Richmond and Wandsworth Safeguarding Adults Board

Safeguarding Adults Review

Mrs. K

Review completed April 2018

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1. Introduction

1.1. Section 44 of The Care Act 2014 requires Safeguarding Adults Boards to undertake a Safeguarding Adults Review when specific criteria are met. This is when there is a concern that abuse may have contributed to the death or significant and possibly life-changing harm of an adult with care and support needs, and that agencies could have worked more effectively to protect the adult.

1.2. The Wandsworth Safeguarding Adults Board (SAB) decided that the criteria set out in the Care Act 2014 were met because:

- Mrs. K had care and support needs
- Evidence provided by the referring agency, Richmond and Wandsworth Adult Social Services Department, indicated that abuse and neglect may have contributed to Mrs. K's discomfort and possibly her death in February 2017.

1.3. The review follows on from a Care Act Section 42 Safeguarding Adults Enquiry, which upheld that Mrs K's needs had been neglected, and is prior to the conclusion of a Coroners' Enquiry. These are all separate processes. The West London Coroners' Office pathologist reported that Mrs K died due to (1a) multiple organ failure, (1b) Staphylococcus Aureus Septicaemia and (2) multiple pressure sores and Parkinson's Disease with immobility.

1.4. The SAR referral was received in March 2017 and agreed by the SAB in April 2017. The methodology for this review, completed between December 2017 and April 2018, consisted of a scrutiny of single agency chronologies, interviews with managers and professionals from all agencies involved and a Panel meeting attended by representatives from most agencies. The following review timeline applies.

- December 2017 - Single agencies chronologies merged
- January 2018 - Single agencies interviews with professionals and managers
- February 2018 – SAR Panel meeting
- February 2018 – Draft Report to all agencies
- April 2018 – Draft Report to SAR Subgroup
- April 2018 – Overview Report to SAB Executive for sign-off

1.5. The review covers the relevant period, 1 December 2016 to 21 January 2017. However, historical information outside this timescale is included to provide necessary context.

1.6. Chronologies were completed by Kingston Hospital, the General Practitioner practice, South West London & St George's Mental Health Trust, Vocare, Central London Community Healthcare NHS Trust (CLCH), Richmond & Wandsworth Adult Social Services and the Metropolitan Police.

1.7. Interviews were held with the following agencies' representatives:

- Senior Social Worker, Richmond and Wandsworth Adult Social Services
- Assistant Clinical Support Manager, Vocare

- Safeguarding Adults Lead Nurse, Richmond CCG (formerly Kingston Hospital Safeguarding Adults Lead)
- Safeguarding Adults Lead Nurse, Kingston Hospital
- Designated Safeguarding Adults Lead, Wandsworth & Merton CCG
- Head of Quality & Nursing, Battersea Health Care
- Clinical Business Unit Manager, Central London Community Health Trust
- GP, The Roehampton Surgery
- Safeguarding Lead, SW London & St George's Mental Health Trust (by telephone)
- Commissioner, Wandsworth & Merton CCG (by telephone)

1.8. The Panel meeting enabled a discussion of the draft review facts and findings, ensuring multi-agency scrutiny. The meeting was attended by representatives of Kingston Hospital, SWLSTG Mental Health Trust, Vocare, CLCH, Richmond and Wandsworth Adult Social Services, Wandsworth and Merton Clinical Commissioning Group (CCG) and Richmond and Kingston Clinical Commissioning Group (CCG).

1.9. The family of Mrs. K has declined to participate in the review. In compliance with family wishes, the Social Worker contact with Mrs. K's daughter, DK, continues to be via telephone. DK has requested written details on the outcome of the review and a copy of this report will be made available with an offer of face to face contact. A copy of the report will also be provided to the Coroner. Bereavement counselling details have been relayed to family.

2. Executive Summary

2.1. On discharge from Kingston Hospital on 23 December 2016, Mrs K did not receive the Community Nursing support and pressure relieving equipment (bed, mattress and cushion) which were assessed as required. Subsequently, she was readmitted to Kingston Hospital on 18 January 2017 due to a deterioration in her health, including multiple pressure ulcers, and died in hospital on 20 February 2017.

2.2. The aims of the review are to promote the safety and wellbeing of adults at risk and, if possible, for the recommendations and actions to provide a legacy to Mrs. K and some comfort to her family.

