SAFEGUARDING ADULTS REVIEW
THE CASE OF BEN

OVERVIEW REPORT
November 2019

Commissioned with: Passiton Consultancy Ltd

Commissioned by: West of Berkshire Safeguarding Adults Board

Endorsed by: West of Berkshire Safeguarding Adults Board, January 2020

Contents

Introduction

This review has been commissioned by the West of Berkshire Safeguarding Adults Board (SAB) in line with its accountabilities under Section 44 of the Care Act 2014. Chapter 14 of the 'Care and Support Statutory' guidance gives further advice on how such reviews should be carried out. The author has been selected to ensure the independence of the review and in terms of her background experience inclusive of enhanced and substantial experience of operational and strategic multi-agency safeguarding practice. A potential conflict of interest was disclosed at the beginning of the commission, legal advice was sought and consultation with the family was made.

The core timescale for the review spans the period from May 2014 to July 2015 however will also have regard to any relevant previous history in this case. The individual relating to this review is to be known as Ben to protect privacy and anonymity. Names of professionals will not be used within the report and likewise the provider organisation or home will not be identified.

At the time of the Safeguarding Adult Review (SAR) notification there were ongoing criminal investigations in relation to Ben and several other ongoing safeguarding enquires. As such, although the notification to the SAB was timely there was a necessary delay in commissioning this review. The SAR panel have confirmed that all criminal and regulatory investigations/actions have now concluded. A press release was issued at that time.

Ben's family have been informed of the review being undertaken, its role and purpose. Although invited to contribute to the review and its final report they have at this time declined. They will however receive a copy of the report at an appropriate time and may wish to make additional comment.

Methodology

In the case of Ben, the Safeguarding Adults Review (SAR) subgroup to the Board have selected a proportionate review methodology with a focus of extracting and drawing together any identified and additional learning in the case of Ben. The methodology agreed for this review is of an appreciative enquiry.

Terms of reference/objectives for the review were developed and agreed by the review panel, individual conversation where required were undertaken with members of staff involved within the case. The review panel members submitted written reports following their review in the format of Individual Appreciative Management Reviews. Reviews focused on identifying good practice and reflecting on the conditions or systems at that time which made innovative work possible. Conversations were undertaken with the family and the provider to ascertain their views. The panel reconvened to agree and develop the best method of sharing the findings with the SAB and to develop a multi-agency learning event in which agencies could endorse practice highlighted from their agencies with frontline staff

The SAB recognise this methodology is not commonly used in terms of safeguarding reviews however the methodology was selected in order to highlight what worked well rather than to focus on poor practice or systems failures. As with any form review where learning has been gained this will be reflected in the agencies arising action plans.

Individual Appreciative Management Reviews were received from:

- Care Quality Commission
- Thames Valley Police
- Clinical Commissioning Group
- GP
- Berkshire Health Foundation Trust – (for District Nurses, Podiatry and Tissue Viability)
- Royal Berkshire Hospital
- Wokingham Borough Council
- Care Home (Individual review conversation)

All Agency Reports were quality assured and signed off by a senior manager within the agency prior to their submission.

Governance of the review was managed by a panel of senior representatives from agencies. Membership of the Safeguarding Adult Review Panel therefore consisted of:

- Clinical Commissioning Group
- Thames Valley Police
- Wokingham Borough Council
- Royal Berkshire Hospital
- Care Quality Commission
- Berkshire Healthcare Foundation Trust

Terms of Reference

The review panel set four key terms of reference relating to the safeguarding (section 42), quality assurance with providers (serious concerns framework) and criminal processes. These were to review and explore:

- How agencies worked collaboratively within existing frameworks/policies and procedures?
- How did the individuals involve, impact on the process? Would it have been different if individuals were not involved?
- Review In the case of Ben how effective was practice in terms of wider safeguarding and quality assurance requirements?
- Given known extensive resource implications and impact for agencies in the case of Ben can this review identify/ recommend better preventative working for agencies?

The findings emerging from this review have been formulated under these terms of reference

Who is Ben? (Background Summary)

Ben was an 89 years old, White British man. A Butcher by trade and would reminisce about this with staff. Ben was a widower (his wife died in 2009). Ben previously resided in a warden controlled, sheltered housing scheme, he had moved from this flat in to a residential home and then into nursing care. The gradual change in his care needs would appear to be in keeping with his advancing dementia and frailty in the last four to five years of his life. There is clear documentation of family involvement in decision making around Bens care and discharge planning from hospital and ongoing care, the family acted as an advocate to Ben when he was assessed to lack capacity to make decisions relating to his care and treatment.

Ben's granddaughter was also actively involved in supporting Ben when he was living alone. Ben's son and daughters offered help with managing his finances and visited him regularly. They lived close by, his son and one of his daughters acted as main representative during contact with the local authority during the review period.

