Safeguarding Adult Review (SAR) in Rapid Time Systems Findings Report

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A SAR commissioned by the Sutton Safeguarding Adult Board

This SAR was commissioned by the Sutton Safeguarding Adult Board following the death of Mrs B. The review is to be carried out as a pilot of a new methodology called "SARs in Rapid Time". This is being done under the guidance of the Social Care Institute for Excellence (SCIE).

The new methodology is seeking to provide a process that (i) enables learning to be identified more quickly than in the usual processes and (ii) has a focus on systems learning.   The aim is to turn this around more quickly (15 working days) than the usual in-depth SAR.

The Independent Reviewer and SSAB Business Manager were participants in SCIE's Cohort Two pilot project and will submit a reflection on the process separately.

Information for the analysis and discussion was provided by partners involved in this case. We acknowledge that all services have been stretched during the Covid pandemic. This is a new methodology, and thanks has to be given to partners, especially in this time pressured period, for the speed in which they contributed to the chronology and participated in the multi-agency discussion. The partners included:

- Metropolitan Police
- London Borough of Sutton Adult Social Care (ASC)
- London Ambulance Services (LAS)
- Epsom and St Helier Hospital
- South-West London and St George's Mental Health Older People's Community Mental Health Services (OPCMHS) which includes the Memory Assessment Service (MAS)
- General Practice X (Mrs B's GP)
- NHS Sutton Clinical Commissioning Group (CCG)

In addition, although not involved directly or indirectly with the care of Mrs B nor with her daughter, thanks are due to Sutton Carers Centre, who attended the multiagency Early Analysis meeting, and contributed to the SAR discussions as a ;key partner and member of the Sutton Safeguarding Adults Board.

Summary of Chronology of Mrs B

Mrs B was an elderly lady of African-Caribbean heritage who was blue-lighted to Epsom and St Helier's Hospital on 24th May 2020 where she died two days later. The accompanying report by the LAS was one of a person suffering from severe neglect: she was emaciated (her BMI was 11), she did not appear to have been fed for days, she had numerous pressure sores, and her home smelt strongly of faeces such that the LAS believed her personal care may not have been carried out for some time, though they noted she was in a clean pad on their arrival. The Police were informed on 26th May and at the time of writing this report an investigation is ongoing into the care provided to Mrs B by her daughter.

Preliminary investigations by the SSAB revealed that three safeguarding concerns had been made regarding Mrs B during the period from March 2015 to March 2017 although none had resulted in safeguarding enquiries.

At the time of death Mrs B was under the care of the Older People Community Mental Health Services (OPCMHS) and had a diagnosis of Alzheimer's Disease. Her daughter was her sole carer. Mrs B had not been seen *in person* by this Service since April 2019. The last contact of the Service had been by way of a telephone call to her daughter in April 2020. Mrs B was not known as a client to Sutton Adult Care Services, despite previous referrals, which should have triggered assessments, given her need for care and support.

Systems findings

This document forms the final output of the SAR in Rapid Time. It provides the systems findings that have been identified through the process of the SAR. The discussions in the Multi-Agency Early Analysis Meeting, held to discuss the early analysis, very much inform the contents of this report and there are a few references to this meeting in the findings below. These findings are future oriented. The findings focus on organisational and systemic factors that impacted on practice in Mrs B's case but also hold true today and therefore impact more widely. They provide learning about issues that need to be addressed in order to provide a timely and effective partnership response to similar situations which may arise in the future. Each finding is listed individually, and these are then followed by a few questions which are designed to aid the SSAB and partners to review practice. It is acknowledged that the constraints of a SAR in Rapid Time mean that the learning captured in this report cannot be comprehensive. This systems findings report is presented as a vehicle for change and improvement in services across the partnership.

Background

This SAR in Rapid Time covers the period from 5th March 2015 to 26th May 2020. All of the underlying systems findings in this report relate to issues that were in existence before the pandemic and are not related to COVID.

Because Mrs B was not seen by any Service after April 2019, it has not been possible for this Review to ascertain the period over which Mrs B declined nor to describe what happened to Mrs B during the final 13 months of her life. The hearing of the Coroner's Court into the death of Mrs B is due to take place in Spring 2021.

Mrs B had a son and a daughter. Her son had little involvement in her care. He wrote to the Reviewer, declining the offer to meet, stating that the last time he had seen his mother was on 13th March 2017, and that he had no knowledge of any care or support offered to her and that he would not have expected to as they never really spoke. It therefore seemed that Mrs Bs daughter was her only carer. It was not possible to make contact with her because of an ongoing Police investigation.

