Adult Safeguarding and Provider Concerns

A Thematic Review for Haringey Safeguarding Adults Board (September 2024)

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Introduction

1.1. In late 2023 Haringey Safeguarding Adults Board (HSAB) completed and published SAR Paulette. Paulette had died, aged 56, in March 2022. Cause of death was multiple organ failure and sepsis. Secondary causes of death were dementia, sarcoidosis, previous Corona Virus 2019 infection, and metastatic malignancy (abdomen) of unknown origin. Paulette was Black Caribbean. She had been diagnosed with dementia by unknown cause following hospital admission after a fall in early 2019.

1.2. From the outset, primary and secondary care clinicians understood that Paulette was a "*complex patient*." That complexity was illustrated by the number of hospital admissions and outpatient investigations between 2019 and 2022, including obstetrics and gynaecology, endocrinal, renal and colorectal, gastroenterology, diabetic retinopathy and ophthalmology, neurology and respiratory, urology and haematology.

1.3. Following the 2019 hospital admission, Paulette had resided in a large care setting. Initially this had been envisaged as a temporary placement However, the placement became permanent. There were periodic efforts to explore alternative living options and differences of opinion as to whether Paulette could live in the community with health and social care support. There were periodic concerns about the quality of care being provided, expressed by family members especially. These concerns had centred on understanding and use of legislation on mental capacity and deprivation of liberty, care planning, pressure ulcer care, responding to Paulette's emotional, social and cultural needs, equipment provision and hospital discharge.

1.4. SAR Paulette concluded with twenty recommendations, the most pertinent of which for the purposes of this thematic review are:

1.4.1. HSAB should convene a summit of commissioners and providers
1.4.2. HSAB should consider an audit of care home practice on assessment and planning to meet needs
1.4.3. HSAB should consider an audit of commissioned placements to ensure needs are met
1.4.4. HSAB should ensure a review of equipment provision (wheelchairs)
1.4.5. HSAB should seek assurance about the use of multi-agency meetings
1.4.6. HSAB should seek assurance about the assessment and recording of pressure damage
1.4.7. HSAB should review the frequency of quality assurance activity and outcomes.

1.5. Towards the conclusion of that review, SAR Paulette was undertaken in parallel with a provider concerns process. Work was continuing on quality assurance in the care setting in which Paulette was placed. This in part was a response to the concerns expressed by Paulette's sisters regarding quality of care and stimulation, and adequacy of monitoring provision. Data and reports from safeguarding teams and commissioning teams were considered on the number of concerns from this care setting. Between March and June 2023 a suspension on new placements was in place. A programme of work involved multi-agency meetings, audits, inspection and drop-in visits, and an action plan involving the care setting, and NHS and local authority staff. All the

residents in the care setting were formally reviewed. This work also included a review of commissioning strategies and an increase in the staffing capacity of the quality assurance officer team. One objective was the strengthening of the interface between commissioning, provider concerns procedures and adult safeguarding. No new or additional concerns were identified during this programme of work, which included letters to residents' next of kin and conversations with residents to obtain their views. Some areas for improvement were found, which were included in the action plan.

1.6. The care setting had made changes as part of the improvement plan by June 2023. These included a change in pharmacy provider to ensure more timely medication management, the introduction of a medication tracking system and medication audits, and weekly night spot checks. A recruitment drive had removed reliance on agency staff as healthcare assistants. To ensure rota safety, there had been over-recruitment. Induction, training and visual observations had been introduced or strengthened. Work on pre-admission assessments and family involvement in assessments and care planning was ongoing. Monitoring and supervision were ongoing, including of care plans, personal care provision, quality of food and use of hoist slings.

1.7. Towards the finalisation of SAR Paulette, HSAB became aware of the first of two further cases that were suggestive of similar issues. A request for a safeguarding adult review (SAR) was received from one of Rosemarie's daughters[1]. Subsequently a referral for consideration for a SAR was received from adult social care relating to another resident in this same care setting, Mearl[2]. HSAB concluded that both referrals met the discretionary SAR criteria outlined in Section 44(4) Care Act 2014.

1.8. Both SAR referrals were considered as part of the provider improvement work. At this time (October 2023), the care setting raised concerns about the challenge presented by patients being discharged to them, the complexity of these patients' needs, the lack of multidisciplinary team support, and the pressure of discharge beds on the rest of their service. The local authority and the care setting reached a mutual agreement to terminate this specific contract. The concerns raised by the care setting at this time reappear in the key lines of enquiry in this review.

1.9. Rosemarie was Black Caribbean. She died, aged 53, of multi-organ failure and disseminated breast carcinoma. Her health history included mental illness, disseminated breast carcinoma, tissue viability concerns, e-coli infection, and non-compliance with some recommended treatments. She arrived in the care setting with a pressure ulcer. During her placement there were concerns about care standards that included manual handling (fractured arm), pressure ulcer and medication management, management of personal care, lack of appropriate equipment, and not being kept mobile. Before she died in hospital, alternative care setting placements were being explored. Eventually, an arrangement for Rosemarie to live with one of her daughters was set up, with carers organised and equipment delivered. Discharge to her

[1] Rosemarie is her given name and is used with the permission of her family.
[2] Mearl is her given name and is used at the request of her son.

daughter's home was delayed because of lack of ambulance transport. The following day Rosemarie's arm was fractured which meant that the discharge never happened.

1.10. Mearl has been described as Black British and Black British Caribbean. Prior to 2018 she had been fully independent but, following a fall at home she experienced a progressive loss of strength. Initially, following a hospital discharge, she lived in a micro-environment at home. However, following elective surgery in February 2019 and neuro-rehabilitation, she was eventually placed in this care setting. Her placement was made permanent during 2020.

1.11. Mearl died, aged 83, with cause of death recorded as pneumonia alongside infected pressure sore, bed bound secondary to degenerative lumbar/cervical spine, and type two diabetes and hypertension. Her health history included diabetes, high blood pressure, osteoarthritis, sensory impairment, and tissue viability issues. She arrived at the care setting with a healing pressure ulcer. Subsequent concerns focused on skin deterioration, not getting Mearl out of bed, and care standards. Before she died her son requested that she be moved to an alternative placement as he was concerned about poor care standards and staff not getting his mother out of bed.

1.12. Rosemarie's family have commented that the reference to Mearl's skin deterioration is consistent with their experience. Their video evidence casts doubt on whether Rosemarie was rotated as advised by the tissue viability nurse. This was raised with a palliative care nurse and with a practitioner working in continuing heath care, and was one motivating factor for exploring an alternative placement and organising for Rosemarie to live with her daughter.

1.13. In consultation with Rosemarie's daughters, son and sister, and with Mearl's son, the following key lines of enquiry were agreed, namely:

1.12.1. How did agencies respond to quality of care and safeguarding concerns raised by Rosemarie and her family and on behalf of Mearl?

- How did the nursing home, palliative care nurse, continuing health care team, tissue viability nurses, adult social care and mental health care coordinator respond to quality of care and safeguarding concerns raised by Rosemarie and her family?
- How did agencies respond to concerns that Rosemarie's mental health medication had been stopped?
- Were quality of care and safeguarding concerns appropriately escalated?
- How did agencies work together to support Rosemarie's and Mearl's care?

1.12.2. What inter-agency oversight was in place to monitor the quality of care in the nursing home?

- What processes were in place for reporting and managing serious injuries within the nursing home?
- What quality assurance processes were in place at the time of Rosemarie's and Mearl's residence and afterwards, and how effective were these?
- How did agencies respond to quality of care and safeguarding concerns to ensure other residents were safe?

1.12.3. What measures were in place to ensure effective pressure ulcer management?

- How was pressure ulcer management managed and overseen at the nursing home? What quality assurance checks were in place?
- What training was in place around pressure ulcer management?
- What facilities and equipment were available to enable Rosemarie and Mearl to mobilise as part of pressure ulcer management, and how effective were these?
- How were concerns about pressure ulcer management responded to?

1.12.4. Are there any other emerging themes to be explored through the Safeguarding Adults Review?

1.13. The three placements in this care setting overlapped. Paulette was resident between May 2019 and March 2022. Rosemarie was resident between September 2021 and December 2021. Mearl was resident between August 2019 and September 2023. The aforementioned improvement work postdated Rosemarie's and Paulette's placement but was coterminous with Mearl's placement.

1.14. Reading across the three human stories, there are commonalities. Some commonalities draw attention to residents' health and care needs, namely comorbidities and complexities of health care (mental ill-health, physical disability and ill-health, sensory disability, cognitive disabilities and palliative care); pressure ulcer care in hospitals and care settings; complex hospital discharge and lack of placement options; missed opportunities for mental capacity assessment and/or review; and missed opportunities to refer, escalate and/or review concerns about care quality.

1.15. Some commonalities centre on the lack of multi-agency meetings; responses to concern about care standards; resources available to this care setting; the interface between Section 42 Care Act 2014 and provider concern procedures; and finally how services respond to involved and concerned family members.

1.16. This thematic review continues the focus on the interface between commissioning, provider concerns procedures and adult safeguarding. Through the lens of two further human stories, it continues the focus on quality assurance of care provision in this same care setting. It offers a learning opportunity to reflect on the outcomes of the improvement work done in and with the care setting, and with staff in health and social care to embed best practice in response to residents' health and care needs. The agreed key lines of enquiry have been designed to build on the learning from SAR Paulette rather than to repeat it. This approach has been strongly endorsed by the learning from the second national SAR analysis[3].

1.17. To inform the learning for this thematic review, the agencies involved were asked to provide management reports that addressed the key lines of enquiry. In addition, the Care Quality Commission provided data that compared notifiable incidents from this care setting with

[3] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. with Spreadbury, K., Taylor, G., Hopkinson, P. and Rees, K. (2024) *Second National Analysis of SARs (2019-2023)*. London: Local Government Association and ADASS.

those from comparable settings. In addition, the agencies involved answered further questions asked by the independent reviewer and participated in a learning event. The independent reviewer also visited the care setting and met with senior staff members. A panel of senior leaders from across the agencies involved supported the process. Contributions to this review have been received from:

- Barnet, Enfield and Haringey Mental Health Trust (BEHMHT)
- Whittington Health NHS Trust
- GP Practice
- The Care Home
- Haringey Commissioning
- Care Quality Commission
- Haringey Adult Safeguarding
- North Middlesex University Hospital
- North Central London ICB
- Metropolitan Police
- University College London Hospitals

1.18. In addition to contributing to the definition of the key lines of enquiry, the independent reviewer has met with members of Rosemarie's family both virtually and in person. They have provided documentation (emails, copies of reports, correspondence with a whistleblower) and video evidence from the camera that the family installed in Rosemarie's room. Some of the family's reflections are included in the key lines of enquiry that follow this introduction. Others follow here to foreground aspects of Rosemarie's human story.

