Bolton Safeguarding Adults Board

Safeguarding Adults Review: Nancy

Author	Paul Nicholls – Independent Reviewer
Document Owner	Bolton Safeguarding Adults Board

1. Background to the review

Nancy was an elderly single female who died in 2022. She lived on her own in a semi-detached bungalow, which she owned, in an area outside Bolton. A Careline365 alarm was installed at the property.

Nancy's family lived nearby, her sister lived across the road and Nancy's son lived locally. Nancy has a nephew, who takes a lead in most of the family's business.

Nancy had been diagnosed with schizophrenia for many years. Nancy was a very proud lady who liked to take care of her home and family. She had a close, family support network around her since her husband passed away. There is evidence to show that Nancy's family were involved in her care planning.

Nancy was a polite and courteous lady with traditional values who enjoyed the simple things in life such as tending to her garden, spending time with her family and going on long walks. She was very proud of her home and her appearance and held high standards for herself. She engaged well with mental health services for many years.

Nancy suffered from complex physical and mental health issues as well as being diagnosed schizophrenic. These meant that she required regular support with everyday living and carers from a local provider, Care Provider, attended up to 3 times a day.

Grants from the Independent Living Service allowed adaptations to be made to Nancy's property, such as a level access shower and other adaptations.

Nancy sometimes would become confused and forgetful, and an assessment showed she had cognitive impairment. On one occasion, when Nancy was in hospital, there was an attempted burglary at her home with damage caused to a rear door. On another occasion, people were seen running away from her property. Both events caused distress to the family and were investigated fully by local Police.

Nancy had good support from her GP at the local Health centre. She also had daily support from her sister and son, as well as the carers and the Older Adults Community Mental Health Team (OACMHT).

In June 2022, her sister discovered Nancy in a neglected and distressed condition upon returning from a family holiday. It was initially assumed that the Care provider (company) had been attending to Nancy daily, but this was not the case. It appeared that there was confusion between the Local Authority and the care provider regarding the renewal of Nancy's care package, three weeks previously. The family made a complaint to the Local Authority about the lack of care provision for Nancy. This was dealt with through multi-agency safeguarding procedures with strategy meetings held in Autumn 2022, attended by the family.

Tragically, Nancy passed away in July 2022, following a month-long hospital stay.

1.1 The review process

A Safeguarding Adults Review (SAR) referral was made to the Bolton Safeguarding Adult Board (BSAB) in September 2022 by Bolton Council Adult Social Care, due to concerns about the care given to Nancy and her subsequent death.

Bolton Safeguarding Adult Board has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

The SAR was commissioned under Section 44 (1) of the Care Act 2014.

2. The purpose of the review

This Safeguarding Adult Review (SAR) will determine what the relevant agencies and individuals involved in the case might have done differently in the case of Nancy. This is so that lessons can be learned from this case and those lessons applied to future cases to try and prevent similar circumstances arising again.

This SAR will:

- Encourage a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults.
- Make use of any relevant research and case evidence to inform the findings.
- Seek the views of the clients on the support services provided to Nancy. This will take place after the initial learning review but before the publication of the final report.

The objectives include establishing:

- Lessons that can be learnt from how professionals and their agencies work together.
- How effective the safeguarding procedures are.
- Learning and good practice issues.
- How to improve local inter-agency practice.
- Service improvement or development needs for one or more service or agency.

3. Period covered by the review

The review covered the period **September 2019** to **July 2022**. Other key events outside of this time were considered if they were deemed relevant.

4. Methodology for the review

The review group identified key practitioners directly involved with the case and explored four key themes (see below). These were agreed in the case discussion at the BSAB Safeguarding Adults Review Group in July 2023.

The review will not include a detailed narrative of each event and aspect of care and support; however, the panel will have had sight of this detail which informs the findings and recommendations.

The review used the **Signs of Safety methodology** when looking at each of the four key themes.

The key questions were:

- What went well?
- What went wrong and could have been better?
- What is the learning for future cases?
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It was agreed on 5th July that this report will be a summarised report, focussing on systemic learning, whilst identifying any good practice and areas for improvement.

5. Key themes identified by the review panel.

Four key themes were identified by the initial review panel in July 2023, these were:

- Did agencies work effectively together to respond to safeguarding concerns from September 2019?

- Was there effective information sharing between agencies, particularly when concerns were raised, and safeguarding risks started to escalate?

- Did the Care providers adequately meet Nancy's needs and respond to any safeguarding concerns?

- Were Nancy's family kept informed of escalating risks and involved in decision making at key stages?

6. Partnership review panel

An Independent Lead Reviewer worked alongside a review panel, composed of senior managers supported by Bolton Safeguarding Adult Board Manager. The membership of the panel was:

- Greater Manchester Mental Health Trust (GMMHT, Older Adult Community Mental Health Team).
- Bolton NHS Foundation Trust.
- Greater Manchester Police.
- Bolton Council Adult Social Care (to include Quality Assurance Team and Commissioning Teams).
- NHS Greater Manchester Integrated Care (The General Practitioner (GP).
- A Care provider
- Home Care Bookings Service.
- Northwest Ambulance Service.
- Independent Living Service.
- Independent Reviewer.

7. Parallel reviews and investigations

Any parallel or similar reviews and investigations in Bolton around the time of this review will be considered and will inform the learning. It is important to consider these to avoid duplication of learning points and to cross reference action plans and changes to practice.

There were no ongoing police investigations at the time of this review. A coroner's inquest into Nancy' s death is due to take place following the completion of this report.

8. Governance

The review panel will report directly to the monthly BSAB SAR subgroup via the Board Manager, which in turn reports to the Bolton Safeguarding Adults Board.

8.1 The views and involvement of the family.

The Independent Reviewer maintained communication with Nancy's nephew during the period August to December 2023. The family were also consulted twice in February 2024 and contributed to the final report.

The family has asked to be kept informed about the progress of implementing the recommendations outlined in this report.

