REPORT OF
LEARNING TOGETHER
SAFEGUARDING ADULTS
REVIEW FOR MS. B

PRESENTED TO THE
ENFIELD LOCAL SAFEGUARDING ADULTS BOARD

June 2021

What can we learn about the way that practitioners involve patients and their carers in decision making around discharge, especially in relation to those with multiple or terminal conditions including high risk conditions such as Category 4 pressure ulcers when returning to live alone?

Preface

The following report uses the Learning Together (Fish, Munro & Bairstow 2008) systems methodology developed by the Social Care institute for Excellence (SCIE) for Serious Case reviews. The Enfield Local Safeguarding Adult Board and member agencies should take ownership and act in response to the findings from this Serious Adult Review to put in place lasting improvements to services.

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1. Introduction

Why this case was chosen to be reviewed

Following the death of Ms. B, the Enfield Local Safeguarding Adults Board (SAB) decided to commission a Safeguarding Adult Review under Section 44 of the Care Act (2014) as there may be lessons to learn from what went wrong (and what went well). SABs must arrange a SAR when an adult with needs for care and support in its area dies, and it is known or suspected that this was as a result of abuse or neglect, and there are clearly identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults are safeguarded in the future. Appendix 1 sets out the principles that the SAR followed.

The Review was commissioned in February 2018 giving consideration to the Quality Markers currently being developed by SCIE in conjunction with Research in Practice for Adults (RiPfA). Ownership of the final report lies with the SAB as commissioner of the case review.

1.2 Summary of case

Ms. B was an 81-year old clinically obese woman, living at home with the support of her neighbours and in receipt of a small domiciliary care package. There were no concerns regarding her mental capacity. Community nurses visited Ms. B regularly to dress her pre-existing leg ulcers and moisture lesion on her sacral area. During a fall Ms. B fractured her left hip and was taken to hospital for treatment. She remained there for over two months following surgery to her fractured left hip. During this admission she also received treatment in relation to a pre-existing diagnosis of bladder cancer which included a surgical TURP (resection of tumour), associated chemotherapy and treatment to manage infection. Whilst in hospital, Ms. B developed a Category 4 pressure ulcer. She was discharged home from hospital with an increased care package and was readmitted 4 days later with suspected sepsis. Ms. B died in hospital three weeks later.

2. Methodology

2.1 Timeframe

The time period examined by this Review was July 2016 until 21st October 2016 when Ms. B passed away. Whilst it is relatively unusual to have such a short timeframe, having examined the Hospital's Serious Incident Review, the SAB wanted to focus on the issues around Ms. B's discharge from hospital. In 2016, the SAB had commissioned a SAR around a case that also concerned pressure damage and hospital discharge and so wanted to investigate these important multi-agency issues again in a proportionate way. Subsequently, when the Review Team developed the Research Questions below, it was agreed that this period was representative of Ms. B's experience of living at home as well as covering her subsequent hospital admittance and discharges.

2.2 Organisational learning and improvement

Rather than conduct a more traditional review, the SAB also decided to trial the SCIE *Learning Together* systems model (Fish, Munro & Bairstow, 2008) to carry out this Safeguarding Adult Review. The Learning Together methodology is explained in more detail in Appendix 2.

2.3 Research question

2.3.1 The use of research questions in a Learning Together Review replaces traditional Terms of Reference. Research questions identify the key lines of enquiry present in the case that the SAB believes are most relevant to current practice. Following discussion, the SAB identified that review of this case may shed light on particular areas of practice, and following discussion, the following Research Question was posed by the Review Team:

2.3.2 *What can we learn about the way that practitioners involve patients and their carers in decision making around discharge, especially in relation to those with multiple or terminal conditions including high risk conditions such as Category 4 pressure ulcers when returning to live alone?*

Subsidiary questions:

2.3.3 *What can we learn about how hand-overs between different services are managed for patients with high risk conditions such as Category 4 pressure ulcer particularly during discharge from hospital*

2.3.4 *What can we learn about what helps and hinders practitioners in Enfield in their communication with patients with complex and/or life limiting conditions?*

2.3.5 *What can this case tell us about the professional interface with 'Next of Kin' in decision-making about patients' health and wellbeing?*

2.4 Acronyms used and terminology explained

In order to explain the terms used in this report, Appendix 3 provides a section on terminology to support readers who are not familiar with the processes and language of adult social care and health provision. In particular, the terminology used for pressure care is likely to be unfamiliar to many readers of this review.

2.4.1 Next of Kin

If a person ("P") cannot make a decision themselves because they are assessed under the Mental Capacity Act 2005 (the "MCA") as lacking the mental capacity to make that decision, practitioners may need to make a 'Best Interests' decision on P's behalf (MA). If this is a medical decision, that decision will be made by a clinician but it is their legal duty to consult with other people who know the P best. This may include family, friends, paid carers or other practitioners who work with that person.

It is likewise expected that clinicians will have a 'duty of care' when they make a best interest decision. In general terms there are two main elements to duty of care. The first is a duty to avoid acts or omissions which may cause harm to others. The second is a duty to promote the rights, independence and choices of the service user including known past wishes or beliefs.

The term "next of kin" has no legal definition in the United Kingdom although it is a term commonly used in a clinical setting to describe an emergency or preferred contact. Clinicians contact a patient's "next of kin" when they need advice from the person they believe to be closest to the patient and best able to reflect the patient's wishes. There is no requirement for the person nominated as next of kin to be a relative, although it is normally the case. However, it can be a friend, neighbour or a paid worker. The Review Team speculated that practitioners may be confusing the term "next of kin" with Lasting Power of Attorney (LPA) for Health and Welfare. The LPA is a legal tool that gives another adult the legal authority to make certain decisions for someone if they are unable to make them, including decisions relating to treatment.

In this case, Ms. B's neighbours Mr and Mrs Q described themselves as Ms. B's '*next of kin'* and were appropriately treated as knowing Ms. B best by clinicians when making best interest decisions.

2.5 Perspective of Mr and Mrs Q

The Lead Reviewer met with Ms. B's neighbours, Mr and Mrs Q on 28th June 2018 to discuss their perspective of what happened to Ms. B and again on 13th December 2018 to share a late draft of this report.

They had lived next door to Ms. B since 1984 and had power of attorney for Ms. B's finances. Ms. B was cared for by Mr and Mrs Q with the support of a small local authority funded care package, arranged following the death of her partner. Mr and Mrs Q provided helpful background to Ms. B's life, her personality and her subsequent reaction to services.

Ms. B had no immediate family although she was one of 10 siblings and had some limited contact with nieces and nephews. Her partner of 50 years had died 3 years previously. *'She died of a broken heart-he did everything for her'.* When he died she told them *'he promised my mum that he would look after me' 'She never had to lift a finger, she did not cook or do anything around the house'.*

Mr and Mrs Q described how charming and yet how strong-minded Ms. B could be at times. Once Ms. B had made her mind up about things, she was difficult to shift and yet conversely she could take a very long time to make decisions. Ms. B hated change of any type-'*the house was just as it had been in the 60s/70s'.* She found change difficult and was often *'anxious'* about seemingly trivial issues. For example, Mr Q described an occasion when Ms. B took all day to decide which alternative milk jug she should use when the one she usually used was broken.

Ms. B used to go to a couple of lunch clubs with her sister but stopped when her sister died a few years previously. Ms. B did not often go out but visited the GPs and hospital with the assistance of Mr Q or using a cab. Although she was slowly becoming less mobile and more isolated, Ms. B was able to cook simple meals with lots of encouragement and enjoyed playing cards and doing jigsaws. She still did a bit of ironing-'*she ironed everything even underwear'*.

She did not like to leave her chair however and Mrs Q bought her incontinence aids as sometimes Ms. B '*wet herself'* although she was not incontinent. Her concerns about money did impact on her care for example she initially refused a key safe, although they eventually persuaded her to accept one. She had also refused to wear a pendant alarm.

Ms. B was also a very private person and found it difficult to be in a room with more than two other people. Mr and Mrs Q and their daughter spent a great deal of time with Ms. B and yet never visited all at the same time as this was too much for Ms. B. She was frightened '*when you went away*' as she had never lived on her own.

