Newham Safeguarding Adults Board

Safeguarding Adult Review

of the 'Ann' Case

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Report Version: Final

1. Background

1.1 Ann died in hospital in February 2017. She was in her mid-70s and had lived in the same road for most of her life. The cause of death is recorded by the hospital as - Septic Shock; Bronchopneumonia; Osteomyelitis; Deep Vein Thrombosis and Severe Degenerative Joint Disease. She had recently been admitted to hospital and on admission she was identified as being significantly malnourished, had developed a grade 4 pressure ulcer and was anaemic.

Until September 2016, when she sustained an ankle fracture, she had been relatively well and was living independently and had a network of local friends. She was admitted to hospital and, following surgery, returned home with support from carers and district nursing staff for wound care She required support to get out of bed and mobilise. Initially recuperation and rehabilitation went well but it transpired that the fracture had not healed, and she was re-admitted to hospital in October. After corrective intervention she returned home, again with support, but was readmitted to hospital within a month after her health deteriorated significantly. On readmission she was diagnosed with hypoglycaemia, urosepsis, hypothermia, DVT and possible osteomyelitis. While in hospital, she was diagnosed with depression. There were initial discussions about discharging her to a rehabilitation unit, but this did not materialise as she did not meet the admission criteria and she returned home in mid-December.

1.2 At the time of this third discharge, she required both additional equipment to assist her get out of bed plus physiotherapy. There were significant delays in obtaining these services to the point where by the time a physiotherapy home assessment took place, she was too weak and disabled for it to commence. She was unable to get out of bed and her health deteriorated further to the point where, in early February, she was admitted to a community continuing health care bed at East Ham Care Centre run by East London Foundation Trust (ELFT). From there she was once again admitted to Newham Hospital with range of serious health problems including acute kidney injury secondary to dehydration, probable pneumonia and osteomyelitis, pressure ulcers and serious malnourishment. At that point there was a view among some community health professionals that she would not recover. She received palliative care initially but on review by a secondary care consultant geriatrician, her condition was thought to require more active management. She died within a few days of acute hospital admission. The coroner found the causes of death to be 1a septic shock and bronchopneumonia; 1b osteomyelitis, pressure sores and malnutrition; 1c healed left ankle fracture – operated August 2016 and 2 severe degenerative heart disease.

1.3 There was a subsequent referral by a hospital consultant overseeing her care to Newham Safeguarding Adults Board requesting a Safeguarding Adults Review. (SAR). Four concerns were raised:

1) NHS Multi-Disciplinary Team care provision during the period between 13/12/2016 - 02/02/2017 and how inappropriate care could have contributed to Ann's deterioration and ultimate demise
2) The decision to fast track her on an end of life pathway in the absence of a comprehensive review or consideration of the causes of Ann's deterioration, or potentially reversible conditions
3) The approval of a fast track form that was completed with errors and omissions
4) The initiation of a palliative subcutaneous syringe driver in a patient who was alert and could swallow liquid medication, and in whom newly-prescribed topical pain relief had not had time to take effect.

1.4 A Safeguarding Adult Review was agreed by the Chair of Newham Safeguarding Adult Board, Fran Pearson, on 17th June 2017. The Board appointed an independent author, Alan Coe, who has no previous connection with Newham. The work was overseen by a Safeguarding Adult Review Panel chaired by Fran Pearson.

2. Methodology

2.1 The process of gaining an understanding of how and why Ann died and the circumstances surrounding that was fourfold.

2.2 Firstly, each agency reviewed their own records, produced a chronology and offered a critique of what they did including whether it followed procedures and represented good practice. Each was undertaken by a senior representative from the relevant agency who had not been directly involved in Ann's care or responsible for the immediate oversight of it. Where there were concerns about practice the individual agencies took immediate action to address them and produced an action plan to support any necessary changes. Those action plans are contained as an Appendix to this report.

2.3 Secondly, the individual chronologies were made available to the author who reviewed them and identified issues about how the combined partnership of services operated to assist Ann and where that partnership could have done more. The independent author also spoke with a close friend of Ann; she had produced a report about her concerns relating to her friend's care. She provided valuable personal information about her friend as well as sharing her own perspective on what, in her view, went wrong. Her views and concerns are shared in this report and make a valuable contribution to shaping its findings.

2.4 Thirdly, there was a learning event which involved the staff who in some way were involved in her life or represented the agencies who provided for the care she received or potentially could have received at the time. Where staff were no longer in post alternative staff attended who had similar responsibilities to those who were at the time.

2.5 Fourthly new information emerged from the Findings and Conclusions of the Senior Coroner of Walthamstow Coroner's Court dated 23rd February 2018.

3. Personal History

3.1 Ann was 74 years old. She had worked all her life and had only fully retired in 2015. She was single and had lived in the same road for over 70 years. She was friendly and sociable and, on discharge from hospital in September 2016, indicated that although she had no close family, there were several friends who would assist her. At the time of her death she lived in a first-floor multi-level maisonette. She had some pre-existing health problems but was fully independent until the time she fractured her ankle. She had experienced a stroke in 2009. Her medical records identified that she had a mild CVA in 1995and hypertension since 1996. She also had Type II Diabetes since 2002, hypothyroidism since 2003, chronic kidney disease Stage 3 since 2005, hypercholesterolaemia since 2006, and a range of conditions affecting her eyesight. She regularly smoked 20 cigarettes a day. Her friend said that Ann did not like hospitals.