Ben had a diagnosis of Vascular Dementia in January 2013 and had multiple co-morbidities; he had numerous visits to the Emergency Department of the Royal Berkshire Hospital (RBH), some of which had led to inpatient admissions during 2013-2015. Although Ben continued to reside at the sheltered housing scheme following the initial diagnosis, his family became increasingly concerned about his ability to maintain his independence. These concerns appear to have been confirmed when Ben was admitted to hospital with a chest infection in January and was subsequently discharged home with a package of care of 4 calls a day from a local domiciliary care agency.

Although it was reported that Ben was settled following his discharge, he was admitted to hospital again a few weeks later, after he was found by the Police in the local community in a state of undress. Ben was very confused and unable to provide details but was wearing an NHS band on his arm which provided a name. He was taken to the RBH by ambulance for treatment of hyperthermia. Ben's son was informed, and the police raised a safeguarding concern. Ben was subsequently admitted to a residential care home locally.

Ben was deemed to lack capacity to consent to the care and support provided to him during his hospital admission and in May 2014 it was following consultation with Ben's family, and a formal best interest's meeting that the decision was made to move Ben to nursing care as the residential home he resided in prior to admission was no longer suitable to meet his needs. Ben was now dependent on carers to meet most of his needs. Ben was unable to walk and needed assistance with transfers. He could not feed himself, requiring staff support. He could not dress, wash or use the toilet independently.

Ben had been a resident in the final Nursing Home subject to this review from August 2014 until the safeguarding concerns leading to hospital admission on the 17th July 2015. On discharge from hospital in August 2015 Ben was moved to an alternative provider to receive end of life care at the request of his family.

Ben sadly passed away on the 24th August 2015. The cause of death was recorded as Bilateral Pneumonia and Severe Ischaemic Heart Disease (pacemaker in situ), Grade 4 Pressure Sore Left Calcaneum. The cause of death is recorded by the coroner as Pneumonia, it was noted that Ben had several pressure ulcers at time of death. They are not however recorded as a contributory factor of his death.

For ease of analysis information from the timeline of events has been divided into four key episodes these are:

- Adult Social Care and Health assessments
- Deprivation of Liberty Safeguards (DoLS)
- Safeguarding
- Serious Concerns Framework

Adult Social Care Assessments and Health assessments

Ben was admitted to hospital from his residential care home. The hospital deemed Ben was medically fit for discharge from 13 June 2014.They completed and sent a section 2 notification to social services to start the process of securing a nursing home placement. The section 2 notification was completed and sent to social services on 16 June 2014. This was good practice and in line with policy and procedures. The case of Ben was then allocated to a Social Care Assessor within the Health Liaison Team (HLT)

The hospital (RBFT) told the review that during the June 2014 admission there was a long delay in finding a nursing home placement, the engagement and documentation regarding discharge planning was lacking and there was no evidence of documentation in the clinical notes from the integrated discharge team. This may therefore have contributed to the delayed discharge.

A Self-Directed Assessment was however undertaken on 18th June 2014. The assessment noted that Ben did not appear to have any pressure sores at the time of his admission. The assessment also stated that Ben has had recurrent Urinary Tract Infections (UTI's) and was incontinent of urine and faeces. The assessment seems to be an accurate picture of Ben's needs at the time of his admission to hospital. The assessment process took place under The NHS and Community Care Act 1990 pre-Care Act 2014 implementation.

On the 31st July 2014, following an assessment of Ben's capacity a best interests meeting was held due to the delayed discharge of Ben and the potential risks associated with delayed discharge. A decision was made arising from this meeting that it would be in Ben's best interests to move into a nursing home placement provision which could meet both his health and social care needs. This was good practice and in line with the requirements of the Mental Capacity Act 2005.

The worker had identified a vacancy at the Nursing Home. The family had viewed the home however expressed concerns about the cleanliness of the home. They had requested a nursing home be found closer to the families' location in order to make regular visiting easier. The worker told the family that due to the amount of time that Ben had been in hospital and the risks to his health of a continuing admission that the local authorities view was that a move to nursing provision would be in Ben's best interest. Ben was assessed as lacking capacity to consent to his care and treatment arrangements. This meeting occurred on 20th August 2014. Ben had been in hospital at this point for over three months. The placement was described as interim, pending a 6-week review

Professionals appear to have been aware of the long-term impact that remaining in hospital would have had on Ben's health i.e. hospital acquired infection. Ben's family appeared to accept, albeit reluctantly, that the move to the nursing home was therefore necessary. Ben's son asked the local authority to still consider finding a home in their local area. The local authority accepted that the

move to this nursing provision was an interim arrangement. Therefore, a decision was taken not to progress to a safeguarding enquiry as the Best Interests framework had resolved the difference in the opinions of professionals and the family. Ben moved to the Nursing provision in August 2014.

