Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board

Safeguarding Adults Review of

'CD'

Presented to

Bracknell Forest and Windsor & Maidenhead Safeguarding Adults' Board

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1. Introduction

1.1 Following the death of CD, Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board made the decision to commission a Safeguarding Adult Review under Section 44 of the Care Act (2015). This was because the circumstances of the case appeared to have a wider significance for practice, in particular, how different agencies worked together in the community to support CD.

1.2 Governance

1.2.1 This SAR was conducted in accordance with the requirements set out in:

- Care Act 2014 and statutory guidance (DH 2015)
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015)
- Multi-Agency Safeguarding Adults Policy and Procedures;
- Bracknell Forest and Windsor & Maidenhead SAR protocol

1.2.2 As the accountable body responsible for its commissioning, Bracknell Forest and Windsor & Maidenhead SAB delegated the oversight of this Review to the Safeguarding Adult Review (SAR) Sub Group.

1.2.3 Following initial discussions, at their meeting held on 22nd February 2018, the SAR Sub-Group determined that a proportionate response to the case meant following Option D from the SAR Framework (See Appendix 1).

1.2.4 The detailed methodology used is shown in Appendix 2.

1.2.5 This report will be published on the Board's website in anonymised form following discussion with CD's family. Any service developments and subsequent rollout of learning to the workforce will be determined by the Board following their acceptance of the Review.

1.3 Publication

1.3.1 For the purposes of anonymity for her family, it was agreed by the Board that that this lady should be known as CD.

1.3.2 Consideration should be given by the Board with regard to the potential impact publishing may have on CD's family. All agencies involved should also be aware of the impact on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date.

1.4 Acronyms used and terminology explained

Appendix 4 provides a section on terminology to support readers who are not familiar with the processes and language of health and adult social care.

2 Summary of the Case.

2.1 Family composition

At the time of her death, CD closest relation was her grandson who visited her weekly despite living some distance away.

2.2 Timeframe

Following discussion at the SAR Sub Group on 22nd February 2018, the period under review was agreed to be January 2016 – June 2017. This timeframe gave sufficient opportunity to review the pattern of interaction between the services being provided to CD.

2.3 Brief Details of the Case

2.3.1 CD was a resident in a care home in Windsor where she died. She was receiving visits three times a week during February and March 2017 by district nursing staff who were treating leg ulcers and daily from April. Towards the end of the review period, district nurses raised safeguarding concerns relating to the appropriateness of care provided by the care home staff.

2.3.2 During the period under review, the care home had already been in a Standards of Care Framework (local care governance framework for commissioned services) for some time.

2.3.3 CD's grandson had also raised concerns about the standard of care in the home and sought to move CD to a home closer to where he lived.

3 Views of the Family

3.1 While the primary purpose of a Safeguarding Adult Review is to set out how professionals and agencies worked together, it is imperative that the views of the family are included, particularly as CD's views cannot be ascertained. The Lead Reviewer was able to speak to CD's grandson by telephone and he helped to provide the family's point of view on what was happening to CD at her home.

3.2 His view also provided a perspective on some of the specific areas of enquiry, detailed within the Terms of Reference, of how service users and their families are informed when the home in which they or their relative is resident is subject to oversight under the care governance framework.

3.3 CD's grandson described his Nan as '*self-sufficient'* and that '*up until the end'* she made her own bed, got dressed and cared about her appearance; she wore make up & had her hair done. '*She had all her marbles, just her legs let her down'.* She was *'depressed and agitated'* about the state of her care. She also was quite clear that she did not want to have painful procedures or go into hospital at the end.

3.4 Initially a self-funder, CD was funded subsequently by the Local Authority. CD had lived there for 7 years but in her grandson's opinion, there had been a slow deterioration of standards of care. The '*company cut corners with regard to staff.' 'The good staff left'*. CD's grandson believed that if the local authority was able to have paid a higher fee, the care provided would have been better. He complained to the home and to the local authority. '*Sometimes things levelled out for a while but then got worse again'.*

3.5 For a long time, he believed that most staff were agency. Often staff had poor English and as they rarely stayed long CD never had a chance to get to know them or interact as she was '*a bit mutton'*. The lack of continuity of care or social interaction was something he thought important for his grandmother. He did not think that staff had the proper training. '*Nan had to tell them what she needed doing'* but often he thought that they were very rough with her. CD's grandson also described Managers who came and went but did not/could not provide pay and training for decent staff.

3.6 CD's grandson visited his Nan three times a week until he moved out of the area when he was still able to visit once a week. He wanted to move her and went to see a couple of places close to where he lived but anywhere he liked was too expensive and others he '*wouldn't kennel a dog there'*. '*Nan decided to stay where she was'*.

3.7 CD's grandson sometimes met District Nurses (DN's) when he visited and he thought they were '*very good'*. He believed that they had also complained about the way staff in the home cared for CD. He was less aware of the role of social care staff in supporting his Nan both directly and did not fully understand the role of the local authority in respect of the care governance framework. He was critical that the '*social*' did not do anything to improve CD's situation.

3.8 CD's grandson indicated that he did not wish to become further involved in the Review process, and that he would prefer not to see this final report.

4 Appraisal of Practice in the Case

4.1 Introduction

4.1.1 This section provides an overview, both of what happened and why it happened. The views of SAR Panel members about the quality of the practice in this case, including where practice fell below what would be expected are included. The SAR Panel has made these judgments in the

light of what was known, and was knowable, at the time. Systemic issues are explored then in more detail in Section 5.

4.1.2 CD had lived at the Residential Care Home since 2009. At the start of the period under review she was receiving routine visits by the District Nurse Team to dress her chronic leg ulcers. Her GP was the residential home GP who visited the home weekly and was able to see CD regularly whenever she requested this.

4.1.3 The Care Home had been in the Standards of Care Framework, the local authority care governance framework for two years. The Care Home had also dipped in and out of the escalation process, the Serious Concerns Framework prior to the review period but never improved sufficiently to leave the Framework entirely.

4.1.4 The Care Home was due to change service provider in December 2017 following a commissioning process. The existing provider had opted not to tender for the contract. At the start of the Review period, following a series of temporary managers in charge of the home, a further temporary new Manager was about to start work.

4.1.5 At the same time, RBWM was in the process of transferring adult social care functions, including brokerage of care, the safeguarding adults function, QA Team and Care Governance responsibility to Optalis.

