Richmond and Wandsworth

Lead Reviewers:

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CONTENTS

1 Introduction

1.1 WHY THIS CASE WAS CHOSEN TO BE REVIEWED

1.1.1 The case of Margaret was chosen for review by the Richmond and Wandsworth Safeguarding Adults Board as it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014; "Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult" (Department of Health, 2020).

1.1.2 Margaret was an adult with care and support needs who lived at home and whose death was believed to have occurred amidst circumstances of neglect and self-neglect, where concerns existed about how services worked together to protect her from harm.

1.2 SUCCINCT SUMMARY OF THE CASE

1.2.1 Margaret was a 90-year-old lady who died in April 2018 from Sepsis as a result of infected pressure sores due to decreased mobility and frailty. At the time of her death Margaret had been living at home with one of her daughters and grandson with support from a local Community Health Team and her GP.

1.2.2 Margaret has been described as a reluctant user of services and her physical health condition deteriorated significantly at home as her daughter struggled to manage her condition. Their engagement with Health and Social Care services was sporadic and health services were not able to maintain consistent contact with Margaret in order to treat her worsening pressure areas. On 15 March 2018, Margaret was admitted to hospital in a state of neglect suffering from skin breakdown. Margaret had a significant number of pressure ulcers and developed an infection from which she could not recover.

1.3 METHODOLOGY, PERIOD UNDER REVIEW AND THE RESEARCH QUESTIONS

1.3.1 The purpose of a SAR is:

- To promote effective learning and improvement to services and how they work together
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm
- To understand what happened and why.

1.3.2 The SAB decided to use a Learning Together review approach (Fish, Munro & Bairstow 2010). This approach supports learning and improvement in safeguarding adults. The aim of this is to support involved staff, managers and strategic staff to use systems thinking to develop an understand of the practice and to promote a culture of learning between involved partners.

1.3.3 Learning Together provides the analytic tools to support both rigour and transparency to the analysis of practice in the case and identification of systems

learning. This creates a two-stage process:

- We broke the timeline down into Key Practice episodes. The quality of practice in each episode was analysed, and contributory factors identified.
- From the case analysis we drew out underlying systemic issues that help or hinder good practice more widely. The Learning Together findings structure requires the provision of evidence about the generalisability of issues that were identified in the case.

1.3.4 The approach has involved two distinct groups of participants:

Case Group - Practitioners with direct case involvement and their line managers, who are central to the learning event

Review Team - Senior managers with no case involvement who have a role in helping develop system learnings and supporting the case groups representatives if needed. They play an important role in bringing wider intelligence to ascertain which issues are case specific only, and which represent wider trends locally.

1.3.5 We also sought to engage with family members to talk through the analysis, answer any queries and gain their perspectives.

TIME PERIOD

1.3.6 It was agreed that the review would focus on the time period under review: from point of Margaret's dementia diagnosis (July 2017) up to point of Margaret's admission to hospital (13 April 2018). The period of time between Margaret's admission to hospital and her death on 30 April 2018 falls out of the remit of the terms of reference of this review.

RESEARCH QUESTIONS

1.3.7 The use of research questions in a 'Learning Together' systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems Findings. The research questions provide a systemic focus for the review, seeking generalisable learning from the single case. The research questions agreed for this SAR were:

- What do practitioners do to get assurance that family carers have the requisite knowledge and skill to carry out a caring role for a person with assessed needs?
- How is this assurance reviewed and maintained over time, so practitioners can determine if a carer is able to continue discharge any caring role as necessary and that the 'cared for' person's needs have not increased to levels above that which a caring can ably meet.
- How do we support professional inquisitiveness, so practitioners do not necessarily take at face value all that is presented to them?
- How do professionals work with people who may lack capacity, where family Carers make access difficult?

1.4 INVOLVEMENT AND PERSPECTIVES OF THE FAMILY

1.4.1 Members of Margaret's family were given the opportunity to contribute to the review. Of those contacted, Margaret's granddaughter, S, responded and was able to have a discussion about the report, it's methodology, and findings. S was able to confirm some of the circumstances of Margaret's support and care arrangements and the challenges faced in meeting her needs. S was also able to clarify the circumstances surrounding Margaret's visits with professionals.

1.4.2 The findings of the review were discussed with S. The findings resonated with her experience, and reflected some of her experience during her interactions with the Safeguarding system in Wandsworth.

1.4.3 S was provided with a copy of the report and encouraged to suggest any changes to improve factual accuracy and to prepare a family statement for inclusion in the report.

1.5 REVIEWING EXPERTISE AND INDEPENDENCE

1.5.1 This Safeguarding Adults Review has been led by Dr Sheila Fish and Eliot Smith. Dr Sheila Fish and Eliot Smith are Independent Health and Social Care Consultant and have no previous involvement with this case, and no connection to the Richmond and Wandsworth Safeguarding Adults Board, or partner agencies.

1.6 STRUCTURE OF THE REPORT

1.6.1 First, an overview is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to Margaret was, including where practice was below or above expected standards and explaining why.