If she did not want to talk, Ms. B took out her hearing aids. Ms. B was also extremely reluctant to let the domiciliary carers help her. Ms. B was morbidly obese and did not like to mobilise, requiring a lot of coaxing to do so. *'We managed to get her out'* just up the road-'*but one time she walked too far and that was it then*.' '*You had to give Ms. B tender loving care-she was like a child in that.'*

The Lead Reviewer would like to thank Mr and Mrs Q for their honesty and candour. Their experience has influenced the Findings within this Review. It should also be noted that Mr and Mrs Q recognised the practice described in the Appraisal of Practice and the Findings below.

3. The Findings

3.1 Structure of the findings

Five priority Findings have emerged from this Safeguarding Adult Review. The Review Team would like to remind Enfield Local Safeguarding Adults Board that organisational systems are complex. Therefore, findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation. The Findings explain why professional practice was not more effective in protecting Ms. B. Each Finding lays out the evidence identified by the Review Team to show why these are not one-off or case specific issues and why they undermine the reliability with which practitioners can do their jobs now and in the future unless remedial action is taken.

3.2 Appraisal of professional practice in this case

This section provides an overview, both of what happened in this case and why it happened and is the view of Review Team members about the quality of the practice in this case, including where practice fell below what would be expected. The Review Team has made these judgments in the light of **what was known, and was knowable**, at the time. Systemic issues are explored in more detail in the Findings and are cross referenced.

3.2.1 Introduction

This is an appraisal of professional practice with Ms. B over roughly the four months prior to her death. Although a short period of time, it was notable because of the large number of different professions working with Ms. B. Everyone did what they were procedurally supposed to do and sometimes went above and beyond this. The Findings that follow however, highlight areas where procedures and structures were not necessarily operating to help practitioners work in a person-centred way.

3.2.2 July 2016 Ms. B living at home

Ms. B had slept downstairs in her raiser/recliner chair since her partner had died 3 years ago. Ms. B was not known to social care until after the death of her partner. It is not clear if social care assessment addressed the risks to Ms. B of sleeping in her chair. She was being treated for leg ulcers and a moisture lesion by the Community Nursing Service. Visiting community practitioners were aware of the risks in Ms. B not moving about and reminded her of these. However, they were not aware of the additional risks in using recliner chairs to sleep in. The preventative role of practitioners in supporting service users and their carers when purchasing equipment is explored further in **Finding 5.**

Although she was slowly becoming less mobile and more isolated, Ms. B managed at home with domiciliary care (5x week, 30 minutes a day) and a lot of support from her next-door neighbours, who spent a great deal of time with her. The Review Team consider that Ms. B's care plan should have included assessment of risk of her falling. It is also surprising that there is no indication that Mr and Mrs Q were offered a carers' assessment despite providing a substantial amount of support to Ms. B.

Community nurses called regularly to dress her wounds. Ms. B sometimes refused to allow the primary domiciliary care worker to wash her despite building a good relationship with her.

On 31st July Ms. B fell very badly whilst alone and remained on the floor overnight. The domiciliary carer discovered Ms. B on the kitchen floor at 09.45 on 1st August. She acted beyond what would have been expected of her, not just ringing emergency services and fetching Ms. B's neighbour, but staying to support Ms. B. Her manager also came to support her. The agency achieved best practice by allowing this, using other staff to cover her work.

Paramedics responded quickly, dispatched at 10.00 and arrived at 10.04. Ms. B was lying extremely awkwardly, '*her legs were tangled'* and she was in extreme pain so paramedics called for backup. They took the time to move Ms. B with dignity, listening to and involving Ms. B, her neighbour and the carer in the removal to hospital.

3.2.3 1st August-6th October 2016 Ms. B in hospital

At A&E, it was confirmed that Ms. B had fractured her hip. A bariatric bed was ordered but due to the ordering system at that time it did not arrive until 4th August. Ms. B was managed on a standard bed with a pressure relieving dynafoam mattress. (The system now allows a bed to arrive within 4 hours).

Ms. B's skin was difficult to examine both because of Ms. B's size and the level of pain she experienced. Practitioners appropriately considered whether pain was impacting on Ms. B's judgement/capacity as she consistently refused to be turned despite being informed of the risks. '*Ms. B screamed when touched and even started to scream when the nurses came close to her'.* Multi-disciplinary meetings (MDT) about Ms. B took place every day between doctors, nurses and therapists who were concerned about Ms. B's likelihood of recovery and motivation.

Ms. B was referred to the Pain Management Team which is standard practice. Once her pain was being managed, Ms. B began to move, although less than clinical practitioners would prefer. Ms. B began to agree to be turned sometimes and get out of bed but needed a minimum of three staff to help her and lots of encouragement. Specialist staff such as the Tissue Viability Nurse (TVN), Mental Health Liaison (MHL) and dietician were involved to try to encourage Ms. B to move, to ensure a nutritious intake (which aids healing) and also reduce the development of ulcers which was positive and usual practice. Both Ms. B and her neighbour as preferred contact were told that Ms. B would develop pressure area damage if she did not move. However, Ms. B developed a Category 4 pressure ulcer despite all these efforts.

Review Team consider that the MDT did not appear to be used effectively enough to develop person centred and alternative strategies. Ms. B was described in records as '*non-compliant'.* There was not enough understanding of Ms. B's behaviour and reluctance to engage with services, or of the impact of pre-existing pressure area damage, bladder cancer and pharmacological treatments on the development of pressure damage. Whilst appreciating the benefit of, and need for, a good interpersonal relationship and communication, Ms. B's non-compliance led to practitioners losing an opportunity to established this, discussed in **Finding 4.**

Plans began in earnest for Ms. B to be discharged home as was her choice. Following OT visits to Ms. B's home and assessment by Adult Social Care as needing 4 calls a day from domiciliary care, specialist equipment such as a hoist and bariatric bed were ordered for use in Ms. B's home. Physiotherapists and OTs tried to involve the support of her neighbour to motivate Ms. B but she remained reluctant to move. In late August the physiotherapist discharged Ms. B because she refused to move or get out of bed despite measures taken; this meant that Ms. B received no physiotherapy for the rest of her hospitalisation.

During her hospital stay, Ms. B was diagnosed with bladder cancer, following an outpatient visit in July. Discharge was then appropriately delayed for cancer treatment including bladder surgery and chemotherapy although it is unclear how the impact of further treatment was conveyed to Ms. B. For example, the cancer treatment would have made Ms. B's skin even more fragile. Ms. B began vacuum pump therapy to treat her pressure ulcer. Whilst her treatment plan was discussed with Ms. B and her neighbour, Ms. B still sometimes refused turning and would not take dietary supplements which were prescribed to help with her nutrition and ultimately with the integrity of her skin. The Review Team speculated that both Ms. B and her neighbour did not fully appreciate the seriousness and the likely prognosis for Ms. B once she returned home. This was an opportunity missed to begin to discuss an end of life plan with them and is further explored in **Finding 3.**

Ms. B was assessed as medically fit for discharge following MDT on 5th October. Her GP and Community Nursing service were informed but the discharge form did not provide sufficient details of the level of support Ms. B required in the community e.g. that Ms. B needed two people to move her or the severity of her condition. This lack of coordination between primary and secondary care in discharge planning is discussed in **Finding 1**.

3.2.4 Ms. B goes home and is readmitted 6th October-21st October 2016

Ms. B was discharged on the evening of Thursday 6th October having had her vacuum pump disconnected in the ward. This treatment to relieve Ms. B's pressure ulcer was stopped because the equipment was not compatible with the vacuum pumps used in the community. This is discussed in **Finding 2.**

The referral that was sent to Patient Transport for Ms. B to be taken home did not provide enough details e.g. that Ms. B was on a trolley. The difficult entrance to Ms. B's house meant that the transfer took much longer than it should have and was undignified and unpleasant for Ms. B.

The Domiciliary care workers made their first call at 9pm as agreed and continued to visit four times a day over the weekend.