3.2 Following her stroke, she discharged herself against medical advice. I was told she could be suspicious and could be stubborn. The records of her care in her final few months demonstrate at times she was reluctant to accept help and sometimes refused recommended medical help. She could sometimes be persuaded through her friends to take a different course of action, but I was told she "accepted help on her own terms" and "knew her own mind". Her friend said: "If she didn't want to do something she didn't". When her health deteriorated she became at times depressed. I was told that in terms of her experience of hospital and subsequent care and rehabilitation she had become disillusioned with the system. She considered it was too painful to get out of the flat and therefore didn't go to some appointments.

4. Summary of Ann’s Care September to February

4.1 Ann had services provided to her in her last months by a number of organisations. Her social care was provided by the London Borough of Newham. Her medical care was provided by:

- Primary Care – her local GP
- Community Health Services – these include district nursing services, community therapy services, community mental health services and inpatient continuing health care services at East Ham Care Centre all of which are run by East London Foundation Trust
- Mental health services – she was seen by the RAID (Rapid assessment, interface and discharge) psychiatrists whilst an inpatient at Newham University Hospital. This psychiatry service is a psychiatric liaison service provided by an in reach service into the acute hospital by East London Foundation Trust
- Secondary care services – these were provided by Barts Health by two of the hospitals in their group, Newham University Hospital and the Royal London Hospital.

4.2 Following surgery to repair her ankle, Ann was discharged from Newham University hospital in early September 2016. There were problems with the discharge planning arrangements. She should have immediately received a support package of home care to assist her with daily living. On discharge she was described as chair bound, keen to start mobilising again and to access the community. Her care was to be provided four times daily and each time with two members of staff. This was combined with visits from district nursing staff to ensure she received appropriate follow up medical care. The care support that should have started immediately failed to materialise. Although the hospital had requested services they were not in place when she went home.

4.3 Although the Hospital Discharge Coordinator confirmed pre-discharge that the care was ready to be delivered, it was not. This led to a call from the GP back to the hospital reporting the lack of care, emphasising that at that point Ann was doubly incontinent and temporarily being supported by a friend. Records indicate that a District Nurse was requested but the FAX from the hospital requesting this ‘failed’ and District Nurses confirm they received the referral a day after her discharge. Newham Council funding panel had agreed to a domiciliary support package of care, but it appeared there were some delays in initiating this through their brokerage service. A Brokerage Officer noted receipt of a request on the day of discharge, but warned that due to the time taken to source a large double handed package, it may not be possible to commence on the same day. It is expected by that service that the hospital does not proceed with

discharging a patient until the care is in place. There appeared to be some miscommunication between the hospital and adult social care services, as the ward proceeded to discharge Ann believing the care package was in place when it was not.

4.4 Once the care arrangements commenced, the care providers immediately expressed concern about the lack of equipment available to assist them with lifting and handling and noted a lack of pressure-relieving equipment. According to the hospital social worker's records: 'She will not be discharged with any pressure relieving equipment and is able to roll over in bed to use bed pan'. There is evidence to indicate that Ann preferred to use her own bed at home, but her carers were struggling to get her out of bed and wanted specific equipment to assist them transfer her to a chair. In a note from the hospital occupational therapist (OT) to the hospital social worker 12 days after her discharge she recommended that the carers were reminded to follow the manual handling plan, 'otherwise they are making this patient bedbound.' According to Council records, the manual handling plan itself was not made available to her carers until three days after her discharge from hospital.

4.5 The manager from the care agency described Ann's medication as being 'in a mess' and also suggested to her friends that a single bed might be more suitable for her care at that stage. The view from the hospital, just prior to her discharge, was that no initial assessment was completed on this first nursing visit on the day after her discharge. The community district nursing service commenced the day after Ann was discharged and the expectation was that daily injections of Tinzaparin – a drug used to prevent the formation of blood clots- was to be administered for the first four weeks-post-discharge. Within the first week three visits for these injections were missed. The Serious Incident Review undertaken by East London NHS Foundation Trust notes that at the time of the first district nursing visit there was no record of an initial community nursing assessment.

4.6 After these initial difficulties relating to health and care support at home, arrangements settled down. There were no further concerns or problems reported prior to Ann's further admission to hospital - this time the Royal London -in October. This was necessary because her wound was not healing properly, and a remedial operation was necessary to remove exposed metal. On discharge from The Royal London a fortnight later the previous care arrangements were reinstated. A physiotherapist visited the day after her discharge, assessed her and revised her care plan. The therapist indicated that Ann was not mobilising in doors and she was limited with her ability to transfer independently from sit – to – stand (STS). The plan of care was for her to practice this with rehabilitation support worker

combined with and mobility practice with A's house with the aid of a walking frame. The physio also identified that a key safe was required.

4.7 Within just over two weeks of her second discharge, her care providers advised Newham Council that they would prefer another care agency took over the responsibility for her care. This was because the care agency as struggling to provide the necessary staff due to the fact Ann's address was outside of the normal catchment area that they worked within. Ann was resistant to changing the care provider so the care agency continued to provide the service. However, shortly after Ann's discharge there was a review of her care and her support was reduced which indicated a reduced requirement for two people to assist with moving and handling. There is no evidence that this review included the views of various health professionals involved at this time. In early November almost two weeks after her discharge and following a telephone conversation between Ann and her GP, there was a request was made for wound dressing. Records indicate that it took ten days to respond to this although there was a visit from a physiotherapist in the intervening period.

