**SAFEGUARDING ADULT REVIEW** **REPORT**

**A THEMED REVIEW**

Older Women, the involvement of family members and the impact of complex health needs managed in the community

**(Mrs N and Mrs O)**

**TOWER HAMLETS**

**SAFEGUARDING ADULTS BOARD**

**Report of Mick Haggar & Fran Pearson**

**PUBLICATION DATE XXXXX**



**Version 16 Completed 14\_12\_2022 Fran Pearson \_archive THSAB**

**Version 17 Completed 23\_04\_2023 Fran Pearson \_archive THSAB**

**What this report is about**

**1.1** This review used the sad cases of Mrs N and Mrs O to explore three complex adult safeguarding issues that Tower Hamlets Safeguarding Adults Board wanted to learn from and make changes.

* **1.2** The implications for multi-agency working around the discharge to home of an older person to be supported by an extensive set of community health services, and using the professional practice that we saw in Mrs N and Mrs O’s cases, to test out how safe current systems are.
* **1.3** The pressure that having a family member or close friend with increasing care needs can place on carers, and the challenge for professionals of working with family members who feel they have little option but to take an older relative in. At the root of this professional challenge is how to fully understand what pressures might influence a family carer who finds themselves suddenly pivotal in supporting a proposed hospital discharge and large, complex care package.
* **1.4** The way our system supports professionals to make crucial assessments of risk that reflect whether or not an older person has or does not have the mental capacity to make specific decisions that impact on their discharge, or how mental capacity affects an older person’s description of how they manage at home.

**An explanation of why this report has taken so long to get to publication**

**2.1** Mrs N and Mrs O’s cases were agreed to meet the criteria for Safeguarding Adults Review in the first few months of 2020. Initially the review was scoped to cover one of these older women and a reviewer appointed. Due to unforeseen personal circumstances, first one, and then a second independent reviewer had to withdraw from writing this report. Mick Haggar was appointed in May 2021 to pick up the review which had now become a commission to look at Mrs N and Mrs O together because there were common systems issues which were a feature of both their cases. Mick worked tirelessly with professionals at workshops and in 1:1s; with Mrs N and Mrs O’s families, and in his extraction of the critical information from a range of documentary sources for the review.

**2.2** When it came to develop recommendations, relevant board members and their colleagues did this at two workshops. During this process it became apparent that the context and policy around hospital discharge for older people had changed significantly since 2019 when Mrs N and Mrs O sadly died. As a result, Mick’s work provides the evidence base for our conclusions and recommendations but services, legislation, pressures on the system and factors such as cost of living, meant that we needed to focus on the recommendations which are very much for 2023, rather than go over outdated practice models and systems risks.

**2.3** The Care and Support Statutory Guidance that Safeguarding Adults Boards follow states that [Safeguarding Adults Review] reports should:

* provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible,
* be written in plain English,
* contain findings of practical value to organisations and professionals (14.178)

**2.4** In this instance the sound analysis has taken place and is referred to in the Findings and Recommendations. It is not included at length for the reasons set out at the start of this section. This report focuses on the views of Mrs N and Mrs O’s family carers and on the ‘findings of practical value to organisations and professionals’.

**Mrs N and Mrs O and their families**

**3.1** Both Mrs N and Mrs O were aged 88 at the time of their deaths. They were both White British women who had managed proudly and independently all their lives until a mounting number of health conditions ended this. Mrs N had managed for a period in supported housing but it was fraught with problems and her increasing frailty led her and her family to conclude that their only option was to move in with her son. For her part, Mrs O was also dealing with the very recent loss of her husband which the evidence base for our review shows was hugely significant for her mood. This caused her to also move in with her son. Distressing circumstances were therefore, in both Mrs N and Mrs O’s cases, the reason for these urgent moves into an adult child, of a different gender’s, home.

**What family members told us**

**3.2** On behalf of Tower Hamlets Safeguarding Adult’s Board, I would like to offer condolences to Mrs N and Mrs O’s families. I would also like to thank them for taking part in the earlier stages of this review and to respect and acknowledge that this long process has been too long for them.

**3.3** Mrs N’s son and daughter and Mrs O’s son contributed to the review by commenting on some early findings of the independent evaluation of their care. This enabled two things to happen – Mrs N’s family talked specifically about central issues which are picked up in the findings and recommendations.

* They explained clearly how, having multiple different professionals delivering care and assessing risk related to Mrs N’s care, made it easier for this determined woman to assert that she did not need help. This in turn caused a dilemma for her son as her carer.
* They talked about the problems of securing Lasting Power of Attorney for their mother. This was their personal perspective on a much wider issue which the independent review identified as the consistent application of the Mental Capacity Act.
* Mrs N’s son specifically said that after one of his mother’s frequent hospital admissions, he was not aware how unwell she was. **All these issues are addressed in the findings and recommendations.**

**3.4** Mrs O’s son kindly made factual corrections around an earlier account of his mother’s care.

**Revised Findings and Recommendations for Themed SAR**

**4.1** This section contains the priority findings from this review. It includes selected references to examples from the work done with Mrs N and Mrs O because the context is now so different, and policy and practice has changed since 2019 and early 2020. In order for Tower Hamlets Safeguarding Adults Board to gain assurance, recommendations have to be ones that can be measured and which benefit older people in Tower Hamlets. Above all they have to be achievable recommendations. As a result, findings from this review reflect the system which professionals work in. And recommendations were developed with the organisations involved in the review, or the commissioners of relevant services.

