Report of the Safeguarding Adults Review regarding April

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1. Introduction

1.1 Why this case was chosen to be reviewed

The Hampshire Safeguarding Adults Board (SAB) decided this case should be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014 because following the death of April, who passed away in acute hospital; this was found to have been a *partially avoidable* death at the Trust's Mortality Review Panel. It was therefore determined that there was 'reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult' and that the 'SAB knows or suspects that the adult has experienced serious abuse or neglect'.[1]

1.2 Pen picture of April

April was described as a bright and cheerful lady who was always immaculately presented. She was an outgoing person who knew her own mind and was considered by the professionals working with her, and her family, to be alert and oriented to time and place with no cognitive dysfunction and capable of making decisions about her life. As she aged, she became frailer and after surgery for a bowel tumour in 2013, moved to live with her daughter. She was however still managing to climb the stairs to her bedroom daily and enjoyed an active social life with her family, who supported her to leave the home for social activities using a wheelchair. April's family also described her as stoical with a high tolerance of pain.

1.3 Timeframe

The review covers the period between July 2018 and 11th January 2019 which was the day April died.

1.4 Terms of Reference

The purpose of a SAR is described in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring. In order to focus that learning as part of developing the terms of reference the SAB agreed some broad research questions that would be explored in the review. These were as follows: -

- What does this case tell us about the factors that influence professionals' ability to work in accordance with the 'Family Approach Protocol', and in a multi-agency holistic manner, to safeguard adults?
- What are the effects of resource shortfalls on the ability of professionals in Hampshire to deliver safe and effective care to vulnerable older people?
- What does this case tell us about how well professionals know and understand the thresholds for raising safeguarding alerts in response to neglect?

[1]section 44 of the Care Act 2014 (1b and 3b) http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

1.5 Methodology

Statutory guidance requires SARs to be conducted in line with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. In addition:

- "there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively." [2]

This review uses the SCIE Learning Together methodology and looks to identify system wide issues. The methodology included:

(i) all agencies completing a brief report on their involvement with April;
(ii) the Reviewer analysing these reports and seeking related documentation as required;
(iii) the Reviewer interviewing some key professionals to gather additional information;
(iv) two workshops facilitated for representatives of all key agencies, with a focus on understanding why front-line staff directly involved in the case acted as they did;
(v) interviews with key family members.

1.6 Reviewing expertise and independence

The review was led by Fiona Johnson, an independent social work consultant accredited to carry out SCIE reviews. She has had no previous direct involvement with the case under review. The lead reviewer has received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.7 Methodological comment and limitations

1.7.1 *Perspectives of the family members* – The lead reviewer and a member of the review team met with April's daughters who were able to provide significant information about April and the services provided to her during 2018. Their contribution was freely given, and they were keen to contribute to the process in order to enable improvement of services.

[2] (DoH,14:138) section 14 of the Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

1.7.2 *Participation of professionals* - The lead reviewer and the review team have been impressed by the professionalism, knowledge and experience that the case group (the professionals from all agencies involved with April) have contributed to the review. In most cases individuals reflected on their own work openly and thoughtfully which significantly enhanced the review process.

1.7.3 *The review team* – Members of the review team provided significant assistance to the lead reviewers both in identifying and accessing relevant documents and in assisting to facilitate the workshop. They were also key when developing the findings providing the wider over-view of service delivery and reflecting on the extent to which practice in this case reflected wider systemic issues.

1.7.4 The review took longer than expected because of difficulties in accessing information from Portsmouth Hospital trust which have now been resolved.

1.8 Structure of the report

The Findings section has two main parts: -

- The Appraisal of Professional Practice which provides an overview of 'what' happened in this case and 'why'. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team's judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects of the case the explanation for 'why' will be further examined in the 'Findings in Detail' and a cross reference will be provided. More specifically, this section provides an overview of professional practice in this case whilst acknowledging the difficult and complex task that frontline practitioners face.

- The appraisal is followed by a synopsis of the views of family members which gives their perspective on the services provided to April as well as enabling greater understanding of her attitude and personality.

- The 'Findings in Detail' section identifies the key messages of learning that have emerged from the review of the services provided to April and elaborates on the areas within the safeguarding system which require strengthening in order to improve future outcomes for vulnerable adults.

2 The Findings

2.1 Appraisal of professional practice in this case: a synopsis.

2.1.1 This review was concerned with April, a woman in her late 70s, who had previously had bowel cancer and was under hospital review. A recent scan had identified a slow growing lung tumour that was not considered to be life threatening and was treatable. April was aware of this diagnosis because she had received a telephone call from the hospital. She had not shared the information with her family, with whom she lived and who provided her care. The only professional outside of the hospital who knew of the possible diagnosis at this stage was the GP.