1.19. Rosemarie's family acknowledge that some staff provided good, compassionate care. However, supported by the video evidence, they recount long periods of time when no-one looked in on Rosemarie. They have described the care on offer as "*slow moving*" in the sense of the time taken to change her incontinence pads, for example, despite significant risk of tissue breakdown. They describe, and have provided photographs in support, an unhygienic and poor living environment, with plates of uneaten food and dirty linen being left in bags in her room. This amounted to poor infection control and was possibly connected to the e-coli virus that Rosemarie caught. They have questioned whether her care plan was written up and appropriately updated. Rosemarie's family have copies of the dated care plans that were not updated until after their mother's death.

1.20. Video evidence seen by the independent reviewer records an occasion when Rosemarie was not provided with a juice drink and water that she requested on several occasions. Her family believe that there were other occasions when Rosemarie experienced dehydration. Video evidence appears to show a lack of assessment and concern when Rosemarie complained that a bone had been broken during manual handling. A detailed assessment was only completed when one of her daughters called for an ambulance, in the evening when the injury had occurred in the morning.

1.21. Echoing family comments in SAR Paulette, Rosemarie's family believe, based on their video evidence and very frequent visiting, that residents were often left in their rooms and that there was a poor level of care when family members were not present. They have commented, for example, on the infrequency of showers and the lack of oral care. They believe that the culture amongst care staff was competitive and also neglectful of the residents, highlighting delays in answering call bells and staff attitudes when Rosemarie used her call bell. The family believe that concerns and complaints that they and external practitioners voiced to senior staff did not result in corrective action. They have strongly questioned the culture of the care setting environment when their mother was placed there and whether the duty of candour was honoured when concerns were raised.

1.22. Mearl's son has contributed to the key lines of inquiry for this review and to the final report.

1.23. Prior to the commencement of the SAR a Coroner had confirmed Rosemarie's cause of death. Information provided by the Metropolitan Police confirms that they had interviewed the lead nurse and a second nurse involved in Rosemarie's care. They had not been able to identify a third nurse, "*despite extensive enquiries*", and had concluded that she might have given false information and "*was not the person she claimed to be*."

1.24. **Commentary**: this conclusion raises a question regarding the adequacy of employment checks before staff are appointed to health care positions within care settings.

1.25. The police presented the case to the Crown Prosecution Service. Their decision in August 2023, as reported by the police for this review, was "*to take no further action as the matter was not in the public interest and it could not be proved that wilful neglect had occurred*."

1.26. **Commentary**: this reviewer is struggling to understand how prosecuting poor quality care is not in the public interest. With video evidence available, the CPS decision raises the question of how to achieve best evidence in cases where neglect and acts of omission are alleged.

1.27. **Commentary**: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 empowers CQC to prosecute organisations and individuals for breach of regulations. This includes:

- Regulation 20(2)(a) duty of candour – notifying a service user or person lawfully acting on their behalf when an unintended or unexpected incident occurs
- Regulation 12 – safe care and treatment
- Regulation 13 – safeguarding service users from abuse and inappropriate treatment
- Regulation 14 – meeting nutritional and hydration needs
- In respect of regulations 12, 13 and 14, prosecution can follow when breach results in someone being exposed to avoidable harm or significant risk of such harm. CQC have not issued proceedings, raising a question about evidential thresholds.

1.28. Rosemarie's family had requested the Parliamentary and Health Services Ombudsman to review the involvement of the Barnet, Enfield and Haringey Mental Health Trust. The

independent reviewer understands from her family that the Ombudsman has declined to review the case because the complaint was out of time.

1.29. At the time of writing this report, other parallel processes are ongoing. The Nursing and Midwifery Council has reopened an investigation into the fitness to practise of one staff member at the care setting, following an appeal by Rosemarie's family against the original decision to issue a warning and to allow the individual to continue to work in this care setting. Another case is still open. Based on the family's personal observations and continuous recorded video footage, the fitness to practise concerns relate to not providing pressure ulcer care and meeting hygiene needs; lack of care and mistreatment, including threats to withhold care; failure to safeguard, especially when Rosemarie reported her broken arm; dishonesty; and failure to treat Rosemarie with dignity and to provide appropriate care when requested. To date there have been no prosecutions.

1.30. Rosemarie's family have also referred matters to the Local Government and Social Care Ombudsman.

First Key Line of Enquiry: Agency Responses to Quality of Care and Safeguarding Concerns

2.1. CQC have provided this review with a comparator analysis of notifications using a database of 65 homes of equivalent size to the care setting in which Rosemarie and Mearl were living. Between September 2021 and mid-July 2023 CQC received 27 notification of safeguarding concerns from this care setting, the second highest in the comparator group. Between mid-July 2023 and the end of May 2024 there were a further 23 notifications of safeguarding concerns, the highest amongst the comparator group.

2.2. Across the same time period CQC received notifications of 43 serious injuries, this care setting ranking in the middle 50% of the comparator group. CQC received 127 notifications of abuse or allegations of abuse , placing this care setting within the highest 25% of the comparator group. From a list of notifications provided by the CQC, the reviewer has noted one relating to nutrition and hydration care, one relating to unsafe discharge, five relating to medication errors, fourteen relating to poor care and thirty relating to falls. CQC have observed that the care setting usually included how it had addressed the incidents that it was reporting.

2.3. CQC have observed that these notifications and safeguarding concerns were often noted for the next inspection. The CQC commented further on this in response to a supplementary question from the independent reviewer. *"We would review the information along with other intelligence we already hold about the service and this might lead to an inspection being planned. For example, a serious individual incident or more likely the identification of a theme of concern such as a number of falls or pressure ulcers could lead to a decision to undertake an assessment of the carrying on of regulated activities. Information of abuse or a criminal offence may lead to a response of information being shared with third parties such as adult safeguarding or the police, including in circumstances where we consider such information is pertinent to their statutory duties."*

2.4. **Commentary**: When there are repetitive concerns being notified, especially when the pattern compares unfavourably against care settings of similar size, a more immediate response rather than waiting for the next inspection would appear warranted. It is noteworthy that the last CQC inspection reported in July 2022, when the care setting was rated good, and that the CQC website for the care setting comments that information and available data were reviewed in July 2023 and there was "*no evidence of the need to reassess the rating*." This is perhaps surprising given SAR Paulette and the concerns raised by the two referrals that prompted this review. However, CQC were involved in meetings held as part of the provider concerns process and subsequent improvement plan.

2.5. **Commentary**: the level of detail and comparator analysis provided by CQC for this review was very helpful. This level of detail should routinely be available to staff within CQC to inform its regulation and inspection duties and its objective for challenging organisational abuse and closed cultures. It should also be available when CQC participates in provider concern procedures and adult safeguarding enquiries, led by the local authority.

2.6. In its initial submission for this review CQC observed that all information, notifications and enquiries it received were reviewed, and that the service provided by the care setting and the needs of residents were understood. CQC also commented that inspectors understood safeguarding and provider concerns processes but there had been changes in personnel and it was unclear if inspectors always attended multi-agency meetings and what engagement work had been undertaken with the care setting to drive improvement.

2.7. In its recommendations, CQC accepted that ongoing concerns and significant numbers of notifications should result in inspections taking place sooner to inspect themes from provider concerns processes and to identify where the care setting had improved and/or where regulatory action was necessary. CQC specifically referenced the high number of unwitnessed falls in the second half of 2023 as an example of where further work on themes arising from received information was indicated.

2.8. **Commentary**: inspections by CQC were planned rather than responsive to the volume and nature of the concerns being expressed. Relevant regulations, about which breach can be considered, include safe care and treatment (regulation 12) when breach results in someone being exposed to avoidable harm or significant risk of such harm; safeguarding service users from abuse and improper treatment (regulation 13), and meeting hydration and nutrition needs (regulation 14). Rosemarie's daughter spoke twice to the CQC around November 2022 but understood that a CQC investigation had been closed. The independent reviewer has been informed that CQC undertook an investigation of potential regulatory breaches and criminal offences. The case was closed following the investigation as there was insufficient evidence to progress the matter. This outcome highlights the challenge of achieving best evidence and the importance of services working collaboratively together, and with residents and their families, to achieve best evidence.

2.9. Local authority commissioners, in their initial submission for this review, commented that routine provider quality assurance and contract monitoring normally took place through annual visits. Visits would be more frequent where concerns had been raised. Monthly data and information returns from care providers were also scrutinised.

2.10. Commissioners have commented that organisational safeguarding concerns were investigated, jointly with CQC and the ICB, with seven visits to the care setting during 2023/24. It was concluded that escalation to the provider concerns process was not warranted; instead an improvement plan was developed collaboratively, the implementation of which the local authority and ICB have overseen. This improvement plan remains in place.

2.11. **Commentary**: it is not clear from this initial submission what involvement care setting residents and/or their families had in the aforementioned visits, decision-making and review of the improvement plan. Also noteworthy is that the improvement work began some considerable time after concerns emerged relating to Paulette and Rosemarie's care.

2.12. Commissioners have observed that the care setting complied with requirements on notifications to the local authority and CQC, which were reviewed during visits. These reviews included the quality of assessments, care plans, risk assessments, staff skill sets, quality of care and staff recruitment. This approach had identified an increase in pressure ulcer concerns, information on which was shared with partner agencies, and gaps in staff training, for which support was provided.

2.13. However, commissioners have reflected candidly that the need for enhanced contract management capacity had been recognised in a 2022 commissioning review, and that steps had been taken to augment resources in order to ensure timely contract management and to move beyond risk-based visits to proactive oversight. The value of enhanced contract management and robust processes for oversight had been recognised.

2.14. Adult Social Care Commissioners commented further on the adequacy of resources for contract monitoring in response to a follow-up question from the independent reviewer. *"The Adult Social Care Provider Quality Assurance team strives to meet with block contract providers, including older people residential and nursing providers within the borough. However, current capacity limits routine meetings with all spot residential and nursing providers, both in and out of the borough. These meetings and visits are conducted on a risk-based basis. There is a quarterly meeting between the local authority and ICB Quality Assurance and Safeguarding Leads and the CQC to share intelligence and discuss providers of concern. Additionally, following the findings of the ASC Commissioning Peer Review, there is a commitment to allocate additional resources to enhance contract monitoring and quality assurance efforts, ensuring more comprehensive oversight and support. Contract Monitoring is already in place for block contract providers."*

2.15. **Commentary**: local authority and ICB resources are finite and the impact on their funding as a result of austerity must not be overlooked. Commissioners have been candid in identifying the need for adequate resources for quality assurance and in acknowledging the importance of continuous interaction and engagement with providers. They highlight particularly the contribution that quality assurance nurses can make, and the benefits of local authority and ICB collaboration on quality assurance. There is a link here to the feedback from the care setting, reported later, that collaboration has been reactive rather than proactive.