1.6.2 A transition section reiterates the ways in which features of this particular case are common to other the work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

1.6.3 The systems findings that have emerged from the SAR are then explored. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in this case

2.1 CHRONOLOGY ON A PAGE

July 2017	• Dementia diagnosis; decline by daughter of further investigation
Aug-Nov 2017	• Daughter-carer request and receives OT support re. Margaret's mobility • Case closed
Jan 2018	• Family call GP to request a visit. Despite 3 attempts GP does not succeed in contacting family in response.
21-27 Feb 2018	•Neglect and carer coping concerns raised by granddaughter •ASC Access team; not deemed safeguarding; contact assessment with daughter; daughter declined Carers assessment or carers •GP does home visits; not deemed safeguarding; arranges District nurse input
27 Feb- 2 Mar	• District nurses arrange pressure -relieving equipment; daughter helping • District nurses daily visits for wound care; then every second day; pressure sores improving • 2 March care package suggested and refused
3 - 11 Mar	• District nurses no longer obtain access (9 days/4 visits)
12 Mar	• GP visit at request of family - anti-biotic eye drops, no physical exam, no other concerns noted
13- 14 Mar 2018	•13th District Nurse make access after 9 days; finds Margaret on the floor; makes safeguarding referral to ASC and requets urgent GP homevisit •GP makes phonecall; speaks to daughter and is reassured •14th District nurse visits again; little improvement; same clothes; new pressure areas; calls MDT for advice
15 Mar	• Community Maron does home visit; further neglect evidence; tells Margaret she needs hospital care and asks if she agrees; ambulance called; GP also there
15 Mar - 30 April	• Margaret in hospital. Margaret died 30 April

2.2 IN WHAT WAYS DOES THIS CASE PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

2.2.1 Co-production and working in partnership with families and carers are key priorities for many organisations, and feature strongly in health and social care legislation, guidance, and policy. The Care Act 2014 sought to raise the status of carers bringing them under the remit of the wellbeing principle – placing duties on Local Authorities to consider the wellbeing of carers in their own right, rather than simply through the wellbeing of the cared-for person.

2.2.2 At the heart of this case are the challenges in supporting an individual through their family carers and identifying when a family is beginning to struggle and disengage from support.

2.2.3 The case of Margaret provides a valuable insight into the challenge of striking the right balance between trust, engagement, and interventions with reluctant families and the need for a direct assessment of needs, risks, and the experiences of the cared-for person – the need to obtain first-hand the voice of the adult.

2.3 APPRAISAL SYNOPSIS

2.3.1 The appraisal sets out for the Review Team a narrative summary of how timely and effective the interventions with the service user were in this case, including where practice fell below or above expected standards and why. This synopsis of practice is a link from the specific case to the wider findings about the local safeguarding system, between July 2017 and April 2018.

2.3.2 Judgements of practice are made in light of what was known and what was knowable by practitioners involved in the care and treatment of Margaret during the identified review period. This case hinges on the efforts of health and social care to work with families who are caring for an elderly parent with dementia, and respond appropriately when concerns for the family carer, about the care of the elderly parent, are raised.

2.3.3 At the start of the time period of review for this SAR, Margaret was living with one of her daughters C and grandson G and she attended a Day Centre. There was no other professional involvement. In July 2017 Margaret was contacted by a Social Worker as part of the review of the day centre because concerns about the quality of the service were raised by commissioners. It was fortuitous therefore that this contact with the SW identified some needs, including with mobility and in her cognition. No Care Act assessment was conducted, so an opportunity to consider the safety of the home environment, Margaret's support network and ability of her daughter and grandson to continue to provide care for her was missed. We have not been able to explore the rationale for this as part of the SAR, but it is common that Care Act assessments are not conducted before family carers are seeking additional support for their relative. It is important to note here however, that from the records it appears that information about how Margaret's needs were being met was obtained through her family members. Margaret's views were not recorded. **The drivers behind this are explored further in Finding One.**

2.3.4 Following this contact Margaret registered with a GP, and shortly afterwards C contacted the Local Authority to ask for an OT assessment. A service was provided in a timely and appropriate way, and the case was closed. This contact

began to identify a picture of Margaret that practitioners described as a “reluctant client” who had not registered with a GP previously and who had chosen not to request additional support. It also created a picture of C as appropriately responsive to her mother’s changing care needs.

2.3.5 The next contact was again through her family when the GP received a request for a home visit in January 2018. The GP made three attempts to call but was not successful. Margaret was not seen or contacted and the reason for the call not established. There does not appear to have been any further follow-up and meant the reason for the call was not established. The opportunity to ascertain the progression of her health conditions, vulnerabilities or any risk factors was therefore missed. It was known at that time that Margaret was dependent on her family for all her health and social care needs, including access to medical treatment. It was not known how well the family were managing her needs. As with the Care Act Assessment opportunity previously, GP input is designed to be responsive to demand rather than proactive and up till this point, there had been nothing to indicate that there were problems with the setup of Margaret being cared for at home by family.