2.1.2 The period under review began with a sudden loss of mobility resulting in the family requesting the GP to visit April. The development of this case hinges on the clinical misdiagnosis by the GP of April's hip fracture that it is now known to have caused her loss of mobility. The GP involved assessed that the loss of mobility was probably caused by arthritis. She did not arrange for an x-ray to rule out a fracture because April indicated she did not want to go to hospital and the GP thought that it would be very difficult for her to access outpatients because she could not go downstairs independently. There is no record of these discussions with April and the GP was unaware that the ambulance service could have arranged to transport April downstairs. It is not uncommon for hip fractures in elderly people to be overlooked through clinical examination alone which is why an x-ray is important. **The systemic issues that influence GPs decision making in these situations are discussed further in Finding 1.**

2.1.3 This diagnostic error led to services being arranged that were focused on increasing April's mobility, which would have been right if her lack of mobility was caused by arthritis but was harmful given her hip fracture. The physiotherapy service are clear that if there is any chance that a patient has a fracture they will not intervene emphasising again the need for an x-ray.

2.1.4 Even if the package of health care support had been correct for the diagnosis, the SAR Review Team identified problems in its delivery. There were delays in service provision, largely due to workload pressures. The package of support provided was not integrated and community nurses, physiotherapists and occupational therapists assessed and delivered their care separately and (in a context of significant work pressures) in a task focused manner. This reduced the likelihood that their observations could have triggered a further assessment of the causes of April's lack of mobility. For example, for a significant period the community nurses visiting did not realize that April's mobility had deteriorated to such an extent that she was no longer sleeping in her bed but was effectively 'chair-bound'. **The lack of integration in service provision makes it less likely that concerns about possible clinical misdiagnosis around hip fractures will be picked up, is discussed in Finding 2.**

2.1.5 As a result of not receiving appropriate treatment and her total immobility, April's health began to deteriorate; she developed pressure sores and a

secondary infection. These were treated by the community nurses and GP however none of this was put in the context of her cancer diagnosis. April's reduced mobility also meant that she had not attended hospital appointments regarding the treatment of that cancer, albeit that the treatment was not urgent. This left concerns for the SAR Review Team about her understanding of the prognosis and potential for treatment. It also meant her family, who throughout the review period provided extensive and exemplary care and acted as an advocate for her to get services, remained unaware of the diagnosis.

2.1.6 The family also requested support from Adult Social Care on two occasions but were told they could not be supported immediately as there was a waiting list and people with more urgent needs were being prioritised. The appraisal of practice identified that Adult Social Care were experiencing resource pressures that was affecting assessments which were being prioritised to those where there was a risk of immediate breakdown in caring arrangements. **This was not prioritised as a finding as the SAR Review Team understands that this issue has been addressed by senior managers in the Locality Area however the SAB may wish to receive a report on how this has been progressed.**

2.1.7 There was also a lack of awareness by the health professionals, involved with April, that she had a very high tolerance of pain and did not tell people how poorly she was, meaning they were less aware of how severely she was deteriorating. This was exacerbated by a lack of continuity of care by most services and the absence of a key worker with a responsibility to foster a relationship with the woman. **Systemic issues that make it harder to establish relationships and so deliver person-centred care, are discussed in Finding 3.**

2.1.8 Eventually more appropriate supports were provided, namely a pressure bed. However, the community nurses reported that current practice for ordering equipment in Hampshire meant that while they could order a bed, they could not order bed sides. On the first night after the bed was provided April was found by her family half out of the bed having rolled over and almost out of the bed. **The processes for ordering equipment for patients in the community are discussed further in Finding 4.**

2.1.9 April's health deteriorated to such an extent that she had to be admitted to hospital late at night. Unfortunately, the care provided immediately after admission was less than adequate and there were delays in providing a catheter, undertaking pressure sore assessment and replacing incontinence pads. This was due to a changed structure of nursing care meaning there was too much work for any one person to do. **The CCG and hospital trust have addressed these issues so this has not been prioritised as a finding of this SAR however Hampshire SAB may wish to receive a report from the Hospital Trust about current practice.** Once the day staff came on duty the errors were rectified and April was provided with good palliative care, however she was very ill and died later that day.

2.1.10 After April died, clinicians involved in her care raised concerns about the care that she had received, both in the community and immediately on her admission to hospital. Whilst there was a full review of the care provided in the community the processes for a systemic review in the hospital were not fully followed. This omission was rectified when the review team raised a further concern with the hospital trust.

2.2 Views of the Family

2.2.1 The daughters reported that one day in November, when April was upstairs, she was heard to cry out in pain and from this point on, she could no longer mobilise. This occurred the day before an oncology appointment regarding her previous cancer. April did not attend the appointment because she was not able to get down the stairs. The daughters advised that they were not told of April's lung cancer until she was admitted to hospital in January 2019.