2.16. The issue of resources and, specifically, workloads emerged strongly at the learning event from all partner agencies. Although there had been some improvements in the level of resources, concerns were expressed about the capacity to respond to all requests to attend multi-agency meetings or support care settings. Nonetheless, it was felt that the improvement work undertaken with the care setting had made a positive impact on the quality of care.

2.17. Commissioners have recommended that communication channels and protocols for sharing concerns and findings be strengthened, that resource allocation for quality assurance be reviewed regularly, and that a culture of continuous stakeholder engagement and collaboration be fostered. **Recommendation One**: HSAB should consider seeking assurance at least annually of how commissioners have taken forward their recommendations regarding resource allocation and information-sharing to improve proactive engagement with care providers.

2.18. The adult safeguarding submission from the local authority, having reviewed the chronologies with respect to both Mearl and Rosemarie, concludes that improvement was needed regarding the timescales related to safeguarding enquiries under section 42(2) Care Act 2014, observing that staff turnover and newly appointed staff in the safeguarding team had impacted on enquiry effectiveness. The submission further concluded that in neither case had multi-agency planning meetings been held in response to safeguarding concerns and that convening such planning meetings was important in order to agree an action plan with partners. The submission reported that staff turnover had been reduced and a new team structure had been introduced that had enabled escalation of concerns and immediate allocation of urgent safeguarding alerts.

2.19. The local authority adult safeguarding submission comments that the care setting provided the information that was requested, drawing on the care setting's own internal investigation and the actions taken or to be taken. **Commentary**: it is not clear how residents and family members were involved by the care setting in the formulation of the information to be provided to adult safeguarding. Nor is it entirely clear how adult safeguarding practitioners triangulated the information provided by the care setting with other information that was available, especially from family members[4].

2.20. The local authority adult safeguarding submission observes that the safeguarding team send the outcomes of safeguarding enquiries to the local authority commissioning team and the CQC. **Commentary**: the submission does not detail what, if any, communication took place then, or occurs now, between the adult safeguarding team, CQC and/or the local authority commissioning team when safeguarding concerns had been referred by the care setting or other agencies under section 42(1) Care Act 2014.

2.21. The adult safeguarding submission notes that, in relation to Rosemarie, no concerns were raised about medication management before she died. Prior to her death the focus of adult safeguarding appears to have been on how she sustained a fractured arm. **Commentary**: this raises a question about the awareness across all agencies of the three criteria in section 42(1), namely an adult with care and support needs, experiencing or at risk of abuse or neglect (including self-neglect), and unable to protect themselves because of their care and support needs.

2.22. The safeguarding enquiry with respect to Mearl was closed when she died. The safeguarding enquiry with respect to Rosemarie was closed when the Metropolitan Police had commenced a criminal investigation. **Commentary**: the Care and Support statutory guidance does not clarify what should happen to an adult safeguarding enquiry when the person dies. The rationale for closing the adult safeguarding enquiry appears unclear as there was ongoing concern about risk to residents. The decision to close an adult safeguarding enquiry because of a criminal

[4] There is reference to Rosemarie's daughter being asked for her desired outcomes of the local authority's safeguarding enquiry since her mother had by then died., and to the information that the family provided as evidence of their concerns, especially about manual handling and pressure sores (Adult Safeguarding IMR).

investigation also appears questionable, both because of other residents potentially being at risk but also because each process, if run collaboratively in parallel, might contribute to achieving best evidence.

2.23. Whittington NHS Trust provided a chronology and reflections on the key lines of enquiry from the perspective of Rosemarie and the involvement of continuing healthcare. In mid-October 2021 the chronology references the infrequency of showers, staff entering her room without knocking, and lengthy waits when Rosemarie had pushed her bell. The CHC nurse was to arrange a meeting with care home staff. This took place subsequently. **Commentary**: the submission refers to Rosemarie's daughter as having raised these issues and describes them as "soft concerns" that did not require referral as adult safeguarding concerns. The three criteria in section 42(1) have already been outlined above. At the very least the concerns expressed by Rosemarie's family were suggestive of neglect/acts of omission. It was good practice to make the care setting manager aware of the concerns but assurances of change should have been closely monitored. This was also a missed opportunity to refer adult safeguarding concerns under section 42(1).

2.24. CHC staff do not appear to have been part of the subsequent section 42 enquiry, prompted by a referral from Whittington NHS Trust and London Ambulance Service when Rosemarie was admitted to hospital with a fractured arm. Indeed the contribution from continuing healthcare staff reflects that they were not informed about the referred adult safeguarding concerns. **Commentary**: the continuing healthcare contribution reflects on poor coordination of concerns and suggests that the safeguarding process was unclear and/or poorly understood at the time.

2.25. Referring to Rosemarie's admission to the care setting, the continuing healthcare contribution refers to a poorly completed care plan. For example, there was no mention of Rosemarie's mental health needs. The submission concludes that the care setting did not have the full history when Rosemarie was admitted. **Commentary**: this will be discussed further below in the context of hospital discharge and the shortage of available placements. However, what is emerging from the analysis is silo rather than whole system working with respect to safeguarding in a context of provider concerns, and the absence of multi-agency, multi-professional information-sharing and meetings with respect to individuals with complex needs.

2.26. Whittington Health also submitted a chronology and management reflections regarding the involvement of community healthcare practitioners with both Mearl and Rosemarie. This mainly relates to the management of tissue viability concerns and will be discussed below as the third key line of enquiry. Of relevance here are the Trust's reflections that there was no safeguarding concern referred when Rosemarie was admitted from home in July 2021 when it was suggested that she had not been coping at home and had no food between care calls, and limited curiosity about Rosemarie declining services whilst an inpatient. This seems to have been attributed to her awaiting mental health medication. It is unclear what, if any, involvement mental health practitioners had at this point. The Whittington Health submission does record the adult safeguarding concern referred by the hospital when Rosemarie was admitted in December 2021 with a fractured arm. There is reference then also to missed medication for her mental health. **Commentary**: the chronology for Rosemarie includes multiple entries when she refused care,

with concerns also about her hygiene. Refusal of care also became a feature of her stay in the care setting. At no time was an adult safeguarding concern referred for self-neglect.

2.27. Much of the initial GP submission concentrates on tissue viability and will be discussed below as the third key line of enquiry. Reinforcing a Commentary earlier, the GP submission observes that there were no recorded multidisciplinary meetings regarding Rosemarie. There is reference to faecal sample testing in response to an e-coli infection. There is also reference to a pharmacist becoming aware of Rosemarie's mental health decline as her medication had been stopped. This was discussed with Rosemarie's daughter and her medication was reviewed and reinstated. **Commentary**: it remains unclear why there was disruption to her mental health medication. The GP submission refers to Rosemarie's low mood, crying, sleep disturbance and frequent telephone calls to her daughter. None of this seems surprising, not because of her mental health diagnosis, but because of the pain she experienced and the amount of time she spent alone in bed.

2.28. Rosemarie's family have questioned whether the GP had sufficient contact directly with her and whether her level of pain was given sufficient priority in weekly rounds. They observe that Rosemarie regularly asked to see her GP but might only have seen the doctor twice. They believe that her persistent use of her calling bell, and regular calling out (or whaling as the family call it and note in passing a connection here with her Jamaican heritage) was in part the consequence of pain. They have questioned whether there was sufficient oversight of pain management. On the basis of what they have observed in recordings, they believe that some staff were "*scornful*" when Rosemarie complained of feeling unwell and did not initiate medical review when she experienced vomiting and diarrhoea.

2.29. The GP contribution regarding Mearl refers to contact with her son, for example about her advanced care plan, the involvement of a pharmacist in her treatment, and respect for the son's wishes regarding the use of sleeping tablets. **Commentary**: the chronology refers to conference consultations and multidisciplinary team meetings. However, the GP submission makes no reference to involvement in adult safeguarding or provider concern processes.

2.30. The chronologies and reflections from North Middlesex University Hospital[5] (NMUH) regarding Mearl provide evidence of assessment by an occupational therapist that identified a borderline depression score and a need for more physiotherapy input. At that point (November 2019) she is reported as saying that she was happy and that her care was good. No physiotherapy input appears to have been forthcoming by February 2020 when a referral was sent. There were hospital admissions in October 2021 because of a low haemoglobin level, and in September 2022 because of vomiting.

2.31. In August 2022 Mearl's son is recorded as being unhappy because his mother was not got out of bed. This was a recurring theme in SAR Paulette also. He is recorded as reiterating this complaint in June 2023, namely that Mearl was not taken out of her room. This might have been

[5] References to pressure sores will be covered below in the third key line of enquiry.

because of the pain she was experiencing. However, in May 2023 Mearl is recorded as having enjoyed a BBQ.

2.32. Mearl's son was apparently involved in a review of her care plan in February 2023. This covered oral care, showering, physiotherapy and activity. He is reported as having been involved also in DNAR conversations in May 2023. The chronology references GP consultations during 2023 with reference to her sleeping pattern, pain levels and blood tests. One multidisciplinary team meeting is recorded in February 2023, present at which were a consultant geriatrician, head of care staff from the care setting and a palliative nurse.

2.33. Mearl's care plan covered communication, diet and nutrition, diabetes care, elimination[6], personal hygiene, skin viability, mobility, inflection control and safety. NMUH observe that the community matron was thorough in their assessment and provided advice and recommendations on how to escalate any issues. The NMUH contribution references good practice as including joint working on complex cases but also acknowledges that NMUH was unaware of a safeguarding referral to the local authority from the London Ambulance Service. **Commentary**: what is less apparent is how Mearl's care plan was actively monitored outside of the one review that is recorded in the chronology, and the response to the concerns/complaints expressed by her son. Indeed, Mearl's son has advised that her care plan was only updated regarding management of her diabetes and pressure sores after he complained. Only one multidisciplinary team meeting is recorded, the focus of which was on her care and treatment plan rather than any wider concerns about the care setting.

2.34. The NMUH chronology and reflections regarding Rosemarie's three-month residence in the care setting record a pre-admission assessment that identified risks of choking, falls, malnutrition and pressure ulcers. Her non-compliance with treatment was noted. There are entries in the chronology recording palliative care nurse visits, GP reviews, CHAT[7] reviews, liaison with pharmacy, and response to an acquired e-coli infection that was followed up by public health and which did not affect other residents.

2.35. The NMUH contribution records communication with Rosemarie's care coordinator in Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) in September 2021 regarding her depot injection but also no apparent mental health team input by late October 2021 despite two requests. The chronology then records a mental health team visit in mid-November that concluded that Rosemarie required involvement by the palliative care team and discussion about DNAR and advanced care planning. This was followed up by the palliative care team. **Commentary**: concern regarding mental health input will be discussed below. In early December 2021 an occupational therapy assessment recorded that a mental health review was needed as Rosemarie did not understand the impact of her non-compliance with treatment. This does not appear to have happened. It is unclear whether this request for a mental health review was in fact and in part a request for a mental capacity assessment relating to her decisions about treatment.