The hospital (RBFT) highlight concerns from the GP in the days following Ben's discharge on the 20th August 2014. During this admission Ben was assessed by SALT and their recommendations were handed over to the home. It was well documented that Ben's oral intake was poor at times and he required assistance and prompting from staff to ensure his nutritional needs were met. There were no other documented concerns about swallow prior to his discharge. Ben's swallowing difficulties were deemed in keeping with a patient with advanced dementia

The subsequent Support Plan Summary produced by the local authority dated the 2nd September 2014 identified the type of support that Ben would need for his move to nursing care. This included support for personal care, socialisation, eating and drinking etc. The review was told supplementary information setting out his care and support would be provided on a day to day basis would usually be held by the care home themselves and held on a separate service user file at the nursing home. This would be the standard process for admission to care and was in line with admission policy and procedures.

A six week statutory review of the placement was then carried out on 7th October 2014 by a Social Worker within the Health Liaison Team. The review documentation notes that Ben had lost weight since admission. A Malnutrition Universal Screening Tool (MUST) was completed for Ben and at the time found that he scored as medium risk of malnutrition, his Body Mass Index was within normal ranges. Reference is also made to Ben's profile bed being on a low setting (i.e. closer to the ground) and a crash mat next to it.

The review found there did not appear to be any analysis of these or other risk to Ben at this point in terms of triangulation of the above information indicating a possible requirement for Tissues Viability assessment and pressure care management plan as a preventive measure. It is noted that within the support plan document this section of the support plan review is usually only completed if there is a positive risk / safeguarding plan in place for the individual. There was not one in place for Ben at the time of that review. The reviewing professional refers to having read the care plans, that they were up to date and covered all aspects of Ben's care. No further actions from the review therefore arose. The document stated that the placement appeared to have been working well for Ben and no further concerns were documented by the reviewer, provider or Ben's family at this review.

As a result of the six-week placement review the decision to then transfer Ben's case to the Brokerage and Support Team for review within a 12-month period was made. This would be standard procedure. In the case of Ben therefore his 12- month review would have been expected to take place in October 2015 sadly this would have been after his death. However, a further Self-Directed Assessment was undertaken following Bens admission to hospital on 17th July 2015 as a result of the safeguarding strategy meeting. This was good practice in line with procedures and responsive to Bens needs.

Deprivation of Liberty Safeguards (DoLS)

Following application by the provider and in line with expected policy and statutory requirements a Deprivation of Liberty Safeguards (DoLS) assessment was undertaken in March 2014 following the

required assessments the deprivation was authorised by the local authority on the 24th April 2015. This confirmed that Ben lacked capacity to consent to the care and support arrangements in place for him at the nursing home.

Concerns raised by the family during the DoLS process to the Best Interest Assessor (BIA) relating to the quality of care being provided by the home were not fully investigated by the local authority as the information was not shared or identified as part of the authorisation and scrutiny role, as such this information remained within the DoLs system.

Having reviewed the information within the BIA assessment, if shared outside of the DoLs system this may have been responded to by undertaking an urgent review or a safeguarding enquiry at that time. According to a case note dated 6th August 2015 which would be subsequent to the safeguarding concerns and enquiry, Ben's daughter raised the following concerns during the BIA assessment this alleged:

- Ben was left to fester in his own urine after having pulled out his catheter
- Not washed for days with an offensive smell present.
- Neglected and left unfed one day in the spring of 2015.
- Staff informed Ben's daughter that the home was experiencing a staff shortage.

However, the information recorded by the BIA was not as detailed. As the concerns were not fully shared with the local authority until 6th August 2015 (directly by the family) approximately 5 months after the submission of the DOLS assessment. The opportunity to appropriately respond and assess the quality of care and impact for Ben was missed.

Pressure Care and Falls Pathways

BHFT told the review that during a visit to the previous residential home on 2 May 2014, that in addition to Bens wounds and wet legs, the nurse had noted bruises on his left foot during a routine bandage change. She did not however make further enquiries of care home staff about how the bruise occurred or check the home records or accident forms. This was not highlighted at the time as a concern. The nurse interviewed stated that she did not consider at the time that were any safeguarding concerns and Ben's general decline in health had contributed to his falls. This was an assumption made without the knowledge or investigation of how the bruise occurred and no checks were undertaken to ascertain if it was noted in the nursing home records. If investigated, earlier identification and review of Bens care and treatment plans may have been undertaken.

In addition, a further entry made in Ben's health progress notes stated that on the 20 May 2014 (again in the previous residential care home) Ben had a fall and was seen in the Accident and Emergency Department. The entry states that 'there is no action plan regarding falls." It is not clear if the nurse completed a falls assessment and made any referrals to the falls team who were part of the reablement team at the time for assessment of rehabilitation potential. The review was told the expectation would have been that the risk assessment would indicate that Ben would have met the criteria for referral to the reablement team.

BHFT records indicated that on 13 July 2015, the Tissue Viability Nurse (TVN) had received a referral from the home clinician and discussed the referral by telephone consultation on 16 July 2015. She was satisfied with the management plan but noted her concern in the record that the referral was for pressure damage to shoulders, hips and sacrum. Ben was now reported to be bed bound with joint degeneration and contractures of the limbs.