During this period ASC services underwent a reorganisation. In 2018 services that had been arranged on a functional basis, with a centralised specialist safeguarding adults team, were re-established within four localities. Each of these localities has a First Response and Review Team which is responsible for the receipt of safeguarding concerns concerning residents within that locality. While all concerns still come into the Council through Referral Point, this single point of entry into the Council is now no more than a forwarding point, sending concerns onto the relevant locality. Within the new arrangements the Safeguarding Head of Service chairs a monthly key meeting with all safeguarding champions representing these teams to track Safeguarding activity and surface operational issues.

The provider of secondary mental health services throughout this period was the South West London & St George's Mental Health Trust Older People Community Mental Health Services (OPCMHS). The OPCMHS have sub teams embedded in the service structure and one of these teams is the Memory Assessment Service (MAS). This is a non-urgent service offering both outpatient and home visits for assessment, diagnostics, treatment, and treatment reviews. The service does not offer care coordination. Where a patient may require care coordination, they will be transferred to the Community Mental Health Team. The MAS will discharge patients back to primary care once pharmacological treatment is at its optimum level, in line with a shared care prescribing protocol for anti-dementia medication.   The Mental Health Trust had carried out its own Root Cause Analysis into the Care of Mrs B covering the latter part of the period – from 18th October 2018 to 24th May 2020, although Mrs B had been under the OPCMHS since March 2017 when she was referred by her GP. This report was shared with the Independent Reviewer.

Mrs B had the same GP throughout referred to in the Report as "GP Practice X". GP Practice X carried out a "Significant Event Analysis" (SEA), that is its own review of Mrs B's care. The findings from this review and the Practice's letter to the Coroner, were shared with the Independent Reviewer.

1. Compliance with the Care Act 2014 to ensure care and support for residents of Sutton

Systems Findings

Local authorities have a number of duties under the Care Act 2014 and require robust systems for all incoming work, including the intake of referrals and safeguarding concerns and their disposal. These systems ensure not just that legal duties are met but that residents receive the care and support to which they are entitled. A strong system will respond quickly to requests for help, noting that delays in response can have negative consequences for both the "cared-for" individual and their carer. The relevant duties referred in the Review are:

- Section 42 of The Care Act 2014: local authorities must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. The system for receiving concerns should include prompt feedback to the agency (or person) raising the concern about the outcome and next steps.

- Section 9 of the Care Act 2014: local authorities have a duty to carry out an assessment where it appears that an adult may have needs for care and support.
- Section 10 of The Care Act 2014: local authorities are required to carry out an assessment of carers needs for support, wherever there is ‘an appearance of need’.

Sutton Council failed in all three of these duties with respect to the experience of Mrs B.

During the early part of the period under review – from 2015 to 2017 - there were three safeguarding concerns raised via Police Merlins. None of these resulted in safeguarding enquiries. Those completing all three ASC safeguarding alert forms recognised that there were mental capacity issues and in all instances either insufficient or no action was taken with the exception of the 2016 alert resulting in the Merlin being sent “for information” to the Mental Health Services who it seems did not respond.

Feedback was not given to the Police with respect to these three Merlins which means that “it is not possible to understand what action has been taken by Social Services once the Merlin is received” (Police at the Multi-Agency Early Analysis Meeting).

In July 2017 the LBS Referral Point received a request from the OPCMHS for a carers assessment for Mrs B’s daughter. The records say that when Referral Point called Mrs B’s daughter, she requested an assessment for her mother, Mrs B. The request for the carers assessment was followed up in October 2017 which is three months after receipt of the request. In the event Mrs B’s daughter did not respond despite numerous attempts to contact her. Eventually the case was closed in March 2018. Good practice would have been to make a visit.

Records do not show any attempts being made to arrange a Care Act assessment for Mrs B, and it seems that a request for a needs assessment could be lost in or fall out of the system in operation at the time. The Review was told that at the time the record on Mosaic for Mrs B and the separate Mosaic record for her daughter were not linked in that the case notes from each record should have been automatically copied over into the other record and this did not happen. It is not possible to say to what extent this contributed to the request for an assessment being overlooked.

As noted above in the Background section, a new structure has been introduced in ASC and all initial contacts are screened by the Locality-based Duty Team – now called the First Response and Review Team – to ensure much tighter oversight over incoming work and timely screening so that nothing can be missed. Forms in use for record safeguarding concerns and decisions are being revised at the moment.