[6] Mearl was doubly incontinent.
[7] Care Home Assessment Team.

2.36. The lack of multi-agency and/or multidisciplinary meetings with respect to Rosemarie has already been noted. The NMUH chronology records a palliative care practitioner recommending a "*meeting of all parties*" to discuss concerns being expressed by staff and by Rosemarie's family. It also records the GP as suggesting a geriatric multidisciplinary team meeting. No such meetings were held although a search for another placement was commenced. NMUH have reflected that a multidisciplinary team discussion would have been helpful due to the complexity of Rosemarie's case. NMUH have also reflected that further access to the palliative care team would have been helpful, "*if only for advice*." **Commentary**: there is some suggestion in the NMUH contribution that Rosemarie did not meet the criteria for palliative care team involvement despite her serious ill-health.

2.37. **Commentary**: concern about the absence of "whole system meetings" is reinforced by the observation in the NMUH contribution that care setting staff had felt intimidated by Rosemarie. A whole system meeting would also have enabled collaborative monitoring of her physical and mental health, and of the treatment plan. It would also have provided a single point of contact for her daughter who, on behalf of Rosemarie and her family, continued throughout to express her concerns. A CHAT review in early October had identified pain and weight loss as a result of her cancer, an old leg fracture, difficult in mobilising, and Rosemarie's non-compliance and lack of interest in advanced care planning. A treatment plan was recorded and there was contact with Rosemarie's daughter. Subsequent reviews by different healthcare practitioners or teams happened in isolation although the community matron did share information with the GP.

2.38. Multidisciplinary and whole system meetings are one means through which care plans can be monitored and, where indicated, amended. Only the ICB have commented explicitly on the review of care plans. *"Care plans are reviewed at regular intervals by clinical staff, both at MDT meetings and in person through regular review. For people on observations because of behaviours that challenge this is weekly and must sit with legal frameworks relating to both mental health and capacity. Ensuring individuals' agency is also critical here so that those reviewing can assess and review their own experience of the care provision. Patients have reviews at 3 months and then annually thereafter. The nursing home would be expected to escalate any concerns regarding care. If concerns are raised by MDT or families, visits are arranged to check on the patient's welfare and this is discussed with the nursing home to update the care plan and put relevant processes in place i.e. behaviour management plan."*

2.39. Rosemarie and her daughter raised concerns throughout. It is clear that a continuing healthcare practitioner also raised concerns and was proactive in exploring an alternative placement for Rosemarie. For both Rosemarie and Mearl there were GP and Care Home Assessment Team reviews. However, particularly in relation to Rosemarie, concerns persisted. This suggests that more frequent whole system reviews were needed, not least to inform care planning.

2.40. The learning event recognised that there had been challenges in ensuring the timeliness of reviews. The care setting have reported difficulties contacting social workers to complete 6 week and other statutory or urgent placement reviews in a timely manner. This created particular

difficulties when a resident might need to be moved from the placement. However, there has apparently been an improvement since the introduction of the locality model.

2.41. At the learning event significant improvement in multi-agency communication was reported as a result of the introduction of the localities model, for example for hospital discharge. There were still improvements to be made to improve pathways and embed multi-agency working, however. Multidisciplinary team meetings take place in primary care, and monthly multidisciplinary meetings take place within the care setting, led by a geriatrician. Participants at the learning event suggested that other agencies/services should also be invited to improve communication. **Commentary**: when residents with complex needs are scheduled for discussion, having all those involved or with a potential contribution to make, would improve a holistic, whole person approach.

2.42. A specific concern voiced at the learning event was the absence of regular strategy meetings about section 42 adult safeguarding enquiries to jointly put protection plans in place. Social workers, it was suggested, tend to work alone. It was argued that this needs to be addressed in the new locality model.

2.43. Despite requests, BEHMHT have not provided a chronology and/or information that specifically focuses on the key lines of enquiry. Their contribution does record a "*full medical review*" having taken place in mid-November 2021 at the care setting. It is noteworthy that the adult safeguarding contribution from the local authority refers to this as a Care Programme Approach (CPA) review wherein Rosemarie expressed her dissatisfaction with all the professionals involved in her care. It is unclear what, if any, plan was constructed in response. Several weeks beforehand the adult safeguarding team submission also observes that Rosemarie had requested a change of care coordinator, which had been actioned. BEHMHT references the safeguarding concern that was referred following the manual handling fracture that Rosemarie sustained at the care setting that resulted in her final hospital admission. It also references the local authority plan for unannounced visits and reviews of residents to ensure care packages were being provided.

2.44. Rather, the BEHMHT contribution focuses on Rosemarie's longstanding mental ill-health, with a diagnosis of paranoid schizophrenia and multiple hospital admissions from the 1990s. It refers to "*complex layers of mental and physical health needs*" and a history of missing medical appointments and a reluctance to accept support, including when she was living at home. It notes her inability to understand or acknowledge the risks associated with her health conditions. **Commentary**: the overlap of physical and mental health needs and risks, and the history of self-neglect, reinforces earlier Commentary about shortcomings with respect to a whole system approach to meeting Rosemarie's needs and minimising risk. Such an approach would also have supported the care setting.

2.45. The BEHMHT contribution refers to recent service reorganisation that has bolstered physical healthcare support for community services. **Recommendation Two**: HSAB should consider seeking assurance about the outcome of service reorganisation in BEHMHT, and about the provision of mental health support for residents and staff in care settings.

2.46. Rosemarie's family have also expressed concern about the lack of mental health involvement. They believe that mental health practitioners (her care coordinators especially) did not maintain sufficient contact with Rosemarie or the care setting[8], and observe that the care coordinator did not know that Rosemarie had died until her daughter called the Mental Health Trust. The family have commented that the care coordinator could not be contacted when Rosemarie wished to discuss her treatment in the care setting. They cannot account for who decided to stop Rosemarie's mental health medication but it does not appear that the mental health service knew this had happened. The medication was reinstated following contact and advocacy initiated by the family. There was no re-referral to psychiatrists at this juncture.

2.47. **Commentary**: the care home assessment team (NMUH) remit is to provide an integrated physical and mental health service, contributing to assessments and care plans. There does not appear to have been any liaison between the CHAT practitioners and the BEHMHT care coordinators.

2.48. In their written submission the care setting picks up the theme of mental health, commenting on the absence of mental health support regarding Rosemarie and observing that there was/is room for improvement with respect to how mental health practitioners respond to crises in the care setting. At the learning event, it was recognised that, in a context of finite resources, mental health services had to prioritise need and risk. Whilst individuals living in the community might not have wrap-around support and be perceived as a higher level of risk, care settings also require a circle of support. To assist with prioritisation, it would assist mental health service providers if the nature of the support being requested could be specified.

2.49. The care setting have commented that they are not aware of any concerns about Rosemarie's mental health medication being stopped. The care setting have also commented that all quality of care and safeguarding concerns raised by Rosemarie and her family, and by Mearl's son, were investigated internally and by external agencies, with feedback given to families. In relation to the serious injury (fracture) sustained by Rosemarie as a result of manual handling, the care setting acknowledge that, as soon as she refused a physical examination, this should have been escalated to the 111 service and/or London Ambulance Service. Their contribution comments that the nurse's clinical assessment did not identify any visible injuries. **Commentary**: however, if Rosemarie did not allow any physical examination, it would have been difficult to establish whether or not a significant injury had occurred. In the video recording of the incident, it does not appear to the independent reviewer that Rosemarie refused a physical examination at the time. There is an audible sound of a break and Rosemarie immediately and persistently asserts that a bone has been broken. "*My body broke*." The independent reviewer was unable to see during the continuous filming of the day in question any meaningful attempt at the time the injury occurred, or subsequently, to conduct an examination or to summon a nurse or doctor despite her requests. When Rosemarie asked to see a doctor, her request was simply repeated back to her. There are other subsequent instances of manual handling that day,

[8] This is not the first SAR completed by Haringey SAB where there have been critical observa6ions of the contact with patients by care coordinators.

normally double-handed but on one occasion by a single staff member. On several occasions Rosemarie was turned to be washed and/or for sheets to be changed. On one occasion a dressing is applied to her sacral area and a photograph taken by a member of care staff on a mobile phone. When Rosemarie requested water and juice, this was usually but not always provided. When Rosemarie contacted her daughter that morning, after the incident, she telephoned and asked to speak to the [named nurse 1]. This call did not result in any changed approach that day by care setting staff from what is observable on the video recording.

2.50. **Commentary**: this view of the video evidence corresponds with the family's perspective, as outlined by one of Rosemarie's daughters: "*(Named nurse 1 checked the shoulder. She refused my mother's request to call me on my mother's mobile, then shouted at my mother to tell her she would not tell me that her arm was fractured. My mother told the nurse to calm down ... No further checks were done and named nurse 1 never returned to the room for the entire 12-hour shift which my mum's arm remained broken, not even when the care staff tended to mum's incontinence pad. This means for the 12 hours mum's dressing on her pressure ulcer was not changed too. The care workers verbally acknowledge the break when it took place. The trainee male nurse attended to mum alone too and seemed to be giving her the run around pretending like he couldn't understand her. My mother pleaded and repeatedly advised staff her arm was broken. I called the nursing home after having spoken to mum around the 9am mark. Mum also pleaded with named nurse 1 to check her arm and 'find out' what was wrong since the nurse kept [asserting] her arm was not broken when mum knew it was. To add to this, I think based on email [exchanges between managers and other staff] the concern I discussed with him about the constant pulling on mum's arm by staff, this email/concern was either not communicated to staff or the staff intentionally went against their training*."

2.51. **Commentary**: the care setting have commented that safeguarding referrals and CQC notifications were sent when appropriate but feedback was not always received. The care setting did not refer the manual handling injury as a safeguarding concern; nor was her non-compliance and/or refusals of treatment and care and support referred as safeguarding concerns under the umbrella of self-neglect.

2.52. **Commentary**: one theme within this key line of enquiry has been the adequacy of resources for ensuring quality of care. In response to a specific enquiry from the independent reviewer, the care setting have sought to provide assurance that the level of staffing and staff knowledge and skills are routinely monitored against the needs and risks presented by residents. The care setting has also instituted routine discussions of safeguarding incidents with nurses and team leaders. Contract managers and CQC should verify these assurances proactively.

Second Key Line of Enquiry: Inter-Agency Oversight of Care Quality

3.1. The care setting have commented that quality assurance processes were in place for reporting and managing serious incidents. However, the care setting then described a list of internal measures that were in place at the time, namely regular walk-arounds, auditing, clinical supervision, monitoring of trend data, improved training and action planning. More recently, as part of an improvement plan and the embedding of a culture of learning, the care setting have reintroduced safety champions, established monthly meetings and reduced staff turnover. The care setting have provided learning opportunities to support staff to understand and manage residents with learning disabilities, mental ill-health and physical conditions, such as epilepsy.

