# Safeguarding Adult Review

# Vera

# OVERVIEW REPORT

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## Acknowledgements

## Governance

The author can declare that he has no conflict of interest in completing this review, and that he is independent to Worcestershire Safeguarding Adults Board and partner agencies. The report has been commissioned by, and written for, the Board and overseen by a multi-agency panel of local senior managers and practitioners from the following agencies:

- Worcester County Council Adult Social Care (WCC ASC)
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)
- Herefordshire and Worcestershire ICB on behalf of Primary Care (HWICB)
- Worcestershire Acute Hospital NHS Trust (WAHT)
- West Mercia Police (WMP)
- West Midlands Ambulance Service (WMAS)

The details of the adult and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

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## 1.0 Introduction

1.1 Vera died in hospital in September 2023, after suffering a heart attack at home. She was a 76-year-old lady, who up until her death, had been living at home with her husband and more latterly her son, who cared for his parents.

1.2 Vera had a number of health conditions. Type 2 Respiratory Failure, which had many factors of need, including oxygen supplementation, posture control, use of a bilevel positive airway pressure ([1]BiPAP) machine night and day, and control of anxiety which affected her breathing. She also had stage 4 chronic kidney disease and type 2 diabetes.

1.3. Vera had a history of falls in the home leading to hospital admissions. In September 2022, following a Continuing Health Care[2] (CHC) Assessment Vera received care at home which was jointly funded by CHC and Worcestershire County Council. Vera had multiple care providers attempt to meet her needs commissioned through the Reablement Team Service.

1.4. In July 2023, Vera was admitted to Alexandra Hospital (Worcestershire Acute Hospitals NHS Trust – WAHT) and after two days transferred to Russell Hall Hospital (Dudley Group NHS Foundation Trust). Vera was discharged four days later.

1.5 In July 2023, Vera was re-assessed for CHC and a fully funded 24/7 wrap around nursing care at home was agreed. This care package was not initiated before she suffered a heart attack at home and was taken to hospital, where she died.

## 2.0 Why a review

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively, and additionally: -

- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults Board in Worcestershire to improve its services and prevent abuse and neglect in the future.

- Agree how this learning will be acted on, and what is expected to change as a result.

- Identify any issues for multi or single agency policies and procedures.

[1] A ventilator to assist for breathing

[2] NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals have to be assessed by integrated commissioning boards (ICBs) according to a legally prescribed decision-making process to determine whether the individual has a 'primary health need'.

- Publish a summary report, which is available to the public.

2.2 The Worcestershire Safeguarding Adult Review (SAR) sub-group considered the circumstances of Vera's death from the referral for a Safeguarding Adult Review by undertaking a rapid review. The sub-group was presented with information from all the agencies involved. The sub-group decided that the circumstances did not meet the criteria for a mandatory SAR but did feel that there were important areas of learning. The sub-group agreed that a discretionary SAR[3] should be undertaken.

2.3 Information was received from the following agencies:-

- Worcester County Council Adult Social Care (WCC ASC)
- Worcester County Council, Reablement
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)
- General Practitioner
- Continuing Health Care, Herefordshire and Worcestershire ICB
- Worcestershire Acute Hospital NHS Trust (WAHT)
- West Mercia Police (WMP)
- West Midlands Ambulance Service (WMAS)
- Dudley Group NHS Foundation Trust
- Department of Work and Pensions
- Care Providers
- University Hospitals of North Midlands NHS Trust

2.4 Terms of reference were developed which, identified several key lines of enquiry shown below: -

- Were safeguarding concerns appropriately progressed and resulted?

- What were the difficulties in securing and sustaining a Reablement Care Provider for Vera and how did this impact on her?

- How did the system of securing CHC for Vera work and is there any learning from this?

- Was the discharge from hospital in July appropriate, were all agencies involved with Vera aware of the discharge?

- If the discharge from hospital was deemed to have been reported as a problematic discharge, what was the outcome of this?

- What was the consideration of the family as carers?

[3] S44(4) Care Act 2014

- To identify any good practice.

It was agreed that the review would focus on the period 1st September 2021 to date of Vera's death on 14th September 2023.

## 3.0 Background and family views

3.1 The view of the family was that Vera strongly wished to remain in her home with her husband. On all occasions when formally assessed Vera had mental capacity and was able to make decisions regarding her health and care.

3.2 The family feel that Vera's condition was such that she clearly fitted the criteria for CHC and this should have been initiated in October 2022 when she was assessed, instead a joint agreement was initiated with ASC. This involved ASC and CHC sharing the cost of care. ASC providing the care during the day and CHC providing the care during the night.

3.3 It is the view of the family that this arrangement did not work and led to a series of providers being commissioned who did not have the required experience to care for Vera. They feel that the splitting of the funding led to the care not being consistent and support that should have been available at all times, only being provided at night.

3.4 This arrangement put extreme pressure on the family and in their view presented a risk to Vera. They believe that the situation also had a significant impact on her mental wellbeing.

3.5 CHC was again assessed in July 2023, and it was after a long wait agreed that Vera met the criteria for CHC, this was never initiated before she died. The family feel that Vera's health and circumstances did not change between the two CHC assessments and that CHC should have been initiated after the assessment in October 2022. This view is supported by other agencies involved in the care.

3.6 The family expressed a view that incorrect medication information was given to Vera and them when she was discharged from hospital in October 2022. This matter has been reviewed by the hospital and found not to be the case. This was communicated to the family in a letter from the hospital trust in June 2023.