The review identified that the provider had made earlier referrals to the TVN service however these were not accepted, as the wound was below the ankle, and therefore the referral should have been made to podiatry. The confusion in these referral pathways led to delays in Ben receiving assessment and the provider being directed to correct management plan,

The following day the TVN phoned the home to make an appointment for an assessment visit and was advised that Ben had been admitted to hospital due to deterioration of his pressure area damage. The TVN then phoned the hospital to get an update on Ben's condition. It was recorded in the notes that 'the referring clinician did not give any indication of concern about Ben that would have triggered an urgent response from TVNs the previous day.' The TVN response was timely in view of the information given within the referral from the home.

When concerns relating to pressure care were raised the GP linked to the home stated "I assumed that the nurses are managing the wounds appropriately as this is their area of expertise. I understand they did refer to the tissues viability nurses and were told this is a podiatry problem as it is below the ankle" the GP highlighted the different commissioning elements and pathway's for Tissue Viability Nurse services and Podiatry as a commissioning issues and a blanket policy not to be in any patient's best interests. In the case of Ben, it is evident that the provider was confused between the pathway and referral requirements between TVN and Podiatry causing delay in the correct service assessing and monitoring Ben.

Safeguarding Responses

The initial safeguarding concern raised by the out of hours service to police on 16th July 2015, late evening Ben was admitted to hospital in the early hours of the 17th July 2015.

On 17th July 2015 the hospital also raised an immediate safeguarding concern under the category of suspected Acts of Omission and Neglect by the nursing home in relation to the care of Ben. The police were notified of the referral due to potential criminal investigation needs as the concern reported Ben was found to have 12 pressure sores and bruises all over his body. He also had a pressure wound to his heel which had maggots in it. The bruises were said to be consistent with a person who is bed-bound and a bruise to his neck was consistent with a hand mark. This was good practice by the hospital and in line with Pan Berkshire safeguarding policy and procedures

On receipt of the concern by the local authority the concern was escalated to the safeguarding service and an immediate safeguarding strategy meeting was convened at the hospital with all key agencies in attendance. This was in line with escalation process and good practice in terms of a timely and expedient response in consideration of achieving best evidence principles.

The outcome of the strategy meeting detailed individual safeguarding actions and enquiries relating to Ben. The direction of the adult safeguarding enquiry included a robust audit of care plan records and an analysis of care delivery to Ben.

Given the serious condition of Ben it was agreed by all agencies that it would be a proportionate response to initiate a welfare check of other residents within the home under the remit of the Care Governance framework within a category of possible organisational abuse or neglect. Agencies agreed additional resource of the required specialism, social workers, TVN; s and District Nursing to support the assessment as due to the timing of the day the visit would need to be undertaken out of hours. This was responsive and collaborative multi agency response to potential transferable risk indicators.

A clear strategy of reviewing the most vulnerable residents within the home in priority order of those who were bed bound, lacked capacity or were known to have pressure areas of concern. The strategy gave clear direction on roles and responsibilities creating a coordinated response to the safeguarding concerns.

On the evening of the 17th July 2015, a multi-disciplinary quality assurance visit was undertaken within the home which evidenced significant concerns on a broader scale. The provider was taken into the Serious Concern's Framework under safeguarding and Care Governance Frameworks.

The strategy meeting had also identified Police as the lead agency as investigation would proceed under TVP relating to possible offences under Section 20 - Ill-treatment or wilful neglect: care worker offence - Criminal Justice and Courts Act 2015 Or, TVP Section 21 - Ill-treatment or wilful neglect: care provider offence - Criminal Justice and Courts Act 2015. Officers attended the home and seized paperwork as potential evidence in support of the criminal investigation. This was in line with safeguarding policy and procedures all agencies were clear on the lead agency role and needs of achieving best evidence.

On 19 July 2015 a detective sergeant added a review to NICHE (police recording system) questioning the care Ben had received in order to sustain such pressure sores and the reasons for admission to hospital except for the pressure sores. The police proceeded to seek independent clinical assessment of Ben's care and treatment.

CQC told the review a statutory notification was made to the CQC by the provider regarding pressure ulcer care on the 19th July 2015. The local authority had however made notification the previous day following the outcomes of the strategy meeting. This was the notification of Ben being admitted to hospital. The records held by CQC show immediate contact from the local authority regarding concerns and that CQC were made aware of a further review strategy meeting to be held on 20 July 2015. CQC were involved in the strategy meeting with the local authority, police and other health care professionals. Communication and notifications across agencies were expedient and appropriate.

Police on the 22nd July 2015 further considered the potential offences for this case.

On 31 July 2015 a Serious Concerns meeting was held with all agencies in attendance to review and share information arising from assessments undertake so far. As a result, of this meeting all agencies contributed and reviewed the Care Governance risk matrix and the provider was placed on the embargo list under a Red status (no placements to be made in the home at this time). A multi-agency action plan to monitor risk and support the provider with improvements identified as being required was agreed. The framework was applied in a timely and effective manner, records and recording provider clear evidenced information to inform decision making and risk levels were agreed in a multi-agency context.