4.2 February 2017 CD's physical health starts to worsen

4.2.1 On a routine visit, the District Nurse (DN) discussed alternative treatment with CD for her leg ulcers which was appropriate and agreed DN visits to dress her wounds three times a week. However the care home could and would request additional unscheduled visits if required. The GP began to prescribe pain killers for leg pain however these were soon reduced, after discussion of the consequences with CD who complained of being sleepy. This indicated a person centred approach to care by the GP.

4.2.2 On Tuesday 14th February an Assessment Officer from Adult Social Care visited CD for the annual review of her care package with her grandson present which is usual practice. CD asked to move closer to her grandson as she and her grandson were concerned about the care at her home and the imminent change of provider. CD's request to move area was approved swiftly and CD's grandson was informed by phone. RBWM commissioning team found 2 homes closer to him and the information was sent to the grandson on 28/02/17. During this time CD had been admitted to hospital, the grandson received details of an extra home. All three homes were rated 5/5 by CQC and the host authorities had placements with them. The grandson did not wish to consider any of the homes. There is no recorded evidence that finance was a factor.

4.2.3 Following the review and reviews of other people living at the Care Home, the Reviewing Officer informed the Manager of the Care Home of care concerns. The Reviewing Officer also informed Safeguarding and the Quality Assurance team which was appropriate.

4.2.4 CD's ulcer's continued to deteriorate and photos were taken with consent and a swab taken for analysis by the DN's. A referral to the Tissue Viability Nurse for special advice was made which was usual practice.

4.3 27th February - 8th March 2017 Hospital Admission

4.3.1 On Friday 27th February a nurse from the care home contacted the GP and requested a visit as CD had a rectal bleed. The GP advised an ambulance and CD was admitted to hospital. Appropriate investigations were made at the acute hospital and although CD indicated that she did not want any interventions, she was persuaded to have these by clinicians. It is unclear how CD was included in information and decision making around these medical decisions. CD had previously expressed strong views about medication and interventions so it may have been beneficial to have discussed this prior to admittance.

4.3.2 CD was found to have MRSA in her wounds following the SWAB made by the DNs earlier and these were treated. There were no further rectal bleeds. CD was discharged back to her home on Wednesday 8th March. The Care home staff were initially unaware that CD had MRSA. It is unclear whether CD was provided with information about MRSA and how to manage it at home and in her care arrangements.

4.4 March 2017 New Manager at Care Home

4.4.1 A new Manager started at the Care Home and RBWM Quality Assurance staff continued to monitor the action plan whilst correctly allowing the manager a period of grace to allow for her influence to have an impact on the running of the home. Unfortunately the new manager took an aggressive stance with regards to community staff visiting the home who found it difficult to approach her. Care in the home did not improve, for example, CD was kept in her room rather than being allowed into the community areas due to the MRSA and the DN's correctly objected to this as unnecessary. There was some discussion about Deprivation of Liberty Safeguards which would not apply as CD had mental capacity. The Manager began to contact the local authority as well as DN's with regard to the MRSA which indicates the breakdown of communications between DN's and the manager of the home.

4.4.2 Staff at the home did not wear uniforms and, because many were short term and agency, it became difficult for visitors to identify who was a staff member. Although it may have been appropriate for DN's to contact RBWM Quality Assurance Team about their concerns about the management of the home; this was not usual practice at this time. DN's were not aware that the home was in the Standards of Care Framework.

4.4.3 Following a medicines review with the GP and following appropriate discussion about the risks, CD decided to discontinue some of her medication. Her grandson was present during discussions and there was no indication that CD lacked capacity in making this decision.

4.5 April 2017 CD's condition deteriorates further

4.5.1 On the 1st April the transfer of RBWM's Adult Social Care Function transferred into Optalis.

4.5.2 In early April CD's grandson informed RBWM Brokerage Team that his grandmother wished to remain at her home rather than move and the transfer referral was closed. It is unknown why CD made that decision. The SAR Panel were surprised that there appeared to have been no exploration of the reasons behind this as this would have been the usual practice. Staff at the home who knew CD well considered that she did not want to leave the place where her husband had lived prior to his death and where there were still some staff who cared for her. They also believed that the continuous nature of her chronic leg ulcers was debilitating and that in a way she '*gave up'* somewhat as a result of the ongoing nature of this condition that she was living with.

4.5.3 On Tuesday 7th April the Care Home contacted the GP on CD's behalf to request a different painkiller to relieve side effects. CD was well enough to visit the GP Practice on Monday 10th April for an unrelated issue.

4.5.4 CD's dressings were now being changed on alternate days by DNs. Following discussion about using a Doppler Assessment to review her circulation, CD declined this further intervention. This discussion would have been an opportunity to discuss possible advanced decision making in terms of treatment.

4.5.6 On Monday 17th April a DN visited and CD told her that she was breathless and was not sleeping well. The DN advised her to contact her GP. She was informed that there was a planned review by her GP the following morning. The DN advised CD to contact the out of hours GP if she became more unwell and advised the care home manager of this who agreed.

4.5.7 On Tuesday 18th April, at a routine residential care home visit to the home, the GP prescribed medication for breathlessness and constipation. Two days later on 20th April CD became more breathless and the Care Home requested a visit. The GP suggested an emergency call out which

was appropriate. The Ambulance Crew provided oxygen and as CD improved and following discussion and agreement with CD, she remained at home. Her grandson was informed of the actions. The GP returned the next day to check on her, when CD's condition had further improved.

4.5.8 The DN visited later in the day and CD was asleep when she arrived. It was noted that CD was pale and slightly confused on waking. There was no Care Home Manager available to discuss this but it was discussed with the carer who was present. CD consented to having her leg ulcer dressing changed. The DN planned to discuss her concerns about CD's condition with her sister in charge which was appropriate and it was discussed at the daily patient handover.

4.5.9 On Saturday 22nd April the DN visited and was greeted by CD into her room. A carer was present throughout the visit. Her observations were normal but she complained of a sore mouth. The Care Home Staff contacted the Out of Hours GP who prescribed treatment for oral thrush. CD was observed to be more lucid and able to eat and drink. DN provided advice on treatment to the Care Home staff.