2.3.6 A month later, in late February 2018, however, this changed when the Local Authority Access Team received a call from Margaret’s granddaughter who shared very clearly her concerns about Margaret and that her daughter-carer C was not coping. Information was provided about Margaret’s home environment, condition, pressure sores, and incontinence. Carer-stress and the ability of Margaret’s daughter to support her and meet her needs were also questioned. This information did not receive the response that was needed. There was a missed opportunity to identify possible neglect or self-neglect through safeguarding – even if unintentional. Most pertinently despite responses by both the Access Team and GP, neither what able to identify exactly day-to-day life was like for Margaret at this point, nor what her wishes were. **The drivers behind this are explored further in Finding One.**

2.3.7 Margaret’s GP responded promptly to Margaret’s health needs, visiting her the following day, and making a referral to Community Nursing service for an urgent response. Community Nurses visited and graded Margaret’s pressure sores as a grade 3 and a grade 4. Advice was given to the family, a dressing was applied (although not the appropriate dressing but the only one available), and a referral to specialist Tissue Viability Nurse was made. The Community Nursing service began a programme of daily (until appropriate dressing could be prescribed) and then alternate daily visits, reflecting the seriousness of her pressure wounds.

2.3.8 The GP’s rationale was that by providing this extra support, the problems in the quality of care being provided to Margaret would be resolved. This is the picture that was conveyed by the GP to Adult Social Care Access Team, when they contacted for information. The GP gave reassurances that there were no immediate safeguarding concerns – as Margaret’s daughter was described as appropriate and caring – and the Access Team accepted these assurances.

2.3.9 Both determined that there were no safeguarding issues; Margaret was not being abused or neglected, nor was she at risk of being harmed. What is problematic about this stance is that the risk factors that had explicitly been identified by Margaret’s granddaughter fell out of anyone’s sight and became ignored. Margaret’s daughter had a diagnosis of bipolar affective disorder. The possibility of unintentional neglect was not considered at this point, when the original information from the family member should have triggered this. Furthermore, the

seriousness and potential severity of her physical health condition and pressure areas was not conveyed. GP's do not routinely use the pressure ulcer grading convention. The Local Authority did not obtain information about Margaret's condition, or the serious implications for risk of harm to her health and wellbeing.

2.3.10 The Adult Social Care Assessment Team, after speaking to the GP, carried out a contact assessment over the phone; on Margaret, but via her daughter – there was no contact with Margaret herself. The daughter-carer was offered and declined carers and a carer's assessment, over the phone, without the opportunity to explicitly raise the concerns that had been shared about her own needs and risks these created for Margaret. The information was not treated as safeguarding, and the case was passed on to a Locality Team waiting list. The lack of urgency meant that the suitability or ability of Margaret's daughter to meet her needs was not assessed, despite the concerns conveyed originally by the family member and Margaret was denied the opportunity to receive professional care at home, and a carer's assessment. Her views on this were not obtained.

2.3.11 The community nursing care was regular and efficient. They continued to visit. The daughter-carer was helping, for example, arranging to have the old bed removed as pressure relieving equipment was brought into the house; changing dressings as required. Margaret's pressure sores were improving.

2.3.12 It was at this point, from 3 March 2018, after a week of visiting, with the wounds improved, that access to the house became a problem. For 9 days the community nurses were not able to gain access. With hindsight, this looks clear that this should have triggered an escalation and referral to safeguarding. However, at the time, it was only four visits that were missed, the team had contact with Margaret's daughter each time and the explanations and reassurances she provided were plausible. It is important to note that the community nursing team had no knowledge of the concerns about the raised by the granddaughter about the ability of the daughter to provide care for Margaret and her own health and care needs. Further, at the time, the Trust Policy was in the process of being revised to change from the requirement to escalate no access only when a person lived alone, to emphasising consideration of risk factors to the person. The result was that the lack of access was not escalated and was not referred to Adult Services under safeguarding.

2.3.13 On day eight of the community nurses having no access provided to Margaret, (12 March 2018) the GP conducted a home visit, in response to a request from the family connected to Margaret having an eye infection. It was an opportunity to both do a physical examination of Margaret's pressure sores and speak to her about whether there were any problems in the care her daughter was able to provide her. However, neither occurred. This omission is in part explained by the fact that the GP at this time was not aware that the community nurses had had any difficulty gaining access. At this time changes to IT systems were in progress but not completed, therefore GPs and Nurses were not yet able to see each other's records. The GP did take physical observations and no concerns were identified.

2.3.14 Having continued to attempt to gain access, the day after the GP's visit, Community Nurses were successful. This was enabled by a fortuitous meeting with a neighbour who made contact with Margaret's daughter, rather than reflecting a reliable safeguarding system. Community Nurses found Margaret on the floor, and on identifying that her condition had deteriorated significantly, Community Nurses responded appropriately to the seriousness of her condition,

by both offering in situ care, and referring her case to the Access Team under safeguarding.