3.2. The care setting have observed the absence of feedback relating to safeguarding concerns referred to the local authority by a hospital when Rosemarie was admitted for the final time. Feedback was received following a safeguarding enquiry regarding Mearl. This feedback commented that the care setting had followed tissue viability procedures and implemented care plans provided by a tissue viability nurse.

3.3. The care setting have acknowledged the need to seek external support immediately if assessments are unable to be carried out because a resident does not cooperate. They have commented that a blame culture across and between services persists that is counterproductive, creating "*unnecessary barriers*."

3.4. BEHMHT have not provided any documentation that comments on this key line of enquiry. As noted earlier, the care setting have commented on the absence of mental health support.

3.5. Local authority commissioners have commented that all provider concerns were shared with the CQC and with the adult safeguarding team and that training requirements were included in the improvement plan developed with the collaboration of the care setting. A provider workshop was held to share insights and lessons learned, and to develop forward plans. This was partly in response to recommendations in SAR Paulette.

3.6. Commissioners have reflected on the importance of timely reporting, of comprehensive documentation to enable an assessment of change, and of effective communication channels and protocols to disseminate findings. **Commentary**: This will need to be regularly reviewed.

3.7. At the learning event it was reported that Haringey have re-introduced monthly contract monitoring visits to the home. Typically, these meetings do not delve into individual cases but they represent an opportunity to discuss complex service users and support liaison with other professionals.

3.8. The reference immediately above to the need for comprehensive documentation highlights the importance of recording, a theme picked up by other initial contributions to this review. The contribution from continuing healthcare (Whittington NHS Trust) acknowledges that records are poor, for example with no mention from the local authority about adult safeguarding concerns

referred concerning Rosemarie, and the absence of recorded action when incidents were reported to senior managers in the care setting. No records exist of safeguarding procedures being followed. The application for a new placement for Rosemarie was not detailed; it did not mention challenging behaviour, nor did it provide a full appreciation of her needs.

3.9. The GP initial contribution refers to timely responses to calls from the care setting but provides no information to indicate if GPs had any involvement in provider concerns procedures despite their longstanding relationship with the care setting.

3.10. The adult safeguarding written submission from the local authority observes that the referred adult safeguarding concerns focused mainly on the fracture Rosemarie had sustained. Other concerns expressed by Rosemarie and/or her daughter, for example concerning pressure ulcers, were known by adult safeguarding only after Rosemarie had died. **Commentary**: two questions emerge at this point. Firstly, why no practitioner had referred concerns to adult safeguarding prior to Rosemarie's final admission to hospital. Secondly, how the agencies involved understood the interface between adult safeguarding referrals and enquiries, notifications to CQC, and alerts to commissioners about provider concerns.

3.11. BEHMHT were asked to undertake the adult safeguarding enquiry, as section 42 Care Act 2014 permits, the rationale presumably being that Rosemarie was known to that service. The adult safeguarding chronology does not record any contact by the team with CQC or contract managers when the referral of concern was received. **Commentary**: the question highlighted just above about how the interface between different processes for care quality oversight were understood by those involved also arises from the adult safeguarding team submission regarding Mearl. It is not clear from the submitted chronology whether the adult safeguarding team shared the referred concerns about pressure ulcers, received from the care setting and from NMUH, to contract managers and/or CQC, although the outcome of the adult safeguarding enquiry was shared.

3.12. The theme of insufficient recording has already been mentioned. It arises again in the Whittington Health written submission's review of how services worked together with respect to both Mearl and Rosemarie. In Mearl's case the critique of recording focuses on a safeguarding decision tool not being completed by a tissue viability assessor. In addition, no entries on her notes regarding tissue viability assessments appear until 2023 even though assessments were completed beforehand. In Rosemarie's case, no details of a pressure ulcer review plan have been found in records, with the Whittington Health submission questioning how the tissue viability nurse was assured that care setting staff had sufficient knowledge of pressure ulcer care. The same concern is articulated when reviewing Mearl's case, namely that limited information has been recorded by tissue viability practitioners so it is not possible to ascertain if care setting staff had sufficient pressure ulcer prevention information after tissue viability assessments.

3.13. The theme of how practitioners understood the duty to enquire (section 42 Care Act 2014) also emerges from the Whittington Health submission. It observes that there were missed

opportunities when tissue viability practitioners would have been expected to refer Mearl's and Rosemarie's pressure ulcers as adult safeguarding concerns.

3.14. Reference has already been made to the comparator data analysis provided by CQC for this review. It is worth recalling here that, between September 2021 and February 2024, there were thirty notifications of falls and fourteen for poor care. There were five notifications of medical errors and three for resident self-neglect. It does not appear that there was the same level of adult safeguarding concerns referred to the local authority, highlighting again the question about the interface between different statutory processes designed to ensure care quality. As already observed, most notifications to CQC were noted for the next inspection and it is unclear from CQC records if their staff at the time attended multi-agency meetings. **Commentary**: it is important to note that CQC has recently undergone reorganisation and now has staff whose role and responsibility is clearly focused on organisational abuse and closed cultures. CQC now has staff working at a national level whose role and responsibility is focused on organisational abuse and closed cultures. The role of this team is to provide front line operational CQC staff with national advice, support and promote best practice.

3.15. The NMUH written submission covers community healthcare for care home residents. Focusing on Mearl, NMUH comment that they were unaware of the safeguarding referral to the local authority from the London Ambulance Service. Echoing earlier references to recording, the submission criticises omissions in hospital records when Mearl was discharged back to the care setting in October 2022.

3.16. The NMUH submission focusing on Rosemarie observes that the care home assessment team (CHAT) were unaware of her death until they were notified of this safeguarding adult review. One chronology records that when Rosemarie alleged abuse by care setting staff in late September 2021, in a telephone call to paramedics, the care home had initially been unable to contact the palliative care team. There is no detail regarding what Rosemarie was reporting and when questioned by care setting staff she denied making the telephone call.

3.17. Responses to the independent reviewer's additional questions pick up themes within this key line of enquiry. Turning first to support for the care setting to manage residents with complex needs, the care setting have reported improved collaboration with GPs and pharmacy. This was confirmed at the learning event, with care setting staff and GPs reporting better two-way communication and improved ability to monitor residents whose health was deteriorating.

3.18. However, help and support have not always been forthcoming because the care setting find partners to be "*reactive*" rather than "*proactive*." Care setting staff have referred to the lack of mental health support in particular, including in crisis situations, and more generally have referred to a "*lack of collaborative working across the system*."

3.19. This perspective contrasts with that offered by other partners. Adult Social Care Commissioners have commented as follows: "*the ASC Provider Quality Assurance team collaborates with health colleagues to explore opportunities for tailored training aimed at enhancing staff competencies in caring for residents with complex physical and mental health*

needs. Additionally, care providers are encouraged to utilise specialist mental health colleagues and the HLDP for access to specialised services such as those for personality disorders, community rehabilitation, occupational therapy, physiotherapy, and speech and language therapy."

3.20. The ICB have observed that *"training and support is available from complex care teams. There is a learning and training hub for social care and health providers across North Central London. There are also various team specialists in supporting providers within community health and primary care providers, e.g. around falls, equipment."* **Commentary**: whilst in theory specialist support is available to care settings, in practice this might not be available either routinely or in crisis situations.

3.21. Turning next to information-sharing about safeguarding and provider concerns across agencies, care setting senior staff have commented on the lack of feedback about outcomes of safeguarding enquiries. Adult Social Care Commissioners have noted that "*commissioners and contract managers share concerns with adult safeguarding and the CQC as soon as they identify potential risks or issues. This proactive approach ensures that timely interventions can be made to protect the well-being and safety of adults in care, even in the absence of formally agreed thresholds for raising concerns.*" The ICB have commented that "*in Haringey, the Integrated Care Board participates in a quarterly meeting with the CQC to share information and address quality issues. Additionally, the ICB has established systems and processes for escalation and oversight working jointly with commissioners/ contract managers.*" London Borough of Haringey commissioners and safeguarding teams also participate in quarterly meetings with CQC.

3.22. The CQC position on information-sharing appears slightly more reserved. *"Subject to sections 76-80 Health and Social Care Act 2008 regarding confidential personal information, CQC has a wide discretion to share information with third parties. This discretion may be applied in a variety of circumstances (as detailed in the CQC Information Sharing Guidance Document). Individual notifications are not automatically shared with commissioners and adult safeguarding. If CQC consider that a potential incident of abuse has occurred or a person is at risk of abuse then a Safeguarding Concern will be sent to adult safeguarding. CQC will also contact the provider to ensure that any immediate steps are taken to reduce the risk of further abuse. CQC will contact the local authority on a case by case basis to share information about providers which may not amount to an abuse. Information will be shared wherever this might help partners to undertake their quality or governance roles."*

3.23. At the learning event it was suggested that there was scope for improvement in information being shared with care settings around the person's history, as practice is inconsistent. It was said to be very good from some hospitals, not so good from others, although it wasn't necessarily related to the hospitals themselves, probably more to the people referring through. Whether there is enough rich information being given to providers for them to be able to make informed decisions on who they take is a theme picked up again in the fourth key line of enquiry below relating to hospital discharge and placement shortages.

3.24. Adult Social Care Commissioners comment further that, when the outcomes of adult safeguarding enquiries are known and have substantiated abuse/neglect, the provider quality assurance team "*will request an action plan from the provider detailing how they intend to prevent a reoccurrence of the incident; the team will also monitor the implementation of the plan*." By contrast the ICB observed that *"currently there is no mechanism to gain feedback on the outcome of safeguarding enquiries. Safeguarding designates are working with the local authority to try and strengthen this area. However there are systems and process in place to ensure that residents are safe and their needs are met. Where there are significant safeguarding concerns the ICB work with the patient and family to ensure they are moved to an alternative placement. The ICB completes welfare checks on all the residents in the nursing home when a safeguarding concern is raised. We may do more frequent checks on residents to make sure they are safe. People placed in provision, or in receipt of packages of care at home, are always reviewed when safeguarding issues are raised. These are often joint reviews with other professionals, nursing, social workers, or care coordinators. People are transferred to another provision when substantiated, and at times, when not substantiated. This process is managed jointly with the local authority too if they are the lead commissioner for the provision. There are also occasions if CQC ratings change negatively each person in that provision is reviewed, and safe and well review checks are completed, and repeated. An action plan is drawn up to improve the provision. There may also be occasions when provision is ceased or paused here too. Further discussion is required to have a better process to receive weekly reports from CQC via the safeguarding team. This would enable the ICB to be updated on CQC reports and changes to so we can act quite quickly when these reports are received."*

3.25. On follow-up when local authority safeguarding enquiries have been concluded, the CQC observed that "*safeguarding is a key priority for CQC and people who use services are at the heart of what we do. Our work to help safeguard adults reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services. CQC will expect the provider to have developed an action plan to make improvements and will follow the progress of the plan through engagement with the provider. CQC will consider the information and the need to undertake an inspection. The findings would be reviewed along with other information we hold and this might lead to an urgent inspection. Where breaches of regulation are found the CQC may use its civil enforcement powers for example imposing conditions on the service or suspending / cancelling a registration. On a few occasions the CQC may use its criminal enforcement powers to prosecute and hold registered persons to account for serious failings.*"

3.26. On safeguarding, at the learning event, a view was expressed that there needs to be better alignment in safeguarding conversations between the hospitals and safeguarding teams where people are being discharged and there are safeguarding concerns attached to those individuals. Some improvement was noted with how the various safeguarding teams work between themselves before discharging people into placements. Where there are challenges in discharge, the discharge to assess pathway is used to support people back into their home if there is not a more appropriate placement. It was felt that there might be more scope to use this pathway.