2.3. The objectives of the review are for agencies to achieve a joint understanding of the facts leading up to the death of Mrs. K, what went wrong, recommendations to reduce the risk of repeat concerns, and resulting actions with effective monitoring arrangements.

2.4. The following focal points have emerged in the course of the review:

- Hospital discharge planning and coordination
- The referral pathway to Community Nursing
- The nature of contacts with adults at risk and family carers in circumstances of complex needs
- Consideration of social care needs and carers assessments
- The application of and compliance with the Mental Capacity Act

2.5. In summary, there is agreement across agencies' representatives interviewed that human and system errors in the coordination of and access to community services on discharge from hospital, in particular community nursing, led to a deterioration of health and readmission to hospital.

2.6. There are agreed recommendations and actions which are outlined in an action plan at the end of this report; concerning improved access to community nursing, improved hospital discharge planning and assessment, and enhanced risk assessment that incorporates personalisation and mental capacity awareness.

3. Safeguarding Adults Review Report

3.1. Mrs. K and family - pen picture

It is notable that involved agencies have very limited background knowledge on Mrs. K and her family, aside from physical and mental health needs. There had been numerous contacts by agencies and ample opportunities to engage with Mrs. K and her family and there was an acceptance of essential support offered, particularly on hospital discharge.

Mrs. K was aged 77 when she died. She lived with her daughter, DK, and grandson (aged 21) in a social housing flat in Roehampton. It is understood that DK was the family carer and main support to Mrs. K and, during the hours each day that DK was at work, the grandson of Mrs. K provided care. Mrs. K enjoyed knitting as an interest at home. There is no further life story information available in agencies records concerning Mrs. K and her family.

Her medical history includes a recorded diagnosis of vascular dementia (although not confirmed), bi-polar disorder, paranoid psychosis and delusional symptoms, Parkinson's disease, hypothyroidism, poor balance and difficulty mobilising outside (and at times inside) the home.

3.2. Facts (what happened)

3.2.1. Prior to initial hospital admission on 19 December 2016

Mrs. K had previously been admitted to **Kingston Hospital** Accident and Emergency Department in August 2014, following a fall, and in November received a CT head scan. The result was normal. There were no further hospital admissions until December 2016.

There was no contact with the **Central London Community Healthcare NHS Trust (CLCH)** during this period.

Wandsworth Police attended Mrs. K's address on 24 October 2011 on information received that the property was open and empty of personal possessions. On contacting DK, she confirmed that her mother was at her home address and was safe and well. On 30 April 2016, Mrs. K contacted Police in a confused state, relaying that she had no money to get home; that her daughter was at work and did not always return. Police attended and found Mrs. K to be safe and well. On 24 August 2016, Wandsworth Police responded to contact from a concerned neighbour who had seen a female wandering on the balcony. On attending, Mrs. K was on the

balcony outside her flat, unaware of where she was or where she lived. The grandson had fallen asleep and confirmed to Police that Mrs. K suffered from dementia, which was getting worse. The Police sent an email report of the incident to Wandsworth Adult Social Services Access Team on 26 August 2016. An Access Officer rang DK and advised of possible respite, which she said she would think about in the future. No further contact was made by Police or Social Services at this time and no other agencies were aware of Police engagement with the family.

The **London Ambulance Service** reports attendance on 24 August 2016. Mrs. K appeared confused and lost. She was left in the care of her daughter and grandson.

Prior to Mrs. K's admission to Kingston Hospital on 19 December 2016, it is understood that there had been no contact with or involvement by **Adult Social Services**, aside from the provision of Occupational Therapy equipment and contact by the Access Team (detailed above). The initial Occupational Therapy assessment was in 2007, following a GP referral for equipment, and there is no record of concerns raised at that time. During this period, it is understood that a social care assessment of need had not been offered to Mrs. K or a carer's assessment to DK.

There was limited **General Practitioner** contact during this period and this comprised surgery visits by Mrs. K and her daughter. DK had raised concerns with the family GP in August 2016 about Mrs. K's welfare, including a concern that she might wander off. There is no record of a request for services via the GP practice. DK stressed that she did not wish her mother to be admitted to a care home and that she was intent on persevering in her caring role.

