Isle of Wight Safeguarding Adults Board

Accompanying Report into the Recommendations contained within the Safeguarding Adults Review for Mr R published January 2022

Introduction and statement from SAB Independent Chair Teresa Bell:

This report summarises the actions which have been taken following recommendations made by an independent Safeguarding Adults Review (SAR) into the tragic circumstances in which Mr R died on 19th March 2015, the morning after he had been moved from a care home which had been judged by the Care Quality Commission to be 'inadequate' to a setting where it was hoped that he would be safe. Mr R was left temporarily unescorted following a visit to the bathroom, was disoriented in the unfamiliar setting and went through a fire door, falling down the fire escape steps to his death. The independent reviewer highlighted a number of concerns about the communication with the family about the move, the short notice of closure given by the provider of the home that Mr R was being moved from, the information given to the receiving home about Mr. R's needs, the awareness of the CQC's rating of 'inadequate' that related to the receiving home and the safeguarding processes after Mr R's death.

Isle of Wight Safeguarding Adults Board (SAB) commissions a SAR when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. The purpose of a SAR is not to hold any individual or organisation to account as there are other processes available for that purpose; they are about learning lessons for the future. SARs ensure that SABs get the full picture of what happened, so that all organisations involved can improve as a result.

As the Independent Chair of the IoW Safeguarding Adults Board, my role is to support and challenge agencies to work effectively together in safeguarding vulnerable adults. On behalf of the SAB, I would like to offer my formal condolences to Mr R's family. His death was a tragedy. I hope that this report gives some assurance that there has been good progress in implementing the independent review recommendations over the intervening years, which will continue to be monitored by the SAB to prevent similar tragic incidents occurring.

Statement from Laura Gaudion, Interim Director of Adult Social Care, Isle of Wight Council:

On behalf of the Isle of Wight council and the Adult Social Care and Housing Needs department I offer my sincere condolences to Mr R's family for their tragic loss.

This report includes specific actions and developments undertaken by the Isle of Wight Councils Adult Social Care and Housing Needs department in response to the Safeguarding Adults review instructed by the Safeguarding Adults Board in response to the death of Mr R. The Adult Social Care and Housing Needs department takes seriously the recommendations made in that report and has taken swift and sustainable action to ensure that any improvements that could be made to our systems and processes have been made and embedded into our regular practice.
The changes to systems and processes have been enhanced by a greater level of partnership working with local care home providers, home care agencies, the Care Quality Commission, Clinical Commissioning Group and the NHS Trust. These partnerships have led to the opportunity to build

trusted relationships which allow for both high challenge and high support ensuring that we strive to do the very best for local people in all circumstances. These relationships are built on strong foundations of robust and appropriate challenge.

Through the implementation of comprehensive quality assurance processes, clear frameworks requiring action where there are failings and management oversight, I am able to provide assurance that the recommendations from the Safeguarding Adults review have been implemented and continue to be monitored.

Recommendations from the Mr R Review:

1. The Safeguarding Adults Board ensures that the actions in place and proposed for safeguarding systems from the range of audit and review activity already undertaken are co-ordinated and as far as possible consolidated into a single process that is well managed, with clear accountability for the actions to an agreed timescale.

- In 2018, a Quality Assurance Framework was developed as a method of continual quality assurance of care providers. The aim was to move away from reliance on results from CQC inspections, which could be scheduled several years apart, and instead provide a system to identify issues early on with support then provided to raise standards and improve quality. The Quality Assurance Framework was set up by Adult Social Care and Clinical Commissioning Group (CCG) as a joint initiative with local care providers and stakeholders such as Fire & Rescue, Healthwatch and Environmental Health. The Framework uses a number of key sources of information to evidence the provision of quality services in a care home. Key stakeholders can provide professional assessments and ratings, for example fire safety, food hygiene, professional visits, visitors by experience etc. Care home providers and home care agencies can also provide information on a regular basis. The information provided in the Quality Assurance Framework then gives an overall quality rating for each service which is timely and enables a risk- based approach to quality assurance and improvement. Quality assurance and service improvement is monitored through the councils commissioning team and is specific to each care home or home care agency. This promotes and enables continuous improvement of the quality of care and support services.
- The commissioning team make weekly calls to providers to provide support and to enable escalation and open discussion in relation to any concerns relating to safeguarding or quality of service delivery. This has been welcomes by local care home and home care providers.
- At the time of the Safeguarding Adult Review, both the home closure and the safeguarding concerns were dealt with within the same internal process. The issues were addressed within the same meeting by one service manager. Since the Safeguarding Adults review, we have introduced a clear Home Closure Protocol and these processes are now dealt with separately by two different service managers who then work together to ensure any cross-over is addressed.
- The focus for the Council's Quality Assurance Team is working with care providers to raise quality standards, which reduces the need for home closures and significantly improved the quality of care received.
- The introduction of the Quality Assurance Framework and the home closure protocol ahs enabled the council to consolidate activity relating to the provision of care and support

services where there are safeguarding concerns or quality issues in to one robust and effective process with clear accountability and management/escalation to provide support.