2.3.15 However, the referral did not receive the urgent response by Adult Social Care Access Team that the Community Nursing team were expecting or was required. This made sense to the Access Team at the time because they were reassured that there were 'eyes on the ground' via the Community Nurses and the GP was to visit and would trigger an urgent response if the situation later required it. The information that had been conveyed by the Community Nursing team had not adequately enabled them to understand the severity of the pressure sores at this point and the implications for Margaret's physical health or how quickly her physical health could deteriorate. Repeating the response to the first referral from the family member, in the response to this safeguarding referral the suitability or ability of Margaret's daughter to meet her needs was not assessed and there was no focus on ascertaining what life was like for Margaret or Margaret's views of the care she had been receiving over the days when community nurses had not been able to gain access to see or treat her. Such an investigation was needed in order ascertain whether Margaret needed hospital admission to be recommended, or an emergency package of care, Instead, the safeguarding referral was passed to a Locality Team for information **Professional norms around making safeguarding referrals are explored in Finding Two.**

2.3.16 The next day (14 March 2018), on the home visit by Community Nurses Margaret was again found lying on the floor and they identified further concerns. At this point, the community nurses' view was that Margaret needed hospital admission. What was needed was a direct conversation with Margaret to that effect, to gain her consent to call an ambulance. A discussion was had with Margaret's daughter who refused hospital admission and claimed she had Legal Power of Attorney. Margaret's views are not recorded. The community nurses then correctly sought advice from senior nurses. This should have prompted clarity about Margaret's experiences and views and, if necessary, consideration of her mental capacity to make the decision about hospital admission. Instead, it resulted in a visit being planned for the next day. When the nurse team leader also escalated the situation to the GP, however, the GP did not visit or speak to Margaret as was needed, but instead had a telephone call with Margaret's daughter. Despite concerted efforts on the part of the community nursing team, their escalations were ineffective, and no-one was any the wiser about Margaret's own views or her experiences over the preceding week and a half.

2.3.17 The next day (15 March 2018), Margaret was admitted to hospital after interventions from a senior Community Matron, who obtained Margaret's consent to admission, and informed Margaret's daughter that she would override her views about admission if necessary. There were missed opportunities throughout this period to convene a multi-agency process to consider the risks of harm of delayed medical treatment or admission, and to consider the legal remedies available.

3 Systems Findings

The Review Team has prioritised three findings for the SAB to consider. These are:

	Finding	Category
1	FINDING 1: **Across health and social care, the organisational priority placed on working closely with family members has created a tendency for practitioners to rely too heavily on information from family carers about whether and how their needs are being met, without also separately ascertaining what life is currently like for the person being cared for. A reliance on second-hand information, without direct contact with the service user, makes it less likely that the needs, experiences, and wishes of the person themselves will be known or recorded, and that their voice may be lost in organisational safeguarding responses.**	Management system issue
2.	FINDING 2: **When raising safeguarding issues with the Local Authority Access Team and/or Hub, is there a pattern of agencies not being specific enough about the risks, implications, and what they think needs to happen? This increases the chances that the urgency of a situation is misunderstood, and appropriate actions are not taken to protect individuals from abuse or neglect. This is exacerbated by a lack of expectation on the referrer to follow up on their contact.**	Norms and culture
3	FINDING 3. **There is a professional norm of turning to GPs in the first instance, and uncritical acceptance of their professional judgment, underpinned by a perceived hierarchy among professional groups, service users and their family. This has benefits of efficiency, but risks what is a partial and misguided view carrying undue weight and going unchallenged.**	

3.1 FINDING 1

3.1.1 Across health and social care, the organisational priority placed on working closely with family members has created a tendency for practitioners to rely too heavily on information from family carers about whether and how their needs are being met, without also separately ascertaining what life is currently like for the person being cared for. A reliance on second-hand information, without direct contact with the service user, makes it less likely that the needs, experiences, and wishes of the person themselves will be known or recorded, and that their voice may be lost in organisational safeguarding responses. [i]

3.2 CONTEXT

3.2.1 Care and support should put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends, and community (Department of Health, 2020). Across health and social care, person-centred care planning is a priority. Individual's involvement in decisions about the services they receive must be genuine and influential. Put simply, being person-centred is about focusing care on the needs of the person rather than the needs of the service. Co-production means that the person is an equal partner in the planning of care and that his or her opinions are important and are respected. Where people may need assistance with making decisions about their care the system should ensure that supported decision-making is routine. It means that practitioners respect a person's human rights and also their wishes and preferences.

3.2.2 In recent years improved status and value have placed on the role of family and informal carers, and carer involvement has been a key priority of legislation and social policy. A greater emphasis on advocacy and family representation for individuals who may be less able to advocate for themselves has seen a shift balance from the individual to the family.

3.2.3 An emphasis on building trust with families and working in partnership may lead to an over-reliance on a relative's assessment of need and risk; this tendency may be so powerful that there may be a reluctance to accept skills or knowledge deficits in family-carers. There is an assumption of carer-suitability which may overshadow the need to consider and be open to situations where a carer may be unsuitable.

3.2.4 It is hoped that putting people and their families at the centre of their care will:

- improve the quality of the services available
- help people get the care they need when they need it
- help people be more active in looking after themselves
- and reduce some of the pressure on health and social services

3.2.5 Making Safeguarding Personal has long been a key agenda of the Department of Health in relation to Adult Safeguarding responses. Statutory Guidance to the Care Act 2014 requires adult safeguarding practice personalised i.e. to be person led and outcome focused, aiming towards resolution or recovery. This embodies the Making Safeguarding Personal approach.

3.3 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.3.1 A striking feature of Margaret's case is that through the documentation available, there is a notable absence of her views. It was a feature at every stage of interaction with professionals.

3.3.2 When Margaret was contacted as part of the Service Review of the day centre she was attending, it was reported by her grandson that all Margaret's care and support needs were being met by family but there is no record of Margaret's views.