Mrs. K was known to **SW London and St George's Mental Health Trust Community Mental Health Services**. There had been some contact by the locality Community Mental Health Team (CMHT) in 2006 and a diagnosis of paranoid psychosis, but there is no available record of the engagement. There was further CMHT contact from 19 July to September 2007, including contact with the Crisis Team, and there is no record of any referral to other services. In 2015, Mrs. K was under the care of a Neurologist at St George's Hospital, who concluded that she had Parkinson's Disease, requested a review of medication, and recommended a referral to a Psychiatrist regarding dementia. It is unclear whether there was a regular review and monitoring of the prescribed anti-psychotic and anti-depressant medication. In August 2015, Mrs. K had become more unwell, with shaking legs and requiring prompting to eat. A GP referral was received in September 2015, which did not have sufficient information to proceed. An appointment at the memory clinic was arranged for November 2015 but Mrs. K did not attend. Mrs. K missed appointments at the memory clinic and was discharged from the service in November 2015, following contact from DK that her mother was under the care of the Neurology Team at St George's Hospital and did not need this further input. The decision to discharge was based on family contact and was not underpinned by contact between agencies or exploration, possibly via a home visit, of the reasons for missed appointments; including whether Mrs. K had care needs (discussed directly) or DK had support needs as a carer. The GP practice has a record of a referral to the memory clinic in September 2016 and a CT scan in October 2016, but there is no record of this referral within mental health services. There is not a record of contact with other agencies to share information on needs and potential risks, subject to consent and confidentiality. It is understood by the Clinical Commissioning Group (CCG) that Mrs. K was living at this time with cognitive impairment but not with confirmed dementia.

During this period, it is noticeable that Mrs. K had a level of vulnerability and there was limited direct and proactive contact with her regarding her needs and potential risks. Also, information held by agencies was limited and largely held in isolation, reducing the scope for a multi-agency understanding of the potential range of needs and risks relating to Mrs. K and her family.

3.2.2. Initial hospital admission on 19 December 2016

Mrs. K fell from the second to bottom step on the stairs at home on 15 December 2016, landing on her side, which had been her only fall in the previous 12 months that is known to agencies. Her daughter supported her in standing. On the following day, Mrs. K was in pain and DK noticed what appeared to be a blister, blood and pus on her left buttock. Mrs. K was accompanied by her daughter to Kingston Hospital on 19 December.

An Occupational Therapy assessment was completed at **Kingston Hospital** on 19 December and Mrs. K gave permission for DK to speak on her behalf. Mrs. K had received constant supervision at home and needed the assistance of one person to mobilise (including stairs), also at times to transfer, and assistance with washing and dressing. Her daughter reported that she was managing, that she would continue to manage care and had no concerns. She intended to arrange day care support the following year. After Christmas, she planned to move her mother's bed downstairs and requested a commode, which was provided. Both Mrs. K and DK agreed with the support plan and DK was signposted to available support.

Mrs. K received an assessment by the Hospital Treatment Team, including a Tissue Viability Nurse (TVN) on 21 December. This confirmed the presence of an abscess, which was either a traumatic injury or pressure ulcer, to her left buttock; redness to her sacral/upper buttock area; and a pressure ulcer to her left ankle. The wound to Mrs. K's buttock was surgically drained, treated with antibiotics and was reported to be healing. Mrs. K was assessed by a dietician on 21 December and was eating and drinking well; her daughter confirmed that this was also the case at home prior to admission. The TVN recommended pressure relieving equipment.

There were no concerns at this time about Mrs. K's mental capacity to make decisions regarding her care.

An appointment at the **Community Mental Health Services** memory clinic on 21 December for an initial assessment was not attended and it is recorded that DK rang, leaving a message that Mrs. K was not well and had been admitted to hospital.

3.2.3. Hospital discharge on 23 December 2016

On 23 December 2016, the decision was taken for Mrs. K to be discharged from **Kingston Hospital** on the same day and she returned home at 13.53. Her daughter requested discharge in time for Christmas and said that she would manage until the pressure relieving equipment was delivered. There was a conversation with DK about returning home and signposting for support, but it is not clear that there was a thorough risk assessment. It was believed that there would be the provision of a Community Nursing assessment and support on discharge and that any risk would be picked up at this point. There was not an awareness that a referral made after 11.00 am would not trigger support by the next day. Mrs. K's needs were not

considered to be particularly complex. It is acknowledged by involved agencies that discharge is not advisable until it is known that pressure relieving equipment will be in place.