Community Nursing Service rang on Friday 7th October to arrange the first home visit but determined that a call was not a priority, which was not unreasonable given the level of detail available about Ms. B's condition. Ms. B remained in bed over the whole weekend. When a Community Nurse visited on Saturday, she needed the neighbour and her daughter (a nurse) to assist in turning Ms. B in order to dress Ms. B's pressure ulcer. She reported Ms. B's level of need to her Community Nurse supervisor.

On Monday 10th October, the Domiciliary Carer's supervisor visited Ms. B to risk assess because of the Grade 4 pressure ulcer & appropriately informed brokerage. The Community Nurse supervisor also visited Ms. B and then asked her Team Manager to attend as she was concerned about how ill Ms. B had become. They called an ambulance. It is unclear if they considered the option of nursing Ms. B at home or discussed care options with Ms. B and her neighbour.

Following pain relief and care to remove Ms. B with dignity, the paramedics transferred Ms. B to A&E. As Ms. B was so poorly and unlikely to recover, the ward doctors talked to a doctor that knew Ms. B from her previous admission which was good practice. The Senior House Officer discussed end of life with Ms. B's neighbour and her daughter and there was also a similar discussion with Ms. B's niece & nephew when they visited.

Her neighbours were able to stay as long as they wanted in the ward (outside of visiting hours) which was appropriate. Ms. B was given palliative care until she died, some 10 days later. Ms. B's cause of death was Bronchial Pneumonia, Pulmonary Oedema, Bladder Cancer and Grade 4 Pressure Ulcer.

3.2.5 Summary Appraisal

In summary, practitioner decision making in care around discharge was not at the standard the Review Team would expect with silo working by services and is discussed in **Finding 1**. Overall whilst practice showed some elements of good care, this predominantly sat with the domiciliary care agency and neighbours who supported Ms. B as well as ward staff who persisted in trying to encourage Ms. B to move to prevent skin damage. However, practitioners were too focused on their specific duties rather than actively listening to Ms. B’s concerns and thinking about her motivation for sometimes refusing care. Practitioners did not consider end of life planning early enough for Ms. B.

3.3 In what ways does this case provide a useful window on our systems?

The case provided a useful ‘*window on the system*’[i]. Whilst in some ways this was an unusual case, aspects of it, such as dealing with people who don’t want to be dealt with and the provision of carefully tailored end of life care, often feature in interactions with vulnerable adults, not restricted to the elderly. For these reasons, despite the characteristics that were unique about Ms. B, there is rich learning about ways in which the multi-agency system and individuals working within it can improve what they do.

It is notable that aspects of this case could easily be identified in similar cases of hospital discharge and subsequent primary and social community care provision for older people. The CQC local system review ‘Beyond barriers How older people move between health and social care in England (July 2018) reported that *‘too often, care is fragmented, choice is limited and people are uncertain about who is coordinating their care needs’* and provides recommendations that will be useful to the SAB when formulating their response to this report.

Note: In order to help with the identification and prioritisation of Findings, the SCIE systems model includes six broad categories of underlying patterns. It is hoped that these will assist in identifying themes from the Adult Safeguarding Reviews library being developed alongside the Quality Markers by SCIE and RiPfA. These may be presented in any order and will shift according to which is felt to be most fundamental for systemic change. Not all will necessarily be covered in a particular review. They are:

- Innate human biases (cognitive and emotional)
- Service user and carer -professional interaction
- Responses to incidents
- Communication and collaboration in longer term work
- Tools
- Management systems

3.4 Summary of Findings

No.	Finding	Category
1.	**There is an operational disconnect between Acute and Community healthcare that can result in unnecessary delays in treatment provided to a patient when the patient gets home and subsequent risk of emergency readmission**	**COMMUNICATION& COLLABORATION IN LONGER TERM WORK**
2.	**The configuration of resources in Health has resulted in fragmented equipment provision with the consequence that patients may not be provided with equipment when they need it.**	**MANAGEMENT SYSTEMS**
3.	**Is end of life planning undertaken early enough and appropriately enough in Enfield for service users with life limiting conditions?**	**COMMUNICATION& COLLABORATION IN LONGER TERM WORK**
4.	**When service users are unwilling to accept a practitioner's help it can, due to frustration, impact on the willingness to reflect and explore other solutions. In Enfield, this is compounded by the lack of a lead practitioner to coordinate activity.**	**HUMAN BIAS**
5.	**Practitioners don't always recognise the potential risks caused by common health problems affecting older people (e.g. lack of mobility, continence and obesity) early on enough to advise carers. So when their carers try to make older people's lives easier, there may be unintended consequences of making their health worse.**	**SERVICE USER AND CARER/ PROFFESSIONAL INTERACTION**

3.5 Findings in detail

3.5.1 Finding 1

There is an operational disconnect between Acute and Community healthcare that can result in unnecessary delays in treatment provided to a patient when the patient gets home and subsequent risk of emergency readmission.

COMMUNICATION & COLLABORATION (PRACTICE NORMS) IN LONGER TERM WORK

Introduction

Discharge of adults with care and support needs from hospital to the community can often involve a wide range of practitioners from health and social care services. Efficient transition back to the community improves the patient experience and helps reduce readmissions.

NHS England defines patients as ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer
- A multidisciplinary team decision has been made that the patient is ready for transfer
- The patient is safe to discharge/transfer.

How did this issue manifest in the case?

Whilst multi-disciplinary meetings (MDT) about Ms. B’s treatment often took place whilst she was in hospital and whilst the MDT took Ms. B’s discharge home into account right from the start and a plan developed over time, a joint discharge plan was not agreed.

Instead the Community Nursing Service received a written referral for Ms. B when she was close to discharge which provided limited information about Ms. B’s needs. Although the Community Nursing Service rang the ward to seek some clarification, they remained unaware, for example, that Ms. B needed two people to turn her in order to dress her wounds.

The Community Nursing Service did not prioritise a visit to Ms. B over other patients because they were unaware of the severity of her clinical condition and the associated risks. The Community Nursing Service also had a differing clinical view from hospital clinicians about Ms. B’s need for a vacuum pump to provide negative pressure wound therapy. This may not have been the case if the Community Nursing Service had been involved in discussion of treatment, for example attending a MDT close to Ms. B’s eventual discharge on the evening of Thursday 6th October 2016.

Similarly, due to the limited information on their referral form, Patient Transport didn’t know that Ms. B remained on a stretcher on discharge, rather than the usual wheelchair. Ms. B received an undignified and delayed transfer to bed because the awkward entrance to her home had not been considered.

In contrast, the hospital social worker did attend MDT in hospital when Ms. B was close to discharge. Following the consequent assessment of need by Adult Social Care, Domiciliary Care was timely and two carers visited.

Ms. B was re-admitted 4 days later as an emergency patient on Monday 10th October 2016. It was identified on admission to A & E that the patient had Bronchial Pneumonia which was a new diagnosis for the patient.

Why is this a systemic issue?

At the Practitioners' Workshop held on 12th July 2018, the Case Group told us that community practitioners were rarely invited to discharge planning meetings, even in very complex cases. Whilst the social care team is based in the hospital and attend MDT in the ward, community practitioners are rarely involved.

The Community Nurse referral form is a document that was designed and lead by the community following an audit of Community Nurse referrals identified the need. However, Community Nurses also told us that discharge forms often don't have much information about the level of need-it is not unusual to have to ring up to ask questions. It was agreed that involvement of community practitioners would ease the transfer of complex patients home by having a consistent treatment plan and thus reduce the need to readmit.

Whilst a Category 4 Pressure Ulcer is serious, it is a manageable condition in the community. Once a patient is medically fit there is often a very short period of time to discharge a patient from hospital. Lots of patients are discharged from the hospital every day and it is also important to be mindful of the availability of community practitioners to attend MDT. However not every patient has complex needs, requiring direct involvement of community practitioners.

The Review Team wondered if the development of locality (area) teams could encourage involvement of community practitioners with MDT?