Since November 2019, monthly safeguarding champions meetings have been introduced to allow safeguarding champion representatives from all teams to attend. Also present at the meeting are the MASH Sergeant, commissioners, business support, and trading standards. The purpose of the meeting is to share information. The meeting is minuted with an action tracker of operational issues arising that relate to Safeguarding. Commissioners, MASH (the Police), business support and Trading Standards and all areas can feedback on any issues. The meeting considers any patterns or themes arising and this can be linked in with the Council’s Learning & Development as required. There is also a bi-monthly operational Sutton Safeguarding Adults Board (SSAB) Partnership meeting where operational issues are discussed across the Partnership.

Questions for SAB and partners

- Is the SAB satisfied that the locality-based arrangements have bedded in and that all duties and responsibilities of the Local Authority under the Care Act 2014 are being discharged properly?
- Is the SAB satisfied that in the new arrangements there are sufficient measures in place to ensure consistency of response to safeguarding concerns within and between each of the ASC teams?
- Could a request for an assessment be missed today?
- Is there a shared understanding of the purpose of Merlins (the forms on which the Police raise safeguarding concerns)?
- What feedback should there be to those who raise safeguarding concerns including Merlins?

2. Developing the “living well with dementia in the community” pathway in Sutton

Systems Findings

Many dementia partnerships have adopted the NHS England “Dementia Well Pathway” Framework[1] for the organisation of services to put in place wrap around services for individuals diagnosed with dementia and their carers. Such partnerships include the specialist mental health trust, local authority ASC, primary care, and the voluntary sector. This framework recognises that ultimately dementia is a degenerative condition, albeit individuals differ greatly in how their dementia develops. MAS sits within the “living well with dementia in the community pathway”.

The point of this pathway is to bring together the functions of MAS (assessment, and diagnosis), with the patient’s GP and ASC so that the patient experience is one of joined up care. Such a system will ensure that there is a shared understanding of thresholds for Care Act assessments. Given that the majority of patients and service users of Dementia Services are elderly, the interface with frailty will be recognised and clinical staff will be aware of physical needs and the interaction between physical health needs and cognitive decline.

It was not evident that support for patients’ social care needs is included in the “living well with dementia in the community pathway” in Sutton.

The Root Cause Analysis, carried out by the Mental Health Trust, describes the functions of the MAS service as limited to assessment and liaison with the patient’s GP, with the aim of discharge back to primary care as an integral part of the local dementia care pathway and *living well with dementia*. The report comments on the fact that the MAS was not discharging patients as rapidly as intended when the service was set up.   When the COVID lockdown occurred the patients of the MAS, including Mrs B, were categorised as low risk and banded green and clinic appointments were converted to telephone consultations. The impact on Mrs B is considered in section 4 below. However, from a systems point of view the underlying challenge was not COVID related but about how the services in the “living well with dementia” pathway were organised.

Clinicians, working within the Memory Assessment Service (MAS), part of the OPCMHS, are often the first point of contact that patients and their carers have with specialist dementia services. It should be part of their role to identify when and how to make referrals to ASC for a

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[1] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Care Act assessment when social care needs are present. The Review was told that in practice "our understanding of what is deemed as "eligible need" is basically assistance with personal care and we have to argue exceptional cases on a case by case basis".

Occupational therapy (OT) within the MAS saw Mrs B in June 2017 and the description of Mrs B would indicate the need for a referral for a Care Act assessment. However rather than sending the report to ASC, the action noted was "the OT to send ['Mrs B's daughter'] information on local care agencies with dementia care trained staff". This action directly bypasses ASC assessment and support planning processes and instead moves directly to proposing private homecare arrangements be made outside the ASC system.

Questions for SAB and partners

- How is the local system going to ensure that the "living well with dementia in the community" pathway includes the contributions of both the NHS and the local authority?
- What are the reasons for the difficulty and the barriers to making referrals to ASC for Care Act assessments of individuals under MAS?
- What plans are in place to review the operational policy, and functions of the MAS, and will this strengthen the overall pathway and experience of joined up care by patient/service users and their carers?
- The Royal College of Psychiatrists has a MAS accreditation programme (pub April 2020 7th edition). Does the Sutton MAS meet these standards? https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/memory-services-national-accreditation-programme-msnap/msnap-standards

3. Systems to support the family carers of patients/service users with dementia

Systems Findings

The support from family or friends of individuals with dementia is often critical and systems and policies should recognise the difficulty of caring for someone who has a degenerative condition that is often accompanied by declining communication skills and increasing physical frailty. Many areas commission specialist services to support family and informal carers, for example the Alzheimer's Society and Admiral Nurse Service. This is in the knowledge that if carers are not supported in their role then plans to support the patient/service user may fail, with adverse consequences for the patient/service user who may then require additional support from unknown carers outside their immediate circle which may cause distress. There is a statutory duty on local authorities to assess carers' needs for support (noted above).

