Safeguarding Adult Review on George
November 2019

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1. Introduction

The Independent Chair of the Safeguarding Adults Board (SAB) agreed to the recommendation from the One Panel[1] to undertake a Safeguarding Adults Review (SAR) for George who experienced very neglectful conditions in his own home before he was taken to hospital and then moved to a residential care home. George had care and support needs and had been provided with a care package of domiciliary care by Adult Social Care/ London Borough of Waltham Forest (LBWF). At the time he had various health issues (i.e. cardiomegaly, alcohol excess, dementia, folate deficiency, B12 deficiency, pleural effusion, stoma bag, frequent falls, hearing difficulties) and was also known to several health services within NELFT. Since moving into a care home, George is reported to be doing well, considering the circumstances that resulted in this move.

The One Panel agreed that George's case met condition 2 in line with S 44 of the Care Act 2014:

"(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met.

(2) Condition 1 is met if –

(a) The adult has died, and

(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if –

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect. (…)"

The purpose of a SAR is to "promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect." (Care and Support Statutory Guidance, October 2018, 14.164)

The purpose of a SAR "is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council etc." (Care and Support Statutory Guidance, October 2018, 14.168)

The One Panel, in conversation with the Senior Responsible Officer and the Lead Reviewers, agreed the focus for this SAR initially as following:

[1] Waltham Forest's Think Family forum which takes referrals for local or statutory reviews and makes recommendations against the statutory criteria to the relevant chair or independent scrutineer.

- Hospital Admission and restarting of the care package upon discharge – how is hospital admission used to "pause and reflect"?
- How are quality assurance processes embedded on various levels – the care agency for the domiciliary carer and the commissioner (the local authority) for the care agency?
- How did professionals and agencies involved with George communicate?

1.1 About George

George is a 93-year-old white British man who lived independently in his own accommodation in LBWF, together with this cat, before his admission to hospital on 4th December, and subsequent move to a 24-hour care home. George has suspected dementia for which he was awaiting formal assessment at the time of this Report and he has several on-going health issues such as a colostomy bag following colon cancer, hearing difficulties, history of pleural effusion, cardiomegaly, folate and B12 deficiency, weight loss and reported frequent falls. Professionals had also raised concerns in relation to his alcohol use which is reported to have significantly reduced since his admission to the care home, possible reasons for this are explored later in the report.

George is a widower; he speaks very fondly of his late wife who passed away in the 1980s. He has no children and has had limited contact with his two sisters. Although George's ability to recall recent events is impaired, he is still able to recall events like his wedding to his late wife and the role he played in the D Day landings during the Second World War.

George had received professional support in his home from several agencies in the recent years, including domiciliary home care (half an hour/ three times a day, since 2017) through a care package purchased through Adult Social Care, installation of community alarm, smoke detector and pull cord as well as key-safe. He had also been known to different health services and professionals, i.e. GP, District Nurses, Community Matron Service, Stoma Nurse, and hospital services.

During the period of this SAR (January 2018 to 4th December 2018) George was largely described by professionals as managing his conditions, including the stoma bag, although on occasion he was known to refuse services/ referrals. He managed his day to day living with the support of the domiciliary home carer and his close friend David who lived around the corner. David and George met each other through their wives and had stayed friends following the passing of George's wife. Professionals describe David as the "good Samaritan" who helped George with whatever he could. He was an informal carer to George and referred to by George as his next of kin and formally recorded as emergency contact on agencies' records. He was George's only constant companion in the period under review, and supported George with appointments, household, finances, paperwork, the care for George's cat and shopping. There were times when he visited George several times a day to check that he was alright and had everything he needed. He also raised his concerns about George's ability to live independently as time progressed and some agencies relied on David's support considerably as the main long-term and consistent support for George. David started to develop his own health issues in October 2018 and the swift deterioration of his health led to his passing in January 2019.

Whilst George's domiciliary care arrangement continued throughout the period under review, professionals' involvement by other agencies varied according to George's needs and level of engagement. Following an increase in visits to the home in October 2018, there was no involvement by these agencies after 29th October 2018. The only agency attending George from this date up to 4th December was the homecare worker. It was on the 4th December 2018 that the Police attended George's home, at George's request because he thought he had been burgled, to find him in a neglected condition. He was taken to Whipps Cross Hospital by ambulance and following further assessment it was deemed that George should move to a care home.

In light of the condition of George and of his home found by the Police on 4th December 2018, it was decided in April 2019 to charge the homecare worker with neglect under Section 20 (The Care Worker Offence) of the Criminal Justice and Courts Act 2015. The trial is scheduled to take place in March 2020. George's admission to hospital on 4th December 2018 marks the end of the period under review.

Following the hospital admission, George moved to a 24-hour care home. He was initially very reluctant to wash or change his clothes and required a lot of encouragement from staff to be able to assist him. He has gradually become used to the staff and the new daily routine to maximize his level of independence and has been able to develop more skills and confidence in washing, shaving and dressing himself with minimal support from staff. Additionally, George was also very reluctant to eat when first admitted and still requires a lot of encouragement to eat a nutritious, varied diet; however, his preference is for porridge (as when he was living in his own home) which he eats in a variety of formats. This can often be used as a dietary supplement when he does not eat enough, as this is a food he does not tire of.

The care home's follow up with Audiology resulted in George having two new hearing aids fitted in August 2019. George was initially reluctant to wear them but with encouragement from staff he will wear "his transmitters" as he calls them and feels he has "ornaments hanging from his ears". He has been in a very jokey mood when wearing his aids as his hearing is much improved.

Staff at the care home describe George as a charming and witty man. George has received visits by David's wife and children and is always appears happy to see them. His sisters have visited him once since he moved to the care home. The Local Authority is pursuing the legal processes in line with the Mental Capacity Act 2005 in relation to George's current living and care arrangements as well as his finances. His cat has since been re-homed.

The lead reviewers consulted with the professionals at the care home about the possibility of meeting with George to gain an understanding of the events that led up to his move to the care home. The lead reviewers were advised not to meet with him as he is assessed as having limited ability to remember recent events and such meeting might cause him undue distress.

1.2 Methodology

The review has been carried out in a way that reflects the values and principles set out in the SCIE 'Learning Together' approach to reviews. These principles include:

- Avoidance of hindsight bias. That is understanding how different professionals saw the case as it unfolded whilst trying not to be influenced by the knowledge of the outcome
- Providing adequate explanations for the practice encountered - appraising and explaining; and
- Understanding how the specifics in this case can be used to generate wider understanding.

The systems approach provides a framework for considering the influences on practice by people. It helps us understand not only why things happened the way they did, but also looks beyond into the "how"; it aims to examine the wider factors that influence practice, practitioners and organisations at any time.

The review was led by external reviewer Daniel Wilson (Specialist Adviser Safeguarding/ Redbridge and Waltham Forest) and the internal reviewer Anna Muller (Practice Improvement and Audit Manager/ Children's Services LBWF). Additionally, the consultant Deborah Cohen provided external, independent advice on "commissioning within the council and partner agencies". Neither the two lead reviewers nor the external consultant had any prior contact with or knowledge of George and his story.

This SAR included frontline practitioners and senior managers from all the agencies that were involved with George. They took the opportunity to reflect and examine practice and together created an environment of constructive challenge and were open and transparent about identifying when practice was not good enough. The Lead Reviewers, External Consultant and the senior managers together formed the "Review Team". The Reviewers thank the practitioners and the Review Team for their honesty and support in ensuring that the review process focused on learning and improving practice.

The agencies involved were:

Agency	Represented
Police	Police Central Statutory Review Team
LBWF	Contracts and Commissioning Hospital Discharge Team (Adult Services – Prevention and Wellbeing) Complex Care Team (Adult Services/ Care and Support) Brokerage Team (Adult Services/ Care and Support)
WF Clinical Commissioning Group (CCG)	Safeguarding Lead GP Practice

Agency	Represented
NELFT	Single Point of Access Rapid Response Team District Nurses and Community Matron Integrated Community Therapy Team Nutrition and Dietetics Falls Service
Barts Health	Whipps Cross Hospital Connaught Day Hospital
Domiciliary Care Agency	

The aim of the Review was to consider George's experience and appraise professional practice to identify learning priorities for the Safeguarding Adults Board to better understand areas of development in working with people with complex needs. This SAR was agreed in April 2019 and started in May 2019. The steps in the review were as follows:

1. Chronologies were requested from each agency who was involved with George and were consolidated into one "Significant Events Chronology".
2. A full day SAR workshop was held on 10th July 2019 with all agencies, including front-line staff and managers, to:
   - Better understand George's story what might have influenced practitioners and agencies at the time in their approach to George
   - Appraise practice, identify themes and reflect on systems in place in Waltham Forest that support people in circumstances such as those experienced by George and
   - Start identifying themes around practice that might not be unique to the experience of George and may therefore be systems issues.
3. A second half day workshop was held with the senior managers of the Review Team on 17th July 2019 and it explored the arising themes in more detail to establish if those were indeed systems issues; following this workshop, additional information was requested from all agencies
4. A follow up meeting (3 hours) was held on 17th September 2019 with members of the Review Team and Case Group
5. A draft report was circulated for comment to the review team
6. The final draft was circulated to Chief Executives of all agencies involved for sense checking
7. The final report will be submitted to the One Panel to be heard on 13th November 2019
8. The report will be presented to the Safeguarding Adults Board on 17th December 2019

1.3 George's story and professionals' responses

The timeframe for the review was nearly the full calendar year leading up to George being admitted to hospital for the final time: 1st January 2018 to 4th December 2018.

This section provides an overview of 'what' happened in this case and 'why'. Sometimes the explanation for 'why' will be explained in more detail in the findings and a cross reference will be provided in this section. Along with the explanation of what happened, the following makes the view of the Review Team about the timeliness and effectiveness of the responses provided explicit, including where practice was below expected standards. Such judgements are made considering what was known and knowable at that point in time.

The integrated chronology gives a real sense of the involvement of the number of services and agencies at any one time, without any or limited awareness of each other's work with George. Professionals presented largely a high level of commitment and showed dedication to the work with George as assigned to them. However, there was limited professional curiosity to explore or attempt to understand the wider situation. Furthermore, communication between the home carer/ home care agency and other involved professionals does not seem to have been proactively pursued and whilst the involvement of the home carer/ home care agency is the single constant over the whole period there was very little recording provided by the agency for the chronology. It should also be noted that the Community Matron Service which sits within the Integrated Case Management and might have provided a level of coordination of George's care and support, ceased any involvement with George in July 2017, which is before the period of this review.

The chronology highlights the important and significant support that George's friend and emergency contact, David, provided. It seems that when David became unwell himself in October 2018 and was no longer able to "look out" for George as much as he used to, this coincided with a swift deterioration in George's living conditions and health, despite the continuation throughout of the homecare package. There has been no evidence provided of any concerns about George's health being escalated by the home carer and there is limited evidence of consistent and ongoing quality assurance mechanism within the homecare agency, i.e. in relation to allocation of home carers, monitoring visits and calls, auditing of the daily communication sheets that presented as repetitive and lacking evidence that George's identified needs were consistently met, as well as supervision of the individual homecare worker.

Additionally, it has not been possible to speak to the home carer who carried out all visits (three times a day, seven days a week) during the latter half of the period under review, from July 2018 onwards) as they have since been charged with neglect (as noted above). Consequently, this impacts on the ability to comprehensively understand the home carer's practice as well as the factors that might have influenced their practice. All information on the homecare agency has been provided by the Manager of the agency who has been a member of the Review Team.