4.5.10 At the next routine visit on the Monday 24th April, CD reported to the DN that carers were using a hoist to move her because of the pain in her legs and the oedema (swelling) of her legs. The DN was concerned that her leg remained oedematous and looked clinically infected and made a referral to the GP. A swab was taken the following day. Visits to dress her legs became daily with CD sleeping much of the time. A Do Not Resuscitate (DNAR) was in place.

4.6 Friday 28th April 2017 Safeguarding Alert Raised (May Day Bank Holiday Weekend)

4.6.1 When the DN visited on Friday 28th April 2017 she was asked by carers to review a pressure sore. Carers used a standing hoist which was incorrect use of equipment and sling. Carers appeared not to know how to safely move CD, causing her additional pain and loss of dignity. Dressings were noted to be sodden in urine. Although the DN challenged the poor use of the hoist she did not speak to the home manager. Although this was understandable given both her inexperience as a new member of staff and the hostility of the manager, the SAR Panel felt that given her level of concern she should have raised this immediately. However, she did report her concerns about quality of care to her manager and together they raised a telephone safeguarding alert to the local authority safeguarding triage. The district nurse manager telephoned the safeguarding team several times during the day for an update but received no response. This was an opportunity lost for an immediate protection plan to be formulated between the RBWM Safeguarding practitioner and the DN Team. The DN Team could have been supported to decide on an immediate safeguarding action plan as part of their continued visits over the bank holiday weekend, and the safeguarding practitioner could have provided reassurance and support to the DNs. As the statutory lead for adult safeguarding the local authority could then initiate the formal safeguarding process after the weekend on Tuesday 2nd May 2017.

4.6.2 Instead a Section 42 Enquiry was opened and a care manager allocated to investigate. However as this was Friday afternoon of a Bank Holiday weekend, the investigation was not initiated until Tuesday 2nd May. Although this was an appropriate response given that the GP had visited and that CD was receiving palliative care and wished to remain at home, DNs remained anxious that there was no plan to protect CD. In the absence of a plan the DN's did all within their ability to support CD over the weekend such as delivering personal care, changing pads etc.

4.6.3 It should be noted that practise has now changed as a consequence of this case and the safeguarding team now proactively discuss immediate protection plans with practitioners raising concerns.

4.7 Saturday 29th April-Thursday May 4th 2017 CD moves to End of Life Plan

4.7.1 On Sunday 30th April, the duty DN noted that CD was unwell but did not initiate a medical review which the SAR Panel consider would have been best practice as the agreed end of life plan could have been initiated at this time.

4.7.2 When the DN visited on Bank Holiday Monday 1st May, CD had deteriorated rapidly overnight. She was in a semi-conscious state and she had not been properly cared for by care home staff, with her dignity compromised. The DN's washed and repositioned CD and made her comfortable.

4.7.3 The DN correctly raised her concerns with the Shift Leader at the home and escalated the concerns to the Clinical Lead which was appropriate practice. Following discussion with the Out of Hours GP, the DN contacted CD's grandson who agreed with the DN's decision that the end of life medications plan should commence. This included CD remaining at home with the DN's administering medication, an appropriate response to the situation from a medical perspective.

4.7.4 The DN Manager was sufficiently concerned to try to contact the Safeguarding Team about the quality of care again on the following Tuesday 2nd May but failed to make contact. The expectation of the LA would be as described in the chapter in the Berkshire safeguarding adults' policies and procedures.[1]

4.7.5 On Wednesday 3rd May the DN again tried to contact the safeguarding team to follow up the safeguarding alert from 28th April. The advice line appropriately asked the DN to raise a second alert following the concerns from 1st May and the DN did so. CD died that same day.

4.7.6 On 6th May the local authority correctly reported the death and the safeguarding enquiry to CQC. Whilst the SAR Panel do not believe that CD's death was preventable by any act or omission, she could have achieved a more dignified passing.

5. Contributory Factors

5.1 Introduction

5.1.1 During the time period under review a number of different contributory factors, came together which impacted on CD to a greater or lesser extent. These factors are considered separately below.

Firstly the broader strategic issues:

- Care Home within Standards of Care Framework
- Change of Provider imminent
- High turnover of Managers and staff at Care Homes
- Transfer of local authority staff to Optalis

Secondly the issues particular within the case:

- CD planning to move (although she subsequently changed her mind)
- Hostile manager present in the home

5.1.2 Separately all these contributory factors are not uncommon and could be viewed as normal risk factors within the multi-agency safeguarding system. It is not unusual for even two or three of these factors to occur at once. However, coming together as they did, the affect was significantly magnified for CD.

5.2 Care Home was within Standards of Care Framework

5.2.1 The Standards of Care framework is used to monitor provider services commissioned by the local authority (now by Optalis). The range of triggers for a provider to meet the threshold include multiple case reviews identifying concerns, multiple complaints or safeguarding alerts or CQC inspection reports which highlight compliance issues.

5.2.2 Whilst in the framework, the local authority Quality Assurance Team work closely with provider managers to develop an action plan for improvement and this is monitored by the governance panel which meets monthly. Usually there is a quick improvement and the provider moves out

[1] https://www.berkshiresafeguardingadults.co.uk/4-adult-safeguarding-procedures/stage-2-enquiry/

of the framework. It is not unusual however for a provider to '*bump along the bottom'*, as it was described by practitioners at the Practitioner Workshop held in April 2018, with a provider moving in and out of the framework as it fails to improve much beyond minimum standards expected.

5.2.3 In a smaller number of providers, the cycle of improvement and then decline also includes escalation into the Serious Concerns Framework. This escalation process applies where the concerns about care quality are of a more serious nature. However, if there is limited improvement, there is little the local authority (now Optalis) is able to do beyond ceasing to use the provider and referral to CQC. If providers don't improve but remain just above thresholds, options are limited. However, the perspective other agencies have is that the LA has some sort of power to control this situation and can compel providers to make improvements. In reality, only CQC has the power to compel providers to act or cancel registration.

5.2.4 CD's Care Home had been in the Standards of Care Framework since May 2016 and in fact remained within the Framework until the change of provider, moving back into the Serious Concerns Framework following the death of CD. The SAR Panel speculated that this would inevitably have a detrimental effect on the care the provider was able to offer.