Robust needs assessment and care planning for patient/service users requires realistic assessment of the ability of a family carer to provide the necessary support and requires clinical staff to maintain vigilance about the quality of care being provided as the needs of the patient/service user increase. Contingency planning is good practice to cover what might happen in the event of the carer not being available.

Caring for a loved one with dementia can be very distressing as that person through cognitive impairment ceases to be the person the carer knew and may no longer recognise the carer. In that context sole carers who decline to engage with offered support might invite professional curiosity as to how well they are coping and about the wider family network.

All agencies involved in a person's care may find their approach reliant on a family carer to deliver the support plan. Clinicians and others who are aware of this hold in their minds at all times that the interest of the patient/service user and the interest of the family carer are not always the same and ensure that sight is never lost of the patient/service user.

Mrs B had a son and a daughter. Her son had little involvement with Mrs B. It therefore seemed that Mrs B's daughter was her only carer.

The GP Practice X and the MAS relied on the availability and wellbeing of Mrs B's daughter to support Mrs B and to bring her to appointments. The MAS described this as a "working relationship" with Mrs B's daughter. This desire to believe in the carer rather than to remain neutral and enquiring meant that there was no questioning of the adequacy or otherwise of Mrs B's care, through the eyes of Mrs B, or of the dynamics in Mrs B's family. This has been described in the Multi-Agency Early Analysis Meeting as 'professional optimism'. Mrs B's daughter cancelled three consecutive appointments at the MAS in the period from October 2019 to April 2020, but this did not trigger safeguarding concerns.

The MAS did request a carer's assessment for Mrs B's daughter, but ASC took 3 months to respond and Mrs B's daughter did not reply to their contact. The MAS made many attempts to encourage Mrs B's daughter to seek support from the local Alzheimer's Society, but she did not follow this advice. No attempt was made to arrange the attendance at one of the review meetings at the MAS with one of the agencies that offer support to carers. In Sutton there are three possible agencies that might have been contacted: Sutton Carers, Alzheimer's Society, and the Admiral Nurses, although it is understood that at the time the pathway for carer support was to refer to the Alzheimer's Society first.

Questions for SAB and partners

- The interests of the cared for and their carer(s) are not always mutual and can even conflict. How do you know that for individuals with limited mental capacity, reliant on their carer, that their support arrangements are safe? What might trigger a safeguarding concern?
- To what extent is the provision of support for carers built into the "living well with dementia in the community" pathway referred to in section 2 above?
- Are referral routes and respective roles of Sutton Carers, Alzheimer's Society, and the Admiral Nurses clear to partners? Are there any gaps in the services provided by these organisations? Do any of these services provide "in-reach" services, i.e. being prepared to attend clinical appointments when a Carer has shown themselves reluctant to seek support?

4. Systems for responding when people dependent on their carers are not brought to appointments

Systems Findings

A safe system for people with dementia care reliant on their carers, needs robust systems for noticing and responding if they are not being brought to appointments. Mrs B's case has shown these systems are not yet strong enough in Sutton.

Mrs B was wholly reliant on her daughter to take her to appointments. The last time Mrs B was seen in-person by the MAS was in April 2019. The next appointment was to have taken place in October 2019 and this was cancelled, together with two subsequent attempts to reschedule this meeting, by Mrs B's daughter. This did not trigger any safeguarding concerns.

With the advent of COVID and lockdown in March 2020, all MAS clinic appointments were converted to telephone consultations without regard to when the patient/service user had been seen last. On this basis, despite the fact that Mrs B had not been seen for a year, a telephone consultation took place in April 2020 with Mrs B's daughter, as Mrs B was not able to participate in a consultation by telephone and therefore was not seen and not heard.

The Mental Health Trust has a policy called "Clinical Disengagement/Did Not Attend (DNA)/" Was not Brought" Policy. The Multi-Agency Early Analysis Meeting was told that this Policy is in the process of being updated to include a section about adults lacking mental capacity who are reliant on their carers for attendance at appointments. Amending this policy and ensuring it is embedded into practice should enable staff to recognise the vulnerability of individuals without mental capacity and the need to respond differently when attendance at appointments does not happen.