<u>Period 1: January 2018 – George's fall and follow up by health services</u>

Agencies involved in this period:

- Single Point of Access (SPA)
- Rapid Response Team (RR)
- General Practitioner (GP)
- Homecare worker/ agency
- District Nurse Team (DN)

On 11th January 2018 George's friend David called the SPA. David had received a call from George's home carer in the morning that George had a fall during the night and had sustained a gash on his right arm. David attended George's injury but remained concerned about his health.

The call was passed on to RR who, after a call by the triage nurse, swiftly facilitated a home visit to assess George. With his consent, the injury was assessed and taken care of and some consideration was given to the potential cause for George's fall by taking a urine sample which indicated a possible infection. George was provided with advice of good self-care by increasing his fluid intake and the information of the interaction was sent to the GP, including a request for antibiotics to treat the urine infection which was in George's best interest. A referral to the DN Team was made for the follow up of wound care in the community which was good practice. Additional possible reasons for George's fall, especially given his previous history of falls, his other health conditions, and knowledge of his alcohol consumption, as shared by David and the home carer, do not seem to have been considered and the reasons for this are not clear.

Records provided by the home care agency said that the home carer had consulted with the agency when the injury on George was noted and subsequently David was called as George's emergency contact which was in line with the agency's procedures and appropriate considering the nature of the injury.

The GP's review of the attendance by RR to George was timely and brief and considered information about a historic fall that had resulted in hospital admission in 2017. It provided no further exploration of potential reasons for the fall, beyond the possibility of the urinary tract infection being the cause and did not offer a review or visit to George. However, it is noted that a urine sample did indicate a possible infection and therefore it was accepted as a matter of clinical judgement that it was reasonable to focus on a urinary tract infection as the cause of the fall. The question of whether George was a candidate for risk stratification at this review or outside by the GP does not seem to have been considered, neither was a referral of George for discussion by the Integrated Case Management Meeting which could have offered an opportunity to assess the risk to George more holistically. Following George's fall, the involvement of the District Nurses started, and they attended his specific health needs, as referred to them, concerning matters of wound management and tissue viability.

The quarterly review undertaken by the home care agency on 24th January 2018 was in line with their procedures. It was good practice to defer the review to a later time in the day, and to involve David as George's emergency contact. However, it would have been helpful for details on the content of the conversation between the agency staff, David and George to be available, particularly with respect to more detailed feedback on the quality of the homecare.

During this period there is no evidence of any communication between the Homecare worker (whose role included personal care of George) and the District Nurses with respect to George's personal care.

Period 2: 2nd February to 9th February 2018 – annual review processes by LBFW

Agencies involved in this period:

- Contracts and Commissioning
- Complex Care Team/ Adult Social Care

- Homecare worker/ agency

On 2nd February Contract Management in LBWF advised the home care agency of the outcome of the recent contract monitoring visit which took place on 16th November 2017. They were scored high/ green with an overall score of 89.83%. This placed them as “business as usual” with no other planned visits until the next monitoring round in January 2019. The Homecare Monitoring tool used by LBWF is comprehensive and detailed and considers a range of evidence from the provider to support the assessment. This is usual practice in line with agreed guidance; there was no need identified to contact any other agencies and the contract with the agency continued as usual. More detail about the commissioning of homecare is at the end of Chapter 1.3.

George’s annual review of his care package of support provided by Adult Social Care was completed in time. It was good practice that the review took place as an actual meeting at which George, David, the allocated Social Worker and the care coordinator from the home care agency were present and it allowed for a better discussion of George’s current situation and care needs

Whilst the assessment acknowledged George’s communication difficulties (‘mild difficulties understanding/ expressing’ and being hard of hearing) and noted that George had difficulties understanding and/ or retaining information, as well as difficulties in making decisions, the assessment and subsequent review went ahead with George’s permission for David to speak on his behalf. At this point it would have been in George’s best interest for his capacity to be explored in more detail in line with the Mental Capacity Act 2005 around his ability to take a decision regarding his care package, whilst also taking into consideration the impact of his hearing loss on the feasibility of a mental capacity assessment. Therefore, a discussion around a physical health assessment would have been beneficial, including a hearing test which might have also brought to light that he had previously been provided with hearing aids. (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).** It seems that whilst the assessment templates require the practitioners to consider the client’s circumstances more holistically, there was no evidence that consideration was given to liaise with relevant health services, with George’s consent, to use up to date information to inform the assessment. The annual review concluded that the current care package met George’s needs: that the domiciliary home carer to continue three daily, half-hour visits

The review also provided a trigger to offer a carer’s assessment to David to identify any needs of support for himself as the informal carer for George. This was good practice in line with the Care Act 2014, although it is not clear why this was not completed earlier on in the involvement as David’s support to George had been known to ASC for some time. The assessment gave an insight into David’s extensive commitment and support. This Review notes that there was a lack of risk assessment and contingency planning, in relation to the reliance being placed on David as informal carer, evidenced during this process which might have contributed to George’s rapidly deteriorating home conditions later in the period under review. Simply put: nobody asked the question what would happen if David was no longer there for George. (**Finding 4 will consider further the issues around practitioner’s understanding of the importance of robust risk assessment and contingency planning when assessing carers).** As a result of the assessment, David was awarded the standard one-off payment of £400 for carers with a review planned for in a years’ time.

Period 3: 13th February to 26th July 2018: continued attendance to several reoccurring health issues, including unplanned hospital admission

Agencies involved in this period:

- Single Point of Access (SPA)
- Rapid Response Team RR)
- District Nurse Team (DN)
- General Practitioner (GP)
- Whipps Cross Hospital
- Adult Social Care (ASC)
- Homecare worker/ agency

District Nurses continued to visit George in his home during this period and on several occasions attended and followed up concerns in relation to wound management and tissue viability, including advice on pressure prevention which was good practice. George's diet and weight were also discussed and checked and a referral to the dietician was proposed due to concerns of George having lost weight. District Nurses informed that the home carer was not usually present during their visits due to the homecare visits being restricted to 30 minutes/ three times during the day and there was therefore no direct communication with the home carer and no evidence of information passed on to them via George or by David. There was also no Communications Book within George's home in which professionals could leave notes for each other. Review Team members were informed that usual practice would be for a leaflet to be left in the patient's home by the District Nurse in order to pass on relevant information although no reassurance was given that this was left in an obvious place and with an explicit note to the home carer or to David. **(Finding 1 focuses on the communication and escalation within and between agencies).**

David called SPA on one occasion to share his concerns about George's tissue viability and pressure areas which was appropriately passed on to the District Nurses and was in George's best interest. During this period, there were reports that George fell on three occasions, one of which resulted in an unplanned hospital admission (March). Following the other two falls (March and April), George attended his GP surgery with skin lacerations which were attended, and pressure areas were also considered. There was limited evidence provided to the Review Team to support a wider exploration of possible causes for falls and George's liking or consumption? of alcohol seems to have been accepted as a potential reason for the fall and his health history, including history of falls, does not seem to have been considered. A referral of George to the Integrated Case Management Service was not considered which could have offered an opportunity to assess the risk to George more holistically. George additionally attended the GP surgery on one occasion (April) with a skin injury for which he was unable to give an explanation. **(Finding 1 focuses on the communication and escalation within and between agencies)**

On 12th March, George called the ambulance but had no recollection as to why. He was taken to hospital, together with David, where necessary checks were completed swiftly and he was sent home as no significant concerns were assessed, apart from him presenting with a level of confusion.

Following another fall (the third fall since the start of the review period), George was admitted to hospital for three days and David took charge of informing relevant health professionals. Conversations with George and David gave reassurance to professionals that the current care package commissioned

through ASC was still meeting George's needs. David's concerns in relation to George's increased alcohol intake were discussed, albeit there was a lack of dialogue with George or David about the pattern of drinking and the quantity. The Drug and Alcohol Team visited George on the ward and the plan was for this to be followed up in the community. However, the specialist team in the community did not have any records in relation to George which raises the question if the referral was made in the first instance. This could have offered an opportunity to assess George's actual alcohol consumption and how this may be impacting on his health including his mobility and risk of falls. The care package was re-instated upon discharge.

This having been an unplanned hospital admission and George's presentation with co-morbidities (stoma bag, pleural effusion, cardiomegaly) would have met the criteria for an assessment by the Community Matron to consider the coordination of his care which would have brought the multi-agency network together. This referral could have been made by any professional involved, such as the Hospital Social Worker, GP, District Nurse or care agency who were all aware of at least the two recent unplanned hospital admissions but was not considered as every agency involved remained focused on the task assigned to them. **(Finding 1 focuses on the communication and escalation within and between agencies).**

Review Team members queried if and how George's mental capacity to understand, retain and weigh up the information given to him, to communicate his decision and to give consent was assessed by professionals during their respective involvements which included the care package, treatments, hospital admission and referrals. There were several occasions when George was described as liking alcohol and being under the influence of alcohol, therefore this would have impacted on his capacity, possibly causing "fluctuating capacity". (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).**

On 28th June, the outreach coordinator at the home care agency carried out a "review of customer care wellbeing". Whilst the general outline of such review was provided to the Review Team, no further information was made available as to the content of any conversation, what questions were asked to George, if any other professionals/ agencies were involved and how any information was shared. It has therefore not been possible for the Review Team to understand the use and validity of such reviews and how they are used to monitor and improve the quality of care provided.

When David called SPA again in July raising concerns about George's general wellbeing, including presenting lethargic and not looking "right", the Rapid Response Team attended George's home on a timely basis at which point he seems to have presented as alert and orientated. His hearing difficulties were noted, and George was engaged in a wider conversation, i.e. about his mobility and mobility aids, pressure areas, support by the home carer, food and drink intake, sleeping habits and his management of the colostomy bag. As they observed a level of difficulty by George to get up and down from his chair, they felt that a Referral to Occupational Therapy could offer necessary support to him which was agreed as a plan forward. This was a helpful approach that identified the necessary actions to provide appropriate support to George. It would have been further helpful to start exploring the issues around George's hearing difficulties and whether he had been referred to audiology for tests, including the fitting of hearing aids. Practitioners also felt that it would have been in George's best interest for a re-referral to the Community Matron to be considered at this point to facilitate coordination of care and support.

Period 4: 30th July to 3rd October 2018: police's concerns about George being a "vulnerable adult" and referrals to several specialist health services

Agencies involved in this period:

- Single Point of Access (SPA)
- Rapid Response Team RR)
- District Nurse Team (DN)
- Falls Service
- Nutrition and Dietetics
- Metropolitan Police
- Adult Social Care
- Homecare worker/ agency

On 30th July SPA received a telephone call from Telecare (the provider of the emergency alarm installed in George's home) to report that George 'seems confused'. The Rapid Response Team visited and as they were unable to gain entry, they appropriately called the police who used their powers to gain entry which was good practice and in George's best interest. The assessment of George's needs led to the proposal for referrals to specialist agencies, namely the Falls Service and Dietetics and Nutrition, to which George agreed. A urine sample was taken which suggested a possible infection.