4.8 In less than four weeks from her second hospital discharge she was admitted – this time to Newham Hospital - having been found by friends to be very unwell in a non-responsive state and with slurred speech. She was both hypoglycaemic and hypothermic, and given a provisional medical diagnosis of sepsis. secondary to osteomyelitis for which she was treated. She was also found to have an acute kidney injury. She was later in the admission found to have a deep vein thrombosis. Her medical stay was complicated by urinary tract infection, urinary retention and depression for which she was referred to the psychiatrists and started on antidepressant treatment. According to social care records Ann was unwilling to return to hospital. According to friends they were unclear about both diagnosis and treatment at the start of this third admission. They noted that she was becoming despondent in hospital, was critical of the food and refused physiotherapy 'a few times.' Medical records refer to her initial diagnosis on admission but within a week this was refined sepsis, possibly due to osteomyelitis. This was subsequently excluded following a scan. While in hospital staff considered her discharge arrangements which included the possibility of a rehabilitation facility as an interim step prior to eventual return home. According to her friend Ann was enthusiastic about the possibility. Although her consultant indicated a rehabilitation unit was to be considered there is no record of a referral being made. However, through the process of writing this report it has become clear that Ann would not have met the criteria for the community rehabilitation unit as she was not sufficiently independent for her to be supported at the unit.

4.9 While in hospital Ann said she was depressed and was observed to be tearful. There was a file note saying that she would be followed up at home by a community psychiatric nurse (CPN). A week after Ann acknowledging her feelings about her mental state, she reported she was feeling more positive and believed that she would feel better at home as opposed to being in hospital. On discharge in mid-December it was stated in hospital records that her GP would review her mental health once at home and if necessary take further action if required. The medical records indicate involvement from hospital physiotherapy, occupational therapy, dieticians and evidence of discussion with the social work team about planning the discharge including referral to district nurses. The medical records and discharge summary also note referral to community physiotherapy and district nursing. There was a discharge letter from the consultant to the GP but this could not be described as a discharge plan.

4.10 Evidence given to the coroner confirms that in response to the discharge letter, Ann was sent a letter by the GP surgery inviting her to come in for an appointment- something it was clear she could not have been expected to do. There was no document for community services that assisted them in understanding what they should provide and the urgency of ensuring there was an active rehabilitative element from the start. There was no reference to the role of home care support, district nurses or community therapists. Hospital social work records indicate that recommendations from hospital therapists informed decisions to provide two care staff for most home visits to support transfers using a rota stand.

4.11 Following her discharge in mid-December, Ann required greater support at home than she had prior to her admission. She received three double-handed calls a day from the care agency and a fourth evening visit by one carer. By three days after Christmas Ann was bedbound and during January her skin condition deteriorated dramatically. According to the care provider, staffing from all agencies was limited over the Christmas period. There is no evidence that calls were missed but continuity of care by the same team was more difficult. On the day of her discharge there was a request for wound dressing and catheter care from community nursing services and the day after that a request for physiotherapy. There was no information provided to the author about what therapy took place in hospital and what they wanted community colleagues to follow up. Just before Ann's discharge her friend expressed concerns to hospital staff about proposals for physiotherapy at home. According to Ann's friend she raised doubts about the ability of community services to deliver what was proposed which was physiotherapy three times per week and stated a preference for hospital-based rehabilitation. She also described the state of her friend as follows. 'She now had a catheter, a DVT, at least one open

wound, wasn't eating or drinking enough, was in pain, once more confined to a single room and was thoroughly pissed off with her situation.' This proved to be accurate as there was a significant delay in offering physiotherapy post-discharge.

4.12 In the period following discharge there was a rapid and significant decline in Ann's health. Within just over two weeks on the 3rd of January, care staff reported to a friend that they were no longer able to safely transfer her out of her bed. From that point on she was effectively bedbound. In view of this the care agency requested an urgent OT assessment pointing out that that it was now unsafe to transfer her without a hoist. The hospital social worker chased this with the OT service a week later saying in an e mail: 'Can you please look at this as a matter of urgency as carers are struggling with transfers and providing bed care due to manual handling issues?' There was a response the same day from the manager saying that she would allocate this request as soon as possible but that she had a waiting list and only two available OTs.

4.13 On the 16th January an email was sent by the care provider to the hospital social worker. It said: 'Please can we have an urgent review of Ann. To date she is still eating and drinking very minimum amounts, Ann remains in bed and we are unable to move her due to her weakness and absence of a hoist. Ann is now developing bedsores on her buttocks and heels.' This was passed on immediately. There are other file references to the social worker becoming increasingly concerned about the impact of the delays on Ann's health and continuing to request urgent OT support. The OT assessment took place 23 days after the original referral, on the 26th January. A day after that the OT contacted community nurses requesting urgent delivery of a high-risk pressure mattress to support her and manage her sacral sores. The e mail commented that the OT understood that the community nursing service was going to provide a hospital type bed but in view of the urgency the OT had arranged this himself along with slings and a hoist, so she could spend time away from the bed. The OT added: 'It is imperative that you provide the air mattress and pressure relief overlay ASAP.' In a parallel process district nurses were visiting.