Questions for SAB and partners

- Are SAB members confident that all agencies have policies that ensure that Services notice and respond if a patient/ service user with dementia and/or without mental capacity is not being brought to appointments?
- Are these policies working in practice?

5. Relationship between the Older People Community Mental Health Services (OPCMHS) and Adult Social Care (ASC)

Systems finding:

It is not clear what operating arrangements exist between the MAS and ASC to ensure that there is mutual support between the MAS and ASC for all patients / service users that might require each other's services, not just patient/service users causing immediate concern. It is not apparent that the benefits of such arrangements are recognised within the Sutton system. The relationships and systems between the Mental Health Trust OPCMHS and the other four boroughs covered by the Trust could be explored as points of comparison of different practices in different places.

A monthly meeting has recently been established between OPCMHS & ASC where cases of concern are discussed – "both agencies bring cases to discuss and action plan. Any staff member can request to go to talk about cases, normally a manager and social worker attend". This meeting is for all of OPCMHS and it is likely that the cases brought to this meeting would be higher risk cases that sit under the Community Mental Health Team rather than the MAS. The operation of this meeting also relies on identification of cases as being "of concern" by practitioners. It is not a meeting that would discuss routine cases that might need attention from each other's services.

It is unlikely therefore that Mrs B would ever have been discussed at one of these meetings even had this arrangement been in place at the time as she would not have met the threshold of being a "case of concern".

Questions for SAB and partners

- Are working arrangements between OPCMHS and ASC safe, so that patients and service users cannot fall between organisations?
- Is there a single understanding of the thresholds for safeguarding and Care Act Assessments?

- Has the SAB considered exploration of how relationships and systems work in other places?

6. Proactive management of patients with dementia and frailty in Primary Care

Systems Findings

A safe system for the proactive management of patients with dementia and frailty did not seem to exist within the GP Practice X over the period of this Review. The protocol in place between the OPCMHS and Primary Care covered medication only and was not a full “shared care protocol”. Such protocols are common and ensure that each party is clear what to expect in terms of monitoring and communication with each other. This would cover repeat failure to attend appointments.

The criteria for inclusion on the Practice risk register should be broad enough to include those patients without capacity (of any age) who are reliant on family carers to bring them to appointments and to speak on their behalf on telephone calls. A system within the Practice to track successive “failed encounters” and to take appropriate action did not seem to be in place. It was confirmed that Mrs B was on the dementia and diabetes registers within GP Practice B.

Mrs B had both dementia and diabetes and increasing frailty. Mrs B registered at the GP Practice X in May 2010. Her first GP appointment was on 13th March 2017 when she attended with concerns about her memory.

On 21st March 2017 a referral was made to the MAS. The GP Practice X relied on the MAS to monitor Mrs B regularly. The expectation of the GP Practice X “was that these reviews would be carried out and the Practice would be notified if there were any concerns until such time in the future when Mrs B was fully discharge back to primary care”. Because the Practice was not fully informed of Mrs B’s failures to attend MAS appointments, Mrs B was not included on the Practice’s risk register.

The relationship between the GP Practice X and the MAS/OPCMHS was governed by a shared care prescribing protocol for anti-dementia medication. Under this agreement the MAS is responsible for reviewing the patient every six months and the Practice is responsible for the repeat prescribing of the secondary care medication. The prescribing responsibility is only transferred to the GP when the patient is stable. There are no specific health checks recommended for ongoing monitoring of these medicines by the GP unless side effects are reported, and there were none in this case.

In October 2017 Mrs B attended the diabetes clinic at the Practice. It was recorded that Mrs B had struggled to arrange an appointment at the Practice due to her daughter needing to take time off work to attend with her. Mrs B was referred to various services in connection with her newly diagnosed diabetes.

Mrs B was last seen by her GP when she attended the Practice in November 2017 for a medication review. Thereafter she was reviewed by the MAS every six months and not seen again by a GP. Reports were sent to Primary Care by the MAS after every attendance by Mrs B including by the MAS occupational therapy following their assessment of Mrs B in June 2017.

Mrs B's annual diabetes blood monitoring tests fell due in November 2018, but these did not take place as despite writing to Mrs B and an attempted phone call to Mrs B's daughter it was not possible to reach her. A reminder letter was sent to her.

The request from the MAS in April 2019 for the Practice to arrange for Mrs B to have a diabetes check with blood tests did not take place – following a number of "failed encounters".