George was sent to Whipps Cross Hospital for further tests which informed two days later that no further treatment was necessary, and he was discharged. This was in George's best interest. It would have been further in George's best interest if contact had been established with the home care agency and David to obtain more information about the food provided to George and what his eating habits were in light of the noted concerns around George's diet. **(Finding 1 focuses on the communication and escalation within and between agencies).**

Additionally, Police attending George's home were sufficiently concerned enough about the "smelly and unkempt" state of the property that they completed a "vulnerable adult" report and shared it with LBWF Adult Wellbeing and Prevention Team. George was identified as receiving a care package by Adult Social Care and the relevant team was promptly notified. This practice by police and Wellbeing and Prevention Team was expected practice. The follow up of this referral by Adult Social Care resulted in the decision that no further action was necessary as they felt reassured by the Police report that George was safe and well and RR did also not consider it necessary for George to be taken to hospital. Their decision taking did not take into consideration George's history which is partly documented on the electronic recording system (more so his involvement with Adult Social Care rather than health agencies). There was also no discussion sought with another manager. This practice was influenced by the high volume of referrals to the service at the time. This was not necessarily in George's best interest. **(Finding 1 focuses on the communication and escalation within and between agencies).**

George continued to be visited by the DN Service in relation to wound care and skin viability which was reported to be healing well. Additionally, contact was made with the home care agency on one occasion when George presented confused about whether the home carer had visited in the morning. This was good practice.

During this time period the Falls Service also started their involvement following the referral made by RR in July. Their attempts to contact George via phone was timely although unsuccessful as he reported that he was hard of hearing and unable to understand the physiotherapist. The phone call therefore ended and a follow up of the referral which was another phone call resulted in the decision taken to discharge George from the service. It would have been helpful for George if the referral had included the challenges around his hearing and for this to be taken into consideration when contacting George, including considering other means of contact. This swift discharge from the service was not in George's best interest, same as the subsequent lack of notification about his refusal to engage with health professionals that had an established relationship with him, such as the District Nurses or the GP.

George's refusal could have been influenced by a number of factors and just the hearing difficulties that were noted by the practitioner making the call could have been a plausible reason. It would have therefore been good practice for the referral to be followed up in a different way, i.e. through a joint visit with the District Nurses who are also part of NELFT or with George's Emergency contact David being present. Additionally, it would have been in George's best interest if his mental capacity was considered at this point in relation to his refusal to engage with the Falls Service (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).**

A month after the referral to the Dietetics and Nutrition Service had been agreed by George, George was contacted via phone call but there was no answer. It was therefore decided to send him a letter asking him to contact the department and arrange an appointment for a dietetic assessment. This was not in George's best interest and it would have been expected practice for attempts on the phone to be made three times before sending a letter. However, additionally George's electronic health records on "RiO" are accessible to all NELFT agencies and the recent entries by the Falls Service informed about George's hearing difficulties and refusal to engage with their service. The records also informed about the successful engagement over the last months by the District Nurses. However, the records do not seem to have been reviewed, and it has not been possible to establish the reasons for this. **(Finding 1 focuses on the communication and escalation within and between agencies).**

On 6th September, the outreach coordinator at the home care agency carried out a "review of customer care". Whilst the general outline of such review as provided to the Review Team, no further information was made available as to the content of any conversation, what questions were asked to George, if any other professionals/ agencies were involved and how any information was shared. It has therefore not been possible for the Review Team to understand the use and validity of such reviews and how they are used to monitor and improve the quality of care provided.

At the beginning of October, George was visited at home by Nutrition and Dietetics which was in George's best interest for this specialist worker to assess George's diet, food intake and weight in light of the recent observations and the limited food intake reported by George himself, albeit with some delay. The practitioner noted a level of confusion in George's presentation as well as his difficulties in understanding her role and reason for the visit. Additionally, he was observed to become increasingly distressed about the practitioner's presence who took the decision to arrange a joint home visit with the District Nurses who knew George. This was good practice. Furthermore, it would have been good practice for clearer reference to have been made to his mental capacity to decide about his engagement with the service. (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).**

Period 5: 5th October to 27th October 2018: reoccurring hospital admission and continued attempts by specialist health services to engage George

Agencies involved in this period:

- London Ambulance Service (LAS)
- Single Point of Access (SPA)
- Rapid Response Team RR)
- District Nurse Team (DN)
- Integrated Community Therapy Team
- General Practitioner (GP)
- Whipps Cross Hospital
- Adult Social Care
- Metropolitan Police
- Homecare worker/ agency

On 5th October George sustained his 5th confirmed fall since the start of the review period and was attended by LAS. Police were called for assistance to gain access to the home who were able to use the key-safe code. Practitioners from both agencies raised concerns about George presenting with dementia due to his confused state and they were aware of the involvement of the home carer due to the presence of the attendance log that indicated that a carer had visited that morning. George was taken to the Accident and Emergency Department at Whipps Cross Hospital where he was admitted as an inpatient. The police completed a Merlin report highlighting George as a "vulnerable adult" for whom it was dangerous to be home alone" which was sent to MASH/ Adult Social Care. Officers were able to identify George's emergency contact, David, and left a voice message for him who subsequently informed the home care agency. This was good practice and in George's best interest at the time. It would have further been good practice for clear consideration to have been given to George's mental capacity at this point in relation to him being taken to hospital and to clearly have recorded such assessment on his file. (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).**

As part of this review no evidence could be provided by Adult Social Care as to their decision upon receipt of the Merlin report. However, it would have been expected practice for this information to be passed on and highlighted to the Hospital Team together with information about previous falls to highlight this pattern. At the time, there was also a reported ongoing high volume of daily referrals which was likely to have impacted on the lack of action taken, including the screening of information available on the electronic recording system "Mosaic".

The information about George's fall, that had been one of the reasons for his hospital admission, stopped featuring on his records (Mosaic) from that point onwards. This was not in George's best interest and did not allow a full assessment of his needs around his mobility and falls history.

Prior to his discharge from hospital, George and David were met by the Hospital Social Worker to discuss the care package in place. Considering their positive feedback and the physiotherapist's assessment of George it was concluded that the care package continued to meet his needs and was re-started upon discharge. However, the assessment did not extend to include George's abilities within his own home but was restricted to the hospital environment and there was also no evidence provided

to suggest that information was sought form other agencies involved. This did therefore not allow for a comprehensive assessment and consideration for appropriate escalation pathways, such as the hospital's Frailty Pathway. This practice was not in George's best interest. A follow up call by the Hospital Team was carried out on 20th October with David who reported that the existing care package continued to meet George's needs. The follow up call was expected practice. Both discharge letters (admission to A&E and admission as an inpatient) were sent to George's GP who completed a hospital discharge review, but no further information was available to allow the Review Team to comment on the quality of such. At that point it would have been in George's best interest for his case to be considered by the GP surgery's Integrated Case Management Meeting.

The involvement of the DN Service came to an end during this period. Their planned home visit was unsuccessful as George had been admitted to hospital. Following a discussion with their case load manager George was discharged from the service which was usual practice. It would have been helpful at this point if the discussion also had considered the reasons for this unplanned hospital admission and to explore if this might require the involvement of and coordination of care by the Community Matron upon George's discharge. **(Finding 1 focuses on the communication and escalation within and between agencies and Finding 3 considers the commissioning of community health services.)**

On 18th October George sustained another fall (the 6th confirmed fall). Neighbours called the ambulance and George was taken to the Accident and Emergency Department. George was reported to be presenting with increased confusion and faecal leaking due to not wearing a stoma bag. Hospital staff also raised concerns around pressure areas. He was brought to the attention of the Admissions and Avoidance Team (AAT) and assessed by the Therapy Team within A&E who also discussed and confirmed his care package with Adult Social Care and the Homecare Agency directly before he was discharged home and the care package was restarted. Staff at A&E noted that a referral to the Integrated Community Therapy Team/ NELFT had been made already by the ward during George's recent admission as an inpatient which offered the opportunity for an assessment of George's home environment and identification for any needs around his safe mobilisation at home. This was in George's best interest.

On 25th October, the care coordinator at the home care agency carried out a "telephone spot check". Their records noted that they were able to speak to George who informed that he was happy with the carer. No further information as made available as to the content of any conversation, what questions were asked to George, and how any information was shared. It has therefore not been possible by the Review Team to understand the use and validity of such reviews and how they are used to monitor and improve the quality of care provided.

The involvement of the Integrated Community Therapy Team started swiftly. They asked for further information from the referrer and following initial unsuccessful phone calls to George it was good practice that David was contacted as George's emergency contact and a joint visit was arranged. The practitioners showed a good level of curiosity into George's situation and also contacted the care agency for more information about George's mobility. They clearly explained the reason for their visit, including the benefits and risks of engaging/ not engaging. They experienced George to be uncooperative and not wishing to engage with them and had concerns about George being under the influence of alcohol which was further confirmed by David's observation of George's drinking habits. Practitioners shared that they had no reason to doubt George's mental capacity, although fluctuating

capacity due to the influence of alcohol as well as issues around self-neglect did not seem to have been taken into consideration on this occasion. (**Finding 2 will examine the consideration given by practitioners to assessing mental capacity).**

David was also engaged in a helpful conversation about the extensive support he was providing as an informal carer, and he shared his general concerns about George living alone and that he should be living in a home instead. He also advised that he was suffering from cancer and that he did not think George was managing at present. This information was not followed up or escalated which was not in George's best interest. It would have been necessary for a review of David's support as an informal carer to be triggered and for Adult Social Care to be notified. Additionally, it would have been good practice for a conversation with David to have been offered to explore how this diagnosis was impacting on him in general and how he may wish to be supported by agencies in line with the "Think Family" approach adopted by Waltham Forest. **(Finding 4 will consider further the issues around practitioner's understanding of the importance of robust risk assessment and contingency planning when assessing carers.)**

As George had declined physiotherapy input and was back to his baseline mobility, he was discharged from the service which was usual practice. It would have been in George's best interest to take into consideration a potential of fluctuating capacity due to him being observed under the influence of alcohol when he took the decision to refuse therapy input.

<u>Period 6: 27th October to 4th December 2018: period of continued involvement by home carer and no involvement by other professionals ending in George's unplanned admission to hospital</u>

Agencies involved in this period:

- Metropolitan Police
- London Ambulance Service (LAS)
- Homecare worker/ agency

From 27th October onwards, the only professional who visited George frequently and consistently (three times a day for 30 minutes each time) was the home carer; it was the same carer for all visits. The agency's care plan and communication sheets completed by the carer support the carer's regular attendance although the quality of recordings is limited. They also do not give reassurance that all tasks, as outlined in George's care plan by Complex Care Team/ LBWF, were sufficiently and appropriately carried out, such as assistance with personal care and hygiene and laundering tasks. Whilst, as outlined before, it has not been possible during this SAR to speak to George nor to the home carer directly, no evidence by the home care agency was provided to inform that the carer had raised any concerns about George's health condition or condition of the home to the care coordinator. Whilst there were no further falls reported to any professional agency during this period, the Review Team felt that the absence of reports did not give reassurance that George did not fall as there was also the possibility that he might have fallen but those falls remained unreported.

Given that on several occasions during this period under review it was George's informal carer who had contacted professionals when he had concerns about George, it was reported that David's deteriorating health impacted on his ability to continue his caring task as he previously used to. On 4th December, George called the police as he feared that his home had been burgled. On police arrival, he answered

the door and police officers noticed he was wrapped in a blanket and there was an “overpowering” smell of urine and faeces coming from the home. Police were also concerned about fire hazards. George appeared very confused and could not answer the usual questions regarding the date or the name of the prime minister. George also disclosed that he was not wearing his colostomy bag which resulted in heavy soiling on his body and clothes. George was helped to replace the colostomy bag. The Police Officer also noted that George had not been washed for several days. The condition of the premises was noted to be very dirty and unsanitary throughout with clear evidence of presence of mice in the property and decomposing food in the kitchen. George was identified as a vulnerable adult that needed medical attention and deemed his living situation to be unsuitable for him to remain. LAS was called who took George to Whipps Cross Hospital to be assessed. Police also took the attendance sheets of the care agency and sent a detailed report to LBWF MASH. The response by police officers and LAS was good practice and an appropriate response to George’s needs at the time. Professionals also arranged for George’s cat to be re-homed.