4.14 File entries from the district nurses, who were visiting most days, mentioned a discussion with Ann on the 9th January when she refused a pressure relieving mattress. She was to think of the importance of the pressure relieving mattress but there is no indication that any other alternative was offered.

4.15 From the 10th of January, the district nurses were emphasising the importance of obtaining lifting equipment and learned that that one had

been requested the following day. The notes also indicate that on the 13th January, nurses were requesting that carers turn her on each visit but also noting that Ann was refusing to change her position thus exacerbating the likelihood of skin tissue deterioration. The nursing notes also commented: 'She reported of eating and drinking well and her bowels functioning well.'

4.16 By the 16th January a neighbour had contacted NHS services expressing concern that Ann was not receiving a coordinated and regular service. A community nurse noted a Grade 2 pressure sore that day. The GP visited the following day and examined her. A friend was present for most of the visit. The doctor noted a reported weight loss caused by her not eating anything but milk. The notes include the phrase: 'Concerned that the patient will soon die if she is not eating …... the patient interjected and said she will by no means agree to further hospital or any other admissions and she will not take any energy drinks cos she hates them.' At the time she was also described as 'mentally alert, kempt and well spoken.' On the 20th January Ann refused wound care from the community nurse because she was in pain and requested this was deferred until the week following. On the 25th January the GP convened a multi-disciplinary meeting concerning Ann. The GP stated that they believed that a social worker was present and requested that enquiries be made to see if his patient was known to social care services, however, LBN had no record of the meeting or what they were asked to do.

4.17 On the 27th January a physiotherapist was assigned to Ann but stated that until the OT equipment that had been ordered was delivered, there was nothing that could be done. The Council management report says an OT assessment took place that day but it took a further 5 days for the required equipment to be delivered. The Council report says delivery could have been given a higher priority.

4.18 On the 28th January a community nurse visited in response to concerns by her carers that she had not urinated for three days and her catheter bag was empty. A new bag was fitted and 2000mls of urine were drained off. On the following day blood was noted in her urine. On the 30th January both a community nurse and a Pressure Ulcer Improvement Facilitator visited. The Facilitator recorded several pressure ulcers including a grade 3 pressure ulcer and raised a safeguarding concern. The notes refer to possible deep tissue damage. In discussion with the care manager the possibility of a return to hospital was mentioned to support better care of Ann. The notes of the Facilitator indicate that initially she was unwilling to agree to this and 'was not afraid to die alone.' The care manager later phoned to say she had been persuaded to go into hospital. The findings of the Pressure Ulcer Facilitator were summarised in a letter to the GP which

said Ann had been referred to a hospice and that the GP should consider visiting his patient to discuss whether Ann should consider Do Not Attempt to Resuscitate (DNAR) status should she decline further.

4.19 On the 31st January, the same day that the Facilitator wrote to the GP A Deputy Team Leader from community nursing visited and updated the nursing plan including a reference to two grade 3 pressure ulcers. The plan emphasised recovery and recommended that Ann required turning every two hours to support the management and reduction of her pressure ulcers. Advice was also given on a healthier lifestyle and improved diet. On the 1st February the deputy team leader and a clinical lead from the primary care team visited Ann. They noted that her catheter bag was clamped and subsequently drained 600mls of urine. They were concerned that she had not been turned and the visiting home carers reportedly could not say whether she had been turned by other carers visiting previously. This lead to the completion of a further safeguarding referral. The notes also mention that: ': she has been refusing solid food for the past three months. Drinking milk, water and the occasional biscuit.' This is not consistent with a previous report dated 11th January when a community nurse reported that she was eating and drinking well.

4.20 Later that day Ann was admitted to East Ham Care Centre (EHCC)- a primary care facility although she initially refused to get into the ambulance. In line with previous references in her community records, the original plan was for her to be admitted to palliative care. However, the proposed application admission was challenged by the provider of that service on the grounds there was insufficient evidence that she was dying, and that patient consent was missing. At that time there was a level of dispute between NHS staff about her acceptance for palliative care. At EHCC she received treatment for her pressure sores but refused medication; her notes say that she refused food and drink also. A GP visited her in EHCC and records a conversation with her where she seemed resigned to and accepting of death. This was confirmed a day later in a second conversation with palliative care staff. However, a review of her care by a Care of the Elderly Consultant on the 3rd February questioned whether Ann's refusal to drink and eat in recent times was a symptom of depression and, in the circumstances, it was possible to consider the reversibility of her condition. A syringe driver, which had been in use, was removed. On this basis she transferred on the same day with her consent to Newham University Hospital. Unfortunately, despite greater medical intervention she died five days later.

4.21 On the 27th February Newham Safeguarding Team received a retrospective safeguarding concern relating to four main issues:

1) Concerns about multi – disciplinary-team care provision during the period between 13/12/2016 - 02/02/2017 and how lack of appropriate care could have contributed to Ann's deterioration and ultimate demise
2) That the decision to fast track Ann towards palliative care in the absence of a comprehensive review/consideration of the causes of Ann's deterioration, or potentially reversible conditions
3) The approval of a fast track form that was completed with errors and omissions
4) The initiation of a palliative subcutaneous syringe driver in a patient who was alert and could swallow liquid medication, and in whom newly-prescribed topical pain relief had not had time to take effect

5. Analysis

5.1 The contribution of Individual agencies

5.1.1 What sort of support from individual agencies and from the partnership of agencies had Ann a right to expect? Decisions about what services she might receive and how and where they might be delivered, rest upon an effective assessment of her needs. That initial opportunity came with her first admission to hospital and plans for her discharge. Beyond that, as her needs fluctuated she ought to have expected a continuing review of her needs and appropriate adjustment of her support, to reflect the changes in her health and abilities. Assessments of need in relation to social care are based on the Care Act and its associated guidance. A key principle of this is described in Department of Health Guidance[1] as follows:
'The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.'