The entrance to a patient's home is not normally part of the assessment for discharge. The Case Group also discussed the fact that the Patient Transport form is usually completed by the ward clerk who will not know necessarily be aware of specific issues such as transfer by stretcher or steps into a patient's home. The Case Group confirmed that the text box, which is available to address such points on the form, is rarely completed. Drivers won't know the home set up and cannot plan to manage particular problems.

How widespread is this issue?

Safe Discharge is a huge issue in Britain. Hospital inpatients are increasingly old. Many such patients leave hospital less mobile and independent than when they were admitted – making rehabilitation after acute illness and injury core business not just for hospitals but also for their community partners.

The Healthwatch Report Safely Home (July 2015) (https://www.healthwatch.co.uk/report/2015-07-21/safely-home-what-happens-when-people-leave-hospital-and-care-settings) showed a wide variation in discharge practice across the country. The report recommends that discharge is coordinated by one individual, who liaises with the hospital, community, the patient and their family (unless inappropriate) to develop and agree a discharge plan.

The CQC National report Beyond Barriers- How people move between Health and Social Care (July 2018) found that agencies:

- Prioritised their own goals over shared responsibility to provide person centred care

- Did not always share information with each other which meant they weren’t able to make informed decisions about people’s care
- Were not prioritising services which keep people well at home
- Planned their workforce in isolation to other services

It is also noted that the regulatory framework focuses only on individual organisations including performance measures such as delayed discharge which can actively discourage joint working.

How prevalent is this issue?

In England during 2012 - 13 there were more than one million emergency readmissions within 30 days of discharge, costing an estimated £2.4 billion. The CQC Local System Data Summary: Older people's pathway Enfield Local Authority Date (28/09/18) indicates that Enfield’s number of emergency admissions for people aged over 65 was similar to the average for local authorities in England in 2017/18 which is an improvement on previous years for Enfield.

What are the implications for the reliability of the safeguarding adult system?

Patients who are assessed to have capacity have the right to make unwise decisions, but practitioners should be encouraged to clearly document their discussions and seek second opinions to support those who wish to make an unwise decision. Lack of co-ordination and communication can cause significant problems when people are being discharged from hospital. When it happens to individuals who are in a particularly vulnerable situation, with complex needs, the risks are even higher. Poor treatment and lack of clarity around coordination leaves older people feeling uncared for by the health and social care system and also leads to readmissions which is neither in the patient’s nor the system’s interest.

FINDING 1

ISSUE FOR CONSIDERATION BY THE BOARD

There is an operational disconnect between Acute and Community healthcare that can result in unnecessary delays in the treatment provided to a patient when discharged home with the subsequent risk of emergency readmission

COMMUNICATION & COLLABORATION (PRACTICE NORMS) IN LONGER TERM WORK

SUMMARY

People experience the best care when services work together to overcome the fragmentation of the health and social care system and coordinate personalised care around individuals. Tensions across health and social care are influenced by system pressures and accountability against performance measures, such as delayed transfers of care. This behaviour hinders operational joint working. In Enfield, the failure of community and acute services to collaborate effectively about the needs of patients leaving hospital means that patients and their carers are unable to make informed decisions about their care and do not always receive high-quality person-centred care to meet their needs. Health and social care organisations need to plan together to assess risk and thus prevent delays in treatment and readmission to hospital.

Questions for the Board and Organisations

- How can the Board support partner agencies to tackle this operational disconnect?
- What multi-agency procedures would the Board like to see in place to ensure a more joined up risk assessment process for discharge?
- How will the Board be assured that practice and behaviours have changed?

3.5.2 Finding 2

The configuration of resources in Health has resulted in fragmented equipment provision with the consequence that patients may not be provided with equipment when they need it.

MANAGEMENT SYSTEMS

Introduction

Since there is no longer a centrally funded programme within the NHS, resource planning and commissioning is often a challenge for individual trusts. As a consequence, when a patient is discharged from one service to another but still requires the same treatment, equipment does not always remain with the patient. Instead the patient receives equipment provided by the new service.

How did this issue manifest in the case?

The Community Nursing Service and the acute hospital use different vacuum pumps providers who supply different types of pumps. These types of vacuum pump are not compatible and so cannot be used interchangeably.

Ms. B was discharged from hospital on the afternoon of 6th October 2016. She was disconnected from the vacuum pump being used to treat her pressure ulcer when she left the ward rather than taking the equipment home. Whilst TVN has advised that temporary disconnection and application of an appropriate dressing would not impact on the deterioration of a wound, termination of treatment may have impacted on the severity and subsequent deterioration of her wound.

Why is this a systemic issue?

At the workshop on 16th July 2018, Community Nurses told us they always wait until someone is home before ordering equipment such as vacuum pumps. Discharge does not always occur when it is planned and to order and not use equipment is a waste of resources. This could happen, for example, if the patient’s health worsens and it is not safe then to discharge. Any specialist equipment that the patient requires such as vacuum pumps are hired in and this can be hired in 24 hours a day, with swift delivery time within 4 hours.

Whilst the four local acute hospitals commission purchase of equipment jointly, community health and adult social care commission equipment as individual services. There are no systems in place to allow patients to take equipment with them when they are discharged from acute hospital either to their own home or to a care home. However, patients who transfer to the hospice are able to take equipment with them although this is an informal arrangement.

How widespread is this issue?

Increasing use of bariatric flow charts helps staff to manage such patients and to get appropriate equipment, etc. Some hospitals use their internal website to help staff to get information.

Lack of resources is an issue but the way they are configured can make it worse. Logic would support a central, shared resource across the local health agencies including community services.

How prevalent is this issue?

The CQC National report Beyond Barriers- How people move between Health and Social Care (July 2018) found that although there was often good planning between services, the way that services are funded did not support them to work together and recommends a reform of planning and commissioning of services.

It is disappointing to note that of the systems CQC reviewed, none had yet matured into joined-up, integrated systems.

The report also recommends a new approach to performance management. Financial pressures on the NHS are severe and show no sign of easing. However, relatively little is known about the impact of resources on patient care, as these are difficult to detect with currently available metrics.

However, ‘Understanding NHS financial pressures; How are they affecting patient care?’ (Kings Fund 2017) found strong evidence that Community nursing services in particular are under pressure and that this is negatively affecting the quality of patient care. The report also highlights the importance of improving the definition and measurement of quality in areas like community services where metrics are currently scarce.

What are the implications for the reliability of the safeguarding adult system?

If patients are not given consistent access to the equipment they need for their treatment, they are likely to suffer unnecessary deterioration of their condition.

Practitioners time and resources will be wasted in providing a disjointed treatment service coupled with the additional bureaucracy to ensure that equipment remains within individual services who have purchased it.

FINDING 2

ISSUE FOR CONSIDERATION BY THE BOARD

The configuration of resources in Health has resulted in fragmented equipment provision with the consequence that patients may not be provided with equipment when they need it.

MANAGEMENT SYSTEMS

SUMMARY

Funding flows are a challenge across systems and financial pressures have affected joint working. Separate funding streams and different payment processes cause divides between agencies. There is a national need to remove the barriers that prevent NHS and social care commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations. Joined-up commissioning across health and social care, and investment in prevention and out-of-hospital provision would prevent decisions about equipment provision being resource driven rather than led by patient need.

Questions for the Board and Organisations

- What value is placed on the importance of partnership working locally and how far is this reflected in shared tools and processes?
- How can commissioners measure the impact of financial restraints on quality of care?

3.5.3 Finding 3

Is end of life planning undertaken early enough and appropriately enough in Enfield for service users with an expected life limiting condition?

COMMUNICATION & COLLABORATION IN LONGER TERM WORK

Introduction

The General Medical Council defines ‘end of life’ as any patient who is likely to die within the next 12 months. End of life planning should help people to live as well as possible and to die with dignity. Everyone can express a preference about where to receive care and where to die and discussions should be timely and honest. Practitioners should take people’s wishes and preferences into account when making decisions about treatment.

The Mental Capacity Act (2005) allows people the legal right to decline treatment when they have the capacity to make that decision. It also allows people with the relevant capacity to arrange to have their wishes respected should they lose the relevant mental capacity. This can be achieved either via an Advance Decision document or by appointing a Lasting Power of Attorney whose powers specifically include making decisions about ‘life sustaining treatment’.