9. Summary of key events and dates

Below is a summary of some of the key episodes, pertinent to this review.

These events were collated from several sources, primarily the combined and single agency chronologies.

Date	Key Events
2019	
September	**9th** – Nancy calls Police who attend, Nancy seemed confused. Son present. **Safeguarding referral made** by Police. Care provider carers make referral to Older Adults Community Mental Health Team (OACMHT). **12th** - Nancy agrees to increase care package but refuses respite as suggested by her sister. **17th** - OACMHT care coordinator notes concern about Nancy's physical deterioration. Notable delay in responding to questions. No recommendation for a capacity assessment at this stage. **19th** – Blood tests show an infection. Care coordinator informs GP, sister included in planning. (Care provider carers attending Nancy twice a day)
October	**23rd** – Call to OACMHT from sister questioning a bill for respite stay. Internal investigation starts. Nancys family disputed the additional cost.
November	**11th** – Nancy attends hospital for planned surgery. Son discusses with discharge team stating Nancy needs carers 4 times a day. **19th** – Nancy discharged – concerns raised by family about level of care provided and questioned if Nancy could cope at home. Discharge team recommend increasing care package to 4 times a day.

Date	Key Events
2020	
January	**9th** - Concerns raised by OACMHT worker as Nancy cannot access keys in key safe. Not raised with Care agency to get key safe details.
March	**19th** - Key safe code given by sister 'in passing' at Nancy address. **29th** – Police respond to report of stolen cigarettes at Nancy address – NFA.
May	**14th** – Neighbours raise concern about Ns presentation, Nancy said to be banging on doors and sat outside her property.
June	**5th** - Son contacts OACMHT raising further concerns about deteriorating Mental health. **9th** – Nancy doesn't answer phone for review with consultant on OACMHT team. **11th** – Annual physical health assessment completed by OACMHT. **30th** – Call to out of hours OACMHT from Care provider carers, Nancy appearing psychotic.
July	**1st** - OACMHT care coordinator contacts Care provider and GP re previous days, concerns. Son was present with Nancy and involved in the discussion. **4th** – Care providers contact OACMHT as Nancy found outside, very confused.
August	**20th** - OACHMT notes more weight loss. Weight monitoring commences, family informed.
Sept	**17th** – OACMHT notes Nancy fall (also in May), **22nd - Falls referral** completed by OACMHT. Sister reports change in presentation since most recent falls.
Dec	**24th** – Further concerns raised by sister following infection to Nancy's arm to OACMHT – no record of discussion with Care providers.
2021	
Jan	**5th** - Nancy admitted to Royal Bolton hospital following a fall and suspected stroke. **16th** – Care package increased to 3 times a day. **18th** - Nancy discharged from hospital. Reports of burglary at home, police attend, no arrests, property secured after door damaged. Son present. **21st** – Seen at home by OACMHT, appears confused. Medication had stopped while an inpatient, noted as possible cause of deterioration.
Feb	**4th** – Sister reports Nancy more stable, levels of medication have been re-established. **6th** – GMP attend after reports of males trying to break into house. CAP triaged by specialist police officer - No referral to other agencies.

Date	Key Events
March	**4th** – Sister reports that 'carers have changed' and Nancy not taking medication but 'hiding it'. OACMHT asks sister to keep an eye on Nancy and the carers and report to OACMHT if any concerns arise.
August	**19th** - OACMHT completes ACE III assessment, low score indicates cognitive impairment.
September	GP completes three home visits for medication reviews.
December	**14th** - New OACMHT care coordinator appointed for Nancy.
2022	
March	**8th** - Call to OACMHT from neighbour regarding concerns about Nancy standing in the porch of her home, not fully dressed. **22nd** – 999 Call, Nancy confused, sister unable to visit for previous 7 days. No referral required, appropriate person-centred response. Evidence of GP/OACMHT good communication due to change in behaviour.
April	**4th** - Letter to GP from OACMHT care coordinator requesting new medications. Further concerns raised by sister to OACMHT regarding possible infection.
May	**13th** – Home visit by GP following call from sister, noted bruising to upper arms, appears long standing. **17th** – Care providers contact Commissioning team to hand back 7 packages of care due to lack of capacity. · Email copied to Home Care Booking (HCB) but on wrong email address. · QA team receive email from Care provider re capacity issues, list included package for Nancy. · Noted that Care provider stated they will 'continue to support the 7 packages until a new provider is sourced'. **23rd** – Note on OACMHT system that Care Provider no longer to support the care package and recommissioning required urgently. **30th** - OACMHT care coordinator calls Care provider to 'ascertain what is going on' – unable to get a response.
June	**6th –** Nancy's sister visits and leaves notes on fridge saying on holiday until 17th. **8th –** Care provider Carers attend care call at Nancy home and report 'no issues. Visit other clients in local area to find new care provider in situ. Carers let manager know that new providers were covering the local area. **14th** – OACMHT completes home visit but didn't check carer notes and therefore unaware carers had not been visiting since 6th June. Later (after GMMH internal review) actions were taken i.e., the care coordinator completed a reflection of the events as learning and attended further documentation training. **18th –** GMMH out of hours (OOH) team called by Nancy's sister after returning from 2 weeks holiday. Family noted in file - no carers since 6th

Date	Key Events
	June, Nancy self-neglecting and in soiled clothes. 999 calls made, NWAS attend, consult with family. OACMHT Out of hours team make **safeguarding referral.** **20th –** 999 call – Nancy taken to Royal Bolton; **safeguarding referral** made by NWAS. **21st** – Medical care and treatment plan put in place by hospital team, **Safeguarding referral** made by hospital. Safeguarding Team commence S42 enquiry. **27th** – Complaint from family received via local MP. **30th** – Discharge team notes indicate 'awaiting capacity assessment'.
July	**6th** – Nancy still in hospital, noted that Social Worker has visited twice and states Nancy 'does not have capacity'. – No evidence of documentation to support this. **8th** - Recorded as 'medically fit for discharge' and Social Worker trying to contact sister to discuss discharge plan. **11th** – Capacity assessment completed by discharge team following discharge discussions. Nancy assessed as lacking mental capacity. **14th** – Recorded as 'waiting for Nancy to be reallocated to a Social worker in IDT' – recorded by Social Care as reallocation of Social Worker causing a delay in discharge. **17th** – Nancy suffers a fall on the ward – CT scans reveal no skull fracture. **20th** - Son informed Nancy is very unwell. Strategy meeting arranged for 25th July. **22nd** – **Nancy sadly passes away**.
August	**5th -** Strategy meeting held to deal with family complaint. QA team and GMP attend. **8th -** Strategy meeting to conclude the meeting held on 5th.
September	**8th –** Professionals/strategy meeting attended by the family. Agreed did not meet the threshold for wilful neglect[1]. No Police investigation.