2. The findings from this review that focus on safeguarding issues are linked into that co-ordinated plan

- The Adult Social Care and Housing Needs department have reviewed all existing policies and processes; A new Home closure protocol has been implemented to ensure that home closures do not impact on the safeguarding activity in a home. Home closures are supported by the social care professionals in the Locality Teams ensuring that the appropriate care act reviews are undertaken. In addition this ensures that robust support plans are put in place to ensure all individuals involved in the process are supported, there is regular oversight and quality assurance incorporated in the process which is managed through a formal action plan and checklist.
- The Adult safeguarding team have implemented clear and robust decision support guidance for triage of all adult safeguarding referrals following the Making Safeguarding Personal (MSP) principles. This has been implemented across all safeguarding forms and records and ensures that safeguarding meetings are about individuals and their personal outcomes, preventing any oversight or confusion between organisational safeguarding and commissioning activity.
- The Adult Social Care and Housing Needs department commissioned an independent review of the Adult Safeguarding Team which lead to the restructure of safeguarding processes, including additional administrative support and a move to the specific role of the Consultant Practitioner and Chairperson becoming a full time post. This has enabled the prime focus of that role to be on making safeguarding personal, chairing safeguarding meetings and quality assurance of meeting documents. The introduction of new administrative processes together with the implementation of routine and robust quality assurance audits and data scrutiny ensure high standard of practice are in place and maintained.
- The Adult Safeguarding Team have developed and implemented a local multi agency approach to safeguarding activity providing multiagency oversight and accountability through close relationships and information sharing with colleagues in the Police, the Clinical Commissioning Group and the Isle of Wight NHS Trust.
- The Adult Social Care and Housing Needs department have developed and implemented the Quality Management System for all social work practice which includes monthly audits of safeguarding records, oversight of supervision recording and meetings, including decision making, actions completed and records of safeguarding meetings.
- New guidance and processes are in place for safeguarding and include new safeguarding training, new pathways relating to medication errors and falls, robust triage of incoming contacts and refreshed decision-making guidance which since being introduced has been reviewed and updated has been updated twice

3. The local authority and IoW CCG, notwithstanding progress already made, ensure that their quality assurance and care governance functions are well-established, and their role understood by all parties. This needs to include:

3.1 clarity between the CQC and local authority and CCG about how their roles and responsibilities interact to respond in a timely manner to provider deterioration or failure;

- The Adult Social Care and Housing Needs department has a new protocol in place setting out the process around home closures. This has been utilised recently, and has worked well in practice. The protocol has also been recognised regionally as an example of good practice by.
- The Adult Social Care and Housing Needs department and the CCG quality teams are in place and work in an integrated way meeting regularly to monitor quality with oversight from the Quality Committee.
- The Director of Adult Social Services meets regular with the Care Quality Commissions Inspection Manager to share intelligence and discussed challenges across the care home and home care sector.
- The Adult Social Care and Housing Needs department is a member of the Integrated Care Partnership Quality Sub-Group which is also attended by representatives of the Isle fo Wight NHS Trust, CCG, CQC, Healthwatch, Primary Care, The Isle of Wight Care Partnership and other key system partners. This provides the opportunity to ensure that there is clarity over the roles of each organisation and who is responsible for doing what where there are concerns relating to the quality of care.

3.2 that standard contractual arrangements state clearly what standards are expected of care providers and what action will be taken where those standards are not met;

- The Adult Social Care and Housing Needs department has put I place a clear policy to ensure they do not place within homes with an 'inadequate' CQC rating. For those homes which 'require improvement', assurance is sought that the home is actively working to improve their rating and a dynamic risk assessment is undertaken by both the social work professional and the service's registered manager to ensure that the care provider is able to meet the needs of the individual for whom care and support is required.
- Contracts clearly state that providers must adhere to all regulatory standards set out by the CQC. Contracts are underpinned by individuals' care plans. Compliance is monitored by the councils quality assurance team, and breaches of contract are dealt with through the Adult Social Care and Housing Needs departments' contract compliance process.
- The Quality Assurance Framework has an escalation process within to report concerns to the Adult Social Care and Housing Needs departments' strategic commissioning team. This enables support to be offered to a provider who may be struggling to improve, or action plans to be monitored more closely, which may also require increased frequency of visits by the quality assurance team to gain additional assurance that quality in the service is improving.