How did this issue manifest in the case?

Ms. B’s neighbour had supported Ms. B to make a Will and had power of attorney for Ms. B’s finances. However, Mrs Q did not have a health and welfare lasting power of attorney which would have allowed her to make decisions about where Ms. B was cared for and what treatment she received, once Ms. B lost the mental capacity to make her own decisions in this regard.

It is not recorded that Community practitioners discussed what Ms. B wanted of end of life before her hospital admission in August 2016. Ms. B had the mental capacity to decline treatment, but she does not appear to have made an Advance Decision about treatment (sometimes referred to as a “Living Will”).

This case is notable for the large number of clinical interventions carried out whilst Ms. B was in hospital. Yet the Review Team also consider that the inevitable discussions that took place about proactive treatment whilst Ms. B was in hospital were also opportunities missed to engage Ms. B in thinking about what she wanted to happen at end of life. This was despite practitioners explaining on many occasions the risks to her health that Ms. B was taking by failing to move around enough.

Ms. B was discharged home as medically fit on 6th October with a range of complex physical health conditions which included a category 4 pressure ulcer. The extensive domiciliary care package provided included Ms. B to be encouraged to sit out and move around. However, given her refusal to do this whilst in hospital, the Review Team consider that Ms. B’s condition was unlikely to improve at home and she was in effect being sent home to die.

When Community Nurse managers visited Ms. B on 10th October they were rightly concerned about possible sepsis. They called an ambulance but there appeared to be no consideration or discussion about the possibility of Ms. B being cared for at home with their support and that of the GP rather than being cared for at hospital. Whilst there was no suggestion that Ms. B was not cared for appropriately once Ms. B arrived in the hospital, practitioners at the workshop on 16th July 2018 speculated whether Ms. B could have remained at home.

Ms. B's neighbours, Mr and Mrs Q told the Lead Reviewer that they were unaware that Ms. B's condition was life limiting and that it was a shock to them when clinicians told them that Ms. B was unlikely to recover when Ms. B was re-admitted to hospital with the additional condition of bronchial pneumonia. '*We did not know how ill she was'*.

When Ms. B was in A&E on the 10th October 2016, the clinical discussion about the likelihood of Ms. B recovering from the possible infection and her other conditions led to her receiving end of life care. On the ward, the Senior House Officer subsequently discussed end of life with Ms. B's neighbour and her neighbour's daughter and there was also a similar discussion with Ms. B's niece & nephew. Ms. B was provided with palliative care until she died, some 10 days later. The Review Team consider that this discussion came too late for Ms. B to make informed decisions about end of life.

Why is this a systemic issue?

At their meeting on the 18th September 2018, the Review Team discussed the difference between a critical condition and a terminal one and the appropriateness of end of life discussions when a patient was in a critical condition. They agreed that the removal of Ms. B from her home when gravely ill was usual practice in Enfield and considered that this was quite a common occurrence.

Interpersonal skills vary based on many different factors including personality, experience and fear of loss of the therapeutic relationship. Whilst practitioners do discuss difficult and complex issues with service users, there may be missed opportunities to allow service users and carers to make well informed and realistic decisions about dying.

How widespread is this issue?

Transitions between care settings in the last year of life are common, with many moves occurring shortly before death (Hanratty B, et al 2014). Regional variation in care transitions has also been shown suggesting that transitions are influenced by regionally determined health care practices or health care supply, (Aaltonen, Forma, Rissanen, Raitenen, & Jylhä, 2013; Gozalo et al., 2011; Wang et al., 2016),

People often say that they would like to die at home, as long as they are not a burden on the family. *"70% of people would prefer to die at home"* - Dying Matters March 2017. However, only about a quarter actually do. To improve services the Leadership Alliance for the Care of Dying People has published 'One Chance to Get it Right: how health and care organisations should care for people in the last days of their life' June 2014. It sets out the approach that should be taken in caring for all dying people in England.

Dying Matters also raised the lack of expertise in end of life care among a hard-pressed health and social care workforce. The culture is focused on saving patients by clinical intervention rather than helping them to die well. Generalists may only have a few patients at the end of life at any one time and find it challenging to maintain expertise. Yet there is evidence that patients receive better, more joined up care if they are identified early and put on the GP Palliative Care Register. Yet only a quarter of eligible people make it onto the system.

These issues are corroborated in the report *Talking About Dying: How to begin honest conversations about what lies ahead by the Royal College of Physicians* (19th October 2018) which acknowledges that doctors (especially in hospitals) struggle to talk to patients and their relatives about dying, believing that patients don't want to discuss death. However, it also says that more than 77% of people would want to know if they had less than a year to live. The report warns that if patients are not identified as being near end of life, they are more likely to receive '*unnecessary, aggressive treatment'* and die somewhere that is not their first choice.

There are a lot of tools available to support practitioners, e.g. *Every Moment Counts: A narrative for person centred coordinated care for people near the end of life* (National Council for Palliative Care March 2015). *Dying well at home*: research evidence (SCIE 2013) accepts that training staff to initiate difficult conversations while remaining sensitive to the patient's response is important. Recording a person's wishes is unlikely to be established during one discussion but will develop over time.

How prevalent is this issue?

Over a third of the 15.5 million people admitted to hospital in 2016 were over the age of 65. Many had existing and complex medical conditions that require particular consideration and care in planning discharge and aftercare at home. These discussions should ideally include planning for end of life.

Findings by the National Audit Office suggest that 40% of end of life care patients have no medical need to be in hospital. Family members also felt health staff frequently focus on continued treatment of the condition rather than controlling symptoms or providing pain management.

The costs of caring for people at the end of their lives is estimated to run into billions of pounds (National Audit Office 2008). Wide variations exist in the quality and cost of end-of-life care across England with some areas spending ten times more than others. Providing good-quality care to people at the end of life is not primarily a matter of cost but one of social values. However, in present circumstances, the relative cost of dying in different settings is important. The limited evidence on costs suggests that dying at home is less expensive than dying in a hospice or hospital.

What are the implications for the reliability of the safeguarding adult system?

Practitioners should be supported to feel able to address sensitive issues including end of life more easily. By failing to adequately consider the consequences of a decision or not being realistic about quality of life may compromise a service user's dignity and potentially put them at risk. Being honest about what the future may hold to patients and their carers could help practitioners to put quality above quantity of care at end of life.

FINDING 3

ISSUE FOR CONSIDERATION BY THE BOARD

Is end of life planning undertaken early enough and appropriately enough in Enfield for service users with expected life limiting conditions?

COMMS & COLLABORATION IN LONGER TERM WORK

SUMMARY

In Enfield, health and social care practitioners, both in the community and in acute settings do not appear to have early discussions about end of life planning and care. This is in common with the rest of England and may be because practitioners find it hard to initiate such conversations.

End of life discussion is not easy and practitioners may not have the skills to undertake these sensitive conversations. However, this means that people are not given the opportunity to think about what they want as they approach end of life. They may receive clinical interventions that they would not wish to have and may end up dying somewhere that they would not choose.

Questions for the Board and Organisations

- Is training of staff in Enfield usually around process and not around the skills needed to talk about sensitive decisions?

3.5.4 Finding 4

When service users are unwilling to accept a practitioner's help it can, due to frustration, impact on the willingness to reflect and explore other solutions. In Enfield, this is compounded by the lack of a lead practitioner to coordinate activity.

(HUMAN BIAS)

Introduction

A person-centred approach is something that all services aspire to. In reality, most people accept the assistance offered by services whilst practitioners tend to do what usually works.

The Mental Capacity Act (2005) allows people the legal right to decline treatment when they have the capacity to make that decision. Practitioners respect that sometimes adults who have the relevant capacity will make unwise decisions about their care. It is sometimes difficult for practitioners to be persuasive but not coercive, and this is not an easy skill to develop and use.

How did this issue manifest in the case?