3.7 The family believe that Vera was not given access to a BiPAP machine on admission to hospital in September 2023, shortly before she died. This has been reviewed by the hospital, and it has been established that Vera was supported by BiPAP on her admission. But once admitted a clinical decision was made not to continue this.

## 4.0 Narrative Chronology

4.1 In January 2021, Vera contracted Covid, she was suffering increased shortness of breath and was taken to hospital by ambulance. It was noted that at the time Vera had a background of heart failure, renal failure, was receiving dialysis three times a week, tricuspid valve disease and insulin dependent diabetes. She was admitted to the vascular unit for eight days.

4.2 In April 2022, Adult Social Care undertook a statutory annual review of Vera's care and as a result her care package was increased to include 60 minutes in the morning, in addition to 45 minutes at lunchtime, 45 minutes at teatime and 30 minutes at bedtime already in place. All calls were for two care staff.

4.3 In May 2022, Vera was visited at home by her GP and an Advanced Nurse Practitioner from the practice. This followed a concern raised by Vera's carers that she had a painful abdomen. It was believed that she was suffering from a Dependent Oedema[4]. Vera was reviewed by the Heart Failure Nurse and as a result there was liaison with the renal team.

4.4 On 10th June 2022 , there was contact between Vera's son's partner and the GP. The partner stated that a duty social worker had suggested there should be a multi-disciplinary team meeting (MDT). The family were concerned about Vera's dialysis and diet. There was also a discussion regarding occupational therapy (OT) for Vera as she was sleeping in a chair. There is no evidence of an MDT taking place.

4.5 The family stated that they were unable to manage Vera's insulin regime. The family said that Vera had developed pressure area damage, which was not being managed by the district nursing service. The GP had recorded that Vera did not wish for further investigations or input. This information was passed to the family, who understood Vera had mental capacity to make this decision. The GP was to arrange a visit to speak with Vera and the family, to arrange a referral to the district nursing service and once a social worker was allocated, for them to make contact with the GP surgery.

4.6 The same day, following discussion with the GP, an ambulance was called as Vera was suffering a shortness of breath. She was assessed and admitted to Russells Hall Hospital. During this stay the family raised concerns regarding Vera not being mobilised.

4.7 Vera was treated in hospital for community acquired pneumonia and discharged to Malvern Community Hospital on 29th July 2022.

4.8 On 5th July 2022, Vera was assessed in the ventilation clinic. It was noted that Vera lived at home with her husband and son. Prior to hospital admission she had care and support four times daily. She required oxygen at night and after walking short distances. It was noted that she had difficulty applying the oxygen mask and that her son and carers would require training to support her before she was discharged. The family recognised her difficulty, but Vera wished to return home. The family stated they would increase care if required. This information was included in the discharge letter to the GP.

4.9 On 4th August 2022, the GP discussed resuscitation with Vera, and it was agreed that a Do Not Attempt Resuscitation (DNAR) was put in place.

[4] Dependent oedema is specific to parts of the body that that are influenced by gravity, such as legs, feet, or arms.

4.10 On 31st August 2022, the family voiced concerns that Vera was being prematurely discharged from hospital, they were reassured that this was not the case. She was discharged from Malvern Community Hospital to Wyre Forest Rehabilitation Ward at Kidderminster Hospital.

4.11 On 22nd September 2022, Vera was reviewed by respiratory department. She was with her son. The son stated that Vera usually resided at home with her husband, who also had care needs. He stated that she would not be able to manage her ventilator. Discharge information was given to the son that Vera would require someone with her at night and they should be trained in the use of the ventilator prior to discharge.

4.12 On 29th September 2022, a request for a Continuing Health Care (CHC) assessment was received by the CHC team.

4.13 On 10th October 2022, ASC recorded that there was a joint funding for a package of care. CHC would fund the waking night support. The following day CHC records indicate that the CHC assessment had been completed and deemed that Vera was not eligible for CHC and that joint funding should be considered.

4.14 Later in October 2022, Vera's son's partner submitted a safeguarding concern of potential neglect. It stated that whilst undertaking dialysis her medication was not available and she went unmedicated, that she had lost her sitting balance due to being nursed in bed all the time, that she was discharged on a dialysis day and that she was discharged home without the care provider being trained in the Bilevel positive airway pressure (BiPAP) machine. This safeguarding concern was finalised in July 2023, as being partly substantiated. There was some learning identified between the ICB and HWHCT, which was taken forward.

4.15 The CHC Quality Assurance Panel (QAP), comprising of senior health and social care colleagues agreed joint funding for 7 hours waking night support. A hospital discharge date was to be agreed and a registered Treatment of Disease, Disorder of Injury (TDDI[5]) care agency was to be sourced.

4.16 On 26th October 2022, Vera's son contacted the hospital and CHC to request that on discharge a care provider supporting Vera's husband could be considered as they had also previously supported Vera. Enquiries were made but CHC were unable to commission this provider as they were not trained, and this provider did not offer clinical oversite and training. A discharge date of 31st October 2022 was agreed with a package of care to be provided by Saroia Care.

4.17 At the time of the discharge Vera's son's partner contacted ICB CHC, she was described as being challenging. The partner stated that there should have been an MDT

[5] TDDI - The provision of treatment for a disease, disorder or injury that is carried out by or under the supervision of a health care professional, or a team which includes a health care professional (or a social worker, or a team which includes a social worker, where the treatment is for a mental disorder). Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

prior to Vera's discharge from hospital. Later the same day the partner stated that the discharge should not proceed as Vera's husband was going to be admitted to hospital.

4.18 Vera was discharged as planned on 31st October 2022; she was seen by a district nurse the following day regarding insulin administration and was to be supported by the Reablement Service.