5.2.5 Non-local authority staff use the safeguarding route when reporting concerns about care providers rather than report concerns directly to the Quality Assurance Team. If the safeguarding threshold is not met, they do not contact Quality Assurance directly and this may mean that intelligence is lost about providers. This is a gap in multi-agency response to safeguarding concerns and is discussed within the recommendations in Section 7.

5.2.6 Whilst the current Protocols do allow for the involvement of multi-agency in Standards of Care and Serious Concerns Meetings, in practice there is limited attendance of non-local authority/Optalis agencies. Practitioners at the Workshop told us that when other agencies do attend or are consulted it is usually at a Manager Level rather than practitioners who have witnessed issues of concern. This may allow for the misinterpretation of the concerns. This issue is discussed within the recommendations in Section 7.

5.3 Change of Provider Imminent

5.3.1 The Care Home is unusual in that the building is owned by the local authority who had commissioned out the care service on a 10 year contract. This was coming to an end on 1st December 2017 and the existing provider had already made the decision not to take part in the recommissioning process. A new provider had been appointed and was scheduled to take over the running of the home. Practitioners at the Workshop agreed that there was a sense that in the period under review, the provider, had already '*given up'* – they remained in the SoC framework but were nearing the end of the contract. This issue is discussed within the recommendations in Section 7.

5.3.2 The Provider Management Committee was certainly less focused on the running of the home than the local authority would have expected. Their head office was not based locally which added logistical problems with regard to contacting and meeting senior managers to discuss problems and concerns. This poor leadership and ownership of the problems had increased as the end of the contract approached.

5.3.3 It may be possible that as the end of the contract loomed, the local authority was also resigned to no great improvement being possible. Instead they too may have been focused on the future and improvements possible with a new provider due in December instead of the immediate impact on people living at the home. This situation combined with the length of time the home had remained in the Framework is one that has the potential of risk to the health and wellbeing of residents and should form part of the risk register when recommissioning care homes or other care services. This is discussed within the recommendations in Section 7.

5.4 High Turnover of Staff and Managers at home

5.4.1 Even before the recommissioning process commenced, there had been a steady loss of permanent staff and managers within the Care Home. It is often difficult to recruit care staff, a national and local issue, particularly in Windsor and Maidenhead, an area with high housing costs and large numbers of care homes. It is often even harder to recruit when a home is subject to the standards of care framework. In addition, the provider had agreed to a voluntary ban on new residents amongst other actions when it entered the Standards of Care Framework. This gave them less income by which to address issues of care.

5.4.2 The home had a number of less than satisfactory temporary managers over the previous few years, some permanent staff had subsequently left and this had a knock on effect in use and turnover of agency care staff. This in turn has a detrimental effect on residents who develop close relationships with carers. In addition their dignity can be compromised by use of many different staff who they do not know.

5.4.3 DN's told the SAR Panel that care home staff were often *'frantic'* and overworked. Care staff did not wear uniforms and the high turnover meant that it was difficult for community practitioners to know who was a staff member or a manager. This meant that they could not discuss care or any concerns easily and managers were not visible. It is also notable that staff within the home including members of the management team were unaware that the home was within the Standards of Care Framework and unaware of how to raise any concerns they had about the care provided to external agencies. These issues are discussed in the recommendations in Section 7.

5.4.4 Whenever a new Care Home Manager is appointed, health and social care staff will give them time to allow them to make improvements whilst continuing to monitor the improvement plan. There is an inevitable optimism that there will be improvements, despite the evidence that the home had been in the standards of care framework for some time with little or no changes. A high turnover of Managers at a care home makes it difficult to build relationships and despite Quality Assurance Teams great efforts to support the home, not much can be done by the local authority if Manager and their higher Managers are unresponsive to implementing any improvement plan.

5.5 Transfer of Local Authority staff to Optalis

5.5.1 The local authority had made the decision to become shareholders in Optalis and transfer adult social care functions across to Optalis and the details were being finalised during early 2017. The planned TUPE of adult social care staff including commissioning, safeguarding and care management practitioners was being implemented during the Spring of 2017. Although there is research which suggests that contracting out of a service can have a detrimental impact on the wellbeing or performance of affected staff, in this case there is no evidence that the transfer of adult social care staff impacted on the management, delivery or outcomes of care for CD.

5.6 CD planning to move

5.6.1 CD had explored moving closer to her grandson because of her frustrations about the quality of care in the home. The agreement to support CD to move and transfer funding elsewhere was expedited quickly. The informal complaints made by both her and her grandson were not dissimilar from other issues already known from other residents. It is sometimes difficult for residents and their families to make formal complaints as they may fear that this may have a detrimental impact on their care.

5.7 Hostile Care Home Manager

5.7.1 It is important for Community practitioners to maintain a professional relationship with Care Home Managers This can sometimes be difficult particularly if practitioners have to challenge any aspects of care or practice within the home that they deem unsafe.

5.7.2 There had not been a Manager at the Care Home for some time. As the Provider had struggled to recruit due to the reasons described above. In April 2017 a new Manager was appointed. DN's told the Panel that the usual practice for an experienced DN who was concerned about care in a home would be to first speak to the manager as well as raise a safeguarding concern if that was appropriate. The new manager was deliberately aggressive and obstructive and was difficult to work with, both for internal and external practitioners. A recommendation around community staff managing this type of situation is discussed in Section 7.

5.7.3 As part of their contract the provider would have been expected to comply with safer recruitment practices. Although it is unclear if the provider followed safer recruitment practices, the person appointed deliberately misled the Provider using both a false name and references which would have been difficult to detect. The conduct of the particular manager has been subject to a separate investigation and is an unusual if not unique aspect to this case.

6. Analysis and Conclusion

6.1 Introduction

'Risk is not caused by people in otherwise safe systems; systems are not basically safe but are made safe through people's practice'.

(Dekker: The Field Guide to understanding Human Error)

The review has examined how services respond to continuing or ongoing concerns about standards of care in individual residential care homes and attempted to answer these four specific questions as shown within the Terms of Reference:

- How do professionals making visits to homes within the framework contribute towards monitoring standards of care?
- How are the concerns of relatives addressed within the framework?
- How are service users and their families kept informed about concerns should they or their relative reside in a home subject to the framework?
- What is the interaction between safeguarding referrals for individuals and the wider monitoring and support of failing providers?