The support of the Care Home in Reach team to undertake clinical review and support the home was made a priority of the commissioners over other care home support at that time.

Records of previous safeguarding concerns were recorded on the notes from the arising quality assurance visit on 17th July 2015. It became known that a safeguarding concern was raised correctly by a worker from the nursing home which if investigated may have identified concerns earlier. The referral was considered by the local authority but ultimately closed as the findings concluded that the care and support within the home were enough to meet the identified needs. It is not clear how this decision was reached by local authority and may reflect the need scrutiny of such decisions in safeguarding,

Good communication and information sharing across organisations was identified following in the safeguarding for Ben raised on the 17th July 2015. The response from Police to the safeguarding concern was coordinated with support from local authority staff. Case notes provide examples of the type of information shared by the local authority including an audit of care plan records carried out by Social Worker leading on the section 42 safeguarding enquiry.

It should be noted as is a common misunderstanding in safeguarding practice and responses that as the burden of proof is different for criminal and civil action under safeguarding, it is not uncommon for outcomes to be substantiated under Sec 42, despite no prosecution following. This is due to the burden of proof under Sec 42 aligning with the civil thresholds (balance of probability), whilst criminal prosecutions consider a threshold of 'beyond reasonable doubt'. In the case of Ben this matter clearly created a view of the provider that safeguarding activity was disproportionate as no criminal charges were made.

Serious Concerns Framework (SCF)

There were 9 incidents reported to the local authority as safeguarding referrals by the nursing home between 14th August 2014 and 17th July 2015 only one of which referred to pressure damage. A referral made on 14th August 2014 (226780) relates to a resident who is usually nursed in bed. A blister was found on the resident's right heel. Assessment by a Tissue Viability Nurse found that the blister was in fact a grade 4 pressure ulcer.

CQC informed the review that there had been three inspections of the home under the provider during the registration period of 04/11/2011 to 09/08/2016.

- August 2013: Inspection outcome judged under 5 outcome areas with all 5 were compliant
- July 2014: Inspection outcome judged under 5 outcome areas with all 5 were compliant
- September 2015: Inspection outcome judged under 5 domains. There were no identified breaches of the regulations. The overall rating was good, with a requires improvement in the domain of effective.

There were no recorded enforcements relating to the home.

During the case of Ben and the organisational safeguarding concerns (Care Governance) raised by the local authority CQC were made aware that significant resources from external agencies, such as the local authority and Clinical Commissioning Group, were put into place to support the provider. The new manager who became the new registered manager was very efficient in gaining a good

degree of oversight very quickly. CQC were kept fully informed of the work being completed and the progress being made which continually fed into their decision making regarding regulatory action.

As such a CQC inspection in the September 2015 rated the service as good overall with requires improvement in effective. There were no breaches of the regulations. CQC was satisfied that improvements required by the local authority or CCG had either been addressed or were in the process of being so. Appropriate enquiries and actions were made. At the time of CQC being made aware of the concerns within the service there were no identified on going risks. The service had been previously managed by another team in CQC, the relationship owner changing in April 2015. When that hand over occurred, the service was deemed to be low risk and well managed with no concerns identified.

Following on from the provider being downgraded from the embargo, due to having made significant improvements, CQC advised they were aware that police had sought advice from CPS regarding a prosecution for the offence of wilful neglect. The CPS determined the evidence did not support this and advised that under the new powers given to CQC on 1 April 2015, consideration be given to the potential for a prosecution under regulation 12 by the regulating body. A Management Review Meeting (MRM) was conducted on the 5th October 2015 following the inspection to discuss findings and possible and appropriate regulatory responses under CQC's regulatory powers.

On 12 April 2017 (post the review period) some of the documentary evidence gathered by the police was delivered to the CQC to assist with information gathering regarding potential prosecution of a regulation 12 offence. Legal advice was sought within CQC. The decision was made by CQC that there was insufficient evidence to support a realistic prospect of conviction of provider level failure in this case. All professional interested parties were informed of this decision.

Previous notifications made to CQC regarding pressure area care on 13/08/2014, 11/09/2014 and 27/02/2015 have been reviewed as part of this review. The notifications detailed the progress of the wound and health care professionals involved. All wounds were located on the feet.

The review was told on 19th May 2018 that CQC had in fact received a notification, in 2015, regarding Ben and his pressure ulcer, with a concise history of the wound and actions taken, including other professionals involved. What is not clear from the notifications are the following:

1. Had CQC received an earlier notification regarding Ben and the deterioration of his pressure ulcer to grade 4, the CQC may have changed their response to the notifications regarding pressure ulcers from this service. However, looking at the level of information received at that time, appropriate action was reported to be happening.