10. Key Themes

10.1 Did agencies work effectively together to respond to safeguarding concerns from September 2019?

Was there effective information sharing between agencies, particularly when concerns were raised, and safeguarding risks started to escalate?

(These two key themes naturally fit together for the purpose of this report)

[1] In *R v Sheppard* [1981] A.C. 394 the Court held that the primary meaning of wilful is "deliberate". Therefore, for example, someone who knows that the person in their care needs medical assistance and deliberately, that is by conscious decision, refrains from calling a doctor would be guilty of wilful neglect. Equally, a person who fails to provide medical care because he does not care whether it is needed or not is reckless and is also guilty.

Nancy had been receiving a care package from a Care provider, Care Company for 5 years prior to her death, with carers visiting twice a day to administer medication. However, in September 2019, concerns arose about Nancy's declining mental state, as noted by her sister and the carers. It was evident that the level of care Nancy was receiving needed to be increased.

In response, the carers referred to the Older Adults Mental Health Team (OACMHT), leading to the appointment of a care coordinator.

Concerns for Nancy were further raised again in September 2019, following a call to Police from her, who was found to be 'very confused' when Police attended. Police logged the call appropriately using a CAP (adult protection) form and made a **referral to adult safeguarding.**

The adult safeguarding team shared the concerns with the Older Persons Mental Health Team who were responsible for the care management of Nancy. No safeguarding enquiry was deemed appropriate. Contact was made with Nancy's son who informed Police he would seek further medical advice from the GP.

It is recorded that Nancy's family felt she may benefit from a period of respite care in October 2019. Nancy had previously had four periods of respite care at a residential care home between May 2016 and September 2019. There was a dispute between the family and the Bolton Council finance team regarding the cost of some of the respite care. It is unclear if this was resolved at the time of Nancy's passing.

In November 2019, Nancy underwent planned surgery and had a short hospital stay. Upon discharge, her family requested that her care package be increased to four visits per day (It was subsequently increased to three in January 2021). This request was discussed with the Integrated Discharge Team (IDT), Older Adults Mental Health Team (OACMHT) and a Social Worker, who visited the ward. After the discussion, it was decided that Nancy would be able to manage at home with the current care package but with additional support provided by District Nurses. However, concerns were raised by family members who felt that this decision might be overly optimistic.

Safety concerns were brought to the attention of OACMHT in January 2020 when Nancy encountered difficulties in locating her house keys and accessing the key safe code. The care coordinator believed that the carers should have communicated this issue to the family and shared the information with her, to ensure Nancy's safety in case of an emergency. The key safe code was eventually given to the care-coordinator by Nancy's sister in March 2020.

It is worth noting that March 2020 saw the beginning of the Covid pandemic and visits to Nancy had to be conducted at a safe distance, often through a window.

In June 2020, additional concerns about Nancy's deteriorating mental health were raised by her son and Care provider carers. Recording shows that there were discussions between the care coordinator, Care provider, and the GP, during which concerns were raised regarding potential infections and Nancy's mental well-being.

In September, the care coordinator completed a falls referral after Nancy fell at home and was unable to get back up. However, it is unclear if this was discussed with the Care provider. Nancy suffered another, more serious fall, in early January 2021 which resulted in admission to hospital, where she would stay for 2 weeks. Recording shows there was

communication between the OACMHT, hospital discharge team and the family regarding discharge planning. This is in line with Health and Care Act requirements[2].

When Nancy was discharged from the hospital in January 2021, neighbours informed her son that they had observed intruders fleeing from her property, prompting him to contact the police. Although no arrests were made, the police appropriately completed a medium-risk CAP form. They also made referrals to Victim Support and the Care Programme Approach (CPA), demonstrating good practice and alignment with current procedures. At this point, the care package for Nancy was increased to three visits per day.

In February 2021, Nancy contacted the Police, reporting two males in her back garden. This was fully investigated and triaged by a specialist safeguarding officer. No referral was made due to officers noting Nancy's relatively stable mental health and the ongoing support being provided by her family, who lived nearby. Police were called to the residence once more in May 2021 after receiving a report from Nancy stating that "people were at her address." Police attended and investigated, and, on that occasion, a CAP record was generated, and the GP and the Mental Health Team at the local health centre were contacted. No offences had been committed. This demonstrated multi-agency collaboration in responding to Nancy's needs and safety concerns.

There is a concern that there was no consideration given at this point to Nancy's Protected characteristics, under the 2010 Equality Act.

The Equality Act of 2010 brought together various anti-discrimination laws into one single act, so any unlawful treatment (discrimination, harassment, or victimisation) relating to one of the Equality Act protected characteristics. **The 9 characteristics** that are protected by the Equality Act 2010 are: **age, disability**, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act also provides for protection against discrimination by association, which provides protection for people who are discriminated against because someone close to them falls under the definition of one of the protected characteristics.