3.27. Despite concerns that some partners lack the capacity to participate effectively in multi-agency meetings, participants at the learning event acknowledged that there have been significant improvements, for example in CQC locally engaging with commissioners from health and social care at regular joint quality and safeguarding review meetings which have recently re-started. It was felt that this would help to pick up concerns earlier before they escalate

3.28. One further observation at the learning event focused on the interface between police and other investigations. It was reported that agencies often stop their own investigations when police undertake an investigation, but the police do not necessarily feedback when they have concluded an investigation, so partners do not re-start their investigations. **Commentary**: it would be helpful for partners to discuss how to achieve best evidence and when, with that objective, investigations by the police, CQC and commissioners/contract managers can or cannot run in parallel. **Recommendation Three**: HSAB should consider initiating dialogue across partners about how to achieve best evidence, including how to manage decision-making about whether investigations relating to care quality can or cannot be conducted in parallel. HSAB should also consider adding this review to an escalation by the national network for SAB chairs to DHSC regarding the need for guidance on achieving best evidence[9].

[9] A process begun as a result of SAR Clive (Staffordshire and Stoke SAB).

Third Key Line of Enquiry: Effective Pressure Ulcer Management

4.1. Tissue viability concerns have already been mentioned. CQC have recorded twelve notifications of pressure ulcers on admission to the care setting between September 2021 and February 2024, and nineteen notifications of pressure ulcers acquired in the care setting.

4.2. Rosemarie's family believe that video evidence demonstrates that she was not repositioned according to the frequency advised by tissue viability nurses.

4.3. The SAR referral for Mearl observes that following elective surgery in February 2019 she was discharged to a rehabilitation placement with a grade 3 pressure ulcer.

4.4. The NMUH chronology for Rosemarie includes a pre-admission assessment in mid-September 2021 that identified risk of pressure ulcers. It also records that there were tissue viability staff shortages in December 2021 that impacted on availability for visits to the care setting. It refers to disputes between Rosemarie's daughter and the care setting regarding the use of dressings and the daughter's wish to take responsibility for her mother's care. Rosemarie's daughter has offered additional clarity here, namely "*I had to buy plasters from Tesco's in South Tottenham across the street because the nursing home were always running out. (Named Nurse 1) advised me that the plasters I had were suitable, however (another named staff member 2) would challenge me about the suitability of the plasters and tell me her colleague 'doesn't know what she's talking about' and that the plasters weren't suitable. I continued to use them when the home would run out of their plasters, since I couldn't imagine leaving my mum's pressure ulcer open to urine and faeces to risk infection*."

4.5. The NMUH chronology for Mearl notes that the care and treatment plan covered skin viability, and the care home assessment team provided advice on monitoring. This included the need for repositioning every two hours, subsequently changed to four-hourly. It appears that Mearl returned to the care setting from hospital in mid-November 2021 with a new pressure sore on her sacrum, an episode that was repeated in October 2022 at which point a safeguarding concern was referred to the local authority. The NMUH chronology does not reference how this was followed up or what the outcome of the referral was. The chronology does observe that when a wound resurfaced in March 2023, the plan was revised for repositioning every two hours. When the wound deteriorated in May , the care setting referred back to the tissue viability nurses who visited six days later. Three days later a safeguarding concern was referred for an unstageable pressure ulcer. The chronology concludes with a tissue viability review in mid-October 2023. This references a healing pressure sore to the sacrum and an unstageable right heal pressure ulcer. Advice was given about appropriate treatment.

4.6. The GP written submission for Mearl comments that pressure sores were addressed during weekly rounds. For Rosemarie it adds that medication was issued when requested either by the care setting or tissue viability nurses.

4.7. The continuing healthcare written submission from Whittington NHS Trust observes that there is little mention of pressure ulcers in their records. **Commentary**: the theme of recording recurs and appears linked to information-sharing across the services involved.

4.8. Whittington Health is not commissioned to provide pressure ulcer training to all care homes and care agencies in Haringey. The Trust does invite them to specialist pressure ulcer training held at Whittington Health on a regular basis, for which there is a charge. This offer of training appears not to have been taken up. Details have also been provided of free pressure ulcer training to commissioners within Haringey and the prevention and learning SAB sub-group for dissemination.

4.9. The Whittington Health chronology regarding Mearl contains reference to a tissue viability assessment in mid-October 2022 at the request of the care setting, and a further such assessment in mid-May 2023. There appears to have been some delay in the care setting forwarding images of a macerated lesion and the chronology questions whether care setting staff had sufficient information and expertise to prevent and treat pressure sores. Records indicate that the care setting referred this as an adult safeguarding concern to the local authority. **Commentary**: pressure ulcer prevention, as part of the support being provided to the care setting when responding to residents with complex needs and comorbidities, has become a theme in this review. There was a further telephone consultation with care setting staff in late June 2023 about pressure ulcer prevention, and a physiotherapy appointment in the care setting in August that focused on Mearl's leg pain. The Whittington Health written submission reflects on the advisory role of tissue viability practitioners regarding care and management. A question arises about the sufficiency of monitoring by healthcare practitioners, health and social care commissioners and CQC.

4.10. The Whittington Health written submission for Rosemarie reflects on an 8-day delay in a tissue viability nurse assessment as a result of not wanting to wake her. The submission questions whether this approach was valid. The chronology observes that Rosemarie acquired a pressure ulcer in hospital and was admitted to the care setting with her skin not intact. The chronology also references pressure ulcer prevention and treatment advice being given to care setting staff in November 2021, noting again that the care setting had not sent images. The same written submission records a grade 4 sacral pressure ulcer when Rosemarie was admitted for the final time, linking this to "*poor care in the nursing home*." Rosemarie's family members and hospital staff were also concerned about her cognition (capacity) following disruption to her mental health medication. **Commentary:** there were missed opportunities to refer tissue viability issues as safeguarding concerns. There is no reference in any of the written submissions to how pressure ulcer trends are monitored in hospitals, care settings or people's own homes. Rosemarie's family have pictures that demonstrate how the pressure ulcer deteriorated after discharge from Whittington.

4.11. The theme of support for the care setting is picked up by adult social care commissioners in their written response, observing that specialist ICB nurses were assigned to support pressure ulcer management. This followed evidence during contract management of an increase in pressure sore notifications and the care setting commenting on the number of occasions when

(new) residents were arriving from hospital with existing pressure ulcers. **Commentary**: if this support has been withdrawn or if withdrawal is being considered, this reinforces the question above about how trends in tissue viability concerns are being monitored and support provided where indicated.

4.12. The local authority adult safeguarding written submission comments that the safeguarding team has no record of a safeguarding concern relating to pressure ulcers being referred before Rosemarie's death by either the care setting or tissue viability nurses. The team became aware of concerns about the management of tissue viability from Rosemarie's daughter after her passing.

4.13. The local authority adult safeguarding written submission for Mearl records that the care setting referred a safeguarding concern regarding pressure ulcers following assessment and subsequent review by tissue viability nurses in May 2023. There was a gap of nine days between initial assessment and the safeguarding referral. The written submission suggests that equipment and a treatment plan were in place. At this juncture Mearl's son is recorded as being happy with the care home but he had not been made aware of a grade 2 pressure sore.

4.14. The care setting have commented that Mearl was admitted with an acquired pressure ulcer and were not given information about this. Tissue viability nurses were involved and the treatment plan then followed. The care setting have stated that they felt fully supported by other agencies with respect to Mearl's pressure ulcer care.

4.15. The care setting have described their current approach to pressure ulcer management. On admission a full body inspection is conducted with completion of a body map and photographs taken. A Waterlow assessment is completed and a MUST score obtained, after which a skin care plan is formulated. Regular checks result in onward referrals to tissue viability nurses and GPs. There are also monthly audits. An external trainer provides training on wound management.

4.16. Both Rosemarie and Mearl slept on air pressure mattresses and there were sliding sheets to assist with repositioning. The care setting have stated that Rosemarie refused to allow staff to use the sliding sheet. However, based on their video recordings, Rosemarie's family have no evidence that she refused the sliding sheet. Her family had also requested that any refusals of care should be escalated to senior nursing staff and recorded fully. The family have no evidence that this was done. **Commentary**: given risks associated with manual handling, advice should have been sought on how to respond to Rosemarie's refusal, if indeed she refused. This might have been prompted by the pain she experienced. Advice should have been sought routinely on pain management.

4.17. It is the family's firm view that staff often lied to cover up their lack of care. They have provided a further example. Rosemarie's family purchased a wheelchair and "*the (named nurse 1) said they asked Rosemarie if they could put her in it, as the family had requested; they said she declined but the video footage shows no one ever came to offer to put her in the wheelchair.*"

4.18. Mearl's son has commented on the serious extent of her pressure sore, stage 4. It is his clear view that "*the obvious lack of/poor care contributed to her death and the stage 4 pressure sore recorded on my mother's death certificate as a contributory factor*." Echoing what Rosemarie's family observed, he has further commented that "*my mother was left for extended periods of time without being visited by staff. I often had to reposition my mother in an attempt to make her more comfortable even after asking staff to assistance*." He is firmly of the view that his mother was not turned frequently enough.

4.19. In response to the independent reviewer's additional questions, the care setting have commented that safety champions have been reintroduced, covering pressure ulcer care and, additionally, falls, UTIs, and nutrition and hydration. Monthly meetings track and discuss data. Adult Social Care Commissioners also commented on pressure ulcer monitoring: "*ASC Commissioning currently does not have knowledge of any specific pressure ulcer monitoring panels. However, for our block contract providers, pressure ulcer incidence and management are components of the monthly monitoring processes and information returns.*"

4.20. At the learning event it was stated that there was good support and timely advice from tissue viability nurses. It was suggested that there has been improvement in the monitoring of pressure care using monitoring forms. This has seen a significant reduction in falls and higher level pressure ulcers. The care home manager has presented to the provider forum on the work they are doing around the use of champions for pressure ulcer care to share good practice.