6.2 How do professionals making visits to homes within the framework contribute towards monitoring standards of care?

6.2.1 It is positive to note from the discussions between Practitioners at the Workshop that, Adult Social Care staff feel confident about raising concerns to the Quality Assurance Team and there is evidence that they did so in this case. However there is a lack of understanding by agencies, particularly front line practitioners most likely to have intelligence about a Provider, external to the Local Authority and Optalis as to what the Standards of Care (SoC) framework actually is, and what could be expected to happen as a result of it. At the Workshop, surprise was expressed about the expertise of the Quality Assurance Team and how much work was involved in developing and supporting providers to implement improvement plans. In addition there was confusion amongst DNs present about the role of the Care Quality Commission in terms of inspection and registration role compared to the role of the local Quality Assurance Team and that they could contact CQC directly themselves. This is an opportunity lost to use the vital information that DN's hold and want to share.

6.2.2 Community Health Practitioners who regularly visit care homes are an important source of 'soft' data about standards of care as they have the professional expertise to recognise poor practice. They have a key role in caring for people living in the community and want to be able to assist in making improvements to their care. DN's told the SAR Panel that they always advise and support carers in residential homes in how best to support residents and this is evidenced in this case that they did so when they were able to. However, there is a gap between practice on the ground and how that intelligence is fed into the SoC framework. For example the Ambulance Service records number of calls to Care Homes which is another data source

potentially available to the SoC framework. This issue is discussed in the recommendations in Section 7.

6.2.3 District Nurses told the SAR Panel that they were usually unaware that Care Homes were subject to Standards of Care Framework when they visited patients or indeed if a Care Home had improved sufficiently to no longer be subject to the protocol. Although senior managers from partner health organisations do attend the Quality Assurance Meetings, they are not necessarily best placed to have the most up to date information available from practitioners on the ground. This issue is discussed in the recommendations in Section 7.

6.2.4 Currently, whilst Optalis informs other agencies that a Care Home is subject to SoC, this is at a senior Management Level so is not systematically fed back to practitioners & vice versa and so intelligence can be watered down. It tends to be senior managers who attend the scheduled Quality Assurance meetings who may not be aware of local team knowledge. Similarly, Practitioners outside of Optalis don't always have up to date information about the status of standards of care frameworks for providers.

6.3 How are the concerns of relatives addressed within the framework?

6.3.1 Service users and their families and friends should be listened to as much as possible as they have the direct experience of living in a Care Home. The Quality Assurance Team does not receive feedback directly from relatives/residents. Formal complaints are fed back through to the Quality Assurance Team however. Concerns about care discussed during Case Reviews by service users and their families are reported back to the RBWM Commissioning Team by Social Care practitioners. However the Quality Assurance Team is reliant on practitioners emailing any issues to them. The SAR Panel agreed that this can be inconsistent.

6.3.2 There is also no service user representation on the Care Governance Panel as individual cases are discussed and this would not be appropriate. General feedback systems are not currently used in the local authority to address service user views. For example there is also no system for feedback via annual service user questionnaires about quality of care. However, this lack of service user feedback has been recognised and the local Healthwatch is planning 'Enter and View' visits to care homes. In addition they are now a member of the Care Governance Board. This issue is discussed in the recommendations in Section 7.

6.4 How are service users and their families kept informed about concerns should they or their relative reside in a home subject to the framework?

6.4.1 When Providers enter the SoC Framework, the onus is on the Provider to tell relatives that this is the case. There is no evidence that the local authority checks to see if that has happened. A direct conduit of communication with families is best practice, providing an opportunity for their comments and views.

6.4.2 When a Provider enters the Serious Concerns Framework in RBWM, it is now Optalis who writes to service users and relatives. However, SAR Panel agreed that feedback to service users in terms of updates was not as robust as it should be. CQC are also informed as it is CQC who will take any enforcement action. Although locally the relationship between CQC and Adult Social care is good, this split between inspection and enforcement is confusing to families as well as to partner agencies. This issue is discussed in the recommendations in Section 7.

6.5 What is the interaction between safeguarding referrals for individuals and the wider monitoring and support of failing providers?

6.5.1 At the Workshop, DN's told the SAR Panel that they were confident about when to make a safeguarding concerns However, DN's also felt that they did not receive sufficient feedback about what happens after a safeguarding alert is made and that they find it difficult to know whom to check progress with. On Friday 28th April DN's were so concerned about the care provided to CD they made several calls to social care to try and get feedback and escalate their concerns. The district nurse again tried to contact the social worker on 2nd May but there was

no response. DN's present also agreed that there were not enough Strategy meetings held to share information.

6.5.2 Following review of this case, the Safeguarding Triage Team have amended their practice and are now more proactive about asking referrers to instigate an initial protection plan prior to the start of a Section 42 investigation. This issue forms part of the recommendations detailed in Section 7.

6.5.3 The Safeguarding Team within Optalis has a key role on the Care Governance Panel. Practitioners within Safeguarding and Quality Assurance Teams told the SAR Panel that they work closely together in sharing knowledge about providers between themselves. However DNs and other community practitioners who interact with providers most often do not share that information. In this case, DN's were concerned about quality of care in the home long before they raised the safeguarding alert but did not pass that information on as they were unaware of how or where to do so. At the Workshop they confirmed that this was the same in terms of other providers and this is addressed in the recommendations below.

6.5.4 The Serious Concerns Framework process is, of course, run on a different timescale to individual safeguarding alerts. It is notable that CD's case was never discussed at the scheduled monthly SoC Meeting as the alerts were raised between meetings. The current SOC framework does not include any consideration of timescales for improvement to indicate when it may be reasonable to escalate to CQC. This issue is discussed in the recommendations in Section 7.

6.5.5 There is also no systematic link between the electronic record for individual service users in Adult Social Care and Provider records within the Quality Assurance Team. Instead knowledge of individual safeguarding investigations must be linked manually. It is also not possible to record if the provider is in SoC framework on the service user record & on safeguarding alerts.

7. Recommendations

7.1 Introduction

7.1.1 This report highlights the strengths present within the multi-agency safeguarding system of which the Standards of a Care protocol forms an important part. It should be noted that the Board has already recognised the need to improve the connections between quality assurance of providers and individual safeguarding investigation at both strategic and practitioner level. The Terms of Reference for this review asked pertinent questions about the relationship between partner agencies and service users and their families and the different processes.