Ms. B, as described by Mr and Mrs Q and the practitioners who knew her, was constantly anxious. For example, her fear of falling and finding large groups of people intimidating. She required *'lots of coaxing'*. Following discussion, the attendees at the Practitioner workshop on 12th July 2018 agreed that the only people that were able to communicate effectively with Ms. B were her neighbours and sometimes the main care worker from the domiciliary care agency.

In the community Ms. B often refused to:

- Accept assistance e.g. refused a referral for dietary advice by GP
- Be washed by the Domiciliary Carer

In hospital Ms. B often refused to:

- Be turned by nurses.
- Work with physiotherapists

These refusals were acknowledged by practitioners to be frustrating, but they continued to try to encourage Ms. B. For example, Ms. B required two or three people to turn her due to her size and injury and this was done, even when Ms. B refused to actually move herself. It was positive that different strategies were tried to try to persuade Ms. B for example:

- The main Domiciliary Care Worker developed a friendship with Ms. B which sometimes meant she was able to persuade Ms. B to allow help
- Specialists such as the dietician & TVN were part of the multi-disciplinary team who provided care and support to Ms. B and to try to persuade Ms. B as well as provide support to the Ward.
- Physiotherapist Service enlisted the help of Neighbours to encourage Ms. B to mobilise
- The Mental Health Liaison were used to investigate Ms. B's multiple bereavements and her fear of falling again.

However, these alternative strategies tended to be practices which usually worked for other patients. When they failed to make Ms. B accept help, there was then no coordinated approach to finding a solution, instead practitioners tried the same things over and over again because they usually worked. For example, there could have been a discussion at the hospital Discharge Planning meeting about the risks of Ms. B refusing physiotherapy or accepting assistance to be turned. No practitioner in hospital knew Ms. B very well and there was no key worker system in place with limited multi-agency discussion about the reasons which lay behind Ms. B's refusal to be helped.

Why is this a systemic issue?

The use of multi-disciplinary meetings as a focus for joint discussion is usually beneficial, but means in practice, an emphasis on process and with the 'here and now'. It is less helpful when there is a need to analyse patterns of the service user's motivation and behaviour. At the Practitioner Workshop on 12th July 2018 it was recognised by the Case Group that the use of MDT does have limitations in ensuring a person-centred approach.

It was agreed that the positive impact of deeper and longer-term relationships on a service user's physical and psychological well-being can sometimes be under acknowledged by the wider practitioner group.

How widespread is this issue?

The use of multi-disciplinary teams rather than the use of a key worker is widespread in England. However, SCIE BRIEFING 36: Reablement: a cost-effective route to better outcomes says coordination or key working is required to monitor this particularly as practitioners involved cannot all know the service user very well.

Key messages detailed in SCIE Research briefing 41: Factors that promote and hinder joint and integrated working between Health and Social Care concludes that *'defining outcomes that matter to service users and carers is important. Outcomes defined by service users may differ from policy and practice imperatives but are crucial.'* If service users do not understand the implications of their actions or if they are not important to them, then they will not be motivated to change their behaviour.

In these cases, practitioners are more likely to label patients 'difficult' or non-compliant without trying to understand the reasons underlying that behaviour.

How prevalent is this issue?

Buxton and Snethen, (2013) found nurses and doctors were focusing on obesity and being indifferent to patients' other personal concerns. They were also seen as not spending enough time with patients or showing any interest in getting to know them as individuals, while underestimating their capacity to understand their own bodies.

Keyworth et al (2013) found that, in some bariatric care settings, nurses had heavy workloads that left them feeling overworked and exhausted to the point that they were unable to practice efficiently and with empathy. Whilst generally nurses provided dignified, empathetic and holistic care to all patients, irrespective of body shape and size, they were concerned about the physical care of obese patients, such as toileting, handling and moving. Nurses dreaded these aspects of care and found them laborious, exhausting, time-consuming and emotionally challenging. Fears for personal safety were compounded by a lack of adequate equipment for safe practice. The demands of caring for obese patients and the shortages of staff, equipment and support created a risk of negative feelings towards patients.

What are the implications for the reliability of the safeguarding adult system?

Service users with concerns that do not match the service on offer, disengage as they see no value in what can be provided. In response practitioners are driven by process rather than actively listening to the needs of the service user. The lack of a lead practitioner or key worker makes it harder to apply alternative strategies.

FINDING 4

ISSUE FOR CONSIDERATION BY THE BOARD

When service users are unwilling to accept a practitioner's help it can, due to frustration, impact on the willingness to reflect and explore other solutions. In Enfield, this is compounded by the lack of a lead practitioner to coordinate activity.

HUMAN BIAS

SUMMARY

The reliance on multi-disciplinary teams in Enfield is usually helpful and allows patients to receive a wide range of support services. But sometimes a person-centred approach is lost if patients do not respond to care plans that are usually effective. Instead practitioners focus on process and continue to use the same strategies that usually work with people rather than consider what the patient may think is important and use this to motivate. This is made more difficult when there is no lead practitioner.

Questions for the Board and Organisations

- How can practitioners be encouraged to explore different person-centred solutions?
- Has the use of MDT in Enfield meant that the value of key workers to service users has been lost?

3.5.5 Finding 5

Practitioners don't always recognise the potential risks caused by common health problems affecting older people (e.g. lack of mobility, continence, and obesity) early on enough to advise carers. So, when their carers try to make older people's lives easier, there can be unintended consequences of making their health worse.

FAMILY/PROFESSIONAL INTERACTION

Introduction

Older people suffering from incontinence, poor diet and/or obesity have a higher risk of health complications. This case has suggested that advice about what can be best done to prevent development of pressure ulcers and risk of falling is not always given to families and other carers early enough. Even if people think that they are doing the best things to keep older people safe, they may actually be making things worse.

The consensus statement Policing, Health and Social Care consensus: working together to protect and prevent harm to vulnerable people (February 2018) sets out the joint commitment to embed prevention across the system and to work together to improve people's health and wellbeing. Prevention is one of the key principles of safeguarding as stated in the Care Act 2014. It is better to prevent harm than take action after harm occurs.

How did this issue manifest in the case?

Ms. B's neighbours, who were extremely caring, had brought a bed downstairs for her to sleep in when her partner had died three years ago. '*We did everything for her'.* Ms. B's neighbours had also helped Ms. B to buy a riser/recliner chair from a local shop but this was not a specialist bariatric chair. Ms. B preferred to sleep in her riser/recliner chair. 'O*nce we bought it we could not get her out of it'.* Mr. and Mrs. Q were unaware of the risks relating to recliner chairs.

Ms. B also used incontinence aids purchased by her neighbour as she would have *'accidents',* preferring to remain in her chair. Although the neighbours knew that Ms. B should move about, they were tolerant of Ms. B's refusal. When they encouraged Ms. B to walk, 's*he would tell us that she already walked whilst we weren't there but we knew she didn't'.*

Both community nurses and domiciliary carers highlighted the risk of pressure sores to Ms. B and to her neighbour. Community nurses also encouraged Ms. B to use a pressure relieving cushion to help with this but she refused to do so, saying it was not comfortable. However, this was after the chair was purchased. There is no evidence that Adult Social Care had highlighted the risks or made any recommendations about chair purchase.

Why is this a systemic issue?

At the Practitioner Workshop held on 12th July 2018, it was agreed that riser/recliner chairs are very commonly purchased and used by older people with the best of intentions. The Senior Occupational Therapist present considered that service users should be actively dissuaded from purchasing riser/reclining chairs as they do tend to use them to sleep in. Riser/recliners are not suitable for constant use-particularly for obese people '*they wedge themselves in and don't move again*'. Instead riser only chairs are useful as allowing people to get up safely and move about, lessening the likelihood of both pressure damage and falls.

It is not only service users and their carers who are unaware of the risks involved in using riser recliner chairs. Other practitioners present at the Workshop were also unaware of the potential risks of using a riser/recliner to sleep in.

It was also agreed that fear of spending money is common in older people-hence they rarely ask the advice of specialists such as OTs about the best chair to purchase even though help with purchase may be available. As a consequence, it was agreed that limited preventative work is currently carried out, such as advice with purchase of riser chairs (whether it should recline, whether it should be pressure relieving, etc.), by practitioners.

