learning Point 10: the Sutton Safeguarding Board must seek assurance from front line services that when S42 investigations are underway, accompanied by criminal investigations, if it becomes clear that the criteria for a S44 Review are also met, a referral to the Board should be made immediately, and investigative processes aligned and coordinated from that point in a coherent manner.

Learning point 11: The Board may wish to ask the public health service to run a major public information campaign in relation to diabetes.

Appendix 1: Context of the Proposed Review: The East Midlands Review

Concern regarding poor quality of care and abuse within care settings remains an issue nationally, a thematic review of SARs[5] reported key learning points, namely:

- There was substantial learning around dignity in care. This included failures to deliver person centred care and inflexible responses that were based on process rather than needs of the person. Dignity in care is as much about the values and attitudes of staff as the professional qualification they may hold.
- Serious abuse and neglectful practice was often endemic rather than limited to an individual practitioner. Culture, leadership and lack of supervision either reinforced poor care or perpetuated it through lack of challenge.
- There were recurrent failures to try and understand the meaning behind the person's behaviours and to involve the person and their families in care.
- Providers, commissioners and regulators need to take necessary additional measures to hear the person and their family's voice regarding their experience of care. Involvement of advocacy is an important aspect of this.
- The poor quality of care plans and assessments was a feature in all the reviews relating to care environments. External practitioners going into the care environments need to see safeguarding as their business and be accountable for looking beyond their immediate task.
- Commissioners and regulators need to draw together all of their intelligence about the home and be alert to indicators of emerging concerns. This includes drawing together themes arising from safeguarding concerns. Assurance activity needs to be more than a desk top exercise.
- Reviews highlighted the need for the involvement of police at the earliest stage when serious abuse of a resident is suspected. Reviews also reinforced responsibility of the Local Authority to maintain oversight of a Safeguarding Enquiry and the adequacy of the protection plan. Reviews highlighted the need for collaboration between Local Authority, Police and Health agencies in responding to situations of organisational abuse.
- There was wider learning about systems and resources – the availability of appropriate care providers to meet the person's needs and using learning from SARs to inform the strategic plans of commissioners.
- Aspects of good practice included how agencies worked together under difficult circumstances in urgent care home closures. One review also noted how the locality had used learning to make extensive improvements in care home quality monitoring.

[5] Undertaken by the East Midlands Safeguarding Adults network and published by ADASS in November 2017 at: https://www.nottinghamshire.gov.uk/media/132275/emsanthematicreviewsars.pdf

Appendix 2: Interviews

- The family of the resident in case 1
- Provider managers (2)
- Local Authority and NHS Commissioners and The Head of Social Care Commissioning
- The lead commissioner for learning disability
- The Head of Safeguarding and Named Nurse Croydon University Hospital Trust
- Director of Operations of LD Home
- The Head of All Age LD Services
- The Head of Social Care and Public Health Commissioning
- Head of Service (locality team)
- Social Worker (case 1)
- Quality Improvement Officer
- Team Manager, Learning Disability Team
- Head of Safeguarding and Principle Social Worker LB Sutton
- Safeguarding Adults Manager