2.2.2 On the day of the incident, the family called the GP who visited and assessed April. The daughters advised that the GP said that she was '99% sure' that April had not sustained a fracture. The daughters described their mother as screaming in pain and that she could not bear to be moved. They contacted the GP again regarding a possible infection in April's nose. They understood that following this contact a further referral was sent to community services.

2.2.3 In January 2019, April's skin on her legs was in a poor condition. The daughters were unhappy that they overheard one community team staff member stating to their mother that 'you're going to lose that toe'. On the last visit to April, she was very confused, and family requested a review as they thought she might have sepsis. Later, when she was admitted to hospital, the family state that the hospital said that April's legs were infected.

2.2.4 The daughters said they contacted Hampshire County Council for support during the period between November and January. HCC advised that they had over 200 people on their waiting list and that April was not an emergency. The family said they were told if circumstances changed to call back. The family explained they did this when April had deteriorated so much that they had to lift her from the chair to the commode as she could not transfer. Following this second contact with HCC, community services attended April and the daughters thought this was related.

2.2.5 The daughters questioned why the GP referred April to Occupational Therapy and Physiotherapy instead of having an x-ray in hospital. The daughter also said that when April fell out of bed ('was hanging out of the bed') they moved the bed so that she was facing the wall. April was only able to lie on one side due to the pain she was experiencing. The daughters confirmed that April had a very high pain threshold.

2.2.6 The daughters had no concerns regarding the response by the ambulance service in January 2019 but confirmed that there were delays in hospital staff fitting her with a catheter. The daughters also described hearing from the hospital staff information about April's cancer and the hip fracture and reported that this was very distressing for them. The daughters felt that April

would have been more comfortable in the last months of her life if her hip fracture had been diagnosed in November 2018 and that they should have been told about her lung cancer. They felt this would have supported them as carers and they would have been more prepared to manage her deterioration.

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

2.3.1 The SAB agreed broad research questions at the start of the process, which go beyond the facts and issues in this case, to look more widely at the safeguarding adults' system within the area that is the responsibility of the Hampshire Safeguarding Adult Board. The questions are set out at in paragraph 2.3.2 and directly link to the areas covered in the appraisal of practice and the findings. The major focus of the research questions was regarding professional understanding of safeguarding in the context of neglect and the impact on services of limitations in resources within services.

2.3.2 The first research questions concerned professionals' ability to work within the 'Family Approach Protocol', and in a multi-agency holistic manner, to safeguard adults. It was agreed early in the review that this protocol was not relevant to the services provided to April and therefore the review did not provide any learning regarding this issue.

2.3.3 A significant part of the review was spent considering the effects of resource shortfalls on the ability of professionals in Hampshire to deliver safe and effective care to vulnerable older people. The review identified pressures across the professional system and showed how this impacted both on individual professional's ability to raise concerns about a possible misdiagnosis but also on the capacity of professionals to build meaningful relationships with the individual client that would enable a better understanding of their response to pain. It also identified that pressures within ASC meant they never were fully involved in supporting April and her family. These matters are explored further in Findings 2 and 3.

2.3.4 The third research question was concerned with professionals understanding of neglect. The Care Act 2014[3] requires a local authority to promote individual wellbeing in all it does, including 'protection from abuse and neglect' however it does not define neglect. Age UK in the fact sheet 78 'Safeguarding older people from abuse and neglect' defines it as: -

> *'…. ignoring medical, emotional or physical care needs; failing to provide access to appropriate health or care and support; or withholding the necessities of life, such as medication, nutrition and heating (whether intentional or not). Not enabling access to assistive equipment like hearing aids, walking aids, or dentures may be neglect….'* [4]

[3] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[4] Factsheet 78 Safeguarding older people from abuse and neglect December 2019 https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs78_safeguarding_older_people_from_abuse_fcs.pdf

In the event it was agreed that, whilst the care provided by the family to April was exemplary and that provided by professionals was adequate, April did experience neglect as she did not receive the services she required. Essentially, the misdiagnosis in November 2018 and the absence of a multidisciplinary assessment meant that April did not receive the right support. This was not because of a failure by individual professionals to understand neglect, rather it reflected the complexity involved in diagnosing hip fractures, which are examined further in Finding 1. There were also pressures within the system meaning there was no multi-disciplinary holistic assessment and ASC had insufficient resources to provide an immediate service. These pressures resulted in a multi-agency act of omission rather than deliberate neglect.

2.3.5 The review also identified some limitations in the current practice for ordering equipment for older people in the community which are detailed in Finding 4.

2.3.6 Finally the review also identified some problems with the Serious Incident Reporting processes within Portsmouth Hospital Trust which have not been explored further as they are outside the scope of the review and are being addressed by that trust.