In actively considering Nancy's protected characteristics, (Nancy was an older woman with disabilities), there may have been a motivation for the attempted burglaries and why Nancy was possibly targeted in the community. When undertaking safeguarding work with a person who has protected characteristics, it is important to sensitively identify, in partnership with the person experiencing abuse or neglect, what significance these protected characteristics may have in terms of the motivation for abuse. We need to consider their everyday experiences of discrimination and future risk of abuse or barriers to safety, recovery, leading a fulfilled life and overall wellbeing.

In March 2021, Nancy's sister raised a concern with OACMHT as it was felt she wasn't taking her medication but 'hiding some of it'. Also, that she had different carers (from the Care provider), who were not ensuring Nancy took her medication. (This is covered in more detail in the next section).

The OACMHT coordinator requested a fire safety check in August 2021 after a concern that Nancy had left a cooker ring on. Nancy had done this while attempting to light a cigarette

[2] According to **Section 91 of the Health and Care Act 2022**, NHS trusts and foundation trusts are required to involve patients and carers in discharge planning when an adult patient is likely to need care and support after their hospital discharge, and the trust considers it appropriate to involve them or their carers in planning their hospital discharge. This duty should be carried out as soon as is feasible after the trust begins making any plans relating to the patient's discharge

and subsequently forgot about it. It's worth noting that this wasn't the first time such an incident had occurred, and Nancy's sister mentioned that Nancy mostly used the microwave for heating food. One question that arises is why the request for a fire safety check wasn't made earlier, considering the concerns over the previous 12 months. Additionally, it's unclear from the recording whether this request was discussed with Care provider carers.

In the same month, the OACMHT care coordinator completed an ACE III[3] assessment, first discussed in December 2020.This resulted in a score of 46/100, which indicated Nancy's cognitive impairment. This was completed following a discussion with Nancy's sister, who reported increased memory loss to the care coordinator. It is unclear if the assessment resulted in any further plan of action.

In Autumn 2021 the GP carried out several home visits to Nancy, following a letter from the Community Mental Health Team (CMHT) requesting a review of her medication following an up-to-date mental health diagnosis. This demonstrated good person-centred care by the GP and co-ordination with the CMHT. A different OACMHT care coordinator was appointed in December 2021.

March 2022 saw a call from Nancy's neighbour stating concerns that Nancy was outside, alone in the cold. An ambulance was called as there were serious concerns for her safety. There was no safeguarding referral at this point as Nancy's family were present and seen by the ambulance service to be caring for her.

In April 2022, new medication was prescribed for Nancy following a diagnosis of dementia and schizophrenia. The following month, the GP attended a visit to Nancy at home following bruising to her upper arms and itching, no safeguarding concerns were recorded and there was no record of any investigation into the bruising to Nancy's arms.

In May 2022, problems arose due to miscommunication regarding the package of care for Nancy, provided by Care providers, (this is covered in more detail later in the report). Care providers were experiencing staffing and capacity issues and say they informed the home booking team that Nancy's package of care would cease in early June. There is some dispute regarding the lines of communication between the Local Authority and Care providers, but ultimately Nancy was left without carers when her sister went on holiday in June for 10 days. Nancy's sister reported that Nancy's son, had been visiting, while she was away and expressed concerns about his mother's well-being. It appears that her son was not aware that the carers had stopped visiting Nancy, which further emphasised the need for effective communication among all parties involved in her care.

Nancy was taken to hospital on 20th June 2022 following further deterioration and a 999 call. A **safeguarding referral** was made by the Hospital Emergency Department and a section 42 enquiry started on 21st June 2022. It was acknowledged that on admission to a ward, safeguarding concerns were passed over from the Accident and Emergency department.

It was recorded that on admission to a ward, Nancy had cognitive impairment and on 22nd June, she refused therapy and was presenting as confused. No capacity assessment was completed at this stage. Later that week, the OACMHT coordinator was recorded as being informed by the Ward Sister that Nancy 'no longer trusts services and the family did not wish to use the Care provider on discharge from hospital. Over the next two weeks in hospital,

[3] The ACE-III is a brief, bedside, cognitive screening test that takes approximately 15 to 20 minutes to deliver; it encompasses five major cognitive domains: attention, memory, language, visuospatial function, and verbal fluency (Hsieh 2013; Noone 2015; Velayudhan 2014)

Nancy was referred to Occupational Therapy and Physiotherapy as well as a dietary assessment. Discharge plans were starting to be made at this point.

On 4th July 2022, Nancy was recorded as being 'medically fit' and hospital staff were expecting Social Workers to complete a capacity assessment that day.

The OACMHT Social worker was recorded as visiting twice the next day (7th July) and stating that Nancy 'does not have capacity' but there is no evidence of a capacity assessment on the Electronic Patient Record (EPR) system.

On 11th July, hospital records indicate that Nancy 'does not have capacity' and cannot decide about her discharge destination, therefore a best interest[4] discussion was due to take place with the family, regarding her discharge home. A discussion took place the following day, with a member of the family (unclear who), they are recorded as being 'pleased with the level of care' Nancy had received in hospital, and she looked 'much brighter and better'.

Things were to take a turn for the worse when on 17th July 2022, Nancy suffered a fall on the ward. Nancy's sister was informed immediately, and the post falls protocol was followed in the hospital. Nancy was recorded as being unable to attend therapy on 20th July and not responding to requests. Sadly, Nancy died two days later.

A S42 strategy meeting was held on 5th August 2022. A further meeting held on 8th August to conclude the initial meeting.

A Professionals meeting was held in September 2022, the family were in attendance. A conclusion was reached that the care given to Nancy did not meet the threshold for wilful neglect.

10.1.1 Nancy's mental capacity

Despite concerns about Nancy's declining mental health, delays in responses and cognitive impairment (as evidenced by the ACE 111 assessment completed in August 2021), there is no record or mention of the need for, a mental capacity assessment between September 2019 and early July 2022. There are numerous mentions in recording of Nancy 'having capacity' or 'lacking capacity'. It appears that there were occasions when assumptions were made around Nancy's mental capacity, or lack thereof. These assumptions should not have replaced a formal assessment. Those who lack mental capacity are managed using best interest considerations, which are taken by professionals to improve outcomes. This was an opportunity not afforded to Nancy.