2. Findings and questions to the Board

The review appraised the practice that George had received and then asked how the system usually works in cases similar to that of George’s. In exploring areas of practice through identifying what worked well, what good practice would look like and encouraging reflection we are able to develop our understanding at a system level of how multi-agency safeguarding partners work together and where there is scope for improved practice.

The One Panel, in conversation with the Senior Responsible Officer and the Lead Reviewers, agreed the focus for this SAR initially as following:

- Hospital Admission and restarting of the care package upon discharge – how is hospital admission used to “pause and reflect”?
- How are quality assurance processes embedded on various levels – the care agency for the domiciliary carer and the commissioner (the local authority) for the care agency?
- How did professionals and agencies involved with George communicate?

The process of this Review has led to most emphasis being placed on the last finding as it became more evident that the whole system worked in a fragmented, uncoordinated way.

The Review was also mindful that the subject of the review, George, did not always engage with services, was reported to have had a degree of alcohol use, and fluctuating capacity, all of which could be said to have indicated a risk of self-neglect. This has also been a common theme in earlier Waltham Forest SAR’s, and this is being explored further by partner agencies.

In considering the above, the review identified four main areas where practice can be improved to deliver the service that vulnerable adults should expect.

1. **Finding 1** - Is communication between all services robust and documented, recognising that the lack of communication within a single agency and between agencies can lead to care and

support needs going unnoticed and uncoordinated, and can prevent practitioners from identifying the need to escalate?

2. **Finding 2** - Is there an indication of a pattern that there are no adequate mechanisms in place that bring together staff across agencies to plan, review and case manage clients presenting with fluctuating capacity, requiring increasing support, and whose needs may fall outside both, the formal safeguarding & Mental Capacity Act (MCA) guidance?

3. **Finding 3:** Is there a pattern in the way the services provided to George have been commissioned that have impacted on George and his experience of care and support?

4. **Finding 4** - Is there a pattern in the current carer's assessment and reviewing process that impacts on practitioner's understanding of the importance of robust risk assessment and contingency planning?

In line with the focus areas agreed by the One Panel as outlined above, the Review Team also explored the area of commissioning and contract management of home care services. Due attention was given to George's story and whether his experience might reflect practice more widely and it was felt that this particular aspect of his story was quite unique and therefore not a wider, systemic practice issue.

An initial full assessment for Homecare was carried out on 9th February 2018 by Adult Social Care and as a result a homecare package of 3 x 30 minutes a day, 7 days a week was put in place and this was provided by the Home Care Agency, who is a provider frequently used by the Council, providing at current date packages to 68 clients (August 2019).

At the time that the package was put into place the Home Care Agency was rated "green" by the Council's in-house monitoring system. The top rating is "gold". Green means that all 10 domains are assessed as green and there is a current GOOD rating by Care Quality Commission (CQC). The agency had been rated GOOD since a full inspection by CQC in 2016. CQC carried out a routine inspection of the Home Care Agency in January 2019 and at that time rated the agency as "Requiring Improvement".

Homecare for George was provided by the same Home Care Agency throughout the Review period. Up to 6th July 2018 it was provided by a number of different carers but from this date onwards a single homecare worker covered all three shifts per day, every day of the week. This is unusual and invites questions about the quality of care that can be given when the homecare worker has no break in the week from their client and might create a level of instability to the client when the carer is off work for any reason. Additionally, it does also not allow the client to compare the quality of care provided by different workers and does not offer the opportunity to raise questions or concerns about a carer to the other carer. However, this practice could not have been known about by Contract Monitoring.

The Home Care Agency has advised that this was the only one of their clients with this arrangement on account of the fact that the home carer lived close to George and only had three clients in total, working 17 hours a week. The Agency also have floating "quality assurance" staff who drop in unannounced on home carers while they deliver their service in order to quality assure this. For example, we were told

that on 6th September, the outreach coordinator at the home care agency carried out a "review of customer care". However, the agency has not been able to provide further information, nor indeed contemporaneous notes, as to the content of any conversation, what questions were asked to George, and how any information was shared. It has therefore not been possible by the Review Team to understand the use and validity of such reviews and how they are used to monitor and improve the quality of care provided. It is the view of the team that the quality assurance mechanism failed in this instance and this is now part of the ongoing review and performance improvement plan for this agency.

The events of the 4th of December 2018 triggered a review of all clients in receipt of care packages from the Home Care Agency, a visit to the agency on 24th December, a meeting of concern on 11th January 2019, and a continuous improvement plan has been put in place which is being tracked. Based on this work with the Home Care Agency it was decided that current clients were safe to remain with the agency. Although this all took place after the period under review, it is included here for completeness.

The flow of information from Adult Social Care was discussed with Commissioning: in the context that there had been three Merlins (Police notifications about vulnerable adults) in the period under review (1st August, 5th October and 4th December 2018) and this information did not reach Commissioning. The only recipient of this information was Adult Social Care, who may have responded to this information by arranging an unscheduled review of the client, and their care package if felt required. It should be noted that the MASH did not cover Adults at the time of the period under review. Its remit has since been extended and it is understood that the operation of the MASH is currently being reviewed and it is recommended that the flow of information to Commissioning, utilising the High-Risk Provider Group is formalised in any new policies or protocols.

The key recipient of this information would be Adult Social Care, and this may have triggered an unscheduled review of the client, and their care package. The commissioning and procurement of homecare contracts and the monitoring of contracts sits outside Adult Social Care in Strategic Commissioning within the Families Directorate

The Commissioning Team covers Adults, Children and Public Health and, because of the size of the portfolio, they take a risk-based approach, using a risk tool. Currently there are 43 providers on the Council's Dynamic Purchasing System. Every provider with a current placement will be monitored as part of the standard annual block monitoring. Those rated green will not have a planned visit for another year. Those rated red are immediately referred to the High-Risk Panel and the suspension of placement process is followed. Those rated amber are given a "performance improvement plan" which is closely monitored, and a follow up visit takes place 6-12 weeks later. If the outcome is green, no further action other than to monitor the continual improvement plan. If red or amber, then providers are brought in for a "Provider of Concern" meeting and progressed under this procedure.

The system in operation is that Contract Monitoring will respond on an unplanned basis on receipt of safeguarding alerts, requests from Adult Social Care, successive complaints about a single provider, whistleblowing, intelligence from CQC, the local NHS, and other Councils. Nothing untoward about the Home Care Agency came to light from any of these sources during the period under review that challenged the original assessment of "green" of the provider agency. Nothing was received about the Home Care Agency by Commissioning from any of these sources during the period under review.

Two years ago, Commissioning set up the High-Risk Provider Group. This group seeks to triangulate "potential risks and concerns raised regarding Residential, Nursing ……. Domiciliary Care….and other LBWF and CCG suppliers…." (terms of reference). The group meets fortnightly, to jointly assess the status of risk, track remedial actions, and ensure that trends and reoccurring themes are surfaced. Membership includes Council contract management, Safeguarding, CCG and Adult Social Care representatives. Anyone can refer a provider to the Group where they have concerns. Nothing was referred to this group about the home care agency in the period under review. The usefulness of the group relies on the intelligence it receives and shares between the different attending agencies.

The four findings are listed on the forthcoming pages.

2.1 Finding 1 – Is communication between all services robust and documented, recognising that the lack of communication within a single agency and between agencies can lead to care and support needs going unnoticed and uncoordinated, and can prevent practitioners from identifying the need to escalate?

Communication is an essential aspect of care delivery for all health and social care professionals. The code of conduct of the Nursing and Midwifery Council (NMC) clearly states the role of the nurse to both clearly communicate and work co-operatively by making and maintain communication with colleagues. The standards of proficiency for social workers documented by the Health Care Professions Council (HCPC) outlines similar requirements that clear communication with clients and carers as well as with inter-professional and inter agency communication is important.

The issue of identification of risk and the roles and responsibility or practitioners to escalate these concerns if needed is again an essential aspect of care that is the responsibility of all health, social care, or private providers with clear mechanisms for escalating concerns such as the NMC "Raising & escalating concerns" document for nurses. This is also supported by the HCPC standards of proficiency for Social Workers.

The need for clear communication between agencies and professionals is essential to establishing and coordinating the client's care and support needs from a holistic perspective and to ensuring they are being met, including using escalation mechanisms.

<u>How are these issues evident in this case?</u>

George was known to numerous community health services as outlined before. Throughout the time under review the lack of escalation and coordination in relation to Georges changing health need was apparent, both within and between agencies.

It is reasonable to assume all agencies did assess, or attempt to assess, his needs as referred to them. However, there is a lack of documentation as to what assessments had been completed and what care and support needs were identified that required communication across services. However, there were several references to changes to George's care and support needs that were not communicated to other professionals or agencies other that the informal carer David. Sharing of information and

coordination of visits might have enabled and allowed increased observation and developed a communication line across agencies.

David, the informal carer, was the only person involved who consistently contacted agencies, mainly within health, advising them on the changes to George, which is supported throughout the chronology. He developed serious health problems resulting in his withdrawal of support suddenly in October 2018. Only one of the services attending George at this time knew about this and they did not share this information with anyone, and it is not clear if they understood the significance of David's involvement. This is also explored in Finding 4.

From this time onwards the only agency to see George was his home carer who was attending to George three times a day. On 4th December when George called the Police in the belief that he was being burgled, the Police found George and his home in a state of serious neglect leading them to raise a safeguarding alert and raising concerns that the one practitioner who was supporting George through this period, did not report/ escalate the change in his circumstances.

Falls

George had repeated falls (the chronology evidences six reported falls during the period under review: 11th January, 15th January, 22nd February, 6th April, 30th July, 18th October; additionally it has been highlighted that he also had falls during the time preceding the review date). RR referred George to the Falls Service on 26th July 2018 who documented hearing issues (see below) following their triage on 1st August.

It has also been noted that from the point David became ill and his involvement with George reduced there appeared to be a reduction in reported falls and alcohol related concerns; however, the absence of reports did not give reassurance that George did not fall as there was also the possibility that he might have fallen but those falls remained unreported.

Weight

Within the period under review George's weight was first documented on 6th March 2018 as being 45kg and on 19th June 2018 he was weighed again and documentation states "some weight loss" but no amount was specified. A referral to the Nutrition & Dietetic service was made on 30th July 2018 but no weight was provided or discussion of reasons for this. Additionally, there was no evidence of discussion with other agencies provided, including with the GP.

Hearing

Hearing difficulties were documented on 26th July 2018 by the Falls Service and a postal appointment was sent on 6th August 2018. They also made phone contact with George a day later but he could not hear them well and this resulted in George becoming frustrated. He was discharged from the service following this which was identified as not being expected practice. George should have had an appointment scheduled with two staff if they were aware of possible hostility. In addition, the Falls Service identified that they should have contacted the District Nursing team and GP to advise that George had refused to be seen and it would have been good practice for a joint visit with one of them to be arranged. The Falls Service recognised that discharging him after two calls was premature when

he was at risk due to his age and falls history. No agencies were referred to for a hearing assessment and there was also no liaison with GP.