4.21. **Recommendation Four**: HSAB should consider inviting the ICB to lead on a discussion of how to further improve the monitoring of, and response to pressure ulcers, acquired in the community and/or in hospitals. The establishment of pressure ulcer panels would enable tracking of data and how occurrences are being prevented and/or addressed.

Fourth Key Line of Enquiry: Other Emerging Themes

5.1. The initial written submissions from the agencies involved draw attention to some additional emerging themes. Several submissions[10] highlight that Rosemarie was unable to understand or acknowledge the risks associated with her ill-health and disabilities, and that she had limited or declining insight. Understanding of and compliance with the requirements of the Mental Capacity Act 2005 was a key theme within SAR Paulette.

5.2. The Whittington Health written submission for the care home assessment team observes the absence of a formal mental capacity assessment in respect of Mearl. Reflecting on Rosemarie's chronology, the submission observes that her mental capacity was questioned but not formally assessed with respect to cancer care when in hospital during August and September 2021, and for her discharge from hospital to the care setting. A mental capacity assessment had been completed on her admission to hospital, however.

5.3. The same submission observes that no mental capacity assessment was conducted subsequently, for example by tissue viability nurses or physiotherapists. It suggests that there was an assumption that she was bedbound. The chronology does record that tissue viability nurses were chasing the care setting to request a mental capacity assessment by adult social care. It also records that the GP had declined to undertake a mental capacity assessment, deferring to a psychiatrist as Rosemarie was under secondary mental health care. The NMUH and local authority adult safeguarding written submissions also reference a request from tissue viability nurses and an occupational therapist for a mental capacity assessment and the GP deferring to psychiatry. As a result, the suggestion that her mental capacity should be reassessed does not appear to have happened. **Commentary**: this raises a question about practitioners' understanding of the Mental Capacity Act 2005 and their confidence in undertaking assessments.

5.4. At the learning event some participants recognised that more work was needed to facilitate high quality decision specific capacity assessments. This included a need to promote multidisciplinary working and clarity on who is the best person to lead particular assessments. The aim should be to further empower all parties to be involved, especially families.

5.5. Also at the learning event, and focusing on hospital discharge (see below) participants commented on a mixed practice around whether mental capacity assessments have been carried out prior to hospital discharge to identify if there is a requirement for the care home to have deprivation of liberty safeguards in place. It was felt that there is an improved process for referring cases to the local authority for deprivation of liberty safeguards and this was an issue highlighted in recommendations in SAR Paulette.

[10] BEHMHT, NMUH and Whittington Health.

5.6. **Commentary**: several written submissions for this review refer to advanced care plans[11]. The Code of Practice for the Mental Capacity Act 2005[12] does not refer to advance care plans but does refer to advance decisions. This enables a person with capacity to make an advance decision to refuse medical treatment. Such a refusal must be respected if valid and applicable to current circumstances. In the event of doubt or dispute, the Court of Protection is available to resolve disagreement. Treatment is permitted whilst the Court of Protection is considering any submission[13]. If the advance decision refuses life-sustaining treatment, it must be in writing, be signed and witnessed, and state clearly that the decision applies even if life is at risk.

5.7. **Commentary**: advance care plans are what the Mental Capacity Act 2005 refers to as advance statement of wishes. Section 4(6) of the 2005 Act requires decision-makers to consider a person's present and past wishes, in particular any written statement made when they had decisional capacity. Section 4(7) requires decision-makers to take into account anyone named to be consulted and anyone caring for the person or interested in their welfare. However, an advance statement of wishes is not legally binding in the same way as an advance decision to refuse treatment[14]. **Recommendation Five**: HSAB should seek assurance from all agencies that the distinction between advance care plans and advance decisions is understood.

5.8. In response to supplementary questions posed by the independent reviewer, the CQC commented on mental capacity as follows: *"as part of CQC's inspection activity we would look at what restrictions, if any, are in place and whether deprivation of liberty safeguard authorisations have been obtained and are being complied with. Providers are legally required to notify CQC of the outcome of a deprivation of liberty application. However, CQC does not have a role in assessing people's mental capacity. CQC's role is to assess the carrying on of regulated activities, to ensure that registered persons are complying with the regulations and conditions of registration. The regulations include regulation 11 (need for consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.*"

5.9. A theme identified in SAR Paulette related to the shortage of available placements. That theme recurs here. The continuing healthcare contribution from Whittington NHS Trust comments that some nursing homes declined to accept Rosemarie because of the complexity of her needs and that, prior to admission, Rosemarie had been nervous about whether the care setting could meet her needs. The family declined one possibility because of the distance from them. A potential move to live with one of her daughters had been organised, with district nursing arranged and an occupational therapist assessment completed and equipment delivered (bed, hoist, chair and other equipment set up), but Rosemarie died in hospital before the move could be made. The move had initially been delayed because of a lack of transport and subsequently because of Rosemarie's broken arm. The shortage of placements for individuals with complex

[11] GP and NMUH.
[12] Department of Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. London: The Stationery Office.
[13] Section 26, Mental Capacity Act 2005.
[14] Grimshaw, K., Brown, K. and Lyne, M. (2020) *Advance Care Planning*. Bournemouth University National Centre for Post-Qualifying Social Work and Professional Practice.

needs and/or challenging behaviours is a national issue that has been escalated to DHSC following identification in several SARs.

5.10. Adult Social Care Commissioners responded to the independent reviewer's supplementary question about placement availability. "*Evidence indicates a shortage of placements for individuals with complex needs through several observable impacts:*

- *Providers quoting prices significantly above NCL local price bandings for clients with complex needs.*
- *Instances where providers refuse to accept clients with complex needs.*
- *The necessity to place clients further afield due to local shortages.*
- *Prolonged hospital stays for clients, indicating delays in finding suitable placements.*

These factors collectively highlight the strain on available resources and the challenges in securing appropriate placements for individuals with complex needs, thereby affecting timely and suitable care provision."

5.11. The ICB also commented on the shortage of suitable placements. "*Evaluation of care markets, and identifying gaps, particularly for people with complex needs, has taken place across all care groups and is used to develop and improve the market. This has been done formally with system partners and using iterative processes using commissioning data, to plan for care provision across the five local authority areas. Care is at times commissioned from providers on the AQP framework.*"

5.12. Participants at the learning event recognised the challenge posed by the shortage of nursing home placements for patients with complex needs.

5.13. The continuing healthcare submission from Whittington NHS Trust also draws attention to the COVID-19 pandemic and the restriction on visits to care homes by family members, practitioners and regulators.

5.14. The Whittington Health written submission notes the absence of any detail in relation to what were Rosemarie's wishes and goals. The care setting's written submission is the only contribution that explicitly references making safeguarding personal. This is in the context of Rosemarie expressing a wish regarding repositioning that was contraindicated. The care setting have commented that they "*felt*" that Rosemarie had mental capacity for this decision and therefore acted in accordance with what they believed to be her wishes. **Commentary**: given that there were concerns about Rosemarie's level of insight being expressed at the time by healthcare practitioners, a formal mental capacity assessment would have been advisable.

5.15. At the learning event it was stated that data on making safeguarding personal is very positive but that there is a gap in the involvement of families when safeguarding concerns are referred. There had, however, been some good work informing families and requesting feedback in the provider concerns and improvement work with the care setting.

5.16. Rosemarie's daughter has provided rich detail that connects mental capacity with making safeguarding personal. It is questionable how far practitioners who knew Rosemarie appreciated this level of detail. "*Mum was fully aware of her condition; she was simply stubborn. In the past when the (hospital) doctors wanted to do a mastectomy she said she came with her breast and she's going back to God with them. I think emotional reasoning/spirituality and religion sometimes made mum seem like she didn't have insight or lacked understanding, but she was fully aware of her condition. Mum and I would often have conversations about her declining mobility and impending death, we prayed together which I have on video while she was in the nursing home, she said 'God if this is my moment I'm bracing it,' thanked God for her children and prayed for peace in the world. She also told me that she often feels scared when left alone in the nursing home room because she had lost her mobility and worried that they would abandon her and she could fall and no one would come to help her.*" **Commentary**: a common finding in SARs is how little we know about the individuals with whom we are working.

5.17. A further theme in SAR Paulette focused on wheelchair services and that theme recurs with respect to Rosemarie. The Whittington Health written submission observes that a referral was accepted by wheelchair services towards the end of September 2021 but no assessment appears to have been completed. **Commentary**: when there are concerns about the amount of time residents are spending in bed and/or their rooms, it is essential that care settings have sufficient equipment to support mobility and social interaction.

5.18. Rosemarie's family have also commented on equipment concerns. They have observed that her bones were weak as her cancer had metasised and this meant that she could not sit up straight or use normal wheelchairs. She required equipment for re-positioning. They have commented on the lack of incontinence pads and dressings, and that incontinence pads would be left on for 6-7 hours. When present, her family would change them more frequently. The home's wheelchairs could not be used by Rosemarie so the family sourced and purchased a specialist wheelchair but staff never used this to mobilise Rosemarie. She would have liked to leave her room and visit the reception or garden for a change of scenery. She was not helped to leave her room. Rosemarie's family raised their concern that she had been admitted to the nursing home without the proper equipment in place. One motivating factor for the arrangements put in place for Rosemarie to leave the care setting to live with her daughter was the lack of focus on all aspects of her wellbeing.

5.19. Hospital discharge was also a concern to emerge in SAR Paulette. In response to a supplementary question asked of all agencies by the independent reviewer on lessons to be learned about hospital discharge of patients with complex needs, the ICB commented as follows. "*A Safeguarding System Discharge and Safety Planning Protocol has been developed to support multi-agency practitioners ensure the safe and timely discharge of children, young people, and adults across the North Central London (NCL) population. The protocol is intended to ensure that all practitioners across all agencies are clear about the steps to take to ensure that no child or vulnerable adult is discharged from hospital within the NCL footprint into an unsafe environment, where their health or well-being may be compromised or where further significant harm could occur. In respect to adults being discharged into unsafe condition, this may require further discussion and liaison with community services who are following up the post discharge aftercare*

in the community. Health and social care practitioners will work in partnership to decide when this is an appropriate option. Learning from unsuccessful hospital discharges is a crucial component of the peer and restorative supervision provided to staff within the directorate. This learning also informs the escalation and market development processes."

5.20. At the learning event an observation was shared that a care setting is put under pressure to facilitate discharges especially for people with a learning disability or mental health need. Echoing earlier comments about support for care settings, support might be promised but was not always forthcoming[15]. It was suggested that care settings do not always receive sufficient information to ensure an appropriate mix of residents, and that care settings might not as a result be sufficiently prepared.