2.4 Summary of findings

The review team have prioritised 4 findings for the SAB to consider. These are:

	Finding	Category
1	**Frail elderly patients can experience fractures without a history of falls making them difficult to diagnose and leading to inappropriate treatment being provided which highlights the importance of x-rays being used in their diagnosis.**	Professional norms & culture around multiagency working in assessment
2	**The silo nature of service provision makes it unlikely that concerns about clinical errors will be picked up through multi-disciplinary working and care planning. This increases the likelihood that inappropriate treatment is provided, causing suffering to the older person concerned.**	Patterns in human–management system operation
3	**A lack of continuity in people providing services makes it difficult for staff to engage with service users and understand the complexity of personal and inter-personal dynamics, potentially leaving staff without the knowledge they need, and a lack of personalised care for the older person themselves.**	Patterns in human–management system operation
4	**The perception by Community nurses in Havant that they can order a bed but are not able to do a risk assessment about whether or not bedsides are also needed increases the chance that people who need bedsides do not get them in a timely fashion**	Professional norms & culture around multiagency working in assessment

2.5 Findings in Detail

FINDING 1: Frail elderly patients can experience fractures without a history of falls making them difficult to diagnose and leading to inappropriate treatment being provided which highlights the importance of x-rays being used in their diagnosis. *Professional norms & culture around multiagency working in assessment*

Description

Hip fractures most commonly occur from a fall or from a direct blow to the side of the hip. Some medical conditions such as osteoporosis, cancer, or stress injuries can weaken the bone and make the hip more susceptible to breaking. In severe cases, it is possible for the hip to break with the patient merely standing on the leg and twisting. These fractures are known as pathological fractures (also called insufficiency fracture or fragility fracture) are bone fractures caused by disease that leads to weakness of the bone structure. This process is most commonly due to osteoporosis[5], but may also be due to other pathologies such as cancer. Fragility fractures are fractures that result from mechanical forces that would not ordinarily result in fracture, known as low-level (or 'low energy') trauma. The World Health Organization (WHO) has quantified this as forces equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fracture. Other factors that may affect the risk of fragility fracture include the use of oral or systemic glucocorticoids, age, sex, previous fractures and family history of osteoporosis. As the longevity of the population increases, so will the incidence of osteoporosis and fragility fracture.

Fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They may also occur in the arm (humerus), pelvis, ribs and other bones. Hip fracture nearly always requires hospitalisation, is fatal in 20% of cases and permanently disables 50% of those affected; only 30% of patients fully recover. Projections suggest that, in the UK, hip fracture incidence will rise from 70,000 per year in 2006 to 91,500 in 2015 and 101,000in 2020. [6]

The most common way to diagnose a hip fracture is by an x-ray and if an older person has a fall and is in pain then the usual response would be for them to be seen immediately in hospital. If they are seen after the event and the older person is still in pain, then it is also usual to arrange for an x-ray. In the absence of evidence of a fall causing the pain the medical practitioner would diagnose from several possible causes which could include arthritis as well as a hip fracture. The most usual medical response to a hip fracture is surgery which is an emergency with increasingly strong evidence that early surgery—on the next available trauma operating list—is associated with a lower risk of death and incidence of pressure sores.[7]

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[5] Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture. Osteoporosis leads to nearly 9 million fractures annually worldwide, and over 300,000 patients present with fragility fractures to hospitals in the UK each year. Because of increased bone loss after the menopause in women, and age-related bone loss in both women and men, the prevalence of osteoporosis increases markedly with age, from 2% at 50 years to more than 25% at 80 years in women. BMJ 2012; 345 doi: https://doi.org/10.1136/bmj.e3698 (Published 08 August 2012)

[6] https://www.nice.org.uk/guidance/cg146/evidence/full-guideline-pdf-186818365

[7] Management of hip fracture M. A. Fernandez†,*, X. L. Griffin‡, and M. L. Costa British Medical Bulletin, Volume 115, Issue 1, September 2015, Pages 165–172, https://doi.org/10.1093/bmb/ldv036

How did the issue manifest in this case?
In November 2018 April suddenly experienced pain and from that point on had limited mobility. The GP visited and in the absence of evidence of a fall determined that April's lack of mobility was caused by arthritis in her knee. The GP did consider whether April had a hip fracture but could not see any evidence of it however she reports with hindsight that it was difficult to assess as April was unable to straighten her leg because of the arthritis. It is unclear whether the GP considered the possibility of a fragility fracture or took into account that April had osteoporosis (diagnosed in 2015). There was also no evidence that the GP fully considered the significant shift in April's mobility now the family member's reports of her experiencing sudden increased pain. The GP was aware that April had lung cancer and was due to be seen for a follow-up appointment therefore her focus was on enabling April to become sufficiently mobile as to attend the hospital. To this end she referred April for physiotherapy and occupational therapy. The GP was also anxious not to admit April to hospital as April had indicated that she was reluctant to go there.