It should be noted that not only did George have a clearly documented hearing loss, but he had hearing aids, which were in a drawer needing new batteries at the point of moving to a care home.

Dementia

Dementia coding was first used when George was discharged from hospital in June 2016. The discharge summary stated he should be reviewed in the memory clinic. The GP took this that George had been referred so did not make a referral or follow up, but the coding remained on George's record with the GP. No evidence that a referral to memory clinic was made by any service and no evidence of follow up with the memory clinic.

Coordination of Care

Although outside the period under review, it is important to note that George was under the Community Matron Service from 8th July 2016 to 2nd August 2017. They informed that their involvement was minimal in terms of his risk and lifestyle and he was reported to be "a challenge to engage with as he often refused to be referred onto other services for support". George's discharge from the service was due to a hospital admission at the time and here was no evidence of a handover to other agencies who were involved with him at the time. Practitioners informed that if a patient is active on the CM caseload it would usually be the role of the CM to coordinate care. However, patients can be on and off the CM caseload depending on their needs so coordination would be expected to be from health care professionals actively engaged at that time. Referrals could be made to reassess at any time. There was no information made available about why George was not re-referred to the service.

The involvement of Adult Social Care during the period under review can be described in two-ways: the Complex Care Team was tasked with annual reviews of George's care package and the Hospital Team became involved following George's admissions to hospital and was tasked to identify if the existing care package was still meeting his needs. Both teams share the same recording system; therefore, relevant information was available to both. Practitioners and Review Team members had shared communication between the teams would be shared when necessary but not routinely. In George's situation, upon his admissions to hospital, there was no evidence that showed communication between these two teams.

An additional contributing factor that has supported this limited communication between agencies is the use of separate communication systems with health and social care being electronic and "paperless". However, in this instance a hand-written communication book in George's home could have enabled everyone (particularly health services) to see who was going in and enable all practitioners to leave messages for each other as well as for George and David, which could have then been photographed and uploaded to notes. It is acknowledged that this approach would have needed to be considered in line with existing legislation around data protection.

It is important to recognise the changing face of health and social care with all agencies being funded to provide episodes of care requiring input only at the point of care or active input being required. This results in involvements with clients starting and ending at the point of activity completion. In these instances, with no agency having overall oversight of the holistic needs the greater picture is missed,

the need to have good escalation policies in place is critical. None of the practitioners escalated either within their own service or to other agencies working with George.

Professional Curiosity

Overall, there appeared to be a lack of professional curiosity with professionals from all agencies focussed on their task without consideration for the wider context, holistic assessments, inter agency communication and documentation relating to Georges changing care and support needs. This also contributed to the inconsistent collaborative multi-agency working and led to missed opportunities in terms of effective information sharing and planning.

Does this happen in other cases? / Is this common practice?

In the second meeting as part of the SAR, managers present shared that robust communication and escalation policies exist within services. However, it was acknowledged there is no evidence they were considered in this case which was a concern to the participants. The group took the view that this practice is a systemic problem occurring with other clients across the borough and across all agencies. Managers' views were that increasing time pressures placed on all services (decreasing services available to meet increasing clients' needs) can contribute to a task and finish approach, which may be difficult to mitigate against through personal knowledge, standard setting and individual case responsibility.

Is this specific to Waltham Forest?

The multi-agency review group felt this this is not localised to Waltham forest. Professional roles are changing with increased pressures and a requirement to start and end their involvement with clients when activity/intervention has concluded resulting in long term involvement only occurring with ongoing and complex. For this reason, services charged with care coordination, such as the Community Matrons Service are commissioned. This is discussed further in Finding 3.

The group also considered this to be a national issue and not limited to Waltham Forest, however, no research was available to substantiate this.

What are the implications for the multi-agency adult safeguarding system?

As identified robust communication, assessment, care coordination, and escalation procedures are essential in care delivery across all agencies. Failure to have robust systems and monitoring of these systems can result in clients receiving inadequate assessment and care that truly reflects their care and support needs.

Questions for the board

- Is the board confident that communication and escalation policies are embedded in all services? And, is the board confident that these are readily available and embedded in care delivery across all agencies and may there be a need for cross agency policies?
- Is the Board assured that the integrated services, such as Community Matrons and Integrated Case Management, provide a robust enough system to support and coordinate care for clients who are known to multiple services? Are the pathways clear enough, including information passed to GPs? Do the criteria and thresholds to access these services work for clients who self-neglect and/or are difficult to engage?

- Is the Board confident that current policies and practice standards emphasise the need for the coordination of care? How might they be strengthened?
- What information/ examples does the board and partner agencies have available to reassure them that agencies are communication effectively to achieve good outcomes for service users? How could this be used to promote good practice/ learning from good practice?

2.2 Finding 2: Is there an indication of a pattern that there are no adequate mechanisms in place that bring together staff across agencies to plan, review and case manage clients presenting with fluctuating capacity, requiring increasing support, and whose needs may fall outside both, the formal Safeguarding & Mental Capacity Act (MCA) Guidance?

Consent and the capacity to consent should be at the forefront of all health and social care intervention, with the same principles applying to a routine daily activity as to a major life changing event.

As stated in the MCA Code of Practice the starting point should always be the assumption that the person has capacity unless it can be established that they lack capacity. However, in the event a client has conditions known to impair their ability to consent to an intervention, practitioners should explore these conditions and their impact upon the client's ability to consent and in turn provide informed consent. *"Be aware that the fact that a person agrees with you or assents to what is proposed does not necessarily mean that they have capacity to make the decision." (4.45)*[2]

The documentation surrounding the assessment of capacity is also paramount as without this there is no evidence to support capacity being considered.

The Code of Practice also recognises that there are people with fluctuating or temporary capacity and their specific needs (4.26)

<u>How are these issues evident in this case?</u>

George's issue of alcohol had been known to professionals since prior to the period under review, i.e. George was reported to have been hospitalised in August 2017 following binge drinking.

Throughout the first SAR meeting it was reported by practitioners that George had capacity and consented to health and social care interventions. However, it was also identified that he also often presented as having diminished capacity particularly in the afternoon and evening. The only service that clearly documented capacity and gaining consent was the Rapid Response Team on 11th January 2018. Whilst consideration was given to issues around capacity at George's annual review of his care package by ASC on 9th February 2018, this did not extend to an assessment of his mental capacity.

George's lapses in capacity were linked by professionals to his suspected alcohol intake with client notes reflecting this on various occasions. However, there was no evidence of records stating he was drunk, with no discussions with him about how much he might be drinking and the impact (short and

[2] Mental Capacity Act 2005 Code of Practice; Department for Constitutional Affairs; The Stationary Office

long-term) on his health, wellbeing and cognition or why he likes to drink. All these lines of enquiry would have given an insight into his actual drinking habits as part of a holistic assessment.

In addition, George has an established hearing loss. This was documented first on 3rd July 2018 by the Rapid Response Team but there was no evidence of sharing this with other agencies at the time. Following July, other health agencies also noted George's hearing difficulties in their communication with him. Practice Guidance informs that this sensory impairment should have been considered when considering mental capacity as this would have influenced George's ability to understand the information shared with him in the first place.

Furthermore, professionals had noted issues around dementia (albeit this not having been formally assessed and diagnosed) which was shared in the Social Worker's assessment of George's needs as part of the annual review of his care package in February 2018; The GP also noted dementia on his health records in April 2018 and the police felt that George presented with dementia when they attended his home on in October 2018.

Finding 1 describes George's history of falls, refusal of support services and the increasing reliance on his main carer and friend David. Knowledge of this might have been expected to trigger consideration and assessment of George's mental capacity. This in term could have been expected to influence the assessment of risk with respect to George's self-care and wellbeing and whether to re-engage the Community Matrons and integrated care service in his care.

Throughout the review there was limited evidence provided to support that consent was discussed with George and/ or George consented to interventions or what his level of understanding was to what he was consenting to, including no narrative on how he gave that consent even if only at the first meeting. There was also a lack of evidence providing more detail on the occasions when he was noted to have diminished capacity, including practitioners' discussion with George about his care and support needs.

The review highlighted that professionals seem to have been focussed on the specific task assigned to them, showing limited professional curiosity and consideration to the wider context. Therefore, there is limited evidence of referrals and signposting to rule out other health concerns to explore or explain his diminished capacity. This has led the review team to have concerns that in George's case diagnostic overshadowing took place. (Diagnostic overshadowing a condition is overlooked due to its symptoms being similar to another primary condition. In this instance dementia, hearing loss & falls were not investigated and were overlooked as professionals perceived the primary concern to be alcohol consumption). This has been explored in more detail in Finding 1.

This lack of consideration of other reasons that could have impacted on his alleged fluctuating capacity, increasing falls and reduced hearing seems to have resulted in his true care needs not adequately being reflected. If in fact George was misusing alcohol as shared by practitioners (although the actual level was not known to them), he was likely to have continued to experience this without the support of David following his own diagnosis of cancer around October 2018. Recent SARs completed in LBWF have explored the ethical dilemma about lifestyle choices of adults who self-neglect due to substance misuse (see appendix).

In addition to the potential co-morbidity of these issues, there are also some parallels in terms of the psychological impact on the adult's mental capacity, the way that capacity can fluctuate and the way that addictive or obsessional type thinking can impact on capacity. The MCA Code of Practice (section 4) and the MCA (page 23) advise that assessments should be undertaken when the adult is best able to respond, therefore acknowledging the concept of fluctuating capacity. However, with George we only have hearsay confirming that George used alcohol without information about the level. This seems to indicate that no clear reasons were assessed for his periods of demised capacity.

Does this happen in other cases? What is common practice?

Both, health and Social Work practitioners shared that they were in general unsure about assessing mental capacity, if it was their role to assess capacity and who to discuss any concerns with, either within their agency or another agency involved. Other practitioners shared that they do not routinely assess capacity.

Additionally, practitioners and review team members shared that a lack of documentation in relation to capacity would normally be understood as there not being any concern around the client's capacity. Following the managers' review meeting those present were not confident that all services involved in George's care clearly understood capacity in relation to the Mental Capacity Act 2005, Care Act 2014 and their roles and responsibilities within it. The MCA Code of Practice provides limited guidance in relation to the assessment of fluctuating or variable capacity which might have influenced practice. Practitioners shared that it may be easier to assess an individual with a condition that is progressively deteriorating because the trajectory of their condition is more easily understood. An individual with a condition who has improved capacity at certain times of day provides specific 'windows' when assessment of capacity can be undertaken. However, if an individual's condition and/or capacity changes in an un-predictable way, practitioners are in a far more difficult position in terms of assessment and planning.

The review team were from different organisations and boroughs as well as having varied practice experience within both, health, and social care. From reviewing this case as well as reviewing SAR reports that had recently been completed in WF this does not seem to be an isolated case.

Is this specific to Waltham Forest?

At this time there is not enough evidence to make a judgment. Whilst it is accepted that this is now 7 years ago the SAR "John" completed in Waltham Forest in 2012 noted: "In line with the Mental Capacity Act in Britain we tend to think of mental capacity in a black or white way, you either have capacity or you lack capacity. However, academics have highlighted that it may be more helpful to consider decision-making capacity as a spectrum rather than a simple dichotomy."[3]

Since then, the Select Committee on the Mental Capacity Act 2005 which was established in 2013 also shared that "that "its [the Act's] implementation has not met the expectations that it rightly raised. The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives.

