Suffolk Safeguarding Partnership

# Safeguarding Adults

# Review

# Maria

Executive Summary

October 2020

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# 1. Introduction

1.1 Maria lived at Lound Hall (LH) for over 2 years before she died at the age of 89. She had moved there following a period in hospital where she had been admitted from a previous residential care home placement.

1.2 In earlier life Maria had been a primary school teacher and was described as intelligent with an interest in current affairs. Maria was visited monthly by her son who, latterly, lived abroad. Her well-being was often noted as having improved considerably after his visits to her.

1.3 During the time Maria was at LH, she had problems with her weight and with eating, infected pressure ulcers and other infections. Maria was often in pain as a result of her pressure ulcers and she was sometimes reluctant for her dressings to be changed.

1.4 At the end of her life, following admission to hospital, Maria had grade 4 pressure ulcers across her body that had been poorly cared for. This meant that she had extensive areas of rotting flesh.

1.5 A Safeguarding Enquiry commenced following Maria's final admission to hospital. At this time Maria had been seen by her General Practitioner and the Tissue Viability Nurse and was conveyed to James Paget University Hospital (JPUH) by the Ambulance service, which also reported profound safeguarding concerns. Maria was admitted to JPUH with poor skin integrity, 3 large Grade 4 pressure ulcers on her thigh, chin and sacrum and skin tears on her arms and legs.

1.6 A Social Worker met with Maria who described her as "a very frail lady who had capacity." She described Maria as "bed-bound" and wanting to talk about her experience of living at LH. Maria said that people walked past her door and did not look at her; that she thought 'they' believed 'she is too far gone and that she is making a fuss'.

1.7 She said that she could not reach her drinks and that "staff do not answer the call bell". The Social Worker described her first impressions of Maria as 'devastating', explaining that Maria did not wish to talk about the condition of her skin and would say "why me? Why would you want to bother with me?". Maria did talk positively about one member of staff at LH who made things better for her.

1.8 A decision to carry out a Safeguarding Adults Review (SAR) was made by the Safeguarding Adults Board (SAB) on 21 February 2019. Terms of reference were agreed at the Safeguarding Adults Review Panel (SARP) on 21 March 2019.

1.9 Several attempts were made to contact Maria's son by letter, once the Review was commissioned, with a view to asking him to contribute to the Review. To date the SAR Panel has not received a response.

## 2. Scope of Review

2.1. The timeframe used was 1 March 2016 up to the date of Maria's death on 28 October 2017. Care/attendance records starting from July 2015 and including the whole period Maria was resident at LH were also scrutinised.

2.2. The specific areas the review considered were:

- What contributed to the lack of identification of harm for Maria at LH;
- The effectiveness of multi-agency responses;
- An analysis of safeguarding alerts in respect of LH;
- Consideration of the role of the CQC and analysis of CQC interventions at LH;
- Commissioning of care at LH and monitoring and review of quality across agencies: in particular a review of the effectiveness of joined up work across NHS & Social Care commissioners, providers & GPs;
- A review of partnership and collaborative working;
- A review of how information was shared and consideration of further implications for the development of the Safeguarding Partnership Policy.

## 3. Organisational Context

3.1. Safeguarding concerns were referred to the Suffolk County Council Multi-Agency Safeguarding Hub (MASH) on 18 occasions in respect of 9 residents in the period under review. 13 of these concerns were progressed to a safeguarding enquiry (s.42 Care Act 2014). At the time of reporting the concerns the Suffolk Safeguarding Partnerships Safeguarding Adults Framework was not in place. The framework was not launched until February 2019. Outcomes of these safeguarding enquiries and the action plans and the service's improvement plans would have been developed on the back of these concerns. Whilst the improvement plans may have addressed individual resident issues, there was no evidence at the time of a collective view taken in respect of the number of concerns in one nursing home establishment and how, collectively, a response could have been made to LH

3.2. Several safeguarding concerns in respect of Maria were received by the MASH in October 2017 shortly before she died – from the Ambulance NHS Trust, from the Tissue Viability Nurse and from James Paget University Hospital. A safeguarding enquiry commenced by Suffolk County Council in October 2017 and was closed in January 2018 as inconclusive pending the outcome and feedback from the police investigation.