3.3.3 Later another family member contacts the Local authority to share concerns about neglect, and the ability of Margaret's daughter to adequately to fulfill a caring role. When information is shared about a number of specific vulnerabilities and risks, the response is a contact assessment with Margaret's daughter; no-one communicates directly with Margaret. Margaret's experience and needs are lost in the reliance on information provided by daughter C for assessment, even though she was the subject of the referral for neglect. Likewise, there is no record of Margaret's views of her care from the GP visit either.

3.3.4 Finally, in the last episode of care, community nurses had been prevented from seeing Margaret over a nine-day period. When the family requested a GP visit there was again no record of Margaret's views being sought or gained. When the community nurses did finally gain access, and found Margaret on the floor, there is no record of attempts to ascertain Margaret's views of the care she had been receiving or the outcome of those attempts. Similarly, on the next day, the attending nurses are noted to have asked Margaret's daughter, not Margaret directly, whether they could call an ambulance. When the nurse team leader escalated the situation to the GP, again the GP did not visit or speak to Margaret, but instead had a telephone call with Margaret's daughter. The Matron who visited the following day was the only person who engaged directly with Margaret, telling her 'you need care in hospital. I am going to call an ambulance' and asking her 'is that ok?'. She said yes, and the matron asked again to double check.

3.4 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

3.4.1 The fact that Margaret's views were not sought on so many occasions, across different agencies, and within different teams in the same agency, suggests this is not unusual.

3.4.2 A 'lack of service user voice in safeguarding enquiries' has also been identified as a theme in local safeguarding case file audits in 2018 /2019reinforcing the systemic nature of the finding. It has also been identified in a local SAR.

3.4.3 As part of the SAR process, we were keen to understand the drivers behind this pattern. We looked at policies and procedures to see how the balance between working with family members and the person themselves was articulated. We noted a relevant difference in emphasis between London-wide policies and procedures and local ones. The London Multi-Agency Safeguarding Policy and Procedures also supports a view of carers as equal partners unless there are valid reasons not to, while recognising that carers may unintentionally or intentionally harm or neglect the adult they support. The Multi-Agency Policy encourages Carers Assessments to be used as a vehicle for assessing individual's needs, and that safeguarding should be at the forefront of these assessments, to identify what support can be provided to remove or mitigate the

risk of abuse (London Safeguarding Adults Board, 2019).

3.4.4 Local Safeguarding Adults Procedures stress the importance of obtaining the views of the adult, including via family members as representatives. Making Safeguarding Personal is a central theme in the procedures, and while the intention behind use of family members as representatives is to ensure that the service user's voice is heard, the procedures place less emphasis on triangulating these views with an assessment of the experiences of the person themselves, and the possibility that family members may themselves be the source of risk.

3.4.5 When we discussed this issue with the review team, it was highlighted that statutory agencies having been criticised more for not involving families enough, in comparison to not including the voice of the person themselves. This works to compound the priority placed on engaging with family members and creates a disincentive to challenge or upset families especially when there are concerns about impaired mental capacity. Put simply, it can be harder to hear the voice of the adult as the voice of relatives, Lasting Powers of Attorneys, and family carers grows louder.

3.5 HOW WIDESPREAD & PREVALENT IS THIS SYSTEMS FINDING?

3.5.1 We use this section to lay out evidence we have gathered about how many facilities are actually or potentially affected by this finding.

3.5.2 This finding potentially affects all people receiving health and care support, who have family members involved in their care.

3.6 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

3.6.1 In health and social care practice it is important that the right balance is achieved in the involvement of family members as partners with services in meeting the needs of individuals and the direct involvement of the person themselves. Where a person may have impaired mental capacity for key decisions within the co-production of their care arrangements, striking a balance becomes even more important. If both sides of the balance are not adequately prioritized, the risks increase that the person's views get lost and, where they are being neglected or abused, this is obscured.

FINDING 1 - Across health and social care, the organisational priority placed on working closely with family members has created a tendency for practitioners to rely too heavily on information from family carers about whether and how their needs are being met, without also separately ascertaining what life is currently like for the person being cared for. A reliance on second-hand information, without direct contact with the service user, makes it less likely that the needs, experiences, and wishes of the person themselves will be known or recorded, and that their voice may be lost in organisational safeguarding responses.

3.7 QUESTIONS FOR THE SAB TO CONSIDER:

3.7.1 Is this an issue that the SAB has previously considered or been made aware of?

3.7.2 Do Making Safeguarding Personal or other audits distinguish between involvement of the service user directly and via family?

3.7.3 Do assessment forms across agencies encourage practitioners to distinguish between involvement of the service user directly and via family?

3.7.4 What would help professionals across agencies manage this balance more confidently? What would help build confidence in managing potential conflict with families? Is there anything to be learnt from children's safeguarding in how to do this? Or from other areas of practice where families are heavily involved e.g. learning disability services

3.7.5 Has it become routine when a person is understood to have communication problems, to go straight to the family for representation of the person's views?

3.7.6 Are there any further measures the Board needs to take in relation to this finding, in light of current Covid-19 restrictions and changes to practice whereby practitioners are relying more heavily on phone calls with family and indirect contact?