How do we know it is an underlying issue and not something unique to this case?
There is significant guidance available about the management of patients with osteoporosis who are at risk of fragility fractures however most of this is focused on prevention of fractures rather than diagnosis. There is little guidance for GPs or other health professionals on diagnosis of hip fractures in the absence of a fall and the CCG representative on the Review Team reported that they are aware that a number of Serious Incidents where GPs have failed to identify fractures that occurred in the absence of trauma. They have used various local channels (training sessions and newsletters) to communicate this risk and increase awareness.

How common and widespread is this pattern?
Around 76,000 hip fractures occur each year in the UK as a whole.[8] The Public Health Outcomes Framework reported an age-standardised rate of emergency admissions for a hip fracture in people aged 65 or over as 575 people per 100,000 in 2016/17.[9] 1 in 2 women and 1 in 5 men over the age of 50 are expected to break a bone during their lifetime as a result of osteoporosis.[10] Data regarding the numbers of people experiencing fragility fractures or fractures where there is no known fall are detailed below.

Year	Number of patients in Hampshire suffering fragility fractures and/or fractures where there is no known fall[11]
2017	1636
2018	1958
2019	1872

It has not been possible to estimate how many people in Hampshire experience hip fractures as this data is collected nationally by hospital and they provide services to

[8] National Hip Fracture Database Annual Report 2018 https://data.gov.uk/dataset/3a1f3c15-3789-4299-b24b-cd0a5b1f065b/national-hip-fracture-database-annual-report-2018
[9] NICE impact falls and fragility fractures https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/measuring-uptake/NICE-Impact-falls-and-fragility-fractures.pdf
[10] ibid
[11] Data provided by Catherine Mead Professional Safeguarding Lead Adults Portsmouth Hospitals NHS Trust

a wider geographical area. Currently there is no data collected regarding delay in diagnosis or misdiagnosis of hip fractures.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
Without appropriate supports to enable better diagnosis GPs and other health professionals will struggle to identify hip fractures meaning that older people will not receive treatment in a timely manner. In the absence of better guidance individual practitioners may fail to identify patients with hip fractures which will result in an increase in deaths of people suffering hip fractures.

FINDING 1: Frail elderly patients can experience fractures without a history of falls making them difficult to diagnose and leading to inappropriate treatment being provided which highlights the importance of x-rays being used in their diagnosis.

Difficulties in diagnosing hip fractures in frail elderly patients where there is no known history of a fall mean that GPs may fail to identify the condition resulting in the older person receiving no treatment or inappropriate treatment. The long-term impact of this is likely to result in the older person being extremely ill or possibly dying as the prognosis for hip fractures is poor particularly if the right treatment is delayed.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is there a need for a more formal nationally disseminated form of education for GPs and other health professionals about diagnoses of fractures in the elderly in the absence of trauma or a low level of trauma?
- What does the Board know about how common this issue is?
- Does the Board think data should be collected on the numbers of people experiencing hip fractures where there is delayed diagnosis?

FINDING 2: The silo nature of service provision makes it unlikely that concerns about clinical errors will be picked up through multi-disciplinary working and care planning. This increases the likelihood that inappropriate treatment is provided, causing suffering to the older person concerned. Patterns in human–management system operation.

Description

In South-East Hampshire community nursing, physiotherapy and occupational therapy services are provided by Southern Health NHS Trust and are entitled Integrated Care Teams. The web-site for the services says that '*Our teams are made up nurses, therapists, practitioners, assistants and support workers who work together to provide care and treatment in your home and local community…..We carry out a holistic assessment of your rehabilitation and care needs and then develop an individual treatment plan'.*[12] On admission to the Integrated Care Team, the patient should receive an initial holistic assessment which is located on the electronic patient record. Each professional then contributes their speciality to the electronic patient record for example wound assessment from community nursing, mobility assessment for physiotherapy. In addition, at the time of the incident, each service completed their care plan according to the care that the professional was supporting. This resulted in many care plans for each patient focussed on the clinical process of delivering care. Recent changes have included the formulation of one care plan visible on the electronic patient record to all health care professionals involved in the patients care and is driven by the patient identifying their goals and needs to support independence and recovery. This care plan is also printed off and placed in the patients record at home and shared with the carer.

How did the issue manifest in this case?

The GP making the initial referral for support for April was unclear exactly what was needed so made two referrals to the Integrated Care Teams describing her needs and requesting initially an assessment of support that could be provided to her to avoid her admission to hospital, both these referrals included reference to her new cancer diagnosis. This GP assumed that the Integrated Care Team would then provide an integrated package of support. The referral was triaged to the community therapy team who carried out a telephone triage with April and rated the referral as routine and the case was placed onto the therapy waiting list.