[3] Dong and Gorbien; Dong, X. and Gorbien, M. (2006) "Decision making capacity: the core of self-neglect"; Journal of Elder Abuse & Neglect, Vol 17, no3, pp19-36). In this way we can remain more alert to the subtle ways that capacity can change and be impacted. (page 17)

The evidence presented to us concerns the health and social care sectors principally. In those sectors the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed."[4]

What are the implications for the multi-agency adult safeguarding system?

Robust systems in relation to assessing and documenting capacity are essential to safe delivery of health and social care and maintaining a client's engagement with both, existing and new services. Within both, health and social care, assessing capacity falls within the remit of all front-line staff with training provided and being mandatory. It is a core aspect of care delivery especially if there are concerns relating to fluctuating capacity resulting from alcohol and potential undiagnosed health conditions that are known to affect capacity.

If staff lack understanding, skills, and confidence to consider, review and robustly document the client's consent to interventions or assess capacity then this can pose risks to the client as well as to the practice delivery. This can create the risk for a service user not to be provided with all necessary support and information to allow for an informed decision to be made and a risk for professionals' accountability for the assessment of capacity to be compromised.

Questions for the Board

- There are mental capacity assessment decision–making tools and guidance available to assist practitioners; is he Board satisfied that these are easily accessible and effective and embedded in the assessment processes?
- Are partner agencies considering the aspect of a vulnerable adult presenting with fluctuating capacity within their respective ways of recording, including referrals, discharge summaries, etc. to bring this complex issue to other professionals' attention for their consideration?
- How is the board assured that practitioners within health, social care and private providers have the right skill set and knowledge base to assist them in the task of assessing the mental capacity of an adult who has fluctuating capacity and distinguish between alcohol related capacity concerns and undiagnosed health related capacity concerns, including sensory impairments, and recognising the limitations of their skill set?
- Are the current training packages on offer regarding the assessment of Mental Capacity fit for purpose, and do they include the complex area of fluctuating capacity and escalation pathways?

2.3 Finding 3: Is there a pattern in the way the services provided to George have been commissioned that have impacted on George and his experience of care and support?

[4] "Mental Capacity Act 2005: post-legislative scrutiny"; House of Lords, Select Committee on the Mental Capacity Act 2005; Report of Session 2013-14; London, The Stationary Office; page 6

In setting up this review, the SAB has asked that there be a focus “on commissioning and the quality assurance process related to commissioning”. In addition [to consider] the restarts of care packages and hospital discharge. This is about Council commissioning of Homecare. However, it was decided at the mid-review meeting with the Senior Reviewing Officer (SRO) on 4th August that the scope should be extended to also include consideration of the commissioning/ service design of community health services to the extent that this is relevant to the other findings in this SAR.

This section is in two parts:

(i) Hospital Discharge
(ii) Commissioning /service design of Community Health Services to the extent that this is relevant to the other findings

The Review Team also explored the commissioning and contract management of Homecare as outlined in the narrative above. There are no findings to be followed up.

(i) Hospital Discharge

How are these issues evident in this case?

George had three unplanned hospital admissions as an inpatient (March, October and December) during the period under review (6 times if the hospital attendances are included of which one resulted in discharge home on the same day following a functional assessment, including a discussion with a Social Worker and the Homecare Agency; two attendances were planned clinical appointments) and in each case his care package was resumed without change on discharge. We were made aware of the Frailty Pathway that is in operation at Whipps Cross Hospital, and we were told that in the light of the frequency of contact with the hospital, George should have been placed on this pathway. It is not clear why George was not on this pathway, nor what benefit this would have been to him.

It was clarified that patients on the frailty pathway, if they attend the emergency department multiple times, the Admissions Avoidance Team (AAT) would add them to the high intensity users list. This list is generated by the community team but can be populated by the AAT. Once a patient is added to this list, it triggers a visit from the community team and they most often reassess the patient’s needs. The patients on this list are discussed at a conference call between the hospital and the community teams on a weekly basis. This also applies to patients who have multiple attendances at the emergency department and are not on the frailty pathway.

ASC reported that they were not aware of what the Frailty Pathway is although the hospital reported that social workers working in the hospital (in the Admissions Avoidance Team and the Discharge Team) are aware of this pathway. It is not clear to what extent being on the Frailty Pathway would trigger a review of a homecare package.

On three separate occasions during the period under review, George was attended A&E and sent home the same day. It was shared that due to the high-pressure environment George was not referred to the hospital social worker. This may have flagged up the frequent admissions and may have enabled referral to the frailty pathway. It may also have generated a discussion with both brokerage and the

care agency. While these points are speculative, the fact that A&E is likely to always be exceedingly busy is not, and this raises the question about capacity to refer to hospital social work and ensure that patients/ residents are assessed appropriately.

<u>Does this happen in other cases? What is common practice?</u>

Issues regarding Hospital Discharge and care packages has been the subject of a previous SAR in WF.

<u>Is this specific to Waltham Forest?</u>

The arrangement exists at Whipps Cross Hospital between Barts Health and the London Borough of Waltham Forest that enables the Hospital Discharge Team directly to restart homecare packages that were in place at time of admission to hospital to resume on discharge where there is no change in the package.

<u>What are the implications for the multi-agency adult safeguarding system?</u>

In a safe and reliable system, it is necessary for an arrangement to be in place that facilitates and fosters a close working relationship between hospital discharge staff and social workers. This will allow for a patient's holistic needs to be considered, using appropriate mechanisms in place, and for arrangements to be made for those needs to be met upon discharge into the community.

If the multi-agency system does not robustly and consistently create opportunities for different professionals within a setting to communicate with each other easily and clearly, this can create a risk to the patient's needs being compromised when leaving this setting. The operation of the Frailty Pathway and the criteria (including self-neglect) to be placed on this pathway should be common knowledge across the whole system to ensure a coordinated approach to supporting adults with high risk factors.

<u>Questions for the Board</u>

- Is the Board satisfied that the Frailty Pathway is understood by all partner agencies?
- How do partner agencies measure the effectiveness of the Frailty Pathway in terms of the quality of care and intervention provided to the client?
- Is the Board satisfied that the capacity in A&E is sufficient for the effective working of the social work team and health staff?

(ii) Commissioning /service design of Community Health Services to the extent that this links to the other findings

<u>How are these issues evident in this case?</u>

NHS Commissioners commission various services that have a role in the coordination of care. This review found that while these services should have been involved in the care of George, they were not part of his support package and this contributed to the fragmented, uncoordinated care experienced by George that meant that there was not a shared understanding of George's needs and risks between practitioners.

In general terms when services are not used appropriately, whether this is due to a lack of clarity around thresholds or within communication, it creates a potential risk that needs are not assessed holistically and that care and support is uncoordinated and that service users can be put at risk by falling through the gaps between services.

George was known to numerous community health services including the Community Matrons Service (CM), within the Integrated Case Management (ICM), District Nursing Team, Integrated Community Therapy Team, Falls Team, and Rapid Response Team, and Primary Care. The Integrated Case Management Team has a "coordination "- function within its role. Adult Social Care works alongside all these services. The uncoordinated and fragmented way these services were delivered is described more fully in Finding 1. The CCG in Waltham Forest commissions these community health services. This section considers the experience of George compared to the expectations of services as commissioned/ common practice.

George was under the Community Matron Service from 8th July 2016 to 2nd August 2017. George was discussed at the Integrated Case Management (ICM) MDT (which includes the CM) on 12th August 2016 at which the GP reported that George "lives alone and had lots of home visits – not eating well. Fall[s] and noted low BP management".

The CM reviewed George on 23rd August 2016. An initial assessment was completed, and he was seen regularly during 2016, and also by the RRT, and he was hospitalised during this the period. This all happened before the period of this SAR but is relevant because George was closed to the Community Matron on 2nd August 2017 when he was admitted to hospital again. We were told that if a patient is active on the CM caseload it would usually be the role of the CM to coordinate care. However, patients are on and off the CM caseload depending on their needs so coordination would be from health care professionals actively engaged at that time. Referrals could be made to reassess at any time.

We were told that the CM found George "a challenge to engage with as he often refused to be referred onto other services for support. He would at times become verbally abusive, particularly when under the influence of alcohol. Therefore, the impact of having a matron co-ordinate the care was minimal in terms of his risk and lifestyle. Most impact was from friend D". The only information about why he was discharged from this service is as above and there is no information about why he was not re-referred to the service. George was not discussed at the ICM after July 2017.

George was seen during the period under review by an Occupational Therapist (OT) and physiotherapists from the Integrated Care Therapy Team. George was seen intermittently by the Falls Service over the course of the period under review. George attended Whipps Cross Hospital on the following dates and arguably should have met the criteria to be identified as a frequent attender.

- 2nd August 2017 (from CM' notes) *[note outside period under review for SAR]*
- 12th March 2018 to 16th March 2018
- 2nd August 2018 [query – notes say 02.08.2018 community matron referral closed as patient was admitted to hospital – this isn't correct)
- 5th October 2018 to 16th October 2018
- 4th December 2018

George's GP was at the Chingford Medical Practice. The Practice had reviewed their records on George for the Review. They had the following observations to feed into the Review:

- Confirmation that the Primary Care records contained the details of the above admissions to Whipps Cross.
- It was not clear in the Primary Carer records whether George was still under the Community Matron Service. The only way the GP could find out is to directly ask the question and then follow up with the CM service. This meant that they were not consciously aware that George was no longer under the CM service at the point of his discharge in July 2017.
- The last discussion about George at the Integrated Care Management meeting was in July 2017.
- The GP relies on the Hospital Discharge Summary. George was discharged from the CM service in July 2017 (see above) when he was admitted to Whipps Cross. The discharge summary did not mention the Community Matron service. The GP would have found it useful to know at this point that George had been discharged from the CM service and to know whether there was an expectation that they re-refer him.
- George's admission in July 2017 was on account of a fall relating to alcohol use. He was treated in hospital but discharged without any plan for follow up in the Community. This meant there was nothing in the discharge summary to alert the GP to any risk factors.

Although these observations largely relate to the 6 months before the period under Review, they are included here as they give an insight into how George started to fall out of sight of services that might have produced a more coordinated approach to his care and support.

<u>Does this happen in other cases? What is common practice?</u>

The following information was received from and shared by practitioners and review team members from different parts of the health services about how they operate and what is common practice within their respective agency:

Community Matron Service (CM): The role and function of the CM, in line with Department of Health guidance, is to actively manage a caseload. It is envisaged that proportion of patients may need long term care/supervision." Referral criteria include:

- Have been identified as very high intensity users of services
- Have co-morbidities (2 or more long-term conditions or highly complex needs)
- Have a minimum of two unplanned admission in the previous year
- Are taking three or more medications concurrently

In addition, patients meeting the following criteria will also be considered:

- Have been identified as having increased falls or at risk of falling
- Are deemed as "high risk" by healthcare professionals using clinical judgement.

Integrated Case Management (ICM) The ICM system was approved by the Waltham Forest Senate in 2011. There is a Chingford Medical Practice document (dated 2018) describing the ICM as a way to identify high risk service users using health analytics, as well as identifying people with frequent hospital attendance, and others can be included based on "clinical expertise". GPs work with CMs via the ICM.

The Integrated Community Therapy Team: We were told that a SOP or service specification for this team are not available. The CCG commissioners agreed that a SOP needed to be put in place which is agreed by partner agencies and has clear criteria for referral in it.

*Falls Service: w*e were sent a copy of the criteria for this service. We were told that the service does not have a formal policy around patients that do not engage or are hostile. “If patients do not engage and we have no reason to doubt capacity or have other contact details, we would inform the GP of their discharge”.