3.7.7 How would the SAB know if this had improved?

3.8 FINDING 2

3.8.1 When raising safeguarding issues with the Local Authority Access Team and/or Hub, is there a pattern of agencies not being specific enough about the risks, implications, and what they think needs to happen? This increases the chances that the urgency of a situation is misunderstood, and appropriate actions are not taken to protect individuals from abuse or neglect. This is exacerbated by a lack of expectation on the referrer to follow up on their contact.[ii]

3.9 CONTEXT

3.9.1 The aims of safeguarding, as set out in policy and procedures, include stopping abuse or neglect wherever possible, and preventing harm and reducing the risk of abuse. The Local Authority-led safeguarding system in Wandsworth is designed around a '4 stage process' with target timescales for completion of each stage. The safeguarding system has been designed to support the Local Authority to discharge their legal obligation to cause or make a safeguarding enquiry under section 42 (Care Act 2014) , to protect individuals who have care and support needs, who are at risk of abuse or neglect, and who are unable to protect themselves from harm.

3.9.2 The specific stages include concern, enquiry planning, enquiry outcome, and safeguarding review; the whole process taking up to 3 months to complete. Timescales are indicative and may be flexible in some circumstances. There is an expectation that the Local Authority will receive safeguarding "concerns" from others, applying the statutory criteria for enquiry under section 42 (Care Act 2014) before determining that the concern should be treated as a safeguarding referral and the enquiry planning stage begins.

3.9.3 Local Authorities receive a considerable number of safeguarding concerns, and in order for the Local Authority in Wandsworth to make timely and appropriate decisions the information they receive about the concern must be clear, concise, and accurate, and should communicate the nature, seriousness, and likelihood of abuse or neglect. The adult at risk's views and wishes in relation to the safeguarding concern should also be communicated clearly and explicitly.

3.9.4 The effective and timely communication of concern information is of vital necessity as the safeguarding system is designed to manage situations of immediate risk as well as non-immediate matters of care quality; the concern stage includes a judgement about the immediate safety of the individual and any actions that may need to be taken. At this stage, it is crucial that if there is a need to contact emergency services, police, or ambulance for an immediate response to preserve life, this should be explicit in the concern information – including any actions already taken.

3.9.5 The management of risk is most effective when referring agencies/individuals and the Local Authority have a shared understanding of the nature of risk, the seriousness and impact of the abuse or neglect on the individual, and the likelihood of abuse or neglect occurring. This requires not only precise communication of relevant information, but also the ability to check out that the seriousness and urgency of the situation has been communicated and understood. This communication and judgement of risk is vital to the formulation

of a multi-agency plan where roles, responsibilities and timescales are clear and communicable to the adult at risk – in line with the safeguarding principle of accountability.

3.9.6 The initial communication of the "safeguarding concern" is crucial to the success of the rest of the safeguarding process and wider risk management planning – evaluating risk, agreeing an approach, cross-agency risk plan with roles, timescales, and review.

3.10 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.10.1 When district nurses raised their safeguarding concern with the Access Team, after they had found Margaret on the floor, the information was received and recorded by an unqualified administrator. This was then passed on for a management decision within the target of four hours. The decision at the time was to pass the case on to the locality team for information gathering. This began three days later after Margaret was already in hospital. The judgement that Margaret was, in the meantime, safe, meant there was no further attempt to interrogate the information provided, or discuss the concern with the reporter to ascertain the seriousness of Margaret's condition, and make a combined judgement in relation to the degree of urgency. The failure to precisely communicate the level of risk and urgency ultimately led to a disconnect in the sense of urgency that each organisation approached the case, and their expectations of what would/should happen next.

3.10.2 The District Nurses expected their concern to result in a visit by social workers to assess Margaret's daughter's mental state and her suitability to care for Margaret, and then to either put in a package of care or facilitate hospital admission.

3.10.3 In contrast, the local authority Access Team's expectation was that the nurses would be continuing to dress the wounds, that her GP would do an urgent home visit and that the immediate risks would be managed. The Access Team believed that their role was therefore to follow the safeguarding decision-making process – to evaluate the concern information against statutory criteria for enquiry planning. The Access Team therefore passed the safeguarding concern to the locality team for further information gathering and a threshold decision against section 42 Enquiry criteria.

3.10.4 When we look at the detail of the write up of the phone-call made by the district nursing manager, what has been captured is a very detailed description of the situation but without a) any clinical specification of the severity of the pressure sores or b) any interpretation for non-clinical staff of the implications for Margaret's physical health or the timescales of those implications. This means that the seriousness of risk is not understood. The conversation is also not ended with a discussion about, or formulation of, the plan. So retrospectively we now know that there were in fact conflicting expectations.

3.10.5 The consequence of this process was that health partners were left managing the risk and interactions with Margaret and her family, without the benefit of any immediate expertise or support from the Local Authority. The local authority also did not get the opportunity to ask questions of the referrer and gain clarifying information. Further, the local authority was then absent from the live management of the case, leaving Margaret receiving only a single agency

response to the risks she faced.

3.11 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

3.11.1 As part of the review process, we explored the extent to which this is usual, input from the case group indicated that this was a common problem and an issue they felt strongly about.

3.11.2 Discussions raised a mistaken assumption from agencies that the person receiving calls in the Access Team is a social worker when they are in fact a non-registered/unqualified call taker. Referrers may also make assumptions about the level of understanding and expertise of other agencies, for example about technical information about health conditions, pressure sores, or other areas of expertise.