4.19 On 1st November 2022 Vera's son's partner contacted the Reablement Service and voiced concerns that the current care provider could not meet Vera's needs and that they had given immediate notice. Saroia Care identified a number of issues, including them finding family to be inflexible, that the care package was not sufficient for Vera's care, the hoist did not operate properly, and that the environment was cluttered. They stated after assessment they felt that there was a very high risk of safeguarding. No safeguarding concern was raised by any agency at this time.

4.20 The following day CHC spoke with Vera's son's partner who requested that Vera was returned to hospital as she felt the discharge was unsafe. She stated that when Vera was bought home no family had been present, and the care arrangements were not adequate to meet Vera's needs, and the care provider were not able to operate the BiPAP machine. It is clear that there was a lot of communication with the family at this time, but the family maintain that sufficient training for the carers on the BiPAP machine had not taken place.

4.21 On 2nd November 2022, a letter from the ventilation unit was received by CHC, informing them that the carers should be trained in the use of the ventilator (BIPAP) before Vera was discharged. This was actually after the discharge had taken place.

4.22 There is evidence that some of the family concerns were quickly addressed with a new hoist being ordered and delivered. There was also evidence of CHC following up with calls to the family. The son's partner complained about the care provider that they were not familiar with the BiPAP procedure.

4.23 On 13th November 2022, the family reported that there had been a medication error, and that Vera was being overdosed by the carers. This complaint was made to the 111 service who raised a safeguarding concern. When triaged this was resolved as an administrative issue.

4.24 On 17th November 2022, the care provider submitted a safeguarding concern by email, being unable to access the online portal. Their carers had witnessed a conversation between Vera, her son and her son's partner, which they perceived as the son and his partner being controlling towards Vera. This conversation involved Vera passing to them a power of attorney. There is no record of this concern being progressed further. The reason for this has been explored and it cannot be explained.

4.25 On 20th November 2022, Vera's son's partner made a complaint to CHC that Vera had been calling out at night, her son went down to her find the carer asleep. VERA's oxygen mask was not properly in place, and this presented a danger. Once CHC were made

aware of this situation a complaint was raised immediately with the provider and investigated, and staff member was removed.

4.26 An OT assessment found the home to be unsuitable for moving and handling, but it was established that both Vera and her husband wanted to remain at home.

4.27 The family continued to raise concerns and complaints regarding the care providers. The care provider was changed on several occasions, the reason for this was cited as the unreasonable expectations of the family.

4.28 On 27th January 2023, a reablement worker logged a concern that a carer reported that Vera mentioned in passing comment that she was frightened of her son and that he gets very hostile and 'dictates all of her life'. The carer also mentioned that Vera does tend to organise things around her son as she feels he will be cross if she or carers leave things around in property. This contact was closed by the reablement worker without any further action or apparent consideration of domestic abuse or coercive behaviour.

4.29 In February 2023, Vera's son made CHC aware that his mother had not been given her heart medication since Christmas. This was raised as a safeguarding concern by ASC, as this involved the day care. This was later resolved that it did not constitute a safeguarding concern as action had been taken to address the risk at the time of the concern being considered.

4.30 The medication issue was also subject of a complaint which was dealt with by the reablement service who acknowledged that they made an error with Vera's medication, the information from the GP at the time was that there had been no adverse effect. The reablement service addressed this by issuing a reminder to all staff completing assessments that they must ensure that when a Discharge Summary detailing medication is missing, they get a current list from either the discharging ward or the GP at the earliest possible opportunity.

4.31 In March 2023, Vera's care within ASC was transferred to the Wyre Forest Area Social Work Team. At this point she was receiving on a weekly basis, 57 hours (daytime) funded from WCC, and 49 hours (night) funded from ICB. This was a total of 106 hours weekly, each day call was 'doubled up', the night support was a single carer.

4.32 Vera's care package was allocated to an experienced social worker. The social worker made a request to CHC for the Decision Support Tool (DST) to be reviewed, which had been completed in October 2022.

4.33 In June 2023, the care provider supporting Vera at night raised a concern that the package was funded for a single carer at night. Vera was requesting re-positioning in bed which the carer was unable to do on their own.

4.34 Towards the end of June 2023, the ASC social worker and CHC liaised over Vera's case. The complications of Vera's care were discussed. Vera had mental capacity and wished to stay at home, the social worker had discussed this with Vera her family and the fact

that it may come to a point where home care will not be safe, if this point was reached a meeting would be required to discuss the risks and consequences.

4.35 On 6th July 2023, a CHC DST was completed with Vera in her home, the scoring found one priority area, three severe areas, one high area, three moderate areas and three low areas. The CHC nurse referred to Vera's eligibility as 'obvious' and that there should be a permanent presence of a registered nurse. The care provider manager was present and stated that they were struggling to meet Vera's needs. The recommendation was for fully funded care.

4.36 The following day Vera suffered chest pains and was taken to hospital with a suspected heart attack. Vera was transferred to Russells Hall Hospital, due to her requirement for ongoing dialysis.

4.37 On 12th July 2023, the social worker made contact with Russell Hall Hospital to establish Vera's condition and spoke to the discharge coordinator. They were informed that she had suffered a large heart attack and was unlikely to return home soon.

4.38 The following day the social worker established that Vera was to be discharged home, contrary to the information received the previous day. The care provider raised concerns regarding her discharge and the current care package in place. The social worker made several attempts to contact the discharge team but was unable to gain a response.

4.39 Vera was discharged from hospital on 14th July 2023 (Friday), Russell Hall Hospital were aware there was a care package in place. She was re-referred to the district nursing team for administration of medication.