It is recorded that on 15th July 2022, the hospital Social Worker concluded that Nancy lacked capacity to make decisions around her discharge destination. A mental capacity assessment was completed, and a best interest meeting was held with family members, ward staff and therapy staff.

This was good practice as the Mental Capacity Act states - '*Capacity is about the ability to take a particular decision at the time it needs to be taken. It is decision-specific and time-specific'* (see below).

[4] If a person has been assessed as lacking mental capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

What can trigger a mental capacity assessment? (Mental Capacity Act 2005)

A mental capacity assessment should be undertaken when the capacity of a patient to consent to treatment is in doubt. Lack of capacity cannot be demonstrated by referring to a person's age or appearance, condition, or any aspect of their behaviour.

Capacity is about the ability to take a particular decision at the time it needs to be taken. It is decision-specific and time-specific.

Where the person's capacity to make a decision has come into doubt because of the persons behaviours, their circumstances or concerns raised, you should consider the following:

- Has sufficient effort been made to help and support the person to make the decision in question?

- Is the decision required imminently, or can it be delayed until the person has sufficient capacity to make the decision themselves? A person may temporarily lack capacity, e.g., if they are taking medication which makes them drowsy.

10.1.2 What went well?

- Referrals form Police to MASH and from Care providers to OACMHT in September 2019, when concerns and potential risks escalated.
- Good lines of communication between OACMHT, Police and GP e.g., May 2021 - Police investigated burglary and the GP and the Mental Health Team at the local health centre were contacted. Demonstrated multi-agency collaboration in responding to Nancy's needs and safety concerns.
- January 2021 - Communication between the OACMHT, hospital discharge team and the family regarding discharge planning, in line with Health and Care Act requirements.
- June 2020 discussions between the care coordinator, Care provider, and the GP, during which concerns were raised regarding potential infections and Nancy's mental well-being, good multi-agency practice.
- August 2021 - Good person-centred care by the GP and co-ordination with the CMHT following medication reviews.
- July 2022 – Nancy unable to make decisions around her discharge destination, led to a Mental Capacity Assessment, which was good practice.

10.1.3 What went wrong and could have been better?

- Listening to the voice of the family when concerns with care packages were raised.
- A safeguarding enquiry should have been considered before June 2022, considering the number of referrals and risks to Nancy's safety, particularly regarding discriminatory abuse, and consideration of Nancy's protected characteristics.
- Review of care plan and risk assessments at critical moments in time, particularly during the period May 2020 to January 2021 i.e. Weight loss, burglary, appearing psychotic, standing in the porch of her home not fully dressed, falls referral etc.

- A fire safety check could have been completed sooner than August 2021, to safeguard Nancy, as recorded that she often used the cooker to light cigarettes, considering her cognitive impairment.
- Safeguarding concerns regarding the loss of keys and access to the key safe should have been shared between OACMHT and Care provider carers.
- March 2021 – Nancy recorded as concealing medication by sister. No record of a discussion between OACMHT and carers to address the issue.
- The ACE 111 assessment was completed in August 2021, it is unclear why there was a delay from December 2020 when the need for an assessment was first documented. It is also, unclear what was the outcome of the assessment or a plan of action.
- A mental capacity assessment should have been completed prior to July 2022, bearing in mind the decline in Nancy's mental health over the previous 18 months.

10.1.4 Learning from this key line of enquiry

- There is evidence that assumptions were made about Nancy's capacity. These assumptions should not have replaced a formal assessment.
- There was a delay in completing the ACE 111 assessment, identifying cognitive impairment, and no evidence of an outcome focussed plan, risk assessment and safety planning, following the assessment.
- There needs to be more evidence of effective communication between the OACMHT care coordinator and the Care provider carers on issues such as missing keys and hiding medication.
- Where there are several agencies involved in delivering care to a person in the community there should be a coordinated care plan, with an identified lead professional.

10.2 Did the care providers adequately meet Nancy's needs and respond to any safeguarding concerns?

Nancy was receiving care from the Older Adults Community Mental Health Team (OACMHT) and had a designated care coordinator who conducted regular visits. In addition to the support from OACMHT, Nancy was also receiving a care package provided by Care Provider, a private care provider based in Bolton.

Care Provider was commissioned by Bolton in 2016 and is one of nine, tier one framework providers, offering services to approximately 1,200 service users. This equates to an average of around 9,900 care hours commissioned per week across Bolton.

10.2.1 The care provided by Care Provider and OACMHT.

Care provider commenced their care services for Nancy in May 2017 helping prepare meals twice a day, personal care, and medication administration (not injections). Initially, carers visited twice a day to offer this support. However, this was later increased to three visits a day in response to Nancy's discharge from hospital in January 2021. This change was made due to the deterioration of Nancy's mental and physical health.

Care provider carers referred to the Bolton Older Adults Community Mental Health Team (OACMHT) in September 2019 after emergency services were called due to a deterioration in Nancy's mental health. This was good practice. Around this time, Nancy's physical condition also began to decline, and she started losing weight.

Nancy requested an increase in care to assist her in managing and taking her medication. These concerns were discussed with family members and the GP. There were some minor issues related to the administration of antibiotics by carers following an infection suffered by Nancy in September 2019. This might have been exacerbated by the OACMHT care coordinator being on holiday, leading to communication breakdown.

In November 2019, Nancy underwent planned surgery and following this, the family, discharge team, and the OACMHT Social Worker discussed the necessity of increasing her care package to four visits a day due to her growing needs. Although the family expressed some concerns at this point, it was agreed that with additional support from District Nurses, Nancy should be able to manage. The care package remained at two visits per day.

There was some confusion in January 2020, when Nancy could not locate her keys or the key safe code, leading to some safety concerns from the OACMHT care coordinator. Recording shows a lack of discussion between them and the Care provider carers. The code was eventually passed on to the care coordinator by Nancy's sister two months later.