3.3. A matter raised at the Learning Review (Practitioner Event) was that there was confusion across the health and social care system in the determination by the MASH as to whether a matter meets the criteria for a safeguarding intervention or is a 'care quality issue'. A further issue is the fact that once a concern is raised, the referrer rarely receives feedback and this in itself may lead to practice where the matter is dealt with by the referrer and not raised as a safeguarding concern. Some participants at the Learning Review expressed the view that the issue of safeguarding or care quality needs to be addressed urgently so there is a common understanding across the whole system by referring individuals/organisations and those who make decisions on s.42 (1) safeguarding concerns.

3.4. For those safeguarding concerns which were appropriate to be taken to safeguarding enquiries, evidence provided shows that these were undertaken promptly, and protection plans were made for individuals as appropriate.

3.5. The SAR Panel noted that at the time, professionals across the system did not have much confidence in the safeguarding process. The general view of the Panel is that confidence in the process has now improved. However, efforts are being taken to ensure that the Safeguarding Adult Framework continues to be promoted across the county and particularly in the north of Suffolk in the Gt Yarmouth & Waveney area.

3.6. The MASH Health Team has been strengthened over the past two years. They are now able to accept calls on the MASH Consultation Line supporting social work colleagues. Alongside 'Liquid Logic' implementation, this has improved information sharing.

3.7. Monitoring of Maria's pressure ulcers and wounds was inconsistent at LH, as was the clarity of instructions to staff about the actions required to minimise damage to Maria. Recording practice was so poor that there was no evidence of any care planning or specific instructions being adhered to on a regular basis. At the end of Maria's life she was only able to offer praise to one staff member and felt on the whole that her life was of little value there – the social worker was quoted as saying "people walk past her door and don't look at her, that she thinks they believe she is too far gone and that she is making a fuss". The de-humanising of service users is characteristic of a response to people who might be described by care givers as difficult or who refuse to engage fully with them.

3.8. The care notes often included instructions which were not followed through or for which there was no evidence in the notes that the instruction on care and clinical practice was being followed e.g. referrals to the Tissue Viability Nurse. Evidence of this was also included in the final Ombudsman Report.

3.9. There was frequent mention in the notes of the need for new pressure care mattresses to be ordered and this was also picked up in CCG follow up visits after concerns had been identified as a result of complaints/CHC assessments or reviews.

3.10. Maria was seen regularly by 'duty' GPs from her local practice. It is important to set these visits out in the context of the current GP contract for visiting patients at Residential and Nursing Care Homes. The GP contract requires that the local surgery undertakes regular visits to residents at Nursing Homes. Each time the staff at LH contacted the GP, it would be usual practice (in the case of a Nursing Home with registered nurses on duty 24/7) for the particular issues requiring medical attention for any resident to be pointed out to the GP by the nursing and other staff on duty. Maria had multiple medical and physical issues and it was notable on most GP visits that only the issue (for which they were called) was attended to and treatment recommended. Maria's medical needs were not attended to holistically and it could be determined that this impacted on her physical health and certainly on her well-being. Had there been improved communication systems at LH in respect of passing on information to the visiting GPs, this may have led to more holistic treatment.

3.11. The need was clear for improved communication systems between staff working in care homes in identifying what needs to be referred to GPs for their attention during weekly visits.

3.12. Each individual organisation involved in commissioning and in monitoring care quality issues and in delivering services directly to Maria i.e. The Great Yarmouth & Waveney CCG, the Local Authority (Suffolk County Council) and East Coast Community Health services had oversight of concerns around care quality issues and responded quickly, acting to point out the concerns to the care provider and specify areas for improvement or detailing individual actions which needed to be taken specifically in relation to Maria. However, there was no evidence of a multi-agency meeting at which all intelligence could be shared, and an action plan agreed. At no time was there an effective provider concerns management system in operation.

3.13. The GP services responded on every occasion to requests for visits to Maria in respect of her individual medical issues which were in need of attention at that time. However, individual GPs were often unaware or did not respond to other ongoing medical issues in the time they had to visit patients at LH. Crucially, the GP service was unaware of the extent of care quality and safeguarding concerns.

3.14. There would have been a benefit to the whole health and social care system if the Suffolk Safeguarding Partnership (SSP) had in place a Provider Risk Strategy/Protocol, agreed by all partners to the SSP and which would have informed improved joined up working and actions to be taken at LH.