3.11.3 Recent local Safeguarding Adult Reviews found a correlation between the number of times information changed hands and the sense of urgency felt by the receiving practitioner. Each time information changed hands the perceived urgency reduced.

3.11.4 A discussion of communication tools revealed that Department of Health guidance for Health Visitors, the "SAFER communication guidelines" was due to be rolled-out across local NHS Trusts to "support efficient and appropriate telephone referrals" – in relation to safeguarding children. Other communication tools exist across health (including the SBAR tool), but at present, none of these is routinely used to support practitioners to raise a safeguarding concern about an adult.

3.11.5 There is no fail-safe within the system to allow the further interrogation of safeguarding concerns at the point of initial contact. If information provided by the concern-raiser fails to be explicit enough about risk, there remains a risk that the seriousness and urgency of a situation could be missed.

3.12 HOW WIDESPREAD AND PREVALENT IS THIS SYSTEMS FINDING?

3.12.1 Safeguarding is everybody's business, and this is a multi-agency issue – safeguarding concerns are raised by many organisations across the borough, including statutory agencies, emergency services, and of course service users themselves, relatives, friends, and members of the public.

3.12.2 Input from the Review Team suggest existing audit activity has not focused on the quality of the concern information received at referral stage, except in certain circumstances like Merlins and private mental health hospital, where the focus was on understanding of safeguarding.

3.12.3 Input from the Review Team also suggested that this may be reflective of a professional norm – a perceived hierarchy

3.13 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

3.13.1 Accurate communication of information is key to success throughout the safeguarding process, and it is vital at all stages to achieve an accurate and shared understanding of the seriousness, impact, and likelihood of abuse or

harm occurring for individuals with care and support needs.

3.13.2 A failure at the concern stage to adequately assess the risk of harm to adults at risk can potentially introduce bias into the remainder of the safeguarding process and response.

FINDING 2 – When raising safeguarding issues with the Local Authority Access Team and/or Hub, is there a pattern of agencies not being specific enough about the risks, implications, and what they think needs to happen? This increases the chances that the urgency of a situation is misunderstood, and appropriate actions are not taken to protect individuals from abuse or neglect. This is exacerbated by a lack of expectation on the referrer to follow up on their contact.

3.14 QUESTIONS FOR THE SAB TO CONSIDER:

3.14.1 Is the Board already aware of issues in the communication of safeguarding information to the Local Authority Access Team? Have there already been any attempts to address issues in this area?

3.14.2 Do individual member organisations publish their own guidance for staff on raising safeguarding concerns?

3.14.3 Are health professionals adequately supported with tools to effectively raise safeguarding concerns to a sufficiently high standard

3.14.4 Is enough known about the quality of referrals received by the Access Team?

3.14.5 Was referral quality considered in the design and improvement to the safeguarding hub and system? Should the Board play a role in supporting multi-agency involvement in single agency service improvements such as the Safeguarding Hub?

3.14.6 Is there clarity across agencies about who is expected to follow up after making a safeguarding referral and how?

3.14.7 How would the Board know if referral practices have improved?

3.15 FINDING 3

3.15.1 On receiving safeguarding concerns, there is a professional norm of turning to GPs in the first instance, and an uncritical acceptance of their professional judgment. This is underpinned by a perceived hierarchy among professional groups, service users, and their family. This use of General Practice has benefits of efficiency for safeguarding services, but risks what is a partial and misguided view carrying undue weight and going unchallenged.[iii]

3.16 CONTEXT

3.16.1 Harm, abuse, and neglect can have a significant impact on a person's physical and mental wellbeing. Individual's experiencing harm, including self-neglect, may present with a health need in addition to a need for care and support from the Local Authority Adult Social Services. For many individuals experiencing harm, the most significant risk may be to their physical or mental health which means that their most pressing need may be for medical input or assessment. Unless the situation calls for an ambulance or admission to hospital, this response is often provided through primary care, and most often by a General Practitioner.

3.16.2 General Practitioners are a patient's main point of contact for general healthcare, they are highly skilled doctors trained in all aspects of general medicine whose role is to assess, diagnose, treat, and manage illness. GPs also provide the link to further health services. GPs are often the first point of contact for anyone with a physical or mental health problem, something that has been incorporated, although not be design, into the social care and safeguarding system.

3.16.3 There are over 1.3 million GP consultations every day – in clinics or in the person's home. The number of contacts and the role of the GP within NHS healthcare places them in a good position to provide an assessment of the possible impact of alleged abuse or neglect on an individual's physical and mental health, or background information on a person's health needs and risks.

3.16.4 A typical GP consultation is scheduled to last 10 minutes which means that a GP has limited time to assess the situation, make their diagnosis and treatment plan, and to form a judgement of a person's wider health and social care needs and risk. A GP opinion may therefore be conveniently obtained but may also be based upon the limited information that can be gathered in the limited time available. It is important that the safeguarding system is mindful of these limitations when assessing the strength and weight of GP judgements on the health impacts of abuse or neglect.