A referral was made by Kingston Hospital on 23 December at 13.01 for Community Nursing support with daily dressing of a grade 3 pressure ulcer to Mrs. K's left buttock and pressure relieving equipment; a hospital bed, mattress and chair cushion. The standard **Single Point of Contact (SPOC)** referral form was sent as an email attachment to the SPOC, which was correct practice, and a Team Leader at SPOC advised that the referral was received at 13.01.

The SPOC is a Wandsworth and Merton CCG and CLCH NHS Trust (at the time of discharge, St George's NHS Health Trust) commissioned service for referrals to Community Nursing. It is provided and managed by Vocare, who are commissioned by six CCGs to deliver the 111 service in South West London, and SPOC is part of the 111 call centre service in Wandsworth. The contract has been with Vocare from September 2016 (previously with Care UK from about September 2014, with close monitoring of response targets). It is understood that regular monthly contract monitoring meetings (involving the provider, CCG, Health Trust and SPOC) were initially held when Vocare began as the provider, but were subsequently less frequent. A document entitled 'dealing with calls for Wandsworth SPOC' was introduced in September 2016 to clarify the referral process. A 111 call adviser (part of a team of non-clinical, trained staff and team leaders) receives phone calls and email attached referrals from any source (checking the inbox hourly) and, if relating to Community Nursing, forwards these to the **Wandsworth Assessment and Coordination Hub (now called the Single Point of Access or SPA)** within Community Services via the Adastra referral recording system; with a follow-up phone call to the Hub to confirm receipt. Routine referrals should be forwarded by the SPOC within 6 hours. Vocare reports that there were difficulties with the Adastra system's compatibility with the Hub's IT system and some referrals were not received by the Hub, which was flagged with the CCG. Vocare staff deployed a back-up system, whereby an email and attached referral were forwarded separately to the Hub in addition to using the Adastra system. The referral pathway incorporates three contact points (involving four agencies) and the inclusion of the SPOC presents no identifiable benefit to communicating the referral. It is acknowledged by all parties involved in the review that the system is complicated and unsafe, despite the subsequent imposition of checks and an assurance that all referrals are now received and acknowledged.

With regard to Mrs. K, the referral for Community Nursing and pressure relieving equipment was entered by the SPOC call adviser onto the Adastra system with the correct case number on 23 December at 15.48 or 15.51 and forwarded to the Hub. A separate email was also sent to the Hub, not via the Adastra system, at 15.58, with the correct case number but with a referral form relating to a different patient.

The Wandsworth Access and Coordination Hub (now the SPA) receives referrals at a reception point and forwards these to **Community Nursing Teams** via the RIO recording system, alongside an email to advise that a referral is on RIO and, if urgent, with a follow-up phone call. In relation to Mrs. K, the Hub has no record of receiving the referral via the Adastra system. The information on a different patient was acknowledged by a Hub team member on 24 December at 10.22 and acted on. The Hub also contacts the Facilitated and Supported Discharge Team (described below) but was not able to do so in this case without information on Mrs. K.

Consequently, Community Nursing was not provided for wound care and the pressure relieving equipment was not delivered to Mrs. K.

DK advised the Social Worker during the Safeguarding Adults Enquiry that she had contacted Community Nurses following hospital discharge, to be told that there was no record of a referral and therefore support could not be provided. The date of this contact is not known but was in the period prior to readmission (23 December 2016 to 18 January 2017). There is no record of this contact being made, which may indicate that the call was handled at a reception point and not passed through to a Nurse. DK also advised that she had contacted the NHS 111 line and was told that pressure ulcer care is provided in the community. There is no record of this call or of transfer to the GP.

DK declined a referral to the **Wandsworth Hospital Social Work Team** as she felt that she could manage and said that she would contact Social Services for annual respite provision after the memory clinic appointment in January 2017. Also, Mrs. K's level of need was not considered to be sufficiently high to warrant a referral and the focus was on health rather than social care provision. It is acknowledged that a referral may have been considered with the benefit of a more holistic understanding of needs and potential risks, including the previous Police, CMHT and GP contacts.

The **GP Practice** received the hospital discharge letter and this did not contain a request for support or information on the Community Nursing and equipment referral, although there is provision on the form to include this information. There was subsequently no contact between the GP practice and Mrs. K or her family between the two hospital admissions.