In mid-2020, Nancy's mental health began to deteriorate further, possibly exacerbated by the COVID-19 pandemic, which prevented her family from visiting her in person. Care provider carers contacted the OACMHT team in June, expressing concerns about Nancy's condition, as she appeared to be experiencing psychotic symptoms. This was followed up with a GP consultation the next day, demonstrating effective multi-agency collaboration.

A falls referral was initiated by the OACMHT care coordinator in September 2020, following two falls that had occurred in the previous two months. This practice aligns with established protocols. However, there is no evidence to suggest that this falls referral was discussed with Care provider, nor that a risk assessment was conducted. This is especially relevant as in July 2020, Care provider reported Nancy as being "outside and confused," indicating an increased risk.

In late 2020, District Nurses were providing care to Nancy, including dressing injuries to her arm, assisting with medication, and conducting blood tests. Nancy's sister raised concerns about her worsening memory issues, and it was decided that the Older Adults Community Mental Health Team (OACMHT) care coordinator would carry out an ACE 111 assessment, (as mentioned in the previous section). There is a concern that the assessment didn't take place until August 2021, eight months after the need was identified, it is unclear why there was a delay or what was the outcome of the assessment.

The OACMHT care coordinator conducted a home visit to Nancy in January 2021. Nancy had returned home after a two week stay in hospital following a fall. It was agreed with the family that the care package would increase to 3 visits per day from 16th January.

The care coordinator observed a further decline in Nancy's mental state, noting that she was becoming increasingly confused. During this visit, the care coordinator expressed concern that Nancy's oral medication may not have been administered during her hospital inpatient stay, potentially contributing to her deterioration. However, it's unclear whether this concern was subsequently communicated to or discussed with the hospital or Nancy's family. However, Nancy's mental state improved in the following two weeks after her medication was reinstated and administered with the assistance of the care coordinator and the carers.

The OACMHT care coordinator observed that Nancy's mental health often declined during periods when she experienced urinary tract infections (UTIs). This is not uncommon, and Nancy's mental health markedly improved once the GP was informed, and antibiotics were administered.

Nancy's sister expressed further concerns in March 2021 about her potentially not taking her medication and concealing it, the records indicate that there had been a recent change in the Care provider carers. It was suggested that the new carers may not have fully understood the importance of ensuring Nancy took her medication as consistently as the previous carers. The OACMHT care coordinator asked Nancy's sister to "keep an eye" on the situation and report any concerns. It's unclear why this responsibility was delegated to the family without more proactive involvement from the OACMHT team. A co-ordinated plan was needed with the carers at this point.

In March 2022, a neighbour raised concerns by contacting the OACMHT through a telephone call, reporting that Nancy had been 'in the porch of her home and not fully dressed' for several hours. Nancy's sister suggested that this behaviour could be due to a urinary tract infection. However, it is unclear if this concern was discussed with Care provider carers, or a plan was put in place to prevent similar incidents from happening in the future.

This may have been a missed opportunity to make a further safeguarding referral or adjust Nancy's care to better suit her declining needs.

10.2.2 The cessation of the care package for Nancy from May 2022.

Care provider experienced difficulties due to a shortage of staffing in some geographical areas, in providing care packages in the local area close to Bolton in early 2022. On 17th May 2022, the registered manager sent a notification via email to the Quality Assurance Team who dealt with a response and alerted a commissioning manager, copied Home Care Bookings (HCB) and the Community Psychiatric Nurse (CPN) employed by the Greater Manchester Mental Health Trust, requesting the re-commissioning of seven care packages.

Initially, Nancy was among the seven, and confirmed (by Care provider) to be included during a phone call between a Care provider employee and HCB on 17th May. There is no evidence of any paperwork sent into the Home Care bookings team for Nancy's care package at this time.

The commencement, de-commissioning, and changes to care packages were typically documented in writing and then emailed to Home Care Bookings via a secure portal. Care provider recorded that they had a good working relationship with the Home Care Bookings Team, but that written communication was not always consistent, and they usually made requests or updated information verbally. Care provider accepted that sharing information in this way was not the correct procedure, and their procedures have subsequently been changed.

It was documented that on 19th May, the OACMHT care coordinator received notification from Social Care that Nancy's care package was on the verge of cessation. The care coordinator attempted to contact the Care provider manager by phone to determine necessary changes, but they were unavailable. The care coordinator was seeking clarification and ensuring the accuracy of Nancy's support plan before submission to Bolton Council brokerage team. Another attempt to make contact was made by phone without success. There was no subsequent communication between the care coordinator and Care provider when the former went on holiday on 2nd June 2022 for 10 days.

It was noted in the GMMH internal review (July 2022), that that there had been no 'end date' of the package of care given to OACMHT and there was none documented on Liquid Logic (recording system) records, leading the care coordinator to believe that Care provider was still providing home care to Nancy.

Nancy's sister left a note on Nancy's fridge, for carers, on the 6th June 2022 stating that she would be on holiday for 2 weeks from the following day. Care provider later confirmed that their carers were aware of the note.

Care Provider care workers visited Nancy on the 8th June 2022 and recorded as being no concerns. The care workers also visited two other residents in the local area, and another care agency was in attendance. The other care agency staff advised Care provider carers that they had taken over the care packages in the area and Care Provider should not be visiting.

Also, on the 8th June 2022, a senior carer from Care provider said they contacted the Home Care Bookings team, to discuss the cessation of the seven care packages. Unfortunately, they did not record the name of the person they spoke to, and the Home Care Bookings Team has no recollection or evidence of the call.

Care provider stated that Home Care Bookings advised them that all the care packages in the local area had been re-commissioned. Based on this information, the senior carer made the decision to cancel future care calls for Nancy. This left her without care from 8th June 2022 until 18th June 2022, so not supported with meal preparation, personal care, or medication.