7.1.2 A review of the Standards of Care Framework is already planned. This case has highlighted, not only particular implications for this review but also for the SAB in its leadership role and for partner agencies in terms of policy and practise. These issues are addressed within the following recommendations:

7.2 Review the Standards of Care Framework

7.2.1 It is recommended that there should be formal joint governance of the Standards of Care Framework between Heath & Adult Social Care to facilitate more effective working at both strategic and practitioner levels.

7.2.2 It is recommended that the review of Standards of Care Framework should consider the following:

- How best to make effective use of intelligence available from community practitioners and families about providers;
- That partner agencies review who attends or receives information from Quality Assurance Meetings and how this information is disseminated within their organisation and fed back to practitioners
- How best to ensure that information about Providers who may be part of the Standards of Care process is fed back to partners, service users and families

- Recognising that employees may not be aware of the situation, consider how best to ensure that information about Providers who may be part of the Standards of Care process is fed back to them in order to support both residents and staff;
- Greater clarity about what 'good enough' when under Standards of Care looks like - for providers as well as staff, residents and their relatives and other carers involved;
- Development of a risk matrix for escalation, whether that be to the Serious Concerns process or referral to the Care Quality Commission, that includes the length of time spent by providers within the framework;
- Widen representation at Standards of Care meetings from partner agencies (or circulation of agenda/minutes)
- Consideration of a range of activities to raise awareness and increase involvement of service user and carers representation in the SoC framework process including Health Watch both at meetings and in supporting residents.
- Use the multi-agency workshops detailed in 7.5 to develop practical processes to support the framework

7.3 Safeguarding Triage

It is recommended that:

- Safeguarding Triage Team consider how best able to provide a named contact to practitioners who make a referral in order to improve ease of contact.
- Consideration be given to how best feedback is given as standard about providers who may be part of a safeguarding investigation to partners, service users and families

7.4 Commissioning of Providers

It is recommended that when planning to recommission health and adult social care services, commissioners should demonstrate that they have:

- Recognised that current providers being in the Standards of Care Framework increases the risk for service users and that the focus remains on the safety and wellbeing and welfare of the people in the home until this period concludes;
- Included the potential impacts on service users, patients and their families within their risk register;
- Contingency plans in place to protect service users.

7.5 Dissemination of learning from the case

7.5.1 It is recommended that learning from this case should be disseminated as widely as possible to provide a consistent understanding of the issues from this case. Multi-agency sessions can be an effective method of dissemination. These could also be used to inform the Review of Standards of Care Framework detailed in Section 7.2 and Safeguarding Triage detailed in Section 7.3. Sessions should include all or some of the following:

- The variety of circumstances that led to the outcomes within this case
- Information/training provided to agencies and partners on how the safeguarding concerns are managed once the Safeguarding Team receive them and how practitioners might be requested to provide support with an immediate protection plan for an individual.
- Practical support to community practitioners on how to deal with hostile Care Home managers
- The escalation process that can be used including referral to Quality Assurance Team and to CQC[2].

[2] https://www.cqc.org.uk/sites/default/files/20180223%20CQC%20Inspector%20Handbook%20Safeguarding.pdf

7.5.2 It is recommended that Adult Social Care provide reflective practice sessions for Provider staff including:

- Reflective practice sessions for staff within the care home featured in this case
- Reflective practice sessions at the various provider forum in the area

7.6 Board Quality Assurance

7.6.1 It is recommended that the Board, via the quality assurance sub group, should:

- Review the data it currently receives regarding Providers and what other proxy data it may use in order to begin to benchmark providers across the area.
- Consider how best to monitor how feedback is built into the safeguarding system to referrers;
- Consider how best to monitor how recommissioning directly impacts on the quality of care received by services users;

7.6.2 The Board via the Safeguarding Adult Review Panel should consider how to develop and monitor an action plan from this report that can demonstrate change within the workforce.

Appendix 1

Terms of Reference for Safeguarding Adults Review (SAR) of CD

1. Aims of Review

To review the effectiveness of multi-agency implementation of the local care governance framework in relation to the death of CD. The review will examine how services respond to continuing or ongoing concerns about standards of care in individual residential care homes and to look specifically at how:

- Professionals making visits to homes within the framework contribute towards monitoring standards of care;
- The concerns of relatives are addressed within the framework;
- Service users and their families are kept informed about concerns should they or their relatives reside in a home subject to the framework;
- Interaction between safeguarding referrals for individuals and the wider monitoring and support of failing providers.

2. Background to the case

CD was a resident in a care home in Windsor where she died. She was receiving daily visits by district nursing staff who were treating leg ulcers. District Nurses had raised a number of safeguarding concerns relating to the appropriateness of care provided and evidence that her deterioration had not been identified and reported by care staff.

At the time of her death, the home was in a Standards of Care Framework following concerns arising from a number of safeguarding referrals. CD's relatives had previously raised concerns about the standard of care in the home and had sought to move CD earlier in the year.

3. Specific Areas of Enquiry:

i. To review the effectiveness of the local care governance framework (including the Standards of Care and Serious Concerns processes) in responding to continuing concerns about standards of care in individual residential care homes.

ii. In light of the circumstances of this particular case where concerns were raised by relatives in the months prior to the death of CD:
   a. How did the concerns raised by relatives influence the position of the home within the Framework?
   b. How did the concerns influence the approach of health and social care partner staff who were visiting the home?

iii. To explore what expectations regarding safeguarding and/or quality of care are made of health and social care staff who are visiting a home in the Framework and how this is communicated. This will include:
   a. What triggers are used to implement serious concerns processes?
   b. What are the barriers to staff raising concerns?
   c. The relationship between safeguarding adults' processes and the care governance process.

iv. To review how service users and their relatives/families are informed when the home in which they or their relative is resident is subject to oversight under the care governance framework.

v. To identify learning from this case and, in particular, any improvements that could be made to the multi-agency operation of the care governance framework to ensure concerns raised are responded to appropriately.