An appointment at the **Community Mental Health Services** memory clinic was scheduled for 16 January 2017 and Mrs. K did not attend. There is a record on RIO of phone contact with DK on the same day, in which she apologised and said that she was not well enough to accompany her mother to the clinic. There is no indication of further enquiry during this contact. Another phone contact was made with DK on 30 January to arrange the memory clinic initial assessment. DK advised that her mother had an appointment with the Neurology Team at St George's Hospital and Mrs. K was therefore discharged back to her GP.

3.2.4. Readmission to hospital on 18 January 2017

Mrs. K was readmitted to **Kingston Hospital** on 18 January 2017 via ambulance, following an unwitnessed fall at home and a deterioration in her health. She was initially drowsy and unresponsive. A one-week history of urinary and bowel incontinence was reported by her daughter.

A Tissue Viability Nurse assessment was completed on 18 January and reported that Mrs. K was thin and frail; had a new deep and infected sloughy pressure ulcer with deep tissue injury to her right hip; a stage 4 pressure ulcer to her right ankle (therefore a deterioration); and a deep tissue injury to her right foot. The wound to her left buttock was healing well. She also had discolouration of two toes and discoloured, broken areas on her left foot. A treatment plan including wound care and 2-3 hourly repositioning was initiated. Sepsis had set in as a result of the skin damage, causing internal injury to Mrs. K's organs. DK had advised on admission that her mother had been experiencing bowel and urinary incontinence and was spending a significant time in bed.

Mrs. K was described on this second admission as disorientated to time and place and that she only recognised her daughter. A mental capacity assessment was not considered in view of Mrs. K's declining physical health condition.

The first referral received by **Community Health Services** was on 27 January 2017. The Facilitated and Supported Discharge Team is provided by CLCH, including Senior Nurses, and would normally receive communication from Acute Hospital Discharge Coordinators when there are complex needs; even if there is not a request for services to be provided. It is a role of this team to check that community nursing services have responded and to liaise with other agencies, including Social Services, if necessary.

Kingston Hospital made a referral to the **Wandsworth Hospital Social Work Team** on 20 January 2017 and a Safeguarding Adults Enquiry was raised on 23 January due to suspected neglect.

A referral to the **Access and Community Hub** was resubmitted on 27 January 2017.

Mrs. K received antibiotics and fluids, becoming more alert, and her sepsis and general health gradually improved. Her health subsequently deteriorated and EA died in hospital on 20 February 2017.

3.3. Findings (what went wrong)

Finding 1 - Referrals to Community Nursing

The pathway to access Community Nursing is unnecessarily complicated and is unsafe, with a total of three contact points and four agencies involved, and with unreliability and insufficient checks on the receipt of information at each stage. Additional missed referrals relating to other patients were unearthed in a subsequent review, mainly comprising referrals not received or delayed; leading to immediate action by the St George's NHS Health Trust and Vocare. This included regular checks of the SPOC inbox, review of the Adastra form, restriction to one referral per email, sharing Community Nursing out of hours details with Vocare, acknowledgement by the Hub of referrals received, and consideration of a long-term solution. There have been performance issues concerning some SPOC staff not checking the inbox regularly and reportedly not communicating effectively. The same system is essentially in place since the incident, except that the Hub email address is now understood to be available to referral agencies and checks are in place, and there are continuing concerns about the effectiveness and safety of the referral pathway.

Finding 2 - Consideration of mental capacity assessments

Whilst it is apparent that a mental capacity assessment was not undertaken by any agency at any point, it is considered that Mrs. K had capacity relating to her care needs up to and during her initial hospital admission and that capacity was impaired due to infection on her second admission, when Mrs. K was very unwell and there were no apparent decisions to be made. However, given the concern regarding cognitive impairment, the presumption of decision specific mental capacity without an assessment is a concern.

Finding 3 – Personalised and inquisitive contact assessments with service users and families

Whilst individual agencies had responsive and purposeful contacts with DK prior to hospital admission, there was not a fully inquisitive approach to explore how Mrs. K and her family were managing and whether they would benefit from and accept a social care needs or carers assessment; particularly in response to concerns raised by Mrs. K and family with agencies and the cancellation of appointments. Furthermore, Mrs. K was considered to have capacity and, whilst she opted for her daughter to speak on her behalf (at least whilst in hospital), her direct voice was not heard in conversations.