**4.2** At heart, the review about Mrs O and Mrs N was about:

* The implications for adult safeguarding around the discharge of an older person to community services.
* The pressure that having a family member or close friend with increasing care needs can place on carers, and working with them to truly understand how their loved one manages at home and how a family carer views a proposed discharge.
* The way our system supports professionals to make crucial assessments of risk that reflect whether or not an older person has or does not have the mental capacity to make specific decisions that impact on their discharge, or how mental capacity affects an older person’s description of how they manage at home.

**4.3 Below are the findings which reflect the following 4 key areas of learning for practice reviewed in both cases.**

* **Hospital Discharge Processes,** Finding 1. Recommendations 1 (a-c).
* **Community Health and Social Care Coordination,** Findings 2, 3. Recommendations 2a & 3a.
* **Assessments of mental health and mental capacity,** Findings 4, 5. Recommendations 4a & 5a.
* **Working in partnership with carers,** Finding 6. Recommendation 6 (a & b).

**5.1 Finding One**

**Hospital discharge for older people is a very challenging experience for services, the older adults themselves and their families. Since the cases of Mrs N and Mrs O, the environment in which different organisations work together on discharge plans has also subsequently been significantly affected both by the impact of the Covid-19 pandemic and at around the same time, a change in requirements for discharge, Discharge to Assess[[1]](#footnote-2).**

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

Although the context of 2019 was very different to that of 2023, Mrs N and her family experienced a substantial reduction in a care package in one instance, which may have been based on a well-intended but inaccurate assessment of what Mrs N said she needed. Mrs O has multiple hospital admissions and assessments and her care package increased steadily but without clear review of its effectiveness.

Moving to 2023, Tower Hamlets Safeguarding Adults Board needs assurance around relevant current multi-agency work on hospital discharge. This is important because the Covid 19 pandemic disrupted established ways of working, and the SAB needs a clear assessment of risks and strengths.

**Recommendation 1a**

Barts Health Trust to work with partners to develop a tool which supports staff in identifying what a complex discharge is and what the trigger is for escalation to integrated discharge hub.

**Recommendation 1b**

Barts Health Trust to provide clarity to the Safeguarding Adults Board that relevant professionals and care providers are invited to ‘Multi-Disciplinary Teams’ meetings to enable safe transfer of care. This will vary from patient to patient depending on their needs.

**Recommendation 1c**

NHS Adult Safeguarding Lead for the Integrated Care System to work with Head of Adults and Children’s Safeguarding at Barts Health and report back on whether any existing governance forum could compare best practice in discharge arrangements across Northeast London, with what is done elsewhere and ultimately share findings with the Safeguarding Adults Board.

# Finding 2

Mrs N and Mrs O both experienced variable coordination of their care, which the independent review suggested could be due to lack of clarity about roles and responsibilities and was clearer in some parts of the borough than others. The independent review made a link between lack of clarity about roles and responsibilities and duplication of care which the SAB now needs to test out via current work underway in this area.

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

# Mrs N had input from

# Her GP.

# An In-reach nurse, as part of the Admission Avoidance and Discharge Service.

# The Extended Primary Care Team, including a Mental Health Liaison Nurse.

# The Memory Clinic.

# We know from her family that she felt overwhelmed and confused by all the different people involved and as the review set out to address - despite this level of input, there were no Mental Capacity Assessments, Risk Assessments or Safeguarding Referrals raised, where these were indicated during this time period.

# Mrs O had input from

# Her GP.

# An In-reach Nurse.

# An Occupational Therapist.

# District Nursing visits.

# Recommendation 2a

# A pilot project for care coordination of services for older adults in Tower Hamlets has been undertaken. The Named Professional for Safeguarding Adults at East London Foundation Trust and Pilot Project Lead from North East London ICB to present the learning from the above pilot project and the implications for adult safeguarding.

# 5.3 Finding 3

# Person centred practice is recognised to be important but is compromised by frequent changes of professionals having brief contact with adults for specific tasks, rather than being able to build up a rapport with adults and their families. This also makes it difficult to consistently assess change over time and the impact, effectiveness and compliance of care services being provided.

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

# In both cases there were multiple handovers of the case, with several different social workers and District Nurses involved over a relatively short period of time. This caused issues with engagement with Mrs N and Mrs Ox, and their sons. It was noted the lack of continuity was associated with a social work focus on tasks rather than the whole person, while escalation of risks was also delayed and assessments/referrals for safeguarding were assumed to be someone else’s responsibility, due to the number of teams involved.