Frequent A&E attendances: The protocol for frequent attendees at A&E says that the CCG will provide practices with data on A&E required to review individual patients attending A&E, and that this data will highlight patients with two or more attendances within a specified period and with 3 or more attendances over the preceding 12 months. This data should trigger a group discussion about the patient with a view to determining any underlying reason for the attendances, their appropriateness, and alternatives to attendance.

Is this specific to Waltham Forest?

The issues of coordination of community health services and their alignment to adult social care and to primary care is not specific to Waltham Forest.

What are the implications for the multi-agency adult safeguarding system?

In a safe and reliable system, mechanisms would exist and be used to ensure that care and support within and across agencies, was coordinated. This is recognised by Commissioners of the Waltham Forest health system and there is a Community Matron Service as part of Integrated Case Management. However, when such mechanisms are not activated, whether this is due to a lack of clarity around thresholds or within communication, it creates a potential risk that needs are not assessed holistically and that care and support is uncoordinated and that service users can be put at risk by falling through the gaps between services.

There is a strategic commissioning discussion to be had between Partners and the Board about the extent to which the local system can support individuals whose self-neglecting behaviours and reluctance to engage in services raises their risk profile.

Questions for the Board

- Is the Board assured that the CM service and ICM provide a robust enough system to support and coordinate care for clients who are known to multiple services? Are the pathways clear enough, including information passed to GPs? What information do agencies have available to support their confidence and assurance?
- Do the criteria and thresholds to access these services work for clients who self-neglect and/or are difficult to engage?
- Do commissioning frameworks, standards, and risk stratification tools incorporate expectations with respect to clients/patients whose circumstances challenge on account of self-neglect?
- What role could the NELFT Care Quality Review Meeting (CQRM) (which the CCG attends) take in developing an approach to frail, self-neglecting clients such as George, with clear SOPs around

when to call for a case meeting about an individual who is known to several services? Should working with self-neglecting clients, a theme in three recent SARs in Waltham Forest, be a key topic for the coming year for the CQRM?

2.4 Finding 4 – Is there a pattern in the current carer's assessment and reviewing process that impacts on practitioner's understanding of the importance of robust risk assessment and contingency planning?

A carer is anyone over 18 years old who provides unpaid care by looking after another adult over 18 years old who is disabled, ill or elderly.[5] Carers provide significant informal support to people in need across the country: The 2011 census found that 6.5 million people in the UK are carers. In 2019, the estimated figures, informed by projections from the Office for National Statistics as well as Carers UK suggest that around 8.8 million adults in the UK meet the criteria of being a carer.[6]

Under Section 10 of the Care Act 2014 the local authority must assess "whether the carer does have needs for support (or is likely to do so in the future), and if the carer does, what those needs are (or are likely to be in the future)." A carer's assessment is therefore an opportunity to record the impact that caring has on the carer's life and what support or services they may need. A carer will be entitled to an assessment regardless of the amount of care they provide, their financial means, their level of need for support or whether they live with the person they care for or not. A carer's assessment should be reviewed at least annually, or sooner if the carer's circumstances have changed. The carer can also ask for their assessment to be reviewed sooner when their needs change

How are these issues evident in this case?

David lived near George and had been known to various agencies as George's informal carer and emergency contact.

The annual review of George's care package on 9th February 2018 was arranged by the Social Worker and took place in his home, together George, David, and the home care agency.

During the review it became clear that David had been playing a significant part in George's life for some time on a daily basis. The Social Worker recognised the need for a carer's assessment to be offered to David which he accepted. The assessment report was shaped and influenced by the carer's assessment template available on the electronic recording system "Mosaic" which presented as the only evidence to the Review Team for the completion of the assessment.

Whilst the carer's assessment was detailed and gave an insight into David's extensive commitment and support to George it also noted his concerns in relation to "the care and support that he was able and willing to provide on an ongoing basis" (i.e. his own age, his wife's health needs and George's potential

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[5] "Assessments. Your guide to getting help and support in England. Factsheet"; Carers UK; April 2019; https://www.carersuk.org/images/Factsheets/Assessments_-_England_factsheet_April2019.pdf

[6] "Facts about carers – policy briefing August 2019"; Carers UK, August 2019; https://www.carersuk.org/images/Facts_about_Carers_2019.pdf

long-term issues) as prompted by the form. No further risk assessment and analysis was provided by the Social worker. However, the form also does not prompt an elaboration of those issues, nor consideration of how this might impact on the proposed care plan for the service user, nor does it prompt thinking around contingency planning. The outcome of the assessment was a one-off payment of £400 to David, with the next review to be arranged in a years' time. The Social Worker sent a letter to David to that respect and invited him to contact Waltham Forest Direct should his needs change. There was no further evidence provided that relevant information and signposting was shared with David which would have been good practice.

On 27th October 2018 David went to visit George at home together with two physiotherapists from the Integrated Care Management Team which was good practice. They offered to complete an assessment in relation to George's mobility. It was at this point that David advised that he was suffering from cancer and that he did not think George was managing at present and should live in a home. This information was not followed up or escalated by the practitioners who might not have understood the reliance placed on David, although records inform that David shared his commitments with her in the conversation. It would have been necessary for a review of David's support as an informal carer to be considered at that point as this diagnosis was likely to impact significantly on his own health and overall needs, and therefore his ability to continue his caring role towards George. This specific situation could not have been foreseen by Adult Social Care at the point of the carer's assessment in February and they should have been notified about it by the professionals who David shared the information with, particularly as David did not contact Adult Social Care to inform them about his illness. Additionally, the home care agency shared that they were not informed about David's health issues.

This was the last reported visit to George by a professional other than the home carer and David's subsequent withdrawal from the support to George due to his deteriorating health seemed to have coincided with a rapidly deterioration of George's home condition and self-care. The Review Team learned that the home carer was aware and relied on David's extensive support to George as an informal carer and that David was no longer able to do this following his diagnosis. It is therefore not clear why the home carer did not alert the agency about this significant change in George's change of circumstances at the time and as it has not been possible to speak to the home carer or David, this remains unknown.

A meeting between the Home Care Agency and LBWF Contracts and Commissioning on 24th December 2018 highlighted a significant and inappropriate reliance by the home carer/ agency on David visiting three times a day in addition to their three daily visits. The police's report of their visit to George's home on 4th December 2018 and their subsequent evidence collected strongly suggested that the home conditions had deteriorated over the course of several weeks. The home carer had contacted David as George's emergency contact and the agency before when they had concerns, and it is not clear why this did not happen on this occasion. Equally, such concerns should have been escalated with WF Brokerage Team or WF Adult Social Care but were not in this case.

<u>Does this happen in other cases? What is common practice?</u>

The template available to complete any carer's assessment on the electronic recording system Mosaic is used by all professionals in Adult Social Care who are allocated such tasks. Therefore, practitioners are not specifically prompted to clearly risk assess and consider contingency planning when completing a carer's assessment. It is therefore likely that this is common practice.

Additionally, it was shared that a significant number of adults with care needs are cared for by their parents or the cared for are older people who may be cared for by an elderly partner/ spouse or friend. Information made available by the Performance and Information Lead (Adults)/ LBWF notes that out of 215 carer's assessments (completed by various teams in Adult Social Care and Transitions between April 2019 and August 2019) 35.8% (77 carers) are 65 years of age or older (with 35 carers, 16.3%, aged 75 and older). This places the current "ratio of carer to client assessment" at 10.6% which falls below the expected 20%-25%. This may therefore indicate that there is a higher number of carers who are likely to be vulnerable, but they are not known to or not recognised by services.

It is therefore likely that such informal carers, due to their own age or health issues, would benefit from a risk assessment and contingency planning when their caring role becomes known, should they no longer be able to continue their caring role. In that respect, George's case does not present unique within Waltham Forest.

Is this specific to Waltham Forest?

"Carers UK" informs that almost 1.3 million people in England and Wales aged 65 years or older are carers, with the number of carers over the age of 65 increasing more rapidly than the general carer population. 90.1% of older carers (aged 85 and above) have caring responsibility for someone aged 75 or over.

Carers Week research from 2018 found that 6 out of 10 people (61%) said their physical health has worsened as a result of caring, while 7 out of 10 (72%) said they have experienced mental ill health.[7]

This data suggests that the issue of carers being vulnerable themselves due to their own age and/ or caring responsibilities is a national issue requiring attention and focus in terms of risk assessment and contingency planning.

What are the implications for the multi-agency adult safeguarding system?

In a safe and reliable system, it is an essential feature that carer's assessments appropriately acknowledge, assess and analyse any concerns shared by the carer in respect of the care and support that they are able and willing to provide to the cared for on an ongoing basis. Additionally, it will support a timely review of the carer's support needs as soon as they change, regardless of whether is shared by the carer themselves or noted by other professionals which therefore carries the potential to allow robust planning, including risk assessment and contingency planning.

If the carer's assessment lacks acknowledgement around changing needs this will impact on the quality of risk assessment and contingency planning. This could cause a lack of timely review of the carer's assessment and care plan which can create a potential risk to the carer and the cared for. The level of risk will depend on the level of support that was provided by the carer in light of the needs of the cared for. A lack of robust risk assessment and contingency planning may also impact on professional's understanding of risk and their understanding of the need to escalate.

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[7] "Facts about carers – policy briefing August 2019"; Carers UK, August 2019; https://www.carersuk.org/images/Facts_about_Carers_2019.pdf

Questions for the Board:

- Are partner agencies satisfied that the current process and template for the carer's assessment sufficiently covers the acknowledgement and analysis of the carer's changing needs in light of the known circumstances as well as assessment of risk and contingency planning?
- How are partner agencies seeking feedback from carers and cared for, including their families and use this to inform their work?
- How can the board be satisfied that partner agencies know about the processes in place to refer for a carers' assessment/ review of carer's assessment?
- Does the carer's place of residence, either with the cared for or in a different home (which may impact on the carer's level of contact with professionals and vice versa), and their nature of relationship with the cared for impact on professionals' judgment when a review of the carer's assessment may be required?

3. Summary of learning and changes already undertaken by agencies

The information below summarises learning and changes within individual agencies. They were either initiated before/ independently of this SAR or as a result of this SAR.

Barts Health:

- "Frequent Flyers" – The agency is attempting robust work with emergency departments to identify regular attenders to services. The Admission Avoidance Team comprises The Senior House Officer and Frailty Consultant. This team holds a bi weekly conference call to review frequent fliers who are put on the high intensity user list. This list is generated by the CCG. The hope is that by identifying and discussing these cases there could be potentially a "Team around the Patient" approach (TAP) or at minimum a review of current services and raising of either referrals to other services, i.e. Community Matrons etc. or safeguarding concerns being escalated where necessary. The Waltham Forest high intensity matron is also able to pass this information across to the other boroughs that do not have a high intensity matron, but the patients are on the list.
- Electronic Mental Capacity Assessment (MCA): As part of the implementation of electronic documentation going live the agency has worked with Cerner to develop an electronic MCA form that is completed initially at arrival in hospital and to determine if the patient has capacity to consent to treatment and will also be further linked to other decisions. The hope being that MCA's will be more visible and will have to be completed.
- There is increased focus on social discharges during out of hours.

CCG (WF): Safeguarding training around mental capacity will be updated during 2020 through the Deprivation of Liberty steering group's review of the new system as it takes shape within Waltham Forest and what the requirements for each agency will be within the new system. Issues of fluctuating capacity and self-neglect should be a recommendation to be built in to the updated training as it is created.