2. The notification states which other health care professionals were notified. The wording implies that the professionals were working together to support Ben and the nurses caring for his wound. What is not mentioned directly or indirectly is that although the appropriate people were informed, they had failed to respond. Again, had CQC been made aware of this failure, they suggest they might have responded differently. However, from the information available at the time this appears to be a miscommunication rather than a complete lack of communication, so did not immediately suggest a breach of the regulations.

CQC noted the previous manager had failed their probation and left in April 2015. There was a gap between April 2015 and July 2015 when the current registered manager commenced employment.

Communication between professionals involved in this process was good. CQC was also made aware of the significant amount of work and support that had been put in place immediately following the

identification of the concern by both the local authority; health and the care home support team. It was clear that although concerns had been identified, with the new manager being in place from the start of July 2015 the service was making good progress. Due to the number of professionals already working with the provider and the positive engagement from the new registered manager it was judged by CQC that an immediate inspection would not be the correct course of action.

CQC have reflected on this and the potential for this to be perceived as a delay in response. It is important to be clear on the rationale behind this decision. In the period of time immediately following the admission of Ben to hospital, quite rightly there were significant concerns. These were promptly acted upon by the local authority safeguarding team who did a comprehensive and very thorough review of safe care within the service which covered significantly more aspects than just pressure wound identification and management.

Alongside the ongoing review and support from the local authority the local care home support team nurses were involved in working with manager and staff to further identify issues and concerns and more importantly address them. CQC were in continual communication with both the local authority and the care home support team. These communications assured the CQC that each resident had been reviewed. They were aware that concerns were being identified but were also assured that the concerns were now known and were being addressed.

Staff in the service were seen to be engaging well with partners and working hard to make the required changes, led by a new manager who had a very clear plan for improvement. CQC were of the view at the time that people were safe and progress was being made. Therefore urgent action from CQC was not required. It was also their view that the concerns had been identified and were being addressed; conducting an inspection putting staff under further pressure was not going to affect better or faster improvements.

It was considered that, in fact, increasing the pressure with an inspection could in this case be detrimental. Hence the decision was made to monitor very closely and keep the regulatory response under review. A comprehensive inspection was planned and carried out on 28th September 2015 and 1st October 2015.

The report published following the September inspection made no mention of the ongoing criminal investigation which on reflection CQC accepts could be misleading. Since this incident changes have been made to the CQC's reporting guidelines. A statement is now made in reports where there is an ongoing criminal investigation: 'The inspection was prompted in part by notification of an incident following which a person using the service [died][sustained a serious injury]. This incident was subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.'

The Clinical Commissioning Group (CCG) told the review they worked very well with their partner agencies within the serious concern's framework. The CCG Head of Safeguarding Adults reported the relationship was both established and strong with the LA and the key health providers. This relationship and partnership work between us are due to regular work on subgroups for the SAB and the regular interface between safeguarding lead professional within the partnership.

It was also their view that knowledge of the strategic leads in relation to each other's roles and function allowed the correct people to be positioned and involved in the SCF and allowed the partnership to make decisions based on the trust of each agency QA visits and concerns.

Provider views

As part of the review the provider was invited to give reflections on their view. The provider felt that the approach in terms of the Serious Concerns Framework "was not conducive to new incoming registered manager, where the focus needed to be on getting to know the home and residents."

In terms of the safeguarding section 42 enquiry for Ben the provider stated requests from police felt excessive for photocopied documentation and they felt this distracted from time which should have been spent with the manager embedding within the home.

The provider told the review anxiety was high within the staff team and for residents and their families due to the high level of activity and presence from external agencies within the home. This often resulted in the manager "not feeling in control of the home". Although additional resource was made available by the organisation the impact in their view gave a chaotic feel to the home.

Although the provider acknowledges the statutory requirements of the agencies in terms of wider safeguarding concerns they felt the approach felt too intensive, it is their view that agencies could have been better coordinated to minimise impact. Comment was made by the provider that in their experience the approach appears more coordinated in other such instances. Focus was needed by the new manager to improve motivation and morale within the homes staff team this often created competing demands for the management team.

Some mixed messages were highlighted as creating frustrations and tension across the partnership operating within the framework. Although all agencies were key stakeholders and decision makers within the Care Governance meetings the provider reports being left feeling that the risk matrix did not reduce expediently enough to reflect the work being achieved. The provider also stated that some key staff had outside of the serious concern's framework meeting expressed a similar view.

This said the provider stated Resource development commissioned by Health and Social Care in terms of supporting the provider within the locality and improving care standards such as the Care Home In Reach service were invaluable. The Rapid Assessment and Treatment Team [1](RATT) being able to provide intensive specialist support and advice to avoid hospital admission/attendance was also seen as positive within the locality promoting good outcomes. The provider felt such initiatives would be valuable as a national initiative. The provider stated "as a national provider it is evident that such support services within the locality are having good impact." CQC inspection gave a good rating 2.5 months following initiation of the Serious Concerns Framework.

[1] Please note the RATT was post the period of this review, October 2018, and were not involved with the case of Ben.