3.15. Individual provider risk protocols and policies are in place for organisations, but nothing joined across the system. The impact of the map and boundaries of NHS and Social Care services across East Anglia and the confusion caused by those organisations which have services which cross the borders between Norfolk and Suffolk is an important factor. This has a particular impact in the Norfolk & Waveney NHS CCG area in the north of the county of Suffolk.

3.16. In May 2017, commissioning teams in Adult Community Services (ACS) in Suffolk were restructured. The aim of the restructure was to bring the function of commissioning closer to the daily work of contract management. The additional resource was designed to close the gap between practice and commissioning. The aim was to build relationships with providers and work with support systems to lead wrap-around support services, giving all providers a named contract manager. This has resulted in NHS and Social Care joint contract visits; the ability to bring support services together to work collaboratively (the Provider Support Team and the Medicine Optimisations Team are two examples) and most importantly to act as a central point of contact.

3.17. The greatest impact of the new team structures is the ability to hold directors/managers of businesses to account for how they run their care businesses.

3.18. The outcome of these changes is a more business-focused approach to the quality of care in Residential and Nursing Homes, which has led to a Suffolk-wide improvement in the quality rating of care homes. This has been based on a more targeted intervention and a proportionate response to contract management linked to a regular assessment of risk. A range of risk factors is now considered, such as safeguarding referrals, feedback from health and care practitioners, contract visits, business credit checks etc.

3.19. During 2018 the Local Authority Safeguarding Service was decentralised to local services areas, leaving a small centrally based team for complex investigations. The emphasis is on 'place based' safeguarding activity across each geographical area in Suffolk whilst retaining an adult team in the MASH and a small Central Safeguarding Team to manage highly complex cases and concerns.

# 4. Key Findings

4.1. The following observations were made for each of the questions posed in the reviews Terms of Reference

### What contributed to lack of identification of harm for Maria and at LH?

4.2. Poor nursing and care practice and recording at LH including a total lack of evidence that person-centred practice was being delivered.

4.3. Lack of leadership at LH which included inadequate responses to quality concerns raised by other professionals and no urgency to make any changes requested

4.4. Lack of an integrated response system from all partner agencies within the health and social care system which, had it been more effective, might have led to joined up action at an earlier stage

### The effectiveness of multi-agency responses

4.5. The Learning Review (Practitioner Event) identified that there needs to be a new organisational concerns policy from the SSP to support the whole system – and encourage early intervention, prevention and professional curiosity. This is linked to safeguarding being everyone's business.

4.6. Practitioners suggested GPs should have a named nurse to whom they report safeguarding concerns (it is noted that GPs should already have a named safeguarding lead within practices). This suggestion shows that GPs are not engaged in the Suffolk Safeguarding system directly and only engaged via the CCG Named Nurse for Safeguarding in Primary Care. There may

need to be some more direct learning offered to GP practices in respect of safeguarding and the processes to follow to report concerns.

4.7. Confusion exists across the health and social care system in the determination of whether a matter meets the criteria for a safeguarding intervention or is a 'care quality issue'. This together with the issue of practice where the matter is dealt with by the referrer and not raised as a safeguarding concern may suggest that the Framework needs improved application across the Great Yarmouth and Waveney area in particular. Many of the points raised at the Learning Review (Practitioner Event) suggest that there needs to be a better understanding and application of the Suffolk Safeguarding Adults Framework across the Waveney area of Suffolk.

4.8. The Suffolk Safeguarding Adults Framework is a tool to help practitioners establish what care quality is and what safeguarding is and directs them to the local resources available to them and their service users/patients to mitigate the presenting risks and keep them safe. It also directs them as to when to use the Consultation Line and when to make a safeguarding referral.

## An analysis of safeguarding alerts in respect of LH

4.9. There was poor understanding in Waveney of the safeguarding system in operation at the time and confusion existed in respect of whether care quality issues reported by NHS professionals could be considered safeguarding issues simultaneously.