4. Period of Review

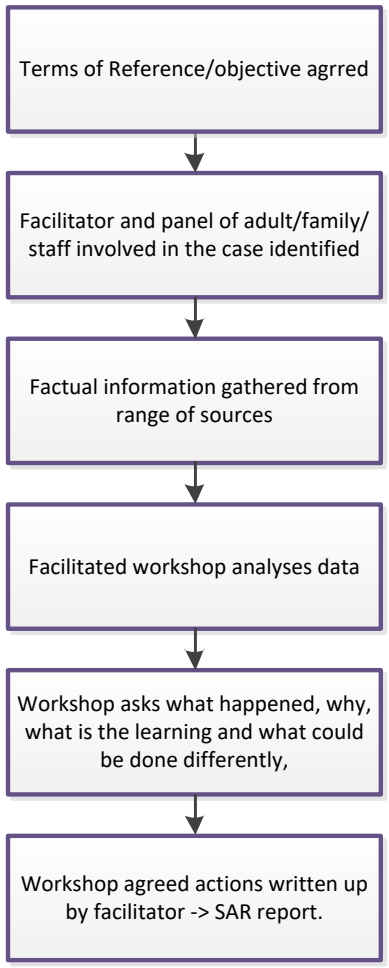
The review should have regard to the period following the concerns raised by family members in February 2017 up until the time of CD's death in May 2017. However, it is anticipated that the review will focus on the operation of the care governance framework and identify learning points with reference to this case.

5. Suggested Methodology

Suggested methodology for this review is the Significant Event Analysis (Option D in the Windsor & Maidenhead Safeguarding Adults Board "Safeguarding Adults Review Framework")

Option D

Significant Event Analysis



Key Features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/adult/family involved via panel
- ✓ No chronology
- ✓ No single agency management reports
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourages reflection and change

Advantages	Disadvantages
• Light touch and cost-effective approach • Yields learning quickly • Full contribution of learning from staff involved in the case • Shared ownership of learning • Reduced burden on individual agencies to produce management reports • May suit less complex or high profile cases • Trained reviewers not required • Familiar to health colleagues	• Not designed to cope with complex cases • Lack of independent review team may undermine transparency/legitimacy • Speed of review may reduce opportunities for consideration • Not designed to involve the family • Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.

Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis
Care Quality Commission, Significant Event Analysis
Royal College of General Practitioners, Significant Event Audit

Appendix 2

Methodology Used

1. Overarching aim and principles of the SAR

1.1 The purpose and underpinning principles of this SAR are set out in section 2.9 of the Berkshire Multi- Agency Adult Safeguarding Policy and Procedures[3]. All SAB members and organisations involved in this SAR and all SAR Panel members agreed to work to these aims and underpinning principles. This SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation, reflecting the current realities of practice.

1.2 The main aim of this SAR is to review the effectiveness of the multi-agency system's implementation of the local care governance framework, using what happened to CD as a 'window on the system'[4]. The review examined how services respond to continuing or ongoing concerns about standards of care in individual residential care homes and looked specifically at how:

- Professionals making visits to homes within the framework contribute towards monitoring standards of care;
- The concerns of relatives are addressed within the framework;
- Service users and their families are kept informed about concerns should they or their relatives reside in a home subject to the framework;
- How effective Interaction was between safeguarding referrals for individuals and the wider monitoring and support of failing providers.

1.3 The SAR sub group (and by extension all contributors) agreed the areas of enquiry detailed in the Terms of Reference detailed in Appendix 1.

1.4 The recommendations in this report will be used to make improvements to the existing Standards of Care Framework and to produce both single and multi-agency action plans. These will be monitored by the SAR sub group who will agree the best ways to share the learning from the review with practitioners.

2 Membership of SAR Panel

2.1 At the meeting of the SAR sub group on 22nd February 2018 it was agreed that the following sub group members and their deputies should form the SAR Panel:

Title	Agency
Head of Safeguarding & Practice Development	Bracknell Forest Council (Chair)
Head of Safeguarding	Berkshire Healthcare NHS Foundation Trust
Lead Nurse for Adult Safeguarding, Patient Safety and Quality	Frimley Heath Foundation Trust
Named Professional - Safeguarding Adults, Children and Children in Care	NHS East Berkshire Clinical Commissioning Group

[3] http://www.sabberkshirewest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/

[4] Vincent 2004

Head of Statutory Services	Optalis
Business Manager – Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board (SAB)	Royal Borough of Windsor & Maidenhead
Head of Commissioning	Royal Borough of Windsor & Maidenhead
Head of Safeguarding	South Central Ambulance Service
Detective Inspector – Domestic Abuse Investigation Unit	Thames Valley Police
Julie Pett	Independent Author/Lead Reviewer

2.2 The Lead Reviewer worked closely with the SAR Panel to develop this Report. Members of SAR Panel did not have any direct management responsibility in relation to the services offered to CD. The role of the Panel members was to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice and to the development of the recommendations from the review.

2.3 A representative of the Provider Agency was not part of the Panel owing to the timescale of provider handover. However the SAR Panel Chair and Lead Reviewer were able to meet with the Care Home Manager in order to share the draft prior to the completion of the final report. His comments have been used to add a provider perspective to the case.

2.4 Sources of Data

The following documentation was made available to the Review:

- Social Care case notes and Optalis including the Safeguarding Investigation of CD
- Standards of Care and Serious Concerns processes followed in respect of CD's Care Home
- Chronologies from agencies who were involved with CD during the period under review.

2.5 Agency Chronologies

2.5.1 Chronologies were received from:

- Berkshire Health Care Foundation Trust
- Frimley Health Foundation Trust
- GP
- Optalis
- South Central ambulance Service - NHS Foundation Trust

2.5.2 In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of CD and include information around wider practice at the time of the incident as well as the practice in the case. These were combined and analysed in order to identify key practice issues and to review the significance of interactions between practitioners working with CD.

2.6. Practitioner Workshop

2.6.1. The purpose of an Adult Review is to achieve enduring systemic change that will improve practice over time. Involvement of the practitioners who were most directly involved in a

dynamic process of learning supports a more open examination of the system. What happened to CD was used as a 'window' on the multi-agency system. The facilitated workshop held on 27th April 2018, gathered practitioners who worked within the Care Home, and other practitioners involved with CD who had cause to visit the home during the period under review, together with their immediate managers from Health and Social Care.

2.6.2 Facilitated by the Independent Reviewer and SAR Panel members, practitioners explored why and what had happened during the review period and related this to how they usually practised within the system. This mixed group provided qualitative data about whether practice was typical or unusual, which helped the SAR Panel understand which practice issues were unique to the case and which issues are more generalised.

2.6.3 Practitioners also shared what had changed within services as a response to what had happened to CD and whether any other changes within the system would have made a difference.