# Recommendation 3a

Adult Social Care Services to assure the SAB that an allocated social worker from one team is assigned so that once a referral is received for Care Act assessments or safeguarding enquiries, these can then be either be completed with sufficient and timely contact with the adults and their carers, or with clear guidance agreed to complete this, before a case is transferred onto another team.

# 5.4 Finding 4

# Older adults with mental health as well as physical health problems are at increased risks, especially where they do not receive appropriate mental health support. This can pose an additional barrier to their ability or motivation to engage with recommended therapy and care. Earlier diagnosis and treatment of their mental health would also assist in improving the viability of plans to meet physical health needs.

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

After Mrs N moved into Tower Hamlets to live with her son, her GP referred her for further memory assessment to complete a process that had begun before her move – this did not happen. Further, attempts to assess her memory whilst she was a hospital inpatient, were also missed. Eventually a joint visit of relevant professionals – as recommended by the Royal College of Psychiatrists – resulted in a diagnosis of dementia for Mrs N.

# Mrs O was noted to be suffering from psychological issues resulting from the death of her husband, affecting her confidence and motivation to engage. There was also a query during her hospital admissions that she had declined cognitively. No conclusions were reached on either issue.

# Recommendation 4a

The SAB to receive assurance that the current dementia screening pathways and services are sufficient and do not disadvantage the needs of adults referred for assessment where they are admitted to hospital**.**

National Institute for Health and Care Excellence (NICE) Guidelines Quality Statement for assessments of people with dementia states that. “People with suspected dementia are referred to a specialist dementia diagnostic service if reversible causes of cognitive decline have been investigated. [2010, updated 2019]. Evidence of local referral criteria and pathways to ensure that people with suspected dementia are referred to a specialist dementia diagnostic service”.

# 5.5 Finding 5

# 4.5.1 This review found that thresholds and responsibility for undertaking formal Mental Capacity assessments are not consistently applied. Records of assessments are not completed, to support opinions about capacity, this should be formally assessed, especially where adults are known to be at risk of harm from refusal to engage in services offered to them.

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

# 4.5.2 Mrs N’s capacity was questioned by District Nurses, but not assessed despite her reluctance to engage with health and social care services. Her son was recorded as having Lasting Power of Attorney for her, but this was not clarified, and the independent review pointed out that no decisions were taken in her Best Interests, because the necessary Mental Capacity assessments to precede such a process did not happen.

# 4.5.3 Despite Mrs O’s GP querying her capacity at a specific time (when she was in placement of ‘step down’ care after one hospital admission) the independent review found no records of an assessment at this time or subsequently.

# Recommendation 5a

Tower Hamlets Safeguarding Adults Board has several pieces of relevant work to seek assurance on in order to assess the quality of multi-agency work around older people and mental capacity. Barts Health carry out regular audits around older people in hospital and separately there is a pilot project for carrying out and recording Mental Capacity Assessments for health-related decisions – both of which the Safeguarding Adults Board can track through its Quality Assurance Sub Committee. And finally, the SAB itself has a priority on Self Neglect with a strand of work on Mental Capacity which has twice yearly oversight back to the SAB.

**5.6 Finding 6**

Family carers who take responsibility to meet aspects of a relative’s personal care may not always fully understand the impact this may have on them or the cared for person, particularly if the cared for person is reluctant to accept support from them or formal care. This can prove particularly difficult when there is limited time for practitioners to arrange hospital discharge.

**Examples for Mrs N and Mrs O and subsequent national policy changes and updated research**

Mrs N and Mrs O were both looked after by their adult sons who faced expectations from their mothers and from professionals, compounded by gender difference and unfamiliarity with caring.

A recent survey of carers undertaken by Carers UK identified widespread issues with how family carers felt they were involved in the process. **“Most carers were not assessed;** 82% of respondents disagreed or strongly disagreed when asked if they had received a Carer’s Assessment; Only one in ten appear to have been assessed (11% agreed or strongly agreed)”. [[2]](#footnote-3)

Recently guidance on support and hospital discharge from DHSC also identified this as an issue, that can affect the outcomes following adult’s returning home to be cared for by their families:

“Where there is disagreement between a person and their unpaid carers or family members, and the person is deemed by the appropriate professional to have capacity to make decisions relevant to their discharge, the person’s right to make these decisions should be respected. Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and care provision required to facilitate the individual’s choice, where possible, and enable a safe discharge.” [[3]](#footnote-4)

# Recommendation 6a

London Borough of Tower Hamlets Adult Social Care to ensure that carers’ needs are considered as part of the discharge process, and concerns about carers’ needs are flagged with the subsequent assessing team to ensure safety of the carer and cared for. Discharge considerations should include concerns identified with no engagement with care and support prior to discharge.

1. <https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf> [↑](#footnote-ref-2)
2. https://www.carersuk.org/for-professionals/policy/policy-library/carer-s-experiences-of-hospital-discharge-discharge-to-assess-model [↑](#footnote-ref-3)
3. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1087354/Hospital-Discharge-and-Community-Support-Guidance-2022-v2.pdf [↑](#footnote-ref-4)