The Practice carried out a "Significant Event Analysis" (SEA) into what it had known at the time about Mrs B's non-attendance at MAS reviews and whether it should have continued to prescribe Mrs B's medication. The SEA also notes that from May 2019 there were a series of five failed telephone encounters that the Practice had instigated and a lack of response to a letter sent to Mrs B on 17th June 2019. The failed encounters are assumed to include failures to attend the Practice for blood tests for diabetes monitoring.

As a result of the SEA, the Practice has introduced a policy for failed encounters for Adults. The Practice has further reviewed the use of its Risk Register and widened the criteria for inclusion with respect to patients with dementia to include patients with dementia and who also live alone, and patients with dementia who live with a person over age 70. The risk register also has inclusion criteria for patients without dementia that are not relevant to this Review.

Inclusion on the Risk Register followed by non-attendance at appointments would trigger discussion at the weekly clinical meetings in the Practice, as well as contact being made with other agencies involved in the care of that patient, a home visit if required, a safeguarding referral as appropriate.

The Practice has recently purchased new software that identifies patients who have a frailty score above a certain point on the frailty index. From the information known to Primary Care, and recorded in Mrs B's records, Mrs B would not have reached the trigger score. However, the Practice were not aware of Mrs B's condition in the final stages of her life – incontinence, impaired mobility, and pressure sores – which would all score highly on an index of frailty. This lack of awareness is because the Practice did not make any attempt to see Mrs B, for example through a home visit, despite the repeated "failed encounters" in their service, and the failed attendance at the MAS.

Questions for SAB and partners

- Are the criteria for inclusion on the Practice Risk Register criteria broad enough to include those patients without capacity who are reliant on family carers (of any age) to bring them to appointments and to speak on their behalf on telephone calls.
- Is there sufficient recognition in the methods used in the Practice to case-find of the *combined* impact of Frailty and Dementia (where there might be a multiplicative effect) regardless of the age of the patient or the age of any other people registered as living with them in their household?
- What ongoing support is provided by the CCG for its members on case-finding and frailty and dementia? What work has been done with practices to implement NHS

England policies on Frailty[2].

- In the light of this case, what benefits would extending the current medication protocol arrangement to a full shared care dementia protocol bring, and should this be put in place?

7. Supporting Families with a member who has Dementia

Systems findings

Caring for a family member with dementia is difficult and often highly distressing. Adopting a whole family approach[3] means considering relationships within families, and how the needs of the person being assessed impacts on other family members. This is usually discussed in the context of the read across between the Care act 2014 and Children's and Families Act 2014. However, the Multiagency Early Analysis Meeting considered that this family approach is relevant to Mrs B's case as well.

On the basis of the records seen and information provided, a notable fact about Mrs B is the minimal information obtained by any of the agencies involved with her care about her family and her relationships that might impact on her wellbeing and on her care and support. This is especially noticeable in the context of a patient/ service user who had a degenerative cognitive condition, and it was known, in absence of paid carers, that she would become increasingly reliant on her family carer(s).

There was consensus at the Multi-Agency Early Analysis Meeting, that this area should be explored further for families with a member who has dementia and declining cognitive function, with the active participation of Sutton Carers Centre, and other agencies that support carers within the Borough.

Questions for SAB and partners

- How is the work on "whole family approaches" to be taken forward?
- What needs to happen to ensure that there are contingency plans for individuals with care needs who are wholly reliant on their families for support?
- What is the role of voluntary sector organisations who work and support carers in the Borough?

8. Capacity for Improvement

Systems Findings

Making changes and ensuring continuous improvement requires at an operational level strong staff and casework supervision and learning and development. This should be reinforced by audit. This is always important but even more so when a majority of staff might be familiar and comfortable with earlier ways of working.

But capacity for improvement also requires a willingness to create shared strategies and

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[2] For example: https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-risk-identification/

[3] https://www.adass.org.uk/the-care-act-and-whole-family-approaches

plans, in this case an integrated dementia strategy, that recognises the contributions of all agencies and addresses how agencies work together to provide a joined-up experience for an individual patient/service user.

All of the three agencies most closely involved in this Review – GP Practice X, the MAS, and ASC, have signalled that they have been reviewing their operating systems, but this is in isolation from each other.

Questions for SAB and partners

- How does the SAB capitalise on the strength in its partnership to ensure that issues raised in this Review are included in key strategies and plans - for example on dementia, frailty, and whole family working?