2.6.4 The following Practitioners and Managers attended the Workshop:

Title	**Agency**
District Nurses x 4	Berkshire Healthcare Foundation Trust
Manager Community Nursing	Berkshire Healthcare Foundation Trust
Managers x 3	Care Home
Safeguarding Nurse	Frimley Health Foundation Trust
Staff Nurse	Frimley Health Foundation Trust
Quality Assurance Officers x 2	Optalis
Safeguarding Manager	Optalis
Social Work Team x 3	Optalis
Commissioning Managers	Royal Borough of Windsor and Maidenhead
Police Officer	Thames Valley Police

2.6.5 Feedback from participants revealed that the workshop had:

- Given '*better understanding of those involved within a framework as to what it is (and isn't')*
- Helped *'to give an understanding of each area's roles and responsibilities'* in *'seeing all organisations point of view*'
- *'Network'.*
- Allowed them to challenge other agencies for example in the discussions about risk assessment.

2.6.6 The SAR Panel concluded that the Practitioner Workshop was a positive and valuable experience for practitioners as an opportunity to reflect critically on practice in the case. The SAR Panel would like to commend the Case Group both for their candour and willingness to reflect on both this case and also the wider system that they work in.

2.6.7 During the course of the review, in addition to the Practitioner Workshop, the SAR Panel met three times to consider the case, to determine contributory factors and how to develop pragmatic recommendations to address the findings of the review.

2.7 Methodological Limitations

2.7.1 In order to be 'proportionate', the commissioner of the report elected to use a data collection exercise together with a practitioner workshop as the central mechanisms rather than conduct a lengthier process that included more detailed individual conversations with practitioners involved in the case. Whilst this was a pragmatic approach, it left some particular aspects of the case unexplored in depth. This was mitigated to some extent by careful analysis of chronologies and examination of case notes and discussion by the SAR Panel about the systemic issues identified.

2.7.2 In December 2017 there was a change of Provider running the Care Home where CD lived. It was a severe limitation to this review that it was therefore not possible to examine CD's case notes and other provider documents as they were not made available by the original provider. However the current management from the home attended the practitioner workshop and included one member of staff who knew CD very well.

2.7.3 The Review was commissioned in October 2017 but there were significant delays in progressing the review, caused mainly due to volume of work caused by the number of reviews commissioned by the Board at the same time and unavoidable extended sick leave from a key member of staff. Appendix 3 shows the timetable followed.

Appendix 3

Timetable for CD Safeguarding Adult Review

Action	Lead	Date
Letter to key agencies to request chronologies	Board Manager	November 2017
Completion date for combined chronologies	Board Manager	January 2018
1st SAR Panel Meeting and Lead Reviewer briefing: To Agree ToR, review combined chronologies and plan Learning Event	SAR Panel Chair	22nd February 2018
Telephone discussion with CD's grandson	Lead Reviewer	14th March 2018
Meeting with Safeguarding Lead & Contracts Team	Lead Reviewer	28th March 2018
Practitioner Learning Event	Lead Reviewer/SAR Panel members	27th April 2018
2nd Panel meeting to discuss issues raised at Practitioner Event and agree next steps of the report and draft SAR Findings.	SAR Panel	2nd May 2018
3rd Panel meeting to discuss draft report	SAR Panel Chair	20th June 2018
SAR sub group Meeting to approve final draft report	Board Manager	18th July 2018
Safeguarding Adults Board meets to consider final report	Board Manager	20th Sept 2018
SAR sub group multi-agency action plan from the SAR recommendations	TBC	TBC
Final report and summary of learning published.	TBC	TBC

Appendix 4

Glossary and explanation of terms

Term	Explanation
Advanced decision	When a patient has capacity they may make an Advance Decision (also called a Living Will) to refuse any medical treatment including life-sustaining treatment or antibiotics
ASC	Adult Social Care
BHFT	Berkshire Healthcare NHS Foundation Trust provides community based physical and mental health services in Berkshire including the district nurse team.
Care Act 2015	The Care Act 2014, which came into effect from 1st April 2015 reformed social care and support. The aim was to put people and their carer in control of their own care and support
CQC	Care Quality Commission is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom which regulates, monitor and inspect health and social care services in England.
DoLS	Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. DoLS aim to make sure that people without mental capacity, particularly in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
DN	District Nurse
DNAR	A Do Not Attempt to Resuscitate process to withhold life support in respect of the patient's wishes, often used to prevent patients suffering from the bad effects that resuscitation can cause.
Doppler Assessment	A diagnostic test used to estimate the blood flow through blood vessels by bouncing high-frequency sound waves (ultrasound) off circulating red blood cells.
FHFT	Frimley Health Foundation Trust manages the local acute hospital which treated CD
GP	General Practitioner
Healthwatch	Every local authority area has a local Healthwatch which aims to share information, expertise and learning in order to improve health and social care services. It role includes: • powers to request information from commissioners and providers of health and social care and to enter health and social care premises • A seat on the local statutory health and wellbeing board, a committee of the local authority. In this way LHW actively participates in local decision making • signposts people to information about local health and care services and how to access them • provides people with information about what they can do when things go wrong or if they have a complaint • is able to alert Healthwatch England (HWE), or the Care Quality Commission where appropriate, to specific care providers, health or social care matters

MRSA	MRSA is a type of bacteria that's resistant to several widely used antibiotics and is quite common in hospitals and care homes. This means infections with MRSA can be harder to treat than other bacterial infections. The full name of MRSA is methicillin-resistant Staphylococcus aureus.
Optalis	Optalis is RBWM Council's trading arm which provides longer term support for older people and people with a disability in Windsor and Maidenhead
RBWM	Royal Borough of Winsor and Maidenhead is the local authority responsible for Adult Social Care
SAB	The Care Act 2014 placed adult safeguarding on a statutory footing and requires Local Safeguarding Adults' Boards to be in place. Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board. Swindon is the multi-agency partnership with the authority to hold local agencies to account.
SAR	Safeguarding Adult Review
Section 42	An **enquiry** is any action that is taken (or instigated) by a local authority, under **Section 42** of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
SoC	Standards of Care Protocol. The Framework operated by the local authority and Optalis to support care homes not meeting appropriate minimums standards
TUPE	Under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE), an employee's terms and conditions of employment are protected when a business is transferred from one owner to another.