5.1.2 One general and overarching responsibility is to promote wellbeing and included in that definition are personal dignity, control by the individual over everyday life and protection from abuse and neglect. At the centre of the determination of needs is an assessment that actively involves the individual. The assessment process also provides the opportunity for local authorities to take a holistic view of the person's needs in the context of their wider support network. The Guidance talks of a holistic approach to assessment aiming to bring together all of the person's needs and the input of different professionals such as adult care and support, health or mental health professionals. The Guidance is specific in terms of meeting urgent needs quickly, talking of providing: 'an immediate response and meet the individual's care and support needs. For example, where an individual's condition deteriorates rapidly, or they have an accident, they

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

will need a swift response to ensure their needs are met.' The clear expectation is that both assessment and service delivery are integrated, and that the individual has some control over the process.

5.1.3 In the case of Ann there were both failings within individual agencies and failings of partnership. Individual management reviews undertaken by each agency involved in her care identified areas where their services could and should have supported her better and also identified remedial actions that can be applied so that lessons for the future can be learnt. The individual reviews were generally thorough, candid and appropriately self-critical. A joint retrospective management review undertaken by Newham Clinical Commissioning Group and East London NHS Foundation Trust listed among its findings the following:

- On Ann's initial return home from hospital some initial visits for the administration of medication were missed. Other examples were found throughout the period from September to January of delays in the initiation of treatment. A request for wound dressing in November took 11 days to commence. A request made for physiotherapy made on the 13th December but there was no further physiotherapy entry until the 6th January and the visit took place on the 9th January – 24 days later.

- Documentation in relation to community health services was described as 'sparse and sometimes inaccurate.' Ten examples were given to support this view. The report referred to there being …' no evidence that effective communication was kept with all the agencies involved, such as carers, regarding continuation of care e.g. importance of repositioning and shared documentation was not always entered.'

- The report talks of there being a failure to appropriately escalate both to senior staff within the primary care or to external agencies when Ann's condition was clearly significantly deteriorating.

- The report identified a lack of clarity around the decision that Ann was on an end-of-life pathway.

- The review found no evidence that the role of a possible depressive illness was considered by any of the health care professionals caring for Ann following her third discharge from hospital in December 2016 although this was mentioned to her GP in the hospital discharge letter.

- The review concluded that It there did not appear to have been one agency or individual who saw themselves as taking the lead in co-ordinating care for the patient following her ankle fracture. It was unclear who was managing the administration of medication, identifying the implications of worsening pressure ulcers and taking responsibility for escalating concerns of a worsening position.

5.1.4 Although this last point relates to health care it is something which I shall comment upon later in terms of escalating concerns and issues across the partnership of agencies that were supporting her.

5.1.5 The management review noted the problems that occurred for Ann and reached the conclusion that her experience was probably not unique and might apply more broadly to community health care in Newham. Their action plan contained in Appendix 1 identifies those actions they believe to be essential to assure themselves and the wider community that this will not continue to be the case.

5.1.6 The East London NHS report rightly identifies concerns about their being confusion over the introduction of an end of life pathway. There is evidence that a syringe driver was used to manage pain for a period before a consultant offered an alternative opinion about her prognosis and the use of it was stopped. I could not find evidence to suggest that Ann had been fully involved in this critical decision and that she had given informed consent. She may well have done so as there is evidence that she had become resigned to her life coming to an end.

5.1.7 A similar approach to reviewing agency practice took place within the London Borough of Newham Council. Their conclusions are summarised below:

- There was a one-day delay in arranging Ann's initial care support in September 2016. It was unclear why this happened, but subsequent commissioning and delivery of care appeared to be reliable. Her manual handling care plan was not delivered to the care agency until two more days after that.

- There was a 25-day delay following Ann's discharge from hospital in December until an occupational therapist visited to assess what her requirements were for effective moving and handling. There had been an earlier occasion when equipment to support mobility was not in place, perhaps caused in part by some reluctance on her part in accepting the professional advice followed. The Council's report identified that the information contained within the initial social work assessment for occupational therapy involvement was minimal and insufficient for the occupational therapy service to determine priority. A contributory factor was an inadequacy of occupational therapy resource at that time. Once the need for equipment was identified the Council review concluded the delivery of it should have been given higher priority.

- When Ann was readmitted to hospital in November 2016 with a range of health problems it appeared to be 'an alarmingly rapid decline within one

week of a positive social care review.' The social care management report concluded that the review did not show that any input was sought from the range of health professionals who were involved in her care at that time, and whether health information formed any part of the decision to reduce her care package.