Two weeks later, when April began having problems with swollen ankles leading to fluid leakage in her feet, a second GP referred April directly to the Community nurses asking for her feet to be dressed, this referral was a specific request for wound management and did not include any further details regarding April becoming immobile or that she had a possible cancer diagnosis. This referral was not processed through the Integrated Care team and the nurses did not see the earlier referrals from the first GP so were unaware of the possible lung cancer. The nurses started visiting immediately but they were task-oriented on care delivery focussing on the toe wounds and not examining the wider picture. There was no holistic assessment that explored why a previously mobile person declined in her mobility to a position where she was suddenly chair-bound. There was also no multi-disciplinary assessment or discussion despite the rapid deterioration in April's overall health. In

[12] https://www.southernhealth.nhs.uk/services/community-services/integrated-care-teams/

January 2019 the occupational therapist visited but by this time April was bed-bound and she died two days later.

How do we know it is an underlying issue and not something unique to this case?
The MDT is defined as a Multidisciplinary team with health and social care providers whose purpose is to provide: 'Person centred care to achieve quality, efficiency, access and customer satisfaction'. Each MDT will be based around a neighbourhood of GP practices with a combined population of 30,000 to 50,000. The team is made up on community nursing, physiotherapy and occupational therapy, social worker, GP, Older Persons Mental Health and the Complex Care team. The meeting is coordinated by an administrator and the plan of care is documented in the electronic patient record, with an indicator of when the patient case should be reviewed. At the time of the incident the local multidisciplinary team did not have GP engagement and had lost a direct access function to the social worker. In addition, the weekly meeting was in a developmental phase, instigated by the Primary Care Network formation, which was aimed at promoting GP engagement through a dial in facility.

How common and widespread is this pattern?
Potentially this applies to all patients referred to the Integrated Care Team in South East Hampshire. Across Fareham & Gosport & South East Hampshire Community Nursing & Therapy teams between 2018-2019 there were around 24,000 referrals of which for Havant and Waterlooville therapy this constituted around 2,500 referrals. For Havant Community Nursing this constituted around 2,500 referrals.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
Given that clinical diagnosis can be difficult, and individual practitioners may on occasion make errors, it is essential that the wider safeguarding system is alert to this possibility and is able to identify when patient's presentation does not match the perceived condition. An integrated assessment process and delivery of care is more likely to enable this to happen that an ad hoc delivery of services in isolation.

FINDING 2:
The silo nature of service provision makes it unlikely that concerns about clinical errors will be picked up through multi-disciplinary working and care planning. This increases the likelihood that inappropriate treatment is provided, causing suffering to the older person concerned.

when there is a lack of a holistic assessment of care needs by the Integrated Care Team, if there is a clinical misdiagnosis by the GP, this is less likely to be identified as individual professionals will focus purely on their area of service provision and are less likely to consider the wider causes of a person's ill-health.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the board know about how Integrated Care Teams are working across Hampshire?
- How will the linking of health and social care through integrated intermediate care affect practice in this area?
- How does the training of professionals address the issues/risks associated with silo working?

FINDING 3: A lack of continuity in people providing services makes it difficult for staff to engage with service users and understand the complexity of personal and inter-personal dynamics, potentially leaving staff without the knowledge they need, and a lack of personalised care for the older person themselves. Patterns in human–management system operation.

Description

It is well-established good practice that continuity of care provides service users with a greater opportunity for a relationship of trust. Good and lasting therapeutic relationships flourish in a culture that values interpersonal care and within organisations that offer enough opportunity to see the same professional. '*Personalised care and support planning is a systematic way of ensuring that individuals …and their health and care professionals have more productive and equal conversations, focused on what matters most to that individual'*[13]. A key component in developing personalised care is the involved professionals having enough time to develop a relationship with the service-user which does require a degree of continuity of care.

At the time of this review the Havant Community Nursing Team supported 8 General Practices, with a practice population of 81,256. They worked as part of the multidisciplinary team which comprised of physiotherapy and occupational therapy, and Older Persons Mental Health. The team comprised 26 WTE funded posts, of which 22.5 WTE were nursing staff. At the time of the review there were 6.2 WTE nursing vacancies which included 3.6 WTE unregistered staff. In addition, there was limited backfill available through agency provision (0.6WTE registered only). The average dependency of visits was 214 units (each 15 mins is one unit) with an average number of staff on duty 11.7 WTE. This indicates that capacity was available to meet demand. Community nursing services were provided over a wide geographical area with a combination of Health Care Assistants (HCA's) and qualified Community nurses providing care. HCA's were providing the bulk of the care, but individual patients should have been visited every third visit by a qualified nurse. Terminal cancer care patients were prioritised for qualified nursing care.

The Nursing workload was allocated daily, and work was allocated based on staff skills and competency, alongside clinical need and taking account of geography. Nurses & HCAs are now assigned to Primary Care Networks[14] providing a smaller rotation of staff to patients. This also improves consistency and continuity of care.

How did the issue manifest in this case?