3.3 consider including in individual service user contracts an explanation of the contractual position and care governance arrangements that are in place, which can assist discussions when commissioners need to take action in response to deterioration or failure;

Rather than each individual having an individual contract, there is an overarching contract which is underpinned by an individual's care plan. There are a number of ways in which issues of quality can be raised, both by the person who is receiving care and support and their families, and by professionals entering a home.

- All care providers have information about how to make a complaint clearly displayed within homes.

- Healthwatch IW are commissioned by the Adult Social Care and Housing Needs department to carry out quality visits to homes as a 'critical friend'. Healthwatch IW also place cards within homes to allow a mechanism for service users and their families to report concerns about standards of care to them.
- A visiting professionals tool has been developed, which is available on the Safeguarding Adults Board website and is used by professionals regularly entering a care home. This form acts as a prompt to initiate a conversation with a registered manager if there are concerns around quality, and is also a mechanism to share these concerns with the Quality Assurance Team. This forms one of the domains on the Quality Assurance Framework and informs the overall quality rating of the service.

3.4 clarity that inadequate standards of care require investigation, even when they fall short of the safeguarding threshold, followed by agreed action to mitigate shortcomings and clear information to any relevant parties about the standing of the care provider while improvements are made;

- Robust contract compliance process in place to support homes identified through the Quality Assurance framework / Quality Assurance visits as having a low rating to achieve continuous improvement improve by creating individual action plans and reporting to the commissioners on their implementation.
- The Quality Assurance Framework is used to identify issues before they reach the safeguarding threshold, and work is undertaken with homes to raise standards.
- Information is regularly shared between the Adult Safeguarding Team and the Quality Assurance Team regarding providers.

4. This will be assisted by the IoW local authority ensuring that information available to service users and their families about safe, good quality care:

4.1 is easily available in a range of formats and signposted from all appropriate locations:

- The Adult Social Care and Housing Needs department now ensure that people who need care and support and their families are sign posted to the CQC website where information about the quality of care and support at the Care home is provided. The CQC are the regulator of Care Homes and provide a robust overview of their findings which is accessible to all. This information is provided to help people with their decision making
- The Adult Social Care and Housing Needs department have put in place a new Information Sharing Policy. It is a requirement that information is shared with care hoe and home care providers to enable them to make an informed decision about whether they can safely meet the needs of the individual the information shared included (but is not limited to) the most recent care act assessment and/or review, the referral received outlining the care and support required, information relating to any other services that are known to be working with the person and any risk assessments which have already been undertaken. Where a person is moving from one care home to another the Adult Social Care and Housing Needs department also seek to ensure that the original care providers records are fully available to the new care provider and to facilitate a discussion between registered manager to support the transfer of care.

4.2 supports their decision-making with clear information about the quality they are entitled to expect and how to assess whether places they are considering meet these standards:

- For people funding their own care, Adult Social Care and Housing Needs department, has commissioned a brokerage service to provide support and to enable people to understand the options available to them. The brokerage service is currently delivered by People Matter IW and is able to support a person and their family with their decision making
- The Adult Social Care and Housing Needs department has a statutory duty to provide advocacy to support those who lack capacity. Advocacy has been commissioned from and Independent provider and internal processes have been developed to ensure that there is appropriate signposting to this support. These processes are now fully embedded
- The Adult Social Care and Housing Needs department also took the decision to commission a service to support people who don't meet the criteria for needing its statutory services but who have a need for care and support I our community. The Living well service is commissioned for all working age adults on the Isle of Wight. The support provided includes help with accessing advice, information and guidance as well as support with decision making.

4.3 is clear about their right to raise concerns, to whom to take them and how they will be responded to:

- Information about how to raise a safeguarding concern about abuse, neglect and acts of omission with a care setting is available both on the Isle of Wight Safeguarding Adults Board Website, and the Isle of Wight Councils Adult Social Care Website.
- Forms have been updated to include statement for people to contact Adult Social Care if they have any concerns about quality of care or services – this includes a duty number, and there is now open case duty for every team.