- Ann's friends raised concerns about the above hospital admission believing it was due was in part due to her being given her diabetes medication despite not eating. This was not investigated at the time.
- In late January Ann's catheter bag was left clamped overnight preventing urine drainage triggering a Safeguarding Adults Concern.
- The review found that social care staff had limited awareness of the parallel Primary Care involvement from NHS colleagues involved in Ann's care. They commented that the case records did not demonstrate that a holistic multi-disciplinary approach was taken to her care and that there no record of community health involvement.

5.1.8 The shortcomings both of health and social care practice as highlighted in their respective reviews have informed the recommendations of their respective agency action plans.

5.1.9 Staffing levels within the Council occupational therapy service over the Christmas period were stretched with only one out of three OT staff being available. The Council acknowledges that one person dealing with all new work would have been difficult and they would have been stretched to respond appropriately and in a timely fashion. The one worker could have referred any difficulties to a line manager and there was an option to pass on urgent requests to one of two community health teams who employed OTs. In the case of Ann this did not happen.

5.1.10 As a final comment on individual practice, I wish to comment on the importance of getting a person's name right in all records. Both Ann's first name surname can be spelled in different ways. Records often got this wrong. On a personal level that shows a lack of care for getting it right for the individual but on a more organisational level names that are spelled wrongly can lead to loss of records and crucial information.

5.2 The contribution of the partnership

5.2.1 Safeguarding Adults Boards have the responsibility of assuring themselves that there is effective partnership and it is to that end that Newham Safeguarding Adults' Board commissioned this SAR.

5.2.2 Care Act Guidance is specific about the importance of agencies working together. Specifically, it says:

‘For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing.’[2]

5.2.3 For a person to feel safe and in control of the care and support they require, they must be a central part of the assessment of their needs and any subsequent reviews of their needs and the support commissioned to deliver it. There is little evidence that in this case both assessment and delivery was in accordance with the Guidance and as such raises the wider question as to whether the experience of Ann represents the generality of day-to-day practice or whether it was an exception. At various points between September 2016 and February 2017, Ann’s care and support was adversely affected by this failure to operate in an integrated way to provide care across health and social care.

5.2.4 Decisions about in what way support could be offered following her initial admission to hospital following her fracture, ought to have rested on a comprehensive assessment of her needs and then an integrated approach to delivering them. The assessment of her social care needs was not informed by any detailed contribution from NHS staff. Had that been the case, there was a greater likelihood that she and her supportive friends would have understood the totality of the plan to promote the return of her independence. They would also have been able to comment more authoritatively on the success or otherwise of the support commissioned to deliver those improved outcomes. Of similar concern, the NHS plan around community nursing support and the role of the GP were not articulated sufficiently clearly. A comprehensive holistic assessment should have identified how Ann would be supported to mobilise and regain the skills and confidence to do so. It would have noted her reluctance to accept certain forms of OT equipment and would have identified the professional advice and support to help her get back the life she had experienced prior to her fall. Such an assessment would have been signed by Ann and would have placed her in the position of making informed choices. Her support plan would have been integrated and available not just to her but to all relevant care givers such as nurses, the GP or home care staff. The latter point was mentioned in the care agency’s management report to this Review. Had there been one report, all would have been aware of who was involved which in turn should have led to better communication and integration of her care.

[2] See previous reference – Chapter 15 -15.1

5.2.5 Multi-agency hospital discharge arrangements were of particular concern. It was unacceptable that Ann was discharged without appropriate arrangements being in place as was the case in September 2016. Although this turned out not to be a critical issue for her it could have been had friends not been there to provide temporary support. It also appears that a FAX requesting community nursing support was not received initially which meant assumptions about the availability of district nursing being in place were incorrect. There seemed to be no process of verification or confirmation that a request for home care was available and in place.

5.2.6 Prior to Ann's discharge from hospital in December, staff considered transferring her to a rehabilitation unit and Ann was accepting of this. Although her consultant was to explore this, there is no corresponding hospital record on the outcome and whether this was conveyed to Ann. The findings of the Coroner also refer to this and she concludes that the lack of documentation meant the reason why she was not accepted by the unit were not clear. On discharge she went home still requiring the necessary rehabilitation in the community as at a time, she was unable to get out of bed or move independently. In evidence to the Coroner, a consultant from the hospital indicated that the issue of providing pressure relieving equipment and a suitable bed for Ann's home environment should have been addressed by the in-patient physiotherapy and occupational therapy, as part of her discharge arrangements. Also, the standard measurement for measuring risk of possible pressure ulcers- the Waterlow Score- had been incorrectly calculated as a lower risk than she actually was. Had the calculation been correct, it should have triggered the need for pressure relieving equipment immediately.

5.2.7 What this report must address is the failure of partnership. There was no evidence that an integrated multi-agency assessment and plan supported her hospital discharge. She required some form of rehabilitative input if to improve mobility and self-care. Prior to discharge a referral was made by the hospital physiotherapist to the community physiotherapy services. This requested community physiotherapy input within 72 hours. Alongside this, she needed an assessment from an occupational therapist and the quick delivery of equipment that would support transfer out of bed and support mobility once up and about. The occupational therapy input could and should have been signalled prior to hospital discharge. Again, an opportunity was missed when a district nursing assessment at Ann's home on the 26th December, correctly identified a high risk of pressure sores but no occupational therapy referral was made. This only came via the home care service supporting Ann eight days later on the 3rd January. As previously stated, major delays in the delivery of both of those services did not support her recovery and was unacceptable. Both the NHS and

Newham Council in their separate management reports, have acknowledged this and taken individual remedial action.