Findings in Line with the Terms of Reference set for this Review

Explore how agencies worked collaboratively within existing frameworks/policies and procedures?

Two frameworks operated predominantly in conjunction in the case of Ben these were the Safeguarding Framework and Serious Concerns Framework. Clear multi agency policy and procedures were available and applied giving an evidence-based approach to all interventions. In fact, this is supported by a Safeguarding Peer Review which was undertaken by the Association of Directors for Adult Social Services (ADASS) South East region at that time. The review focused on the Safeguarding and Commissioning arrangements and cited the development of this framework as "innovative" and resourceful promoting good outcomes in addition to early identification and support to providers by providing a timely multi agency approach to address such concerns and avoid provider failure.

The interface and developed framework between safeguarding and care governance within the locality was effective and facilitated clear lines of communication, information sharing, clear lines of accountability and directed the correct resource support at the right time to drive improvement and embed protection and prevention principles within the partnership. This is supported by comments made by CQC as the regulator and all partners concerned. Good partnership working was evident throughout the review of this case

Further comments as highlight in the report made by CQC stated it was the assurance that the partnership and governance framework, allocated resource and risk management strategy was proportionate and appropriate in terms of identified transferable risk that negated the requirement of them undertaking an unplanned inspection. Partners told the review the framework facilitated a collaborative and supportive approach in monitoring risk and improving care standards.

It is highly evident in terms of this review that all agencies felt the Serious Concerns Framework gave clear structure and guidance in which to operate. This is evidenced in both agencies reports and conversation held as part of the review the CCG stated the framework ", was an effective and dynamic response to the needs of residents care and safety. The care governance process within the local authority followed a clear structure, which framed the partnership and built on the established relationships from previous meeting or networks"

The expedient response from identification of the initial safeguarding concern for Ben throughout the safeguarding enquiry to completion was exemplar practice in terms of its practice and recording which supported the criminal investigation whilst upholding Bens Human Rights as an adult at risk lacking capacity.

Multi agency communications within the safeguarding were clear and effective. This was reflected by comments made by the police and conversations held with the Criminal Prosecution Service (CPS). Practice followed the Pan Berkshire Policy and Procedures. Transferable risks were identified and responded to proportionately and within a multi-agency context, this is reflective of the prevention principles in safeguarding.

There was however a missed opportunity to initiate earlier assessments and interventions for Ben in terms of the information relating to the reported care quality concerns made to the Best Interest Assessor by the family during the DOLs process. If this information had of been effectively shared from the DOLS framework to the safeguarding or commissioning service Given the framework for

response to quality concerns at that time this may have acted in some degree as a preventative measure to safeguard Ben.

How did the individuals involved, impact on the process? Would it have been different if individuals were not involved?

Whilst the review identified that individual professionals involved within the frameworks and working with Ben held significant experience in their professional fields for example the Social worker undertaking the section 42 enquiry, the new manager coming into the home at the time of concerns, clinical staff undertaking review and supporting the home which contributed to the effective and efficient management of concerns and collaborative working. This review highlights the importance of all agencies knowing and understanding both policies and procedures and being clear on their respective roles and responsibilities within them.

In the case of Ben and other residents it was evident that all professional involved were clear and operating within the relevant policy and procedures which produced the required outcomes in order to safeguard Ben and to use information to inform early intervention in line with prevention principles for other residents. This may be reflective not only of the already established collaborative professional multi agency relationships but clarity and familiarity with the process.

The role of the GP can be pivotal in terms of their observations and relationship with a provider, it was striking within the review in terms of the GP's reaction when presented with the safeguarding information relating to Ben. He stated as a GP – "I feel let down by the staff at the home , there needs and always has been an element of trust between the surgery and the home. There has always been an understanding that patient's wellbeing is paramount both in terms of care but also appropriate treatment, also I have always been insistent on family involvement. I was not aware of any physical problems with the patient except a pressure area on the foot, also never aware of any family concerns".

On reflection by the CCG regarding involvement with the GP for Ben, it was highlighted as part of the review that in relation to supporting and informing the GP of Serious Concerns Framework that this could have been improved by keeping the GP and the surgery more informed about the Serious Concern Framework and the homes action plan .. The police led investigation process resulted in a distance between primary care and the CCG during the section 42 enquiry, which in hindsight may be able to be improved in police led investigations and in terms of GP's communications within the Serious Concerns Framework.

Review In the case of Ben how effective was practice in terms of wider safeguarding and quality assurance requirements?

In the case of Ben, the individual safeguarding enquiry was focused on review of care plans against the standard of delivered care by the provider. Usual practice in undertaking the enquiry would have engaged practitioners with the required clinical skill to evaluate any clinical aspects of the safeguarding a point which was raised by the provider.

However, given the worker undertaking the enquiry had been notified by the police who were the agreed lead agency following on from the strategy meeting for Ben, that a specialist independent clinical consultant had been appointed by the police to the case it was not appropriate to seek

further duplicate clinical input as part of the safeguarding enquiry. The provider would not at that time have been made aware of the detail of the criminal investigation process.