3.17 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.17.1 At the start of the review period Margaret had not been registered with a GP who later became involved after requests by family for a home visit, and after concerns were raised to the Local Authority about Margaret's wellbeing, carer-stress, and about C's ability to adequately meet Margaret's needs. On receipt of the concerns raised by Margaret's Granddaughter the Local Authority safeguarding response was a discussion with the GP, who provided reassurances that Margaret's daughter was appropriate and caring. Despite the significant concerns raised by Margaret's granddaughter, this reassurance proved sufficient – even though based upon a short snapshot and evaluation of the situation, following an evening home visit. The GP assessed "no immediate

safeguarding concerns" which is not the same as no concerns at all, however what was meant by this was not further explored. The judgement of the GP was accepted, and Granddaughter's concerns were progressed no further.

3.17.2 Safeguarding services continued to rely, too heavily, on the reassurances of GP contact when safeguarding referrals were made later on by Community Nurses, and undue weight was given to the GP opinion over other information from family members or other healthcare professionals. Another GP visit had been requested by family due to an eye infection. Margaret's GP visited the home address to assess Margaret's eye problem, taking physical observations and examining her eye, before prescribing ointment and medication used in the treatment of Urinary Tract Infection. When, the following day, Community Nurses found Margaret on the floor and made their referral to Social Services, the Local Authority were reassured that the GP and Community Nurses were visiting – implying from this that concerns would be raised by the GP if safeguarding was needed.

3.18 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

3.18.1 Evidence from the Review Team indicates that such a reliance on the use of GP's as first contact, and an acceptance of their judgement is routine and a professional norm in Richmond but no consensus as to whether this extended to Wandsworth as well. The practice in the case of Margaret did not appear, to professionals in the case group or review team, to be unusual or out of the ordinary.

3.19 HOW WIDESPREAD AND PREVALENT IS THIS SYSTEMS FINDING?

3.19.1 Across the NHS in England, general practice and the role of the GP in the healthcare system encourages the referral of safeguarding concerns to GPs where a person's physical or mental health may have suffered as a result of abuse or neglect. Within the contraints of the review process, we have not been able to identify more substantive data as to how widespread or prevalent this finding is.

3.20 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

3.20.1 GPs play a crucial role in the assessment, diagnosis, and treatment of the health impacts of abuse or neglect on people who experience harm, including from self-neglect. The responsiveness of primary care to an individual's needs (that fall short of emergency attendance by paramedics) makes this use of GPs more likely as a first response to referrals of safeguarding concern and an efficient way for the Access Team and Safeguarding Hub to obtain quick information about a person's situation and impact of abuse.

3.20.2 The health condition-focus of the GP intervention however, and the limited time available to GPs to make assessments, diagnosis, and treatment plans, means that their opinion must be taken in context. GPs may have access to only partial information to inform their snapshot assessment of a situation in which abuse, or neglect may be occurring. A problem-solving approach, in which risks may be temporarily mitigated may also result in a misguided reassurance of a person's long-term safety.

3.20.3 When services rely too heavily on a GP opinion, or give a limited snapshot

assessment too much weight, then their ability to triangulate and formulate a judgement on wider evidence may be compromised. This in turn may introduce bias into decision-making and lead to safeguarding services under-responding to situations of harm, abuse, and neglect.

FINDING 3 – There is a professional norm of turning to GPs in the first instance, and uncritical acceptance of their professional judgment, underpinned by a perceived hierarchy among professional groups, service users and their family. This has benefits of efficiency, but risks what is a partial and misguided view carrying undue weight and going unchallenged.

3.21 QUESTIONS FOR THE SAB TO CONSIDER:

3.21.1 Is there clarity about the extent to which this is an issue across both boroughs?

3.21.2 Is there a role for the SAB in supporting professional assertiveness in safeguarding practice, in face of perceived hierarchy of professions?

3.21.3 How would the Board know if practice has improved?

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1.1 [i] FINDING 1. SAR LIBRARY CODING:

1.1.1 This coding helps to specify with more precision the exact nature and relevance of the finding.

Which group of people or situation is this finding relevant to?	**Which profession(s) or agencies is the finding relevant to?**	**Does the finding relate to a particular aspect or type of work within the care and support system**	**What type of systems issue is it: what kind of thing needs to change?**
People being cared for at home by family members or informal carers	Not specified	Assessments and care planning	Management system issue

1.2 [ii] FINDING 2. SAR LIBRARY CODING:

1.2.1 This coding helps to specify with more precision the exact nature and relevance of the finding.

Which group of people or situation is this finding relevant to?	**Which profession(s) or agencies is the finding relevant to?**	**Does the finding relate to a particular aspect or type of work within the care and support system**	**What type of systems issue is it: what kind of thing needs to change?**
Not specific	Not specific	Sharing information about risk / safeguarding referrals	Professional norms and culture

1.3 [iii] FINDING 3. SAR LIBRARY CODING:

1.3.1 This coding helps to specify with more precision the exact nature and relevance of the finding.

Which group of people or situation is this finding relevant to?	**Which profession(s) or agencies is the finding relevant to?**	**Does the finding relate to a particular aspect or type of work within the care and support system**	**What type of systems issue is it: what kind of thing needs to change?**
People with a health need or health impact of abuse or neglect	General Practice, Local Authority safeguarding decision-makers, health professionals	Sharing information about risk / responding to safeguarding referrals	Professional norms and culture