4.10. The issue of feedback to those referring concerns meeting with Section 42 (1) of the Care Act is mentioned in Suffolk (and frequently across the country). Whilst there is no regulatory requirement to provide feedback, the SSP needs to agree how partner agencies can feel more engaged and understand how their actions are being responded to e.g. referral for a Section 9 Care Act 2014 Assessment of the individual which might lead to identification of needs and potentially analysis of what resources may be offered even if the person is not eligible for a service.

4.11. The Learning Review (Practitioner Event) identified that the Provider Support Team and Health Support Duty role with the MASH needs to be reviewed, resourced appropriately, and made more consistent.

## Consideration of the role of CQC and analysis of CQC interventions at LH

4.12. Although notifications were sent to the CQC, these were not using the appropriate statutory notifications. Work needs to be undertaken with providers on how to make appropriate notifications and CQC should consider its thresholds when receiving multiple, non-statutory notifications.

## Commissioning of care at LH and monitoring and review of quality across agencies - in particular, a review of the effectiveness of joined up work across NHS & Social Care commissioners, providers & GPs

4.13. Even though some of the care commissioned at LH was commissioned by the CCG for continuing health care (CHC) funded residents, a more integrated approach to commissioning would have ensured a more effective response to the concerns and complaints which were raised and the care quality issues being pursued. The Funded Nursing Care (FNC) applied to most residents.

4.14. Care quality audits should also include appropriate equipment in care homes and advice available for care homes to make specific enquiries in relation to the equipment needs of individuals.

## A review of partnership and collaborative working

4.15. The structure and delivery of NHS commissioning functions across Norfolk and Suffolk leads to difficulties in joining up strategic plans and delivery of effective services across borders. This is

particularly the case in the Great Yarmouth & Waveney CCG which straddles the border of both counties.

4.16. Collaborative posts in any health and social care system are beneficial and the role of the Lead Safeguarding Nurse and Lead Social Care Safeguarding Practitioners are a means by which collaborative work may be improved. This is essential in terms of consultation whilst there are concerns and complaints being raised and should not only be utilised after the event or following notification of a serious safeguarding concern leading to a s.42.2 Enquiry. There are 2 Safeguarding Leads, one for West Suffolk CCG, Ipswich & East Suffolk GPs, and one for the Norfolk & Waveney CCG.

## A review of the information sharing and consideration of further investigative partnership policy

4.17. Consideration of further investigative partnership policy refers to the underlying policy which enables all partners to the SSP to carry out investigations into key events:

4.18. The absence of a 'Provider Risk Strategy' (which would have informed an investigative partnership approach) and a protocol undoubtedly hampered effective joined up working. Delivery of a single policy across partner organisations is essential moving forward.

4.19. Consideration should be given as to whether the above can also be joined with Norfolk and whether this can be a joint strategy across both counties.

4.20. Concerns were expressed regarding Suffolk Police being able to review all the information in an evidentially controlled manner which would preserve the integrity of any future prosecutions, whilst also allowing the CQC to undertake their investigation. Not being able to undertake investigations simultaneously added significantly to time delays in relation to reaching a final prosecution decision.

4.21. At the time of completion of this report in December 2019, the Police Senior Investigating Officer (SIO) has decided that the facts, when considered together, did not meet the evidential threshold required to present the case to the CPS for a charging decision. The Police decision is to take no further criminal action against any party, because of a lack of specific available evidence against any individual. Thus, the case will not formally be referred to the CPS as this is a Police SIO 'no further action' decision.

4.22. In completing this report, the Police advised that they had assistance from SCC Adult Safeguarding, and an independent expert provided by the National Crime Agency both of whom provided reports for the Police, after reviewing the notes on Maria from LH. The Police also advised that they worked with the CQC on the matter and asked for them to review the material provided to the Police and produce a report. CQC declined to do this, instead moving forward to complete their own investigation. This was as a result of advice from their legal department as the CQC were considered an 'expert witness' and this was not in line with their own processes in terms of undertaking internal investigations/prosecution. CQC did speak to Police on several occasions and answered questions about the quality of records.