The outcome for Bens safeguarding was substantiated as neglect and omission to act by the provider. The safeguarding enquiry was detailed, well evidenced and proportionate considering the nature of concerns raised and ongoing criminal investigation

As stated, above practice and process was effective in terms of safeguarding and quality assurance activity undertaken within this review. However, points were raised which individual agencies and the Board may wish to further consider. From a provider perspective the framework created additional work and distraction from the smooth running of the home in addition to creating anxiety within the staff team.

Recent SAR's commissioned by the Board have identified the discrepancy in application of the serious concerns framework across the three localities governed by the Board. This can create confusion for staff in agencies that operate across all three in addition to providers who may have placements commission by all three authorities.

Transparency and challenging conversations were reflected on as part of the review some professionals felt that "elephant in the room" was not addressed as expediently as it could have been this appears to have cumulated in tensions arising between the provider and lead investigator/quality assurance lead leaving some individuals feeling targeted as being disproportionate "looking for fault". In reality there was evidence of contradictory information from various sources which should have been further challenged and should have resulted in staff being better supported given the impact and longevity of their involvement. The accumulative effect on individual practitioners in such cases requires careful consideration in terms of debrief and closure.

The staff directly involved within the safeguarding of Ben reflected on the accumulative impact that such intense work and the nature of harm to such a degree on individuals as Ben can have. It was highlighted that organisations need to acknowledge the emotional impact on individual workers within such processes and ensure appropriate support and "debrief" are fully considered. This was likely not as fully considered in this case due to senior level and known expertise of individual practitioners. Furthermore, it was highlighted that following such prolonged involvement the importance of "endings" should not be overlooked for all concerned.

Given known extensive resource implications and impact for agencies in the case of Ben can this review identify/ recommend better preventative working for agencies?

It is evident that the responsive nature of work undertaken across agencies within this review created a need for additional capacity within the system to produce the require assurance and outcomes. Whilst all agencies where responsive to this and additional commissioning was made by agencies such as the CCG, Local Authority and Police it was clear that preventative measures such as regular a programme of contract monitoring and proactive quality assurance visits by the commissioners was not at that time in practice within the locality.

The review highlighted that the framework and processes worked well however we need to ensure that they are adequately resourced as it takes a lot of time/funding to make a good investigation and to ensure prevention principles are operating throughout frameworks and practice. Better cross agency preventative work with the care home involved in this case may very likely have reduced the level of resource required in the organisational investigation that occurred.

Recommendations

1. The Board should review and highlight the good and effective practice highlight within this review-Safeguarding and Serious Concerns Framework interface and practice. The Board should develop methods to share such examples.

2. The Board may wish to review and evaluate strengths and weaknesses across the three authorities Care Governance policies and procedures with a view to developing (as much as possible) a consistent multi agency framework for the management of Serious Concerns.

3. The Board should consider seeking assurance on how training within agencies is given in identifying and responding to provider concerns in both a commissioning/contract monitoring and safeguarding framework.

4. The Board may wish to initiate conversations with commissioners on their resource and capacity requirements to ensure preventative and responsive management of provider concerns. Or alternatively to seek assurance that appropriate resource is in place.

5. The Board should seek assurance that Local Authorities DoLS systems have a mechanism to share safeguarding or care quality concerns with the relevant teams and departments inclusive of commissioning.

6. The Board may wish to clarify how agencies inform families of how to identify and to whom to report arising care quality concerns.

7. The Board may wish to develop a method of promoting and assuring that the Pressure Care Pathway Protocol is disseminated by commissioning to all providers within their locality.

Learning Links and references

• Statement on CQC's role and responsibilities for safeguarding children and adults (February 2018). Date of next review April 2019
https://www.cqc.org.uk/sites/default/files/20180209_SC121706_CQC_safeguarding_statement_February_2018_v2_0.pdf

• Inspector's Handbook Safeguarding (February 2018)

https://www.cqc.org.uk/sites/default/files/20180223%20CQC%20Inspector%20Handbook%20Safeguarding.pdf

GLOSSARY

Best Interest Assessor (BIA)

Berkshire Health care Foundation Trust (BHFT)

Brought in by Ambulance (BIBA)

Clinical Commissioning Group (CCG)

Care Quality Commission (CQC)

Deprivation of Liberty Safeguards (DOLS)

Emergency Department (ED)

Electronic Patient Records (EPR)

Funded Nursing Care (FNC)

General Practitioner (GP)

Health Care Assistant (HCA)

Inpatient (IP)

Mental Capacity Act 2005 (MCA)

Multi-disciplinary team meeting (MDT)

Royal Berkshire Hospital (RBH)

Rapid response assessment team (RRAT)

Serious concern framework (SCR)

Tissue Viability Nurse (TVN)

Thames Valley Police (TVP)

Wokingham Borough Council (WBC)