4.40 On 15th July 2023, the care provider made contact with the social work emergency duty team (EDT) stating that they did not have the correct medication when Vera was discharged. This was later resolved as a miscommunication in the prescription.

4.41 On 17th July 2023, the social worker submitted a problematic discharge form to the Russells Hall Hospital, on behalf of the family and care provider. This was not received by Russells Hall Hospital. It stated that there had been an attempt to discharge Vera on 13th July 2023 but there was no transport available. It was the view of the care provider that Vera had been discharged without appropriate medication, heading into the weekend. Also, that the discharge letter mentioned a number of complications without appropriate guidance on how they would be managed. (This is commented on at 5.4.8 below)

4.42 There was some discussion between ASC and ICB CHC over the CHC scorings, which prevented the CHC DST being signed off until the end of July 2023.

4.43 In early August 2023, ASC have a record that they were contacted by CHC (not clear who) that there was a ratified CHC eligibility decision in place.

4.44 Vera's son made contact with ASC with concerns that the care provider was unable to meet Vera's needs. She had missed a medical appointment the previous week, due to

insufficient support to transport her. He stated he was concerned as Vera's mental health was declining. He was informed that there was now fully funded CHC in place and as such ASC (WCC), were unable to increase the current care package.

4.45 The family also made contact with CHC to find out when the fully funded care package would start. They were informed that this would require a provider being found and that they would approach the current day time care provider.

4.46 On 11th August 2023, the allocated social worker made contact with CHC to chase the ratification of the CHC decision. It would appear that the decision was awaiting sign off from seniors within CHC. CHC records indicate that the clinically approved commissioning care plan (CCP) had been forwarded to brokers to be sent to providers.

4.47 There is evidence that the position on the CHC funding was still being chased at the end of August 2023 and into September by ASC managers. It is apparent that the CHC complex care panel was involved and discussion around the care were ongoing in CHC.

4.48 On 1st September 2023, an ambulance was called to Vera's address on report of her having a shortness of breath after her carers had moved her. Vera was assessed by ambulance and left at home with advice to contact again if symptoms had not improved.

4.49 On 11th September 2023, the care provider stated an intention to withdraw the service, due to the risk to the staff by being asked to provide care at a level they were not equipped to do. The manager referred to the CHC decision, on 6th July 2023, which deemed the care being provided to Vera by the care provider as sub-standard to her needs.

4.50 On 12th September 2023, Vera was assessed on the phone by the CHC GP. Vera stated that that she had continued issues with her bowels and the need for care to support this.

4.51 The same day, an ambulance was called to Vera's address as she was suffering a shortness of breath. Vera was conveyed to hospital and admitted to the acute medical unit. Later that day She died. ASC, the care provider and CHC were all made aware.

4.52 Four days after Vera's death a letter from CHC was received which expressed that Vera would receive fully funded care.

## 5.0 Discussion

### 5.1 Were safeguarding concerns appropriately progressed and resulted?

5.1.1 During the time period in focus, Vera's family made two safeguarding referrals: -

- October 2022 – The family raised a safeguarding concern of potential neglect of Vera whilst she was a patient at Kidderminster Hospital. The concerns were that

whilst she was undertaking dialysis her medication was not available and she went unmedicated, that she had lost her sitting balance due to being nursed in bed all the time, that she was discharged on a dialysis day and that Vera was discharged home without the care provider being trained in the BiPAP machine.

- February 2023 – The family raised a safeguarding concern that Vera had not been given some of her medication since December 2022. This related to medication due to be given on the days that Vera was receiving he dialysis treatment.

5.1.2 Although these were two separate concerns, the safeguarding from October 2022 was not concluded until July 2023. At this time, it was concluded as partially substantiated. The March 2023 concern therefore ran in parallel with the October 2022 concern and the matters became conflated, as both involved similar concerns.

5.1.3 One of the matters raised in the first concern was the inability of the staff to effectively operate the BiPAP ventilator. This concern continued through November with the family raising concerns on two occasions (6/11/22 and 23/11/22).

5.1.4 These concerns were regarding the care staff having the necessary training to operate the BiPAP. Whilst there is evidence that care staff did attend some training (10/11/22), it would appear that these staff were then not always the staff involved in the care. The training also only included the staff caring during the night period and not those during the day. It had been recognised that Vera could require support of the BiPAP at any time. On one occasion Vera's son was disturbed at night by his mother calling out and when he went to investigate, he discovered the carer asleep and his mother with the BiPAP mask incorrectly positioned and his mother unable to breathe.

5.1.5 Although the concerns raised different issues, they point towards the same core issue of whether the commissioned care was able to appropriately and effectively meet Vera's complex needs. These safeguarding concerns were investigated over a protracted period (21 months), with other concerns being raised during this time. It would have been good practice for the care arrangements, including the joint commissioning to be reviewed during this investigation. This is subject of recommendation 4 below.

5.1.6 On two occasions care providers raised concerns with ASC regarding their perception that there had been controlling behaviour demonstrated by the son and his partner towards Vera. The first of these was witnessed by the care providers (November 2022) and the second was as a result of comments made to carers by Vera (January 2023).

5.1.7 Whilst these concerns were recorded there is no record of them being appropriately addressed. On the first occasion ASC phoned Vera and spoke to her, with her son and the partner present. This contact was indiscreet and potentially put Vera in a difficult position if not at risk. It is not clear whether elements of coercive control were present,

but on being reported they should have been further investigated further. This should have been triaged for a s42 enquiry and Vera spoken to alone to allow her to freely express any concerns that she had.