Mrs. K was under the care of a Neurologist and it is unclear from information received whether she was living with ongoing mental health concerns and whether there was a regular review and monitoring of her prescribed anti-psychotic and anti-depressant medication.

Finding 4 - Multi-agency information sharing

The information held by individual agencies did not lead to an assessment of complex needs or high risk, but a multi-agency sharing of information may have triggered increased concern and an offer of comprehensive social care needs and carers assessments. This may have included flagging the need for an enhanced care pathway and referral to a Community Team, linked to the GP practice.

Finding 5 – Hospital discharge assessment

The complex needs and potential risks which should have been apparent on discharge, alongside the timescale involved in accessing community nursing and equipment, should have led to a decision to advise against discharge until these services were in place. This did not happen as the level of complexity and risk was not understood and the timescale for delivery of services was not known. Community nursing services can provide a holistic coordination role in the community, but were not contacted or engaged following hospital discharge due to the breakdown in the referral pathway. Furthermore, inclusion of discharge needs and services in the hospital discharge letter may have prompted the GP to contact Mrs. K and her family between admissions. Whilst not a direct finding of this review, it is not clear to the author whether a comprehensive understanding of complex service user and carer needs would have led to a coordinated discharge assessment, planning and delivery. For this reason, it is appropriate for health and social care agencies to continue to monitor the effectiveness of the hospital discharge pathway, in particular that it is coordinated, and to review the process if concerns arise.

Conclusion

There is agreement among agencies that the absence of professional wound care and pressure relieving equipment was a factor in Mrs. K's deteriorating health and readmission to hospital.

The risk of a repeat occurrence can be reduced by relevant managers and commissioners implementing the agreed actions (in the appended action plan), and ensuring that there is robust oversight and monitoring of the effectiveness of systems and procedures for:

- accessing community nursing
- multi-agency risk management, and
- effective hospital discharge planning and delivery.

4. Mrs K – Recommendations and Action Plan

Recommendations/Findings	Additional comments, points of clarification and actions	Assigned Lead Agency Officer	Target Date
RECOMMENDATION 1: (Finding 1) **Put in place an effective, streamlined operating system to access Community Nursing.**	Urgent review of the current operating system to access Community Nursing and of staff compliance.	Wandsworth & Merton CCG	October 2018
RECOMMENDATION 2: (Finding 2 and 3) **Raise awareness of the Mental Capacity Act and of Personalisation.**	*Health and social care commissioners to offer the SAB assurance on compliance with training on the Mental Capacity Act and involvement of the person.* *Health and social care commissioners to demonstrate impact of learning though a sample audit of a current case* *To review and improve the completion of Carers assessments as part of the hospital discharge process, particularly at times of high pressure in the systems such as bank holidays.*	SAR Subgroup SAR Subgroup Assistant Director: Operations Richmond and Wandsworth Councils	November 2018
RECOMMENDATION 3: (Finding 4) **Develop a shared multi-agency risk assessment and management protocol.**	*SAB members to contribute to a shared understanding of effective management of pressure ulcers through the adoption of a shared protocol on pressure ulcer management.*	Richmond & Wandsworth Council, Head of Safeguarding and Professional Services Adult Social Services	February 2019
RECOMMENDATION 4: (Finding 4 and 5) **Review hospital discharge procedures to ensure that detailed information is held to**	*Liaise with South West London hospital discharge group to identify learnings from across south west London and identify how*	Director Adult Social Care	October 2018

Recommendations/Findings	Additional comments, points of clarification and actions	Assigned Lead Agency Officer	Target Date
support effective discharge planning around weekends and public holidays.	*these can be applied to the local health and social care system.*		
<u>RECOMMENDATION 5:</u> (Finding 5) **Provide assurance that, on hospital discharge, Wandsworth & Richmond residents receive assessment, planning and delivery of services that meet their needs; including effective handover between acute and primary health care** (Hospital and Community Nursing)	*Sample audit of hospital discharge practice, including interface with both primary health care and community services, over a bank holiday period and identify actions to mitigate the risk.*	Director of Quality & Governance (Wandsworth & Merton CCG); Director of Quality and Safeguarding Lead (Kingston and Richmond CCG)	April 2019

5.