The community nurses received the referral from the GP on 10th December 2018 and started visiting the next day. Initially they were visiting twice weekly but as April's health deteriorated the visits increased to every other day and then daily. Most visits were undertaken by HCA's because there was a shortfall in required numbers of qualified nursing staff. April was visited for a five-week period and in that time, she was visited by 1 Student nurse, 6 HCA's, 2 Community Staff Nurses and 1

[13] Personalised care and support planning handbook: NHS England https://www.england.nhs.uk/publication/personalised-care-and-support-planning-handbook-the-journey-to-person-centred-care/

[14] A primary care network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Primary Care Networks: Frequently Asked Questions: NHS England https://www.england.nhs.uk/wp-content/uploads/2019/04/pcn-faqs-000429.pdf

Community Team Clinical Lead. Given the lack of consistency in the personnel providing the service it is unsurprising that individual practitioner's knowledge of April's personality and wishes and feelings was limited and that it largely focussed upon the task in hand. During the review it became apparent that professionals were unaware of April's high tolerance of pain alongside a desire to avoid hospital admission.

How do we know it is an underlying issue and not something unique to this case?
Members of the case group reported that the work allocation and community nursing service provision for April was typical and they confirmed that a shortage of qualified nurses and a high level of need for nursing for patients with terminal cancer meant that there was significant pressure in the service.

How common and widespread is this pattern?
Potentially this applies to all patients receiving community nursing in South East Hampshire. Between 2018-2019 there were around 2,500 referrals for Havant Community Nursing. There is currently no data recorded about continuity of care provided to patients receiving community nursing services.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
If effective personalised care requires continuity of care in service providers and it is not possible to ensure that this is reliably provided; its absence will result in less effective safeguarding of vulnerable adults and to them receiving sub-standard care.

FINDING 3: A lack of continuity in people providing services makes it difficult for staff to engage with service users and understand the complexity of personal and inter-personal dynamics, potentially leaving staff without the knowledge they need, and a lack of personalised care for the older person themselves.

Continuity of care is an essential ingredient for the effective provision of personalised care. Where a service user is unable to build a trusting and meaningful relationship with the professionals providing their care then that professional will not understand fully the needs and personality of the patient resulting in less effective care being provided and potentially safeguarding issues being overlooked.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the board know about practice in this area?
- Has the change in practice whereby a link nurse is allocated to a Primary Care Network improved continuity of care for patients?
- Does the Board think that agencies should be requested to provide information regarding how continuity and consistency of care is provided?

FINDING 4: The perception by community nurses in Havant that they can order a bed but are not able to do a risk assessment about whether or not bedsides are also needed increases the chance that people who need bedsides do not get them in a timely fashion. *Professional norms & culture around multiagency working in assessment.*

Description
In Hampshire usual practice is that whilst community nurses may order a bed for a patient, they would not undertake a risk assessment regarding whether 'bed-sides' were required. 'Bed-sides' are not routinely provided because they present risks to a mobile patient who is confused and may attempt to climb over the sides which would risk them falling and hurting themselves. To order 'bed-sides' a risk assessment must be undertaken, and an additional form completed that identifies the clinical need for bedsides.

How did the issue manifest in this case?
The community nurses became aware in mid-December 2018 that April was sleeping in her chair because she could not tolerate laying on a bed due to the hip extension. Community nurses discussed with April providing her with an alternative bed, but she initially refused this. Eventually this was discussed with April with family members present and she agreed to a bed being ordered. A request was made by the community nurses to Joint Equipment Services for the provision of a profiling bed and associated alternating pressure relieving air mattress. 'Bed-sides' were not ordered, despite them being requested by April's family, as community nurses cannot order them unless an OT has undertaken a risk assessment and authorised their provision. The bed and mattress were delivered and installed on the 8th January 2019; the next day the first Occupational Therapy Home visit took place. It was observed that the bed had no rails, an assessment of risk was undertaken, and rails were ordered. During the evening of the 9th January 2019, April partially rolled out of bed.

How do we know it is an underlying issue and not something unique to this case?
This was reported by staff at the workshop to be usual practice in Havant however the Review Team did not consider that it was usual practice across Hampshire.

How common and widespread is this pattern?
In 2019 it is reported that approximately 4,460 beds were issued in Hampshire and that most of the beds were provided with 'Bed-sides'.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
The current custom and practice that prevents community nurses from ordering 'bed-sides' means that, even when it is apparent that there are significant risks in leaving a patient without this protection, they are unable to provide the best equipment for vulnerable older people. The effect of this practice could be that an older person would be left in a risky environment without effective protections.

FINDING 4: The perception by community nurses in Havant that they can order a bed but are not able to do a risk assessment about whether or not bedsides are also needed increases the chance that people who need bedsides do not get them in a timely fashion.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the board know about practice in this area?
- Are the Board confident that this issue is limited to Havant?
- What does the Board know about how this applies to risk assessments regarding other equipment that is ordered?