5.1.8 It is not clear why this did not happen. The fact that the son and his partner were seen as being difficult may have impacted on the conversations that were required to take place. This matter not being effectively addressed has left it unresolved. The family strongly refute any controlling behaviour towards Vera. The lack of appropriate investigation resulted in the family not being made aware of the concerns at the time and therefore not having the opportunity to give any explanation.

| **Recommendation one** |
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| ASC should ensure that all staff are able to recognise and take the appropriate action when there are concerns of coercive or controlling behaviour in a caring relationship. |

5.1.9 One of the safeguarding concerns took a considerable time to reach a conclusion. At this time Worcestershire Adult Social Care had a significant backlog of enquiries waiting to be progressed, this was recognised, and an action plan put in place to address and prioritise the backlog. This had been raised in another review, but reassurance should be put in place to ensure the situation has been resolved.

| **Recommendation two** |
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| Worcestershire Adult Social Care should provide reassurance to the Safeguarding Adult Board that any backlog in safeguarding enquiries has been addressed and continues to remain at an appropriate and sustainable level. |

## 5.2 How did the system of securing CHC for Vera work and is there any learning from this?

5.2.1 The first CHC checklist referral was received by the ICB In September 2022. The CHC DST was completed on the hospital ward. It was deemed that Vera was not eligible for CHC funding, but consideration should be given to joint ICB and ASC funding. It is the CHC position that Vera was assessed under discharge to assess in line with the National Service Framework for continuing health care in hospital, with the appropriate and quorate MDT and the recommendation was Vera was not eligible for CHC at this point.

5.2.2 It was agreed that CHC would fund waking night support as Vera required BiPAP machine support at night. It is recorded that in the ASC notes that if the BiPAP were to come lose Vera would be unable to adjust it due to her lack of dexterity.

5.2.3 Vera was due to be discharged from hospital with the joint funded care package at the end of October 2022. The CHC records show that they were trying to source a care provider, who was TDDI registered, to cater for the use of the BiPAP at night. CHC

sourced a care provider for the night care and ASC commissioned the same provider for the day care.

5.2.4 At this point of discharge there are records of the family contacting CHC and being concerned about the discharge. They requested a care company that were already engaged with the family caring for Vera's husband be used, but CHC stated that this was not possible as the care provider was not TDDI registered. The family were recorded as being challenging, but it was their view that there should have been an MDT before the discharge, which should have included the ambulance team, who conveyed Vera for regular dialysis. This was made subject of a complaint by the family, which was addressed by hospital trust. There was evidence of a number of meetings taking place, prior to the discharge, some of which included the family.

5.2.5 In September 2022, prior to the hospital discharge Vera was reviewed in the ventilation clinic. This clinic was part of the University Hospitals of North Midland Trust. During this clinic Vera's son was trained in the use of the BiPAP ventilator. It was recognised that nighttime carers needed to be aware on the use of the BiPAP and a letter was provided to highlight this in discharge planning. This was a complex hospital discharge with several agencies involved and it would have been helpful for an MDT to have taken place.

5.2.6 Hospital Discharge and Community Support Guidance states '*Multidisciplinary discharge teams and care transfer hubs (see section 5 of this guidance), comprising professionals from all relevant services across sectors (such as health, social care, housing, the voluntary and community sector), should work together alongside the person being discharged and their carer or family, where relevant, to plan the person's discharge.*'[6]

5.2.7 The guidance also recognises the need for family members and unpaid carers to be involved in the decisions, it is the strong view of the family that they were not involved in these decisions and that when they raised concerns, they did not feel heard and that issues like the occupational therapy review of the home were not considered prior to the discharge.

5.2.8 The day following the discharge, the care provider gave immediate notice to ASC. Nationwide also state that the discharge document mentions "complications", but do not state what these are or if the provision of care is needed to be changed or adapted. There is mention of "restricted fluids" with no mention of what the restrictions are or if this needs to continue after discharge. There is mention of "compliance" issues, without acknowledgement of these, or how this may affect the delivery of onward care. Nationwide say the document states "anti-embolism stockings" and "insulin", but not who is to deliver these as, following an assessment by their registered nurse, they were not prepared to input into the medical realm of care delivery. The care provider cited

[6] Hospital Discharge and Community Support Guidance, Department of Health and Social Care and NHS England, 2024

their rationale as 2 staff were unable to provide the care Vera required, that the family wished for female carers and the provider could not meet this need, although the family say that this is Vera's request. The care provider stated that the family were not flexible on call timings, that the hoist was not in a good condition and could not be operated due to clutter around it. They stated that '*there was a very high risk of safeguarding'*. The fact that the care agency was immediately unable to meet Vera s needs would indicate that they were not previously sufficiently involved in the discharge process.

5.2.9 At this time it would have been good practice for CHC and ASC to arrange a joint review of the care. There should have been consideration of an occupational therapy (OT) review of the environment and consideration of a safeguarding referral being raised on the information passed by the care provider.

5.2.10 When the experienced social worker became involved in March 2023, one of the first things they undertook was a review of the previous CHC decision and a re-assessment for Vera. The social worker queried the scorings on certain domains due to the experiences of trying to support Vera in the home. It was recognised that Vera's needs may be accentuated in the community setting as opposed to a hospital setting where the previous assessment had been carried out.

5.2.11 This assessment showed that Vera was eligible for CHC and it was agreed that Vera met the required criteria. The CHC nurse stated that the eligibility was 'obvious'. The assessor nurse recorded on the DST paperwork.