During this period Nancy's son visited her most evenings. However, he wasn't aware that carers were not attending during this time. On the 14th June 2022, during one of his visits, he noticed that Nancy was unsteady on her feet. Concerned for her safety, he left a note in the care records for carers, requesting that they check on her well-being. This was a missed opportunity to notice that the carers records, in Nancy's kitchen, had not been updated for a week.

On 14th June the OACMHT care coordinator visited Nancy at home to administer an injection and failed to check the carers record. Later (after GMMH internal review) actions were taken i.e., the care coordinator completed a reflection of the events as learning and attended further documentation training. During this visit, the care-coordinator allowed a gas engineer into the property for routine maintenance.

When her son visited again on the 15th June 2022, he observed that Nancy was wearing multiple clothes and was again unsteady on her feet. He helped remove some of these and helped her settle on the couch for the night, as he said he was worried, she might fall down the stairs if she tried to move. On the following Thursday, when her son visited Nancy, he found her sleeping on the couch once more and decided to leave her undisturbed.

Due to her son not being made aware of Care provider attendance protocol it was not noticed that carers were not attending, assisting with personal care, and preparing meals, contributing to a deterioration in Nancy's condition. This was a missed opportunity to raise concerns with the Local Authority or the care provider.

When Nancy's sister returned home on 17th June, Nancy was found to be in neglected state and in poor physical condition. A call was made to the out of hours OACMHT team and ambulance service. It was apparent that no carers had been to Nancy's property whilst she was away. Nancy's sister confirmed that the last entry on the MARS (Medication Administration Records) was on the 8th June 2022.

A **safeguarding referral** was made by the OACMHT out of hours team on 18th June. Nancy was admitted to hospital on 24th June 2022 and sadly died 4 weeks later.

10.2.3 The Quality Assurance of the Care provider

In line with the local Provider Quality Assurance Framework (QAF) several quality assurance visits were conducted by Bolton Quality Assurance Team between September 2019 and July 2022, with no significant issues noted. During this time CQC rated Care provider as "Good" (August 2021).

10.2.4 What went well?

- Evidence of regular communication between OACMHT coordinator and family.
- Care provider referral to Bolton Older Adults Community Mental Health Team (OACMHT) in September 2019 after emergency services were called due to a deterioration in Nancy's mental health.
- Regular quality assurance checks of Care Provider and responding to concerns.
- Good multi-agency discharge planning in November 2019 involving the family, discharge team, and the OACMHT Social Worker discussed the necessity of increasing Nancy's care.
- June 2020 – Care provider carers contacting the OACMHT team, expressing concerns about Nancy's condition, as she appeared to be experiencing psychotic symptoms. This was followed up with a GP consultation the next day, demonstrating effective multi-agency collaboration.
- Recognition that Nancy's mental health deteriorated during UTIs, which was dealt with by the care coordinator contacting the GP for antibiotics.
- GP worked in a person-centred approach, Home Visits were always facilitated/completed and communication with family was good.

10.2.5 What went wrong and could have been better?

- The Home Care Bookings team procedure stating that the care provider should receive confirmation in writing was not followed. Clarity on providers requesting to cease packages was needed.
- No recognition or action from Care provider carers following Nancy's sisters note left of fridge on 6th June informing them of her holiday.
- On 14th June the OACMHT care coordinator visited Nancy at home and didn't check the carers record, therefore a lack of professional curiosity.
- There was a missed opportunity for her son to raise the alarm, during one of his regular evening visits, missing signs that the carers had not been attending.
- A missed opportunity to share concerns regarding Nancy's oral medication not being administered during her hospital stay in January 2021, with the hospital discharge team.
- In March 2022 Nancy was seen to be alone and outside for hours. it is unclear if this concern was discussed with Care provider carers, or a plan was put in place to prevent similar incidents from happening in the future.
- A better Local Authority protocol for external care providers, outlining a clear process for the cessation of, or amendments to care packages. This should include communication details for families to formally contact a care provider to communicate significant events such changes in presentation, going on holiday etc.
- Communication issues between the care provider and the family as outlined in section 10.3.1.

10.2.6 Learning from this key line of enquiry

- Missed opportunities for the OACMHT care co-ordinator to review the carer attendance records, realise they were not attending and raise the alarm.
- Provide feedback to the hospital discharge team if it is felt that the appropriate medication has not been administered during the stay or at discharge.
- Multi-Agency regular reviews of care need to routinely be undertaken – to ensure that new and emerging risks are risk assessed and reflected in the care plan.

10.3 Were Nancy's family kept informed of escalating risks and involved in decision making at key stages?

Numerous instances are evident in timelines and records of interagency conversations involving Nancy's family, primarily her sister and son, particularly as concerns started to intensify from September 2019.

The communication and support provided by the OAMHT care coordinator to family members (before June 2022) were noteworthy. An instance of this was the coordination between the GP, Care Coordinator, and Nancy's sister after a blood test and the diagnosis of an infection in September 2019. Also, conversations between her sister and the care coordinator following a falls referral. It's important to acknowledge that face-to-face contact was significantly limited due to the COVID-19 pandemic starting in March 2020.

There is documented evidence of the family's active participation in decision-making during a critical point in November 2019. This occurred after Nancy's hospitalisation, during which the family expressed concerns about the continuity of care upon her return home. Records indicate that discussions took place involving the Hospital Discharge team, the OACMHT Social Worker, and the family regarding this matter. While complete agreement with the family concerning the level of care may not have been achieved, a mutually accepted solution was to provide additional support from District Nurses.

After Nancy experienced a more severe fall and was subsequently admitted to the hospital in January 2021, which also led to another hospital admission, records indicate that there was communication between the OACMHT, the hospital discharge team, and the family concerning the planning for her discharge. This subsequently led to an increase in the care provision to three times a day, which was deemed necessary by the family and responsive to need.

As previously discussed in this report, the decision to conduct a mental capacity assessment for discharge decisions in July 2022 was considered a commendable practice and included the involvement of family members.