5.21. Rosemarie's family have also commented on hospital discharge. They have observed that Rosemarie was admitted to the home sooner than the home expected but there was never any welcome conversation or information given (for example one of her daughters received parking tickets because relevant information was not given).

5.22. At the learning event, it was also noted how challenging the market is and how difficult it can prove finding places to be able to discharge people with complex care needs. People potentially have to remain on the wards for periods of time because there is not a correct discharge destination. To some degree the challenge had been mitigated through use of the assessor role within some of the hospitals to ensure there is a really good understanding of the person and whether they are mentally fit for discharge and the level of support that those individuals would need[16]. Participants also expressed some optimism that the introduction of the localities model had resulted in significant improvement in multi-agency communication, for example for hospital discharge. However, further improvements were necessary to improve pathways and embed multi-agency working.

5.23. **Commentary**: Successful hospital discharge requires that a care setting has all available information about a patient's needs prior to admission and that follow-through services will be available to ensure that their mental and physical health needs are fully met.

5.24. A further theme to emerge has been family involvement. Rosemarie's family feel that they were labelled as complainers and have commented that "*staff seemed vexed to see us*." However, they believe that it was necessary to advocate for their mother/sister. In general they point to poor communication with them and believe that, had they been involved in the care setting's investigation of safeguarding concerns, they could have corrected inconsistencies in the account being given.

5.25. Echoing concerns expressed by family members in SAR Paulette, Rosemarie's family point to disagreements with the care setting about their involvement in their mother/sister's care and

[15] Support from mental health practitioners was highlighted as one example.
[16] Currently there is no single patient record. Information-sharing, it was suggested, might be improved when all agencies have access to the developing London Care Record.

about what they were providing, for example in relation to treating her pressure sores. A recliner chair that the family provided was never used. They believe that more could have been done to appreciate and respond to her cultural needs, noting for example that the family provided “rags” (flannels) and other toiletries, important in Caribbean culture.

5.26. Research[17] has sometimes found a fear of expressing complaints. Rosemarie’s family believe that their concerns were often dismissed by external agencies and the care setting, and that they and their mother were reluctant to complain because of the fear that Rosemarie would be victimised. **Commentary**: the CQC inspection report published in July 2022 comments that improvements had been made by the care setting to the management of complaints since the previous inspection in June 2018. **Recommendation Six**: CQC should be invited to comment on the care setting’s current management of complaints.

5.27. Both Rosemarie and Mearl had relatives who maintained oversight and who were alert to symptoms of deterioration and ill-health, and to poor care standards. **Commentary**: this observation invites a question about who advocates for those residents who cannot rely on a family circle of support. There were no Healthwatch enter and view reports for the timeframe considered in this review. Statutory rights to advocacy might not extend to the quality of care and treatment experienced by residents. This gap in advocacy provision has been noted in other SARs, for example focusing on learning disabled people in supported living[18].

5.28. Prior to the learning event, the care setting had commented that family meetings had been reintroduced, with mixed results. At the learning event the involvement of families was recognised as really important. Participants recognised that there is some learning from this review, from SAR Paulette and from ongoing complaints to different agencies about the importance of communicating back to families what is going on, even when it is news that they do not want to hear, for example delays in finding an appropriate placement . The culture of communicating and engaging with families needed to be heavily emphasised to pre-empt complaints, distress and confusion, and to enable families to cope with difficult situations.

[17] Braye, S. and Preston-Shoot, M. (2016) Practising Social Work Law (4th ed). London: Palgrave Macmillan.
[18] SAR Bill and Jim (2024) Somerset SAB.

Concluding Discussion

6.1. The purpose of this review has been to enable HSAB and its partners to reflect on how services worked together to ensure that residents in a care setting are safe and that their care, support and health needs are fully met.

6.2. The recommendations in SAR Paulette are being implemented by HSAB and its partners, and those recommendations remain pertinent. HSAB's quality assurance sub-group and SAR implementation group have been given the governance responsibility for the improvement plan relating to this care setting and that should provide a level of assurance to HSAB and its partners about the quality of care in this care setting and to enable any further corrective action that might become necessary.

6.3. Both Rosemarie's family and Mearl's son have strongly criticised the lack of attentiveness to the health care needs and wellbeing. Mearl's son, for example, has commented on the "*high level of staff turnover which impacted on my mother's continuing care. Caring staff were far and few between as a result*." He has observed that when staff moved on, this impact on the continuity of care and, sometimes, on the lack of personal care and attentiveness. Rosemarie's daughter raised concerns with senior staff in the care setting, including via email about manual handling before the injury that resulted in her final admission into hospital. That injury could potentially have been avoided if the expressed concerns had been heeded. There are strong resonances between their observations about care quality and those expressed by Paulette's family. As we know, Rosemarie's family planned for her discharge so that they could care for her at home. Mearl's son asked that his mother be moved. That was also a feature in SAR Paulette. Mearl's son has recounted how his mother asked him to buy presents for staff "*to encourage them to treat me better*."

6.4. The independent reviewer cannot express too strongly that the focus on care quality must be persistent and proactive, not reactive. External agencies, and the scrutiny they offer, "must be present."[19] That learning is a clear message from SARs on organisational abuse.[20] It requires adequate resources to be available to commissioners, safeguarding teams, hospital and community-based services, and regulators to provide support to care settings and to monitor the quality of care.

6.5. The independent reviewer has been informed that CQC now has an inspector dedicated to working in Haringey and liaising with the local authority and other partners. This inspector attends regular information sharing meetings and is able to identify themes of concern from multiple sources. Where CQC has information indicating a significant risk to service users CQC has the resources to respond to concerns and to undertake inspections. CQC cannot respond to all potential risks and therefore uses a triage system to focus its regulatory response where significant risks to service users have been identified. This review has also noted the improved

[19] Observation from Margaret Flynn relating to SAR Bill and Jim (2024) Somerset SAB.
[20] For example, SAR Whorlton Hall (2023) Durham SAB; SAR Joanna, Jon and Ben (2021) Norfolk SAB.

level of resourcing intended for commissioners, although additional resources for contract monitoring and quality assurance are currently not in place. Oversight by HSAB of the improvement plan provides some level of assurance about care quality going forward. However, SARs on organisational abuse have found that providers are not always able to sustain improvements and have emphasised the importance of the relationships between health and social care safeguarding teams, health and social care commissioners and CQC. **Recommendation Seven**: HSAB should consider seeking assurance, at least annually, about how safeguarding teams, commissioners and CQC are working together to prevent abuse/neglect in care settings and to address concerns when they arise and are referred. This should include assurance regarding reviews of care plans for in-authority and out of authority placements.

6.6. SAR Paulette invited HSAB and its partners to consider what would be Paulette's legacy. This review invites HSAB and its partners to consider the same question in relation to Rosemarie and Mearl. In particular, what ambitions do services aspire to for the provision of care, support and treatment for people with complex needs? Are commissioned providers enabled and supported to meet those ambitions through the environments they provide and the knowledge and expertise of their staff. Guidance[21] is available for commissioners and providers about what good looks like, the components of high quality care. **Recommendation Eight**: HSAB should consider requesting that commissioners and providers include in provider forum meetings a focus on learning from, and monitoring the quality of local provision against available guidance, in a way that clearly articulates goals and actions to meet the questions posed in this section of the report.

6.7. As already stated, the recommendations in SAR Paulette remain relevant and will not be repeated here. However, HSAB should ensure that the recommendations regarding the availability of specialist (wheelchair) equipment, use of multi-agency risk management meetings (including under section 42), recording (for example of pressure ulcer damage) and mental capacity (and deprivation of liberty safeguards) are fully implemented.

6.8. Three themes emerged from this review that were additional to the three explicit key lines of enquiry. They relate to hospital discharge of patients with complex and co-occurring needs, making safeguarding personal for residents with complex and co-occurring needs in care settings, and understanding of law and practice surrounding advanced care planning and advance statement of wishes or decisions. **Recommendation Nine**: HSAB should consider a programme of audits regarding hospital discharge of patients with complex and co-occurring needs, making safeguarding personal for residents with complex and co-occurring needs in care settings, and understanding of law and practice surrounding advanced care planning and advance statement of wishes or decisions.

[21] For example, Preston-Shoot, M. and Lawson, J. (2019) Making Safeguarding Personal for Commissioners and Providers of Health and Social Care: "We can do this well." Local Government Association and ADASS. Also, Preston-Shoot, M. (2020) Practical Examples of Making Safeguarding Personal from Commissioners and Providers of Health and Social Care: "we are doing this well." Local Government Association and ADASS.

6.9. The Pan-London procedures for adult safeguarding are currently being revised. HSAB should consider sharing the learning from this review about the interface between adult safeguarding concerns (section 42), provider concerns procedures, police investigations and CQC inspection.

Recommendation One: HSAB should consider seeking assurance at least annually of how commissioners have taken forward their recommendations regarding resource allocation and information-sharing to improve proactive engagement with care providers.

Recommendation Two: HSAB should consider seeking assurance about the outcome of service reorganisation in BEHMHT, and about the provision of mental health support for residents and staff in care settings.

Recommendation Three: HSAB should consider initiating dialogue across partners about how to achieve best evidence, including how to manage decision-making about whether investigations relating to care quality can or cannot be conducted in parallel. HSAB should also consider adding this review to an escalation by the national network for SAB chairs to DHSC regarding the need for guidance on achieving best evidence[22].

Recommendation Four: HSAB should consider inviting the ICB to lead on a discussion of how to further improve the monitoring of, and response to pressure ulcers, acquired in the community and/or in hospitals. The establishment of pressure ulcer panels would enable tracking of data and how occurrences are being prevented and/or addressed.

Recommendation Five: HSAB should seek assurance from all agencies that the distinction between advance care plans and advance decisions is understood.

Recommendation Six: CQC should be invited to comment on the care setting's current management of complaints.

Recommendation Seven: HSAB should consider seeking assurance, at least annually, about how safeguarding teams, commissioners and CQC are working together to prevent abuse/neglect in care settings and to address concerns when they arise and are referred. This should include assurance regarding reviews of care plans for in-authority and out of authority placements.

Recommendation Eight: HSAB should consider requesting that commissioners and providers include in provider forum meetings a focus on learning from, and monitoring the quality of local provision against available guidance, in a way that clearly articulates goals and actions to meet the questions posed in this section of the report.

Recommendation Nine: HSAB should consider a programme of audits regarding hospital discharge of patients with complex and co-occurring needs, making safeguarding personal for residents with complex and co-occurring needs in care settings, and understanding of law and practice surrounding advanced care planning and advance statement of wishes or decisions.

[22] A process begun as a result of SAR Clive (Staffordshire and Stoke SAB).

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