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high-risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009).

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

- **a.** **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?
- **b.** **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
- **c.** **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
- **d.** **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known but are less helpful for puzzles that present more difficult conundrums.
- **e.** **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5 Typology of underlying patterns

To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively? They are presented in six broad categories of underlying issues:

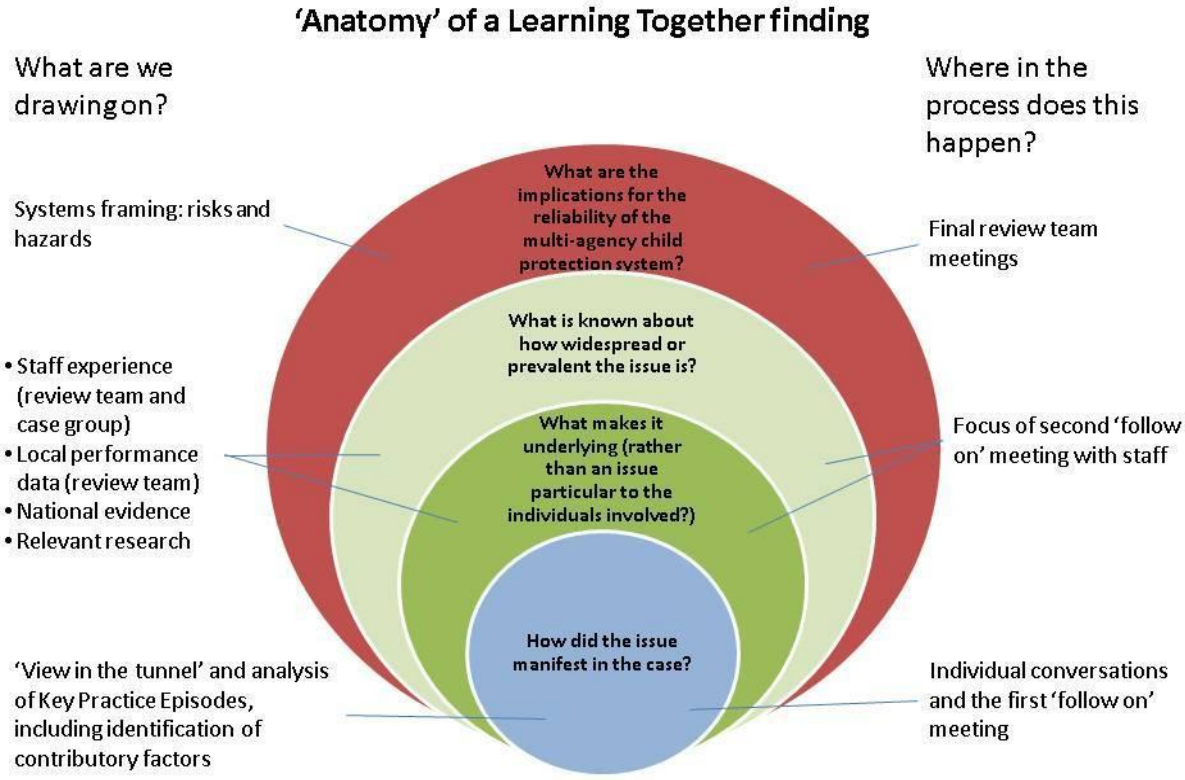
1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

6 Anatomy of a finding

For each finding, the report is structured to present a clear account of: -

- How the issue manifests itself in the particular case?
- In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. Illustrated below.



7 Review Team and Case Group

7.1 The review team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by an independent lead reviewer, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The review team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

7.2 The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.
In this case review,

7.3 **Structure of the review process**

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The review team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings. The sequence of events in this review is shown below:

Date	**Event**
September 2019	Introductory meeting for the Review Team and Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.
25/10/2019	Workshop with Review team and Case Group • identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case • appraising the practice in these KPEs • considering what was affecting the work/workers at the time (the 'view from the tunnel')
4/2/20	Meeting with the Review Team who were provided with a draft report which set out the emerging underlying patterns and findings and where the Review Team were asked to consider whether these are specific to this individual case or pertain more widely and form a pattern.
12/3/2020	A follow-up meeting with the Review team and Case Group to agree the final report.
27/4/2020	SAR/Practice Learning Review Group – to consider the draft final report
TBA	SAB meeting – to consider the draft final report
TBA	Publication of the report

7.4 Scope and terms of reference

Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

Appendix 2 - Glossary

ASC	Adult Social Care
CC	Care Coordinator
CCG	Clinical Commissioning Group
GP	General Practitioner
HCA	Health Care Assistant
MDT	Multi-disciplinary team
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCIE	Social Care Institute for Excellence

Appendix 3 – Bibliography

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