The family actively participated in various discussions with the Police following a burglary and intrusion at Nancy's property. This situation led to a safeguarding referral by the Police, and Nancy's son agreed to consult the GP for further medical advice. The GP practice regularly worked together with Nancy's family during crucial moments, especially when adjustments to medication were required and merited a thorough review. This process encompassed home visits and dialogues with family members to ensure their involvement in the decision-making process.

10.3.1 Involvement of the family in the breakdown of the care package.

When the care providers, Care Provider, initially conveyed in May 2022 that they would no longer be able to continue providing care for Nancy, as well as for others, it is unclear how or

whether this information was communicated to the family. There is no supporting evidence to confirm any communication with the family, at this stage, either from Care provider or the Local Authority, which is a concern.

On 6th June 2022, her sister left a note for the carers on Nancy's fridge, notifying them of her upcoming holiday. Unfortunately, there is no evidence to suggest that the Care provider carers responded effectively to this note, particularly as they would have been aware the care package was set to conclude just two days later. Communication with the family should have taken place, rather than assuming another company would take over the care for Nancy.

There was a notable absence of communication with the family from the OACMHT Care Coordinator after a visit on the 14th June 2022, following a home visit. There was no record of any deterioration in Nancy's condition, or any concerns raised to Nancy's son, or other members of the family during this crucial period.

In July 2022, a complaint was received by the Local Authority through the local Member of Parliament before Nancy's passing. The decision was made to address the complaint through the Local Authority safeguarding process, leading to strategy meetings in August and September. Members of the family attended these meetings.

The minutes from the September 2022 strategy meeting have been made accessible to the reviewer, along with copies of the complaint letter, sent to various parties by the family.

There is a concern that the family has informed the reviewer that they have not received any written communication following their letter of complaint in July 2022.

10.3.2 The family as carers for Nancy.

There is no doubt that Nancy's family, her sister in particular, provided a high level of care and support, over many years. They worked in partnership with the carers and until the last 2 months of Nancy's life, this worked well.

An area for consideration in this report is the question of potentially a missed opportunity for a carers assessment for Nancy's sister and son. The rationale for this line of enquiry would be the lack of care Nancy received when her sister went on holiday, albeit due to the confusion and subsequent lack of care from Care Provider.

Care provider carers helped prepare meals and helped with personal care three times a day, which didn't happen when they stopped attending on 8th June.

Nancy's sister described (in her letter of complaint dated 25th June 2022), her sister as being 'in a life-threatening condition' and 'her mouth was bone dry' on her return from holiday. This was in addition to having had little or no personal care in the previous 10 days. Her sister described a strong smell of urine when she visited Nancy.

This may lead to a conclusion that a carers assessment, might have identified a potential shortfall in the care provided by the family in the event of a crisis. The Care Act 2014 states, that where it appears to a Local Authority that a carer may have needs for support (whether currently or in the future), the Authority must assess: -

(a) whether the carer does have needs for support (or is likely to do so in the future), and

(b) if the carer does, what those needs are (or are likely to be in the future).

The recognition and requirement for carer assessments and understanding family dynamics has been identified in other SARs nationally and subject to much research[5].

A carers assessment would have given an informed view of how the family could be best supported, in the event of a crisis, which this was.

10.3.3 The views of the family

The family have been contacted for their views on communication at key stages.

There has been some feedback on the S42 meeting process, attended by the family. Nancy's nephew felt the Section 42 process was 'good, professionally managed with all the responsible agencies being involved with the process on a timely basis.'

10.3.4 What went well?

- Police responded appropriately in response to burglaries and intruders, resulting in referrals to the Local Authority and communications with the family.
- There is evidence of effective communication with the family and other agencies from the OACMHT care coordinator.
- The GP surgery involved and supported the family with medication reviews and responded to concerns regarding physical deterioration.
- There is evidence to show family members being included in decision making with hospital discharge and IDT teams, particularly regarding the level of care provision.

10.3.5 What went wrong and could have been better?

- There was a lack of communication with Nancy's family when Care provider notified the Local Authority about the forthcoming reductions in service provision.
- There was a lack of formal written communication with family following their compliant in July 2022.
- There is a concern that a S42 enquiry may not have been the appropriate method for dealing with the family's complaint, especially after Nancy had died.

10.3.6 Learning from this key line of enquiry.

- There needs to be a process for communication with the family when a care package is at risk of being re-allocated to another provider.
- A process for formal communication with a family when they request this following a complaint.
- A missed opportunity to conduct a carers assessment for Nancy's family, to ensure they would be able to continue with appropriate care in the event of a crisis.

11. Internal system improvements since July 2022.

[5] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection (2015) 17 (1), 3-18.

The review acknowledges that various systemic improvements have been implemented following the passing of Nancy in July 2022. These changes were a direct outcome of internal reviews conducted by partners, including GMMH, in July 2022.

Additionally, actions were taken in response to a complaint from Nancy's family. The Local Authority agreed to address the family's complaint through their internal safeguarding process, leading to strategy meetings held in August and September 2022. Importantly, the family actively participated in both meetings.

Below is a summary of the main changes that have been made across the partnership since July 2022.

11.1 Care Provider (now owned by a different company name)

- All communications must record the full name and job title when speaking to someone at the Local Authority.
- Continue to provide care for any service user until necessary paperwork received from Home Care Bookings for any re-commissioned packages, not to accept verbal notice.
- Care provider have embedded their Serious Incident Process, which provides an audit trail of communications.
- Careline live system implemented – family and professionals' access to the care circle via an app.

11.2 Bolton Home Care Bookings:

- Team training regarding appropriate processes of commissioning and de-commissioning of care packages.
- Staff required to ensure all changes are documented on the on-line portal.
- Staff advised not to take any requests for changes to care packages from providers, over the telephone and all requests to be emailed or completed via the on-line portal.
- A change to a package of care is sent to a framework agency (Care provider) via the Portal, once they reply, HCB copy their reply onto