> *"If these needs were not met in a timely way, she is at high risk of CO2 narcosis, respiratory arrest, and hyper or hypo glycemia. Missing dialysis treatments would place her at risk of build-up of high levels of 2 minerals: High potassium, which can lead to heart problems including arrhythmia, heart attack, and death."*

> *"If the need for BiPAP is not addressed when it arises, the consequences are significant. Vera becomes drowsy, confused, and disorientated caused by CO2 narcosis which can lead to depressed levels of consciousness, coma, or death. If she requires oxygen, she become drowsy and cyanosed, low oxygen saturations (hypoxia) can lead to interference with heart and brain function and ultimately respiratory arrest."*

5.2.12 Vera's reliance on BiPAP was not confined to nighttime hours, it was also required during the day following short periods of movement. It is difficult to see therefore why the care was divided into day and night care, when the care commitments were likely to be the same.

5.2.13 The social worker and the family in this review have both stated that between the first CHC review and the second review Vera's circumstances and needs did not change. Vera's daytime care, funded by local authority involved numerous care provider companies, who were unable to meet Vera's needs. Some of this is attributed to the family being viewed as being difficult but this aside, it is apparent that they were not equipped to meet Vera's and the family needs. These factors would support the view that Vera's care should have been CHC funded sooner. The CHC position is that there is evidence from the DSTs completed in 2022 and 2023, that there was a significant change in needs. Vera's breathing had deteriorated requiring her to need BiPAP during

the day and night. This impacted on her nutrition, mobility and all the other domains increasing her health and care needs.

5.2.14 Even after the CHC had been agreed (18/07/23) the funded care package was not put in place before Vera's death in September 2023. There is evidence that the start of the package was chased by the social worker on numerous occasions in August and September 2023. The social worker also recorded the family also chased the start of the package and informed CHC that Vera was requiring oxygen (BiPAP) support more during the day and the daytime care providers could not support this (10/08/23). CHC record that several care providers were contacted, but unable to provide the required care.

5.2.15 It is apparent that although CHC had been agreed there were still time delays within the CHC structure with the commissioning plan having to be signed off by the Complex Care Panel.

5.2.16 After the second assessment it was clear that Vera required the enhanced care, potentially nursing care in the home, it was recognised and recorded that without this there was a risk of heart attack, potentially being fatal. Despite this the care was not in place up until Vera suffered a heart attack at home and later died in hospital.

5.2.17 The day before Vera was conveyed to hospital the care provider providing care during the day contacted ASC and informed them that they were considering pulling out of the care package as the situation was breaking down and managers had concerns about the position staff were being placed in by providing 'care they knew to be substandard for what Vera needed to remain alive and well'[7]

5.2.18 The CHC framework allows for the process to be fast tracked in circumstances where the person has a rapidly deteriorating condition and may be entering a terminal phase. Whilst this was not Vera's position, her situation was such that an inability to meet her care needs was presenting a significant risk to her health.

5.2.19 It was four days after Vera's death that the family received a letter from CHC informing them that the care would be fully funded by CHC. This caused the family some distress.

| **Recommendation three** |
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| CHC should ensure that where decisions are made regarding a person being eligible for care that it is delivered in a timely fashion and that where this is not the case there is clear communication with all the parties involved and a clear process for concerns to be escalated. |

| **Recommendation four** |
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| CHC and Worcestershire County Council should ensure that where there is co-funded care and there are complications or concerns, that a care review is undertaken which reflects the views of the person and their family/carers. |

[7] ASC case chronology

5.3 **What were the difficulties in securing and sustaining a Reablement Care Provider for Vera and how did this impact on her?**

5.3.1 Care was provided or commissioned by reablement from October 2022 to March 2023 whereby responsibility for the case transferred to the Wyre Forest Area Social Work Team. During this period there were numerous care providers who found it difficult to provide the care that Vera required and which the family expected.

5.3.2 Part of the difficulty was the arrangement that split the care between daytime and night time, with the funding being split between the local authority and CHC. Not only did this cause a difficulty in the continuity of care but there was difficulty over the accountability. When the family raised concerns with one commissioning party, they were often deferred to other commissioning party.

5.3.3 The difficulties in maintaining reablement care from the start were immediately recognised, with the first care provider giving notice on the first day. Over the period there were numerous care providers engaged (up to 9). This led to a lack of continuity of care for Vera.

5.3.4 A number of these care providers cited the family, their inflexibility and unreasonable expectations, as being reasons why the care for Vera could not be maintained. There is no doubt that the family could be demanding, but they would say that this came from a position of concern and a desire to care for Vera.

5.3.5 During the rapid review for Vera it was said by one care provider that at times the family acted in way that was controlling towards Vera. This was not the view of the social worker who worked closely with Vera, her husband and the family. There is no evidence of concerns regarding controlling behaviour being raised with commissioners or safeguarding concerns being raised in relation to this.

5.4 **Was the discharge from hospital in July appropriate, were all agencies involved with Vera aware of the discharge?**

**If the discharge from hospital was deemed to have been reported as a problematic discharge, what was the outcome of this?**

5.4.1 On 7th July 2023, Vera suffered chest pains and was conveyed to Alexandra Hospital by ambulance. Shortly after this Vera was transferred to Russell Hall Hospital as she required dialysis.

5.4.2 On 11th July 2023, the social worker contacted Russell Hall Hospital discharge coordinator and was informed that Vera had suffered a large heart attack, and she would not be discharged in the near future. It is clear that it was Vera's own wish to be discharged home.

5.4.3 Despite this, arrangements were made for Vera to be discharged on 13th July, this did not happen until the next day as there was confusion over transport. This caused some distress for the family.