Whilst the Community Nursing Service provides leaflets around pressure ulcers and requires patients to sign to say they have received the leaflet, the Review Team considered that this may not be the most appropriate method of highlighting the risk and is often provided too late to prevent initial pressure damage. The leaflets may also be lost amongst the host of other written advice provided to patients.

Similarly, damage limitation equipment such as pressure cushions is provided but is often uncomfortable and may not fit patient's furniture well. Again, these types of equipment are often provided after damage is present. Other preventative advice e.g. dietary is provided, but this also tends to be provided once damage has occurred.

It is important to consider whether practitioners have the right skills, knowledge and expertise in recognising the triggers for pressure damage before it occurs.

How widespread is this issue?

This is not an issue unique to Enfield. For example, the two lead reviewers undertook a SAR in 2015. Mrs EE was hospitalised immediately prior to her death with sepsis due to pressure sores. Evidence showed that both practitioners and family considered that it was safer for an older person to stay in their riser/recliner chair rather than move around. (https://www.sloughsafeguardingboards.org.uk/assets/2/serious-case-review-mrs-ee-executive-summary.pdf).

'Helping people stay healthy and well' is one of the priorities for 2018/19 for the North London Partners in Health and Care[1]. The Care Act 2014 Statutory Guidance suggests that a SAB should link in with their local Health and Wellbeing Board's stated approach and practice for preventive work.

How prevalent is this issue?

Most obese people in Britain do not recognise themselves as obese or even very overweight and public health initiatives are likely to be hampered by people's lack of recognition of their weight status and the related risks. (BMJ 2014;349:g6825).

Falls were the most common injury related reason for hospital admission in Enfield (The Enfield JSNA[2]) in 2014/15, with 1859 people admitted of which 511 suffered hip fractures. In

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[1] North London Partners in Care and Health is made up of 21 health and social care organisations in North London

[2] Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

addition, 42% (20,000 people) of people aged over 65 in Enfield report a long-term health condition, with 7,200 reporting 2 or more and 4500 reporting 3 or more long term conditions. Of the 511 people who suffered fractures, 50% were no longer able to live independently, 30% died with one month and 30% within one year.

Pressure ulcers: applying All Our Health (Public Health England April 2015) recognised the importance of prevention and engaging the public, particularly those people most at risk. It suggested that community health professionals and providers of specialist services can have an impact by *‘engaging individuals, carers and families in what to look for and how pressure ulcers can be prevented* and *‘providing holistic health assessments for people at risk of developing pressure ulcers’.* The guidance also recommends developing targeted social marketing and public health campaigns to raise the awareness that pressure ulcers can affect anyone in their lifetime.

What are the implications for the reliability of the safeguarding adult system?

Fundamental to the core principles of safeguarding systems is promoting informed choice, with the public understanding the implications of being cared for at home. If early prevention is not built into services, rather than services reacting once harm has already occurred, the risk is that people will continue to both deteriorate and die in pain, compromised in their dignity and with serious health conditions.

FINDING 5

ISSUE FOR CONSIDERATION BY THE BOARD

Practitioners don’t always recognise the potential risks caused by common health problems affecting older people (e.g. lack of mobility, continence, and obesity) early on enough to advise carers. So when their carers try to make older people’s lives easier, there can be unintended consequences of making their health worse.

FAMILY/PROFESSIONAL INTERACTION

SUMMARY

The public health message about preventing the risks caused by common health issues is not getting to informal carers or even practitioners early enough. This means the benefits of community practitioners in promoting preventative care is diluted and provided too late making it difficult to reduce risks to older people.

Questions for the Board and Organisations

- How can the Board work with partners including the Health and Wellbeing Board to tackle the lack of understanding about the risks of common health problems to older people?
- How can practitioners be supported across agencies to proactively assist service users and carers to make more informed choices in their lives early enough to make a difference?

4. Conclusion

This Review has shown that there are a number of systemic issues, illustrated by the case of Ms. B. The research questions developed by the Review Team were the starting point to begin to examine the way in which partner agencies work together to provide preventative and clinical services.

The Review examined the way that practitioners involve patients and their carers in decision making around discharge, especially in relation to those with complex physical health conditions including high risk conditions such as Grade 4 pressure ulcers when returning to live alone. The findings show that hand-overs between different services, particularly during discharge from hospital were not as effective as they could have been, and the procedures and structures used are not always operating to help practitioners work in a person-centred way.

Practitioners carried out the roles as they were expected and in some cases even beyond what could have been expected, in particular, Ms. B's main domiciliary care worker. However, the review has found that Multi-Disciplinary Teams, whilst in the main positive, can become process driven and lose the person-centred approach they were developed to encourage. In addition, whilst the NHS focus on older people and 'staying healthy and aging well' supports a personalised approach, this is difficult to achieve in the face of competing priorities and scarce resources. Examination of the CQC Local System Data Summary: Older people's pathway Enfield Local Authority Data produced: 28/09/18 shows some improvements in emergency readmissions to hospital compared to 2016 which is positive. Certainly, this review has observed a willingness by practitioners to address such issues proactively.

The Findings notably mirror the conclusions of *Beyond Barriers: how services are working together to support and care for people aged 65 and over*. In common with other areas, Enfield agencies:

- *'Are prioritising their own goals over shared responsibility to provide person centred care*
- *Do not always share information with each other which means they cannot make informed decisions about people's care*
- *Are not prioritising services which keep people well at home'*

It is significant that Ms. B received a wide range of clinical treatment, but these may not have been the choices she and her 'next of kin' may have made if given earlier or more person-centred support. Services in Enfield fell short of best practice standard within available national guidance for example in end of life care.

Enfield SAB has a powerful leadership role in encouraging adherence to the principles detailed in *Policing, Health and Social Care consensus: working together to protect and prevent harm to vulnerable people* (February 2018) and committing partners to work together to improve people's health and wellbeing and protect the most vulnerable people. It is to be hoped that this Review will provide the SAB with the focus to build on the avowed willingness of agencies to work together to safeguard and promote the wellbeing and empowerment of people and those close to them.

APPENDICES

Appendix 1: Care Act 2014

The Care Act 2014 requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

- A*n adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,*

  And

- T*here is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.*

The Care Act states that: *each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:*

- *Identifying the lessons to be learnt from the adult's case,*

  And

- *Applying those lessons to future cases.*

The Care and Support Statutory Guidance [14:138] DoH, October 2014, sets out the following principles which should be applied by SABs and their partner organisations to all reviews:

- *There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,*

- *The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined,*

- *Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed,*

- *Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith,*

- *Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.*

Appendix 2: The Learning Together model

i. Introduction

This Safeguarding Adults Review was carried out using the systems methodology called Learning Together (Fish, Munro & Bairstow, 2008). The focus of a case review using a systems approach is on multi-agency professional practice; so the primary emphasis is on what the practitioners did, thought and felt, not on the service user.

The aim of a Learning Together Review is to move beyond the specifics of the particular case (what happened and why) to identify the underlying issues that influence practice more generally. These generic patterns become the ‘Findings’ from a case. Changing them will therefore help to improve practice more widely.

ii. Methodological heart

What is referred to as the “Methodological Heart” of the Learning Together model is made up of 3 distinct stages;

1. The **“View from the Tunnel”** - understanding how practitioners understood the ‘local rationality’, allowing us to reconstruct what happened without the benefit (trap) of hindsight
2. Carrying out an **“Appraisal of practice”** to understand what happened and explain why it happened through the analysis of Key Practice Episodes (KPE’s).
3. Using the case as a **“Window on the system”** to assess its relevance and understand the implications for wider practice

This approach studies the system in which people and the context interact. It requires the use of qualitative research methods to improve transparency and rigour. The key tasks of a Learning Together Review are therefore data collection and analysis. The data is obtained through structured conversations with the practitioners involved in the case, and from documents provided by the organisations. Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process.

iii. Methodological comment and limitations

When commissioning the review the SAB gave consideration to the draft Quality Markers currently being developed by Social Care Institute for Excellence in conjunction with RiPfA. As such this report should contribute to the growth of the Safeguarding Adults Review library project by separating learning into case findings as discussed in Section 3.2 Appraisal of Practise and within each Finding ‘How did this manifest in the case’ and system findings – examining the causes of those practice problems and successes including what helped or hindered the practice on a systemic level.