Home Care Agency: Following George's admission to hospital on 4th December 2018 the Home Care Agency has been investigated by LBWF Contracts and Commissioning and was also referred to CQC; this has resulted in various changes/ improvements so far such as:

- Pre-/ Re-Assessments by the agency of clients in hospital for whom a care package has been commissioned are completed timely.
- Increased focus on personalized care plans for each client
- Improved QA processes of service users' files and care workers' files

LBWF – Care and Support: Adult MASH was implemented in June 2019; Waltham Forest Direct Liaison (WFD) receive all referrals in relation to adults; Merlin (police) reports and Adult Safeguarding concerns (S42) are sent straight to Adult MASH which then offers an opportunity for the referral to be explored in more detail, including history available on Mosaic as well as seeking information from partner agencies that are represented within the team. As part of the screening process the service user's consent and capacity is taken into consideration. This is a new and evolving service; therefore, the team's capacity and workflow are currently being tested within the existing structure of adult workflows and Children MASH.

LBWF – Care and Support: **SAB Adult Threshold work**

The Safeguarding Adult Board has led work to develop an adult threshold document.

The Think Family vision is for people and families in Waltham Forest to be independent, resilient, well and safe. People and carers should always have access to support from their family and community, and from universal services, such as GPs and healthcare, Police and the voluntary sector. For most people this support will provide everything they need to reach their potential and to maintain their wellbeing. However, there are times when people need more support to improve their outcomes, either due to the complexity of their needs, or the impact of external factors in their life.

The guide has been developed in collaboration with partners and organisations in the borough in consultation with residents, building on previous work across the adult services system and aims to: Provide clear, simple information on how to respond with the right conversation, right care, at the right time. The document and a bitesize video will be launched in November 2019, followed by multi-agency training and awareness raising. Work to test and learn and develop the local process Team around a Person, will be undertaken November to February and formally launched in March 2020.

LBWF – Care and Support: A new Adults' Carers Strategy 2019 - 2021 was taken to Cabinet and agreed 21st March 2019 and carer's engagement events were held before completion of the strategy to inform it. As part of its implementation carer's engagement events are running in October 2019 to inform the design of new carers services which is due to be recommissioned to take over from the current contract (running until the end of September 202). Work has also taken place to refresh the carers' assessment used by practitioners to make this more streamlined and easier for practitioners to complete.

4. Glossary

Terminology	Explanation
Adult Social Care/ London Borough of Waltham Forest	Adult Social Care within LBWF is divided into two areas: Care & Support (consisting of Complex Care, Provider Services, Adult Safeguarding, Mental Health, Learning Disability) and Prevention and Wellbeing (Hospital Team,, Wellbeing and Urgent Response Team, Social Prescribing and Occupational Therapy Team)
B12	It is a water-soluble vitamin that is involved in the metabolism of every cell of the human body; it is a cofactor in DNA (Deoxyribonucleic acid) synthesis, and in both fatty acid and amino acid metabolism. B12 is needed to make red blood cells which transport oxygen throughout the body. Common symptoms of B12 deficiency are weakness and fatigue.
Care Act 2014	The Care Act 2014 is legislation that sets out in one place, local authorities' duties in relation to assessing the needs of adults and their eligibility for publicly funded care and support.
Cardiomegaly	Abnormal enlargement of the heart
Care Quality Commission (CQC)	The independent regulator of health and social care in England that monitors, inspects and regulates health and social care services. Their findings are published, including ratings to help people choose care.
Dementia	Dementia is an umbrella term for a range of progressive conditions that affect the brain, there are over 200 subtypes of dementia but the five most common are: Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia and mixed dementia.
District Nurses (DN)/ NELFT	The district nursing service is part of the adult community health service and provides 24-hour care for people aged 16 and over who have identified nursing need. The service is provided in the patient's own home, or in residential care settings, except for leg ulcer clinics and wound clinics for mobile patients which are held in health centres. District Nurses care for patients with a wide range of nursing needs including the chronically sick and terminally ill. They also provide nursing services to those who are acutely ill and need intensive and technological care or who have specialist care needs. This service is based out of a number of health centres.
Folate	Folate is essential for the body to make DNA (Deoxyribonucleic acid), RNA (ribonucleic acid), and metabolise amino acids, which are required for cell division. As humans we cannot make folate, it is required from the diet, making it an essential vitamin. Folate deficiency can use anaemia (lack of red blood cells to carry adequate oxygen to your body's tissues).
LBWF	London Borough of Waltham Forest
Multi Agency Safeguarding Hub (MASH)	MASH this is the front door of LBWF Children's and Adult's Services (now under "Care and Support) which receives all referrals in relation to children and adults where there is a concern; it is part of a local authority and consists of professionals from Children's and Adult Services, Health, Education, Police, Probation, Housing, Early Help Service, Youth Offending and London Victim

Terminology	Explanation
	Support. This means that a joint decision can be easily made about how best to meet a child's/ adult's needs.
MERLIN	Merlin is a database run by the Metropolitan Police that stores information on children and adults who have become known to the police for any reason.
North East London NHS Foundation Trust (NELFT)	North East London NHS Foundation Trust provides an extensive range of mental health and community health services for people living in the London boroughs of Waltham Forest, Redbridge, Barking and Dagenham and Havering, and community health services for people living in south west Essex.
One Panel	The One Panel is Waltham Forest's Think Family forum which takes referrals for local or statutory reviews and makes recommendations against the statutory criteria for safeguarding adult reviews and local reviews/national review (previously known as serious case review in the case of children) to the relevant board chair.
Pleural Effusion	Also referred to as "water on the lungs"; it is a build-up of excess fluid between the layers of the pleura outside the lungs. The pleura are thin membranes that line the lungs and the inside of the chest cavity and act to lubricate and facilitate breathing.
Rapid Response (RR)/ NELFT	The RR service, now part of the Waltham Forest adult community health service, provides assessment, treatment and support to patients who are experiencing a crisis and who might otherwise be admitted to hospital. The team provides an urgent assessment service for worsening health problems, minor injuries and minor illnesses and works closely with General Practitioners (GPs), social and community services including care homes, to ensure patients are supported in a home environment wherever possible.
Safeguarding Adults Board (SAB)	The Safeguarding Adults Board represents organisations and agencies involved in safeguarding adults with care and support needs.
Safeguarding Adults Review (SAR)	A Safeguarding Adults Review is a multi-agency process which seeks to determine what relevant agencies and individuals involved could have done differently, which may have prevented harm or a death. The purpose of the review is for all agencies to learn from findings.
Social Care Institute of Excellence (SCIE)	SCIE it is a leading values-driven improvement agency. It is independent and people-focused, operating at policy and practice levels with a huge database of 'what works' good practice, eLearning tools and resources. Working beyond and across social care and health and children's and adults' sectors, SCIE contributes to the development and implementation of better care, support and safeguarding at national and local level.
Single Point of Access (SPA)/ NELFT	The service was official commissioned by the CCG from 04/04/2016 and provides a coordinated approach for the referrals received, and when relevant, signposts people to the appropriate services that are external to NELFT.
Stoma Bag	A stoma bag collects faces or urine through an opening on the front of the abdomen which is made using surgery. There are several reasons why this may be necessary.

Terminology	Explanation
The Care Act 2014	The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.
The Mental Capacity Act 2005	The primary purpose of the act is to promote and safeguard decision-making within a legal framework by - by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process - by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number

5. Appendix: Lessons from other SARs within LBWF relevant to George

History

George is the fourth relevant SAR commissioned by the Safeguarding Adults Board in Waltham Forest since 2014 as follows:

Mr W - 2014

Andrew - 2018

John - 2018

George - 2019

The Reviewers of the John SAR extended their review to consider whether there were any cross-cutting themes or patterns that were common across all three of the reviews (i.e. Mr W, Andrew, and John). They made the observation that all the cases concerned adults who misused alcohol and exhibited some behaviours associated with self-neglect.

The Review Team of George have been asked to go back to this an to look at the three cross cutting themes that were identified to see any relevance to George.

The three cross cutting themes identified were:

1. The ethical dilemmas about lifestyle choices raised when working with adults who self-neglect are closely linked to those raised in cases where the adult has a significant addiction and would benefit from increased focus by practitioners and managers.
2. The issue of how to manage risk across agencies in response to cases of self-neglect that do not meet safeguarding criteria (or are not suited to safeguarding processes) has continued to generate difficulty for practitioners and care workers.
3. Practitioners need additional support and guidance to respond effectively to the complexities of assessing the mental capacity of an adult who shows signs of self-neglect and/or addictions.

The George Review Team believes that cross cutting themes one and three are relevant to George. This is considered below and a summary of the three earlier cases is included for information and background context.

Relevance/ connectedness with SAR of George

Cross cutting theme 1

The SAR of John (Sept 2018) discusses the two perspectives that can be brought to bear in circumstances where an adult self-neglects and has an addiction: that the adult has an inability to care for themselves and requires support vs the adult is capacitous and has made a lifestyle choice. The difficulties that this presents practitioners is acknowledged and that it can result in a reluctance or ambivalence about whether it is appropriate to intervene.

It is not clear if and how in George's case, the risks of self-neglect through drinking were reduced by the active presence of his informal carer David. We do know that no consideration was given to what

might happen in the absence of David and George's care plan was constructed on the basis of David's ongoing presence and support.

Reviewing the three cases the following is noted with respect to the first cross cutting theme.

Mr W's case review – in this case there was a lack of meaningful intervention by the services. Mr W was seen as an adult who had the mental capacity to make his lifestyle choices. The review notes that if Mr W had been seen as an individual with a mental illness or a learning disability and as being unable to care for himself, the professionals would have been more likely to have thoroughly assessed him and he would have been less likely to have been harshly judged by professionals. One of the report recommendations Dr Brown proposed was that "all agencies should work to dispel stigma so that people suffering from addictions and the illnesses that are associated with them, are not marginalised within mainstream health services and receive health care and palliative care equitably alongside other citizens" (Recommendation 2).

Andrew's case review highlighted the links between self-neglect and chronic alcohol mis-use, noting that it is not routine practice to accept chronic alcohol misuse as a form of self-neglect, particularly if the adult has capacity (Finding 2). The finding also noted that self-neglect demonstrated by hoarding was often easier for professionals to see and name as self-neglect, whereas the effects of chronic alcohol mis-use become apparent over a long time period and could be less tangible.

In an echo of recommendation 2 in the Mr W report, the Andrew review identified that "There is no widely used care pathway, or allocation of role or responsibility for the palliative care of self-neglecting adults who are terminally ill, as a consequence of their addictions. This leaves frontline workers trying and often not succeeding to respond appropriately, increasing the risks that people with alcohol dependencies die with little support or dignity" (Finding 4).

In John's case the adult was generally assessed as having capacity, however there were occasions, particularly in the last six months of his life, when care workers instinctively felt that he had lost capacity and that his repeated refusal to seek medical assistance indicated that he was no longer making informed decisions. The care workers struggled to know how appropriate it was for them to intervene to try to reduce John's use of alcohol and cigarettes or to insist on him seeing a doctor. He was repeatedly found injured following falls that he could not explain. It seems likely these falls may have been linked to his alcohol use, however this was never addressed in a direct way with John or his family.

The third crosscutting issue is about the additional support and guidance that practitioners need to respond effectively to the complexities of assessing the mental capacity of adults who show signs of self-neglect and/or addictions. This has a direct read across to one of the findings in the George SAR.