5.2.8 Without it the immediate and integrated assistance of community services, the physiotherapy and occupational therapy, home carers and community nurses were effectively a maintenance service. All they could do was to observe her almost inevitable decline. The referral form used by the hospital services for physiotherapy, had an expectation of a 72 hour response and it was on this basis they presumed her discharge to be appropriate and safe. Evidence from the CCG management report and the coroner, make it clear that this expectation could not have been met at the time due to the numbers of other people waiting for a similar service.

5.2.9 Ann's care was far from coordinated. At one stage the GP, in what is described as a multi-disciplinary meeting in January 2017, asks whether social care services were involved. Both the community health and the council social care services were independently chasing the slow engagement of physiotherapists and occupational therapists. What nobody seemed to recognise was that without coordinated intervention by both, the chances of Ann recovering were significantly impaired. Not just in this respect but more widely, nobody took ownership to prevent and address the significant problems she was experiencing. Potentially a meeting that brought together Ann, plus anybody helping to advocate for her, with representatives of community nursing, GP services and those responsible for social care would have brought that coordinated and holistic approach to improving her health and support. Despite the lack of clear collective ownership of who was managing her care on discharge in December any individual professional could have taken responsibility for convening a meeting to put the individual jigsaw pieces of her care together into a recognisable picture. Had they done so Ann might have improved as a result of better coordinated care at home. Had that not been possible, preventative action could have been taken to support greater initial rehabilitation in a residential or hospital setting.

5.2.10 There are some strategic issues for Newham Safeguarding Adults Board to consider as there was a similar incident in 2014 where issues of poorly coordinated care were apparent. This related to an 89-year-old woman who died in hospital in 2012 following admission with a Grade 4 pressure sore. At the time she was receiving support from council-commissioned home care services and the community nursing service including the tissue viability team – who specialise in the treatment of pressure sores. It was considered that her care and support had been poorly co-ordinated and delivered, with serious concerns regarding communication between agencies. While living in the community it had been known that she was at

high risk of pressure sores, dehydration and malnutrition. There were other striking similarities including confusion over visiting at home from the NHS provider of community services -including no input at all over a three-week period. It was judged that there was a lack of timely follow-up for discharged high risk patients. The overall conclusion was that better organised and more effective care planning and care delivery would have led to *'better monitoring and treatment of the person's health and physical condition and might also have led to earlier admission to hospital to manage her condition, to achieve a more peaceful end stage of life.'*

5.2.11 Inevitably such a review, completed in 2014, produced recommendations. Included within them was that high-risk patients should be followed up within 24 hours of discharge and a new policy and procedure were developed to support this. Another recommendation was that all interventions should be recorded in a timely manner. This further SAR has to raise the question whether these recommendations were implemented effectively. Judging by the responses of the 20 plus staff at the event few if any people have knowledge of the report and its implementation.

5.3 Professional Practice Issues

5.3.1 There were examples of good practice as reports indicate that following her first discharge from hospital, she valued the support and care she received from the home carers who supported her.

5.3.2 A lack of resources and/or high demand can affect outcomes for people reliant on the services concerned. In the case of the District Nursing service, there were significant staff vacancies which were partly offset by the use of agency staff – who tend to be less knowledgeable of the area and local procedures. Specifically, the District Nursing Service had a complement of 20 whole time equivalent staff. In December 2016, there were four agency staff covering vacancies and three other posts which were vacant or occupied by somebody on long-term sick leave. In January 2017 the situation was similar. I was informed that more agency staff could have been recruited, but that a general shortage in London meant that it was impossible to do so. This may have also had implications in terms of the quality of staff available. There were similar issues for the Council OT service as outlined in 5.1.9.

5.3.3 I am concerned that there seems not to be a clear understanding of how and when to escalate concerns. The care agency was given tasks to do without there being any discussion about their capacity to undertake it. For example, there is reference in nursing notes to Ann needing to be turned every two hours to ensure that pressure sores were better

managed. To achieve this would have required more home care visits and they would have had to be commissioned to do this. The care agency commented in their management review that despite being the only agency to visit her daily, their concerns were not taken seriously when they reported them. Ann's friends were similarly frustrated that they were unable to get their concerns listened to. This raises the question about how both front-line staff as well as family or friends can raise concerns and get a response.

5.3.4 Despite a range of professionals delivering care nobody took a personal professional initiative to call a strategy meeting involving all partners. Such a meeting would have identified the dual delay of physiotherapy and occupational therapy. It would have helped Ann understand better the consequences of her occasional unwillingness to accept that an effective moving and handling plan would give her the best possible chance of improving her independence. Friends could also have been part of the discussion and maybe offered the necessary influence to improve her willingness to cooperate fully.

5.3.5 At various points it seemed that Ann made unwise decisions about accepting help. It was her prerogative to do this assuming she had the capacity to make informed decisions. Although there is plenty of evidence to suggest she was able to do so it appears that professionals did not make this explicit. It is good practice to be clear about mental capacity and how any judgement has been reached. This was particularly relevant towards the end of her life after her hospital discharge in December 2016. Her decision not to accept all treatment might have been influenced by a level of depression but this was never formally established. The GP had been asked to monitor mental health there is nothing to suggest that front line carers or district nurses knew this.