# 5. Recommendations Emerging from this Review

5.1. The following recommendations were identified through this review process:

1. To further develop and embed the Safeguarding Adults Framework by:
    a. Developing training and tools that showcase the Framework, what it means to practitioners and how to apply the principles in everyday practice. This should include easy read guides, videos, and case studies of how the Framework can be applied, as three examples
    b. The SSP should look to develop a quality assurance mechanism for identifying the level of application individual organisations have of the framework. They should look to develop targeted training and support that can be applied in settings which require further support in applying the Framework in the organisation.
    c. The SSP should ensure that a collaborative approach to safeguarding is enabled across the entire area of its influence including the Waveney district. There should be consideration of working in partnership with the Norfolk SAB and Norfolk & Waveney CCG when developing policies and procedures which may differ across local borders thus ensuring that the introduction of any changes is consistent.
2. For the SSP to be assured that all health providers are aware of and appropriately utilise the safeguarding resources within the health and social care economy in its area. The SSP should be assured that all GP practices understand and appropriately use the safeguarding framework to support decision making and referral.
3. The SSP to expedite the publication of the Managing Organisational Concerns Policy which will recognise the connection between care quality and safeguarding concerns which if not monitored may accumulate and become abusive and leave adults at risk.
4. For the SSP to make a clear statement on the method and circumstances of feedback to the referrer when raising concerns.
5. The SSP should routinely review the effectiveness of any changes implemented by Partnership following learning from Practice Reviews with mechanisms in place to enable further changes and learning to be applied with ease.
6. For individual agencies across NHS and Adult Social Care in Suffolk to develop a memorandum of understanding on best practice in delivering person-centred care in the provider market. This should include what good person-centred care looks like.
7. For NHS and Social Care to jointly arrange provider engagement sessions which ensure that all providers understand and sign up to the memorandum in delivering and reviewing effective person-centred care.
8. For the CCGs to consider how use of pressure relieving mattresses and other medical equipment is checked as part of quality assurance visits with recommendations made to providers where appropriate. The CCG should consider introducing a checklist for care providers which can provide greater assurance that appropriate equipment is being used for individuals with health needs.
9. For the Suffolk and Norfolk and Waveney CCG's and Adult Social Care Commissioners to work collaboratively and not in isolation when responding to complaints, quality issues or safeguarding concerns. All organisations to improve internal communications to join up complaints, quality and safeguarding work streams.
10. For Suffolk Police to review how it responds to Safeguarding Enquiries and in particular how it ensures that both the Police Investigation and single agency enquiries are enabled to proceed in tandem to allow quick decisions and the collection of appropriate evidence with particular focus on the most important enquiries which may have significant volumes of data and information. A joined-up police and health approach is required at the early stage of an investigation to help establish lines of enquiry and the early identification of potential criminal offences.

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# 6. Glossary of Terms

| | |
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| CCG | NHS Clinical Commissioning Group |
| CQC | Care Quality Commission |
| CQC KPIs | CQC Key Performance Indicators – against which they measure their effectiveness |
| ECCH | East Coast Community Healthcare |
| Grade 4 Pressure Sore/ Ulcer | Grades qualify the seriousness of a pressure sore or ulcer and Grade 4 identifies extensive skin destruction, tissue necrosis* or damage to muscle, bone or supporting structures |
| GP | General Practitioner |
| JPUH | James Paget University Hospital |
| LH | Lound Hall Nursing Home |
| MASH | Suffolk County Council Safeguarding Multi-Agency Safeguarding Hub – central point through which all safeguarding referrals are made |
| MUST | Malnutrition Universal Screening Tool |
| PST | Suffolk County Council Adult Social Care Provider Support Team – officers who support all care providers commissioned by the Council to provide care in care homes or at home for Suffolk citizens |
| SAR | Safeguarding Adults Review |
| SCC | Suffolk County Council |
| 'Sharepoint Meetings' | meetings held across the NHS and adult social care and with other agencies e.g. CQC to discuss the quality of care provided by care providers |
| SSP | Suffolk Safeguarding Partnership |
| Pt | acronym often used in clinical records for 'patient' |
| 'SystmOne' | NHS clinical notes recording system used by GP practices |
| TVN | Tissue Viability Nurse |

### MEDICAL CONDITIONS (which are less well known)

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| Hypocalcaemia | a condition in which there are lower than average levels of calcium in the liquid part of the blood. This can lead to dental changes, cataracts, alterations in the brain and osteoporosis which can cause the bones to become brittle |
| Neutropenia | when a person has a low level of certain types of white blood cell which can help the body fight infection |
| Necrosis | the death of most of or all the cells in an organ or tissue |

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