5.4.4 If Vera had been admitted to hospital for a period exceeding 7 days her package of care would have been terminated. This was communicated to the hospital by the social worker but there seems to have been some confusion over what the expected course of action would be. The social worker was under the impression that Vera would be admitted for some time, whilst the hospital discharge felt that a discharge needed to be expedited before 14th July 2023, or the care package would be lost.

5.4.5 There appears to have been some confusion over the discharge, this included the day and how Vera was to be transported. There is evidence that there were difficulties in communication between the social worker and the discharge team.

5.4.6 After the discharge the social worker submitted a problematic discharge form. This form has been reviewed and would appear to be a legacy form referencing three Clinical Commissioning Groups, Worcestershire County Council, Worcestershire Health and Care Trust, Worcestershire Acute Hospitals Trust and West Midland Ambulance Service. The form details the difficulties on discharge including that raised by the care provider who was unable to meet the medical needs detailed on the discharge letter.

5.4.7 The problematic discharge form was not received by the discharging hospital (Russel Hall) as they are an out of area hospital. Enquiries show that there is no policy of procedure to support the problematic discharge process and therefore it is not clear what action should be taken if the complaint is received. The parties involved need to review this process.

5.4.8 Whilst it was the view of the care provider that Vera was discharged without appropriate medication; a review of the hospital discharge documentation indicates that the discharge medications were endorsed by a pharmacist and nurse checks were appropriately completed prior to the discharge. The discharge letter is predominantly written to inform the GP of the hospital admission, although a copy is provided to the patient. The complications in the discharge letter referred to the situation if a surgical intervention had been necessary. This was not clear to the care provider or family and hence a concern was raised.

5.4.9 This would have to be regarded as a complex discharge with a number of parties involved, there was confusion between the agencies on what was expected, the timescale and what the care arrangements were.

| **Recommendation five** |
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| The Dudley Group NHS Foundation Trust should ensure that where there are hospital discharges in complex cases that all parties, including the person and family, are clear of the requirements, this may entail an MDT meeting or discussion. |

| Recommendation six |
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| Worcestershire County Council (ASC) and Herefordshire and Worcestershire Integrated Care Board should review the process and policy of raising a concern of a problematic discharge, to ensure the process is effective and understood. This should include action to be taken when the discharging hospital is out of the area. |

5.5 **What was the consideration of the family as carers?**

5.5.1 The Care Act 2014 statutory guidance states '*Where an individual provides or intends to provide care for another adult, local authorities must consider whether to carry out a carer's assessment if it appears that the carer may have any level of needs for support.'*[8]

Carers' assessments must seek to establish not only the carer's needs for support, but the sustainability of the caring role itself, which includes both practical and emotional support the carer provides to the adult.

5.5.2 It was clear that Vera's son was providing significant care to both his mother and father, he had moved into the house for this purpose. He undertook training in the use of the BiPAP ventilator and was heavily relied upon for this both during the day and night.

5.5.3 In October 2022 the son was referred to the Carers Association at his request. In January 2023 the Carers Association spoke with the son, completed a carer's assessment and offered what support they could. Vera's son's partner was also referred to the Carers Association in January 2023, however this referral was closed after they were unable to contact her by telephone or e-mail.

5.5.4 Whilst the support was offered to the family from the service commissioned by ASC, the family was not aware that these conversations were a carer assessment and at no time received a copy of the assessment. They also drew attention to the fact that it was closed due to their lack of response but at the time they were under stress and caring for Vera and her husband and this made contact with agencies difficult.

## 6.0 Conclusion

6.1 Vera had a number of complex health conditions, which required significant care. Vera had mental capacity to make decisions regarding her health and treatment. It is clear that it was Vera's wish to remain at home with her husband and family.

6.2 Vera's family wished to care for her at home and made personal lifestyle changes to accommodate this. This included moving into Vera's home to undertake an informal caring role.

6.3 During the course of Vera's care and her family's interaction with agencies, there was undoubtedly some friction. The family accept this but add context that they were often

[8] Department of Health, June 2014, Care and Support Statutory Guidance

in very frustrating and stressful situations. At times the agencies recorded the behaviour of the family as rude, confrontational and difficult. All agencies should be aware of the language being used and recorded as this not only has the ability to impact on the current relationship but has the ability to taint future relationships and perceptions.

6.4 Vera needs were assessed, and it was initially deemed that she did not meet the criteria for CHC. An arrangement was made between CHC and WCC to jointly fund day and night care. The circumstances show that this arrangement was not sustainable and could not provide Vera with the care she required. This was raised by the family on numerous occasions and included the raising of safeguarding concerns.

6.5 It was not until an experienced social worker was allocated to Vera, that a review of the care was undertaken, this was identified as good practice. The review in July 2023, identified that the care should be fully funded by CHC. Despite this decision, the care package was not in place by the time Vera died.

6.6 It was clear that the care providers could not meet Vera's needs, this is highlighted by the high turnover of care providers. The commissioning arrangement also meant that Vera received a disparity in levels of care between the day and night. The second CHC assessment clearly identified the risk to Vera if the correct care was not in place.

6.7 With this risk identified, it is not possible to say that all that could have been done to ensure Vera's safe care was in place in a timely fashion.

## 7.0 Recommendations

7.1 ASC should ensure that all staff are able to recognise and take the appropriate action when there are concerns of coercive or controlling behaviour in a caring relationship.

7.2 Worcestershire Adult Social Care should provide reassurance to the Safeguarding Adult Board that any backlog in safeguarding enquiries has been addressed and continues to remain at an appropriate and sustainable level.