6. Conclusions

6.1 Ann had a range of health problems that could not have assisted her recovery. As both the medical records and a testimony of a friend indicate, she did not always accept advice regarding her treatment. That would have not helped. However, it is clear her care was poorly planned and coordinated, significantly delayed at times and inconsistent in its delivery. Indeed, Ann could have been empowered to be at the centre of the process possibly coordinating her own care. Post- discharge, arrangements failed on at least two occasions. After her first discharge Ann should not have had to go home to care that did not arrive and nursing and therapy that was poorly administered initially. Similarly, her discharge from hospital in December was predicated on reasonable

assumptions that services necessary to support Ann were available and in place. It reality there were substantial delays in obtaining both physiotherapy and occupational therapy support. Finally, when it was clear that her health was failing there should have been more rapid and effective professional coordination to assist her. Each agency worked in isolation and there was no process that brought the different strands of care together in a coordinated picture. Her care was certainly not person-centred. Her views and wishes ought to have been at the centre of integrated assessments and plans. What plans there were did not have her views clearly identified. It's impossible to know whether, had all the care services worked better together, she would have recovered but she would have stood a much better chance.

6.2 Decisions about whether Ann was nearing the end of her life and subsequent treatment arrangements were not handled correctly and there is a clear implication in one IMR, that had there been different and earlier intervention she might have survived. There are recommendations within Newham Clinical Commissioning Group and East London NHS Foundation Trust's IMR that cover this point and highlight the importance of clear process and patient involvement in such critical decisions.

6.3 Staff attending the development day identified some philosophical differences about how and when an end-of life pathway should commence. Decisions about when to treat and for how long are always immensely difficult but can be more so if there is not an agreed and shared view within the various community and secondary care strands of the NHS. I make one specific recommendation about this.

6.4 The health and social care partnership appear not to be clear how widespread are the failings described in this individual case. I recommend below the introduction of multi-agency audits as an assurance process. As part of the audit it is important to review hospital discharge plans against care delivered and review cases where both community nursing and social care services have made a significant contribution. The accuracy of recording a person's name consistently should be checked as part of this.

6.5 The recommendations below are framed with the intention of improving outcomes in similar circumstances and giving greater assurance in future that community health and social care support can demonstrate how it fulfils government guidance.

7. Recommendations

Newham Adult Safeguarding Board should:

7.1 seek assurances from partners that the recommendations of a previous similar review have been fully implemented and are understood by staff;

7.2 seek assurances from partners that their staff understand and apply the principles of Making Safeguarding Personal;

7.3 ensure additional recommendations contained in agency management reviews for this SAR have also been implemented;

7.4 ensure all agencies understand their professional responsibility to escalate serious concerns about care and initiate multi-agency strategy discussions;

7.5 seek assurances that all agencies have in place clear information for carers about how to escalate concerns about the quality of care delivered;

7.6 as a matter of urgency introduce a process of multi-agency audits of case files where there has been a significant contribution to care from health and social care agencies;

7.7 ensure there is multi-agency scenario-based training that highlights the professional issues illustrated by this SAR;

7.8 ensure that there is a robust and well-understood multi-agency escalation policy;

7.9 seek assurances from NHS colleagues that staff work to a shared understanding of when and how end of life care is applied to individual patients.

Appendix 1 – Agency recommended actions resulting from Individual Management Reviews

NHS Newham CCG and East London NHS Foundation Trust

1. That the Directorate (ELFT) should offer training to all relevant staff in EPCT in the documentation of end-of-life pathway decisions to ensure that this is compliant with NICE guidance. There should be discussion with Newham Clinical Care Group about the index GP practice being included in the training in the first instance. (Wider training in general practice may be considered following the Safeguarding Adult Board review).

2. That the Directorate should offer training to all relevant staff in EPCT in the assessment of depression in the context of mental capacity. There should be discussion with Newham Clinical Care Group about the index GP practice being included in the training in the first instance. (Wider training in general practice may be considered following the Safeguarding Adult Board review).

3. That the Directorate should undertake an audit of handover and PU RAG meetings against expectation documents.

London Borough of Newham Council

1. Review quality monitoring processes to ensure that MDT involvement is sought and included within customer reviews. For example, this could include guidance for managers approving review reports, adding this area as a focus within routine case file audits and developing guidance notes within AzeusCare for frontline staff.

2. Develop effective mechanisms to cascade learning from complaints, serious incidents and safeguarding adults' reviews across all staff working in Assessment and Care Management.

3. That support and training should be offered to all relevant multidisciplinary staff in risk assessment and risk enablement approaches in the context of customer's choices and their mental capacity. This could also be supported by the implementation of a revised risk assessment and enablement tool within the AzeusCare system for adult social care staff.

Help in Newham – Care Agency

1. Help in Newham Ltd to raise safeguarding concerns regardless of any ongoing concern.

2. One communication record per customer so all involved can be aware of actions and concerns in a timely fashion- e.g. GP would record brief outcome

of visit in the same communications folder as District nurse and home care provider.

3. Referrals from hospital team to include details of medical conditions past and present / medication. (Customers somehow manage to lose their copy and it is difficult requesting information from GP.)

4. Referrals from Brokerage to include Assessment / Risk Assessment and Support Plan. Currently providers are accepting referrals based on requested times only.

5. Risk assessment(s)to be shared and compared on a regular basis.