In order to be ‘proportionate’, the commissioner elected to use a Practitioner Workshop, as the central mechanism for case-specific data gathering and analysis, rather than conduct a lengthier process that included more detailed individual conversations with Case Group members. While this more proportionate use of Learning Together served the purpose intended very well, it left the Review Team with some frustrations because they were unable to delve more deeply into all aspects of the analysis in the time afforded to the review process, for example in exploring practitioners’ understanding of their duty of care.

Not all Practitioners involved with Ms. B were able to attend the Practitioners event. However this gap was mitigated to some extent by alternative practitioners or practice lead from that organisation attending. Although it would have been helpful to have the benefit of the views of some other practitioners e.g. the GP, the Review Team do not consider that this has had a material impact on the Findings.

iv. Reviewing expertise and independence

The Lead Reviewers, Julie Pett and Kathy Kelly, are accredited to carry out SCIE Learning Together reviews and have led a number of SARs using this methodology. They had no previous involvement with this case, or any previous or current relationship with any agency in Enfield.

The Lead Reviewers received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and the reliability of the findings as rooted in the evidence.

The Lead Reviewers worked closely with a Review Team consisting of a group of senior managers from agencies that had been involved with the care of Ms. B. Members of the Review Team did not have any direct management responsibility in relation to the services offered to Ms. B. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice and to the development of the findings from the review. Review Team members worked collaboratively with the Lead Reviewer reading documentation and analysing the data.

The Review Team were drawn from the following agencies/departments:

Enfield Council – Strategic Safeguarding Service, Adult Social Care

Enfield Council – Social Work Service, Adult Social Care

Enfield Council – Access Service, Adult Social Care

Enfield Council – Brokerage Service, Finance, Resources and Customer Services

Barnet, Enfield and Haringey Mental Health NHS Trust (BEH-MHT)

London Ambulance Service NHS Trust (LAS)

North Middlesex University Hospital NHS Trust (NMUH)

Core Outreach & Care Services UK Ltd

Falck UK Ambulance Service Ltd (formerly Medical Services Ltd)

v. Sources of data

The systems approach requires the Review Team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the ‘local rationality’. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context. The Lead Reviewers would like to thank both the Review Team and the Case Group for the valuable contribution they made to the contents of this Report.

vi. Data from case group

During the Practitioner Learning Event on the 12th July 2018 the Review Team facilitated group discussions around key practice episodes with the following staff:

During the Practitioner Learning Event on the 12th July 2018 the Review Team facilitated group discussions around key practice episodes with the following staff:

North Middlesex Hospital Social Workers – Enfield Council, Adult Social Care

Carer – Core Outreach & Care Services UK Ltd

Designated Professional for Safeguarding Adults – NHS Haringey Clinical Commissioning Group (CCG)

Practice Development Nurse – Barnet, Enfield, Haringey Mental Health NHS Trust

Matron – North Middlesex University Hospital NHS Trust

Ward Manager – North Middlesex University Hospital NHS Trust

vii. Practitioner workshop

The Practitioner Learning Day on 12th July 2018 was central to the Review process as it brought practitioners involved with Ms. B together to discuss practice. Facilitated by the members of the Review Team, it was an opportunity for reflective practice and this was born out by comments made by participants for example *'Good discussion and information about* and '*Interesting to hear the perspective from other professionals, '[I intend to] incorporate this into my own role'* as well as *'Highly relevant to my practice'.* Feedback forms were extremely positive and included comments that participants '*Liked the transparency between agencies'* and concluded that they *'Did not feel the 'blame culture' at all'*

The chance to challenge other agencies was also welcomed for example around risk assessment and roles and responsibilities.

Practitioners were particularly struck by the value of the domiciliary care worker personal relationship with Ms. B. The Review Team concluded that the Practitioner Workshop was a positive and valuable experience for both the Case Group and the Review Team, both as an opportunity for practitioners to reflect critically on practice in the case as well as providing a 'window on the system' as detailed in the Findings. The Review Team would like to commend the Case Group for their openness and willingness to reflect on both this case and also the wider system that they work in.

viii. Data from documentation

The following documentation was available for the Review Team:

- Chronologies of time period from all agencies involved in the case
- GP Records
- Adult Social Care Records
- Acute Hospital records
- Serious Incident Report Acute Trust

ix. Activity

Date	Meeting Purpose
12th June 2018	Initial meeting between Lead Reviewer and Review Team to plan and consider possible Key Practice Episodes (KPEs)
28th June 2018	Lead Reviewer meeting with Next of Kin

12th July 2018	Learning Event with Case Group and Review Team to review draft KPEs and consider underlying patterns
6th Sept 2018	Follow on Meeting with Review Team to consider draft findings
November/December 2018	Review Team Members consult ‘their’ Case Group members regarding draft Findings
December 2018	Review Team revise Findings and Appraisal of Practice and agree draft final report
13th December 2018	Lead Reviewer meeting with Next of Kin to feedback draft report
June 2021	Publication of Final Report
31st March 2022	Completion of action plans

Appendix 3: Glossary and explanation of terms

Term	**Explanation**
ASC	Adult Social Care
Bariatric	Bariatrics is the branch of medicine that deals with the causes, treatment, and prevention of obesity. An individual is considered morbidly obese if he or she is 100lb over his/her ideal body weight, has a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions.
Community Care	'Community Care' is used to describe the various services available to help people manage their physical and mental health problems in the community e.g. nursing or social work support, domiciliary care, day centres, supported accommodation.
Community Nursing Service	Community Nursing Service is made up of different types of nurses who manage care within the community, rather than in a hospital. They visit patients in their homes and provide the advice and care regarding wound management, continence care, catheter care and palliative care amongst others.
Domiciliary Care	The service which helps people to live at home proving personal care and practical support commonly described as ‘home help’
MDT	Multi-disciplinary team, a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions, commonly used in clinical settings.
Metrics	Clinical trial performance metrics (also commonly referred to as operational metrics, or key performance indicators) is data collected about operational performance.
MHL	Mental Health Liaison Team provide psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital and provide a valuable interface between mental and physical health.
Moisture lesion	Widespread superficial damage that is the result of episodes of incontinence *moisture* (incontinence or perspiration). A *moisture lesion* and a pressure ulcer may exist in the same area where dermatitis/moisture lesions are accompanied by pressure.
OT	Occupational therapy aims to help people who have difficulty with their everyday work, home or leisure activities because of illness or disability.

Pressure Ulcer	Pressure ulcers described in four stages: Category 1 are not open wounds. The skin may be painful, but has no breaks or tears. Category 2, the skin breaks open, wears away, or forms an ulcer which is usually tender and painful. Category 3, the ulcer gets worse and extends into the tissue beneath the skin, forming a small crater. Category 4, the pressure ulcer is very deep, reaching into muscle And Bone and causing extensive damage. Damage to deeper tissues, tendons, and joints may occur. In stages 3 and 4 there may be little or no pain due to significant tissue damage. Serious complications, such as infection of the bone (osteomyelitis) or blood (sepsis), can occur if pressure ulcers progress.
Physiotherapist	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.
RiPfA	Research in Practice for Adults aims to support people working in social care and health to improve outcomes for adults, their families and carers. Bringing together academic research, practice expertise and the experiences of people accessing services, RiPfA enables professionals across the sector to make evidence-informed decisions about the design and delivery of Adults' Services.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCIE	Social Care Institute for Excellence
TVN	Tissue Viability Nurses provide specialist advice and care to patients with a wide variety of complex and ongoing wounds. These include pressure ulcers (both the prevention and management of such), traumatic injuries and complex non-healing wounds.
Vacuum Therapy	The therapy involves using a sealed wound dressing attached to a pump to suction fluids from wounds that are difficult to heal on

	their own.

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[i] Vincent 2004: 13