7.3 CHC should ensure that where decisions are made regarding a person being eligible for care that it is delivered in a timely fashion and that where this is not the case there is clear communication with all the parties involved and a clear process for concerns to be escalated.

7.4 CHC and Worcestershire County Council should ensure that where there is co-funded care and there are complications or concerns that a care review is undertaken, which reflects the views of the person and their family/carers.

7.5 The Dudley Group NHS Foundation Trust should ensure that where there are hospital discharges in complex cases that all parties, including the person and family, are clear of the requirements, this may entail an MDT meeting or discussion.

7.6 Worcestershire County Council (ASC) and Herefordshire and Worcestershire Integrated Care Board should review the process and policy of raising a concern of a problematic discharge, to ensure the process is effective and understood. This should include action to be taken when the discharging hospital is out of the area.

**Appendix A –**

**Rapid Review SAR – Worcester Safeguarding Adult Board –**

**Safeguarding Adults Review**
**Vera**
**Terms of Reference and Scope**

## 1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

**Condition 1 is met if—**

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

**Condition 2 is met if—**

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

**A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).**

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within 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;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;

- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

## 2. Case Summary

2.1 Vera died in hospital in September 2023 after suffering a heart attack at home. Vera was a 76-year-old lady who up until her death had been living at home with her husband.

2.2 Vera had a number of health conditions. Type 2 Respiratory Failure, which had many factors of need, including oxygen supplementation, posture control, use of a BiPAP machine night and day, and control of anxiety which affected her breathing. She also had stage 5 chronic kidney disease and type 1 diabetes.

2.3 Vera had a history of falls in the home leading to hospital admissions. In September 2022, following a Continuing Health Care[9] (CHC) Assessment Vera received care at home which was jointly funded by CHC and Worcestershire County Council. Vera had multiple care teams attempt to meet her needs through the Reablement Team Service.

2.4 In July 2023, Vera was admitted to Alexandra Hospital (Worcestershire Acute Hospitals NHS Trust – WAHT) and after two days transferred to Russell Hall Hospital (Dudley Group NHS Foundation Trust). Vera was discharged four days later.

2.5 In July 2023, Vera was assessed for CHC Fully funded 24/7 wrap round nursing care at home. Care to this level was not achieved up until the point that Vera suffered a heart attack, from which she died.

## 3 Decision to hold a Safeguarding Adults Review

3.1 The SAR referral was received in September 2023. Initial scoping information was gathered, and a Rapid Review meeting was held on 12th February 2024, chaired by an independent Rapid Review Chair. Members of the Case Review Subgroup and invited guests who had been involved with the care of Vera attended. After hearing all of the information It was agreed that the criteria for a mandatory Safeguarding Adults Review were not met. It was agreed that the information that had been gathered identified that there was learning, which had not been addressed by the Rapid Review meeting. It was therefore decided that a discretionary SAR (section 44(4) Care Act) would be commissioned.

[9] NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals, have to be assessed by integrated commissioning boards (ICBs) according to a legally prescribed decision-making process to determine whether the individual has a 'primary health need'.

## *4* Scope

The review will cover key issues for learning between **1st September 2021 to date of Vera's death (14th September 2023)**

## *5* Method

5.1 The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

5.2 WSAB chose to use a methodology that uses the information gathered and discussed in the Rapid Review meeting to formulate these Terms of Reference. Agencies will be asked to review their own involvement in order that learning can be disseminated promptly within single agencies. The overview report will analyse the systems that agencies work within and identify what is currently working well, as well as any blocks and barriers within those systems at the time that work was being undertaken with Vera.

## 6 Parallel Processes

At the time of drafting these TOR's there were no other known processes.

## 7 Key Lines of Enquiry to be addressed

Systems for analysis will be related to the key learning themes identified from the Rapid Review Meeting.

7.1 Were safeguarding concerns appropriately progressed and resulted?

7.2 What were the difficulties in securing and sustaining a Reablement Care Provider for Vera and how did this impact on her?

7.3 How did the system of securing CHC for Vera work and is there any learning from this?

7.4 Was the discharge from hospital in July appropriate, were all agencies involved with Vera aware of the discharge?

7.5 If the discharge from hospital was deemed to have been reported as a problematic discharge, what was the outcome of this?

7.6 What was the consideration of the family as carers?

7.7 To identify any good practice.

## 8. Independent Reviewer and Chair

The named independent reviewer commissioned for this Review is Jon Chapman

## 9 Organisations involved with the review:

- Worcestershire County Council Adult Social Care
- Worcestershire Acute Hospitals NHS Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Herefordshire and Worcestershire ICB for GP
- West Mercia Police
- West Midlands Ambulance Service
- Department for Work and Pensions
- Dudley Group NHS Foundation Trust
- Monahen Care and Support Limited
- Stonehouse Care
- TLC Care
- Nationwide Care
- University Hospitals of North Midland NHS Trust
- Worcestershire County Council – Reablement Service

## 10 Family Involvement

A key part of undertaking a Safeguarding Adults Review is to gather the views of the family and share findings with them prior to finalisation of the report. Vera's family will be informed of the review and invited to participate in the review.

## 11 Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

Any media strategy around publishing will be managed by the Learning, Development, Practice and Communication subgroup of the WSAB and communicated to all relevant parties as appropriate.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date.

Whenever appropriate an 'Easy Read' version of the report will be published.

## 12 Administration

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account. Failure to do so will result in data breach.

The Board Co-ordinator will act as a conduit for all information moving between the Chair, Author and the Case Review subgroup.

## 13 Confidentiality

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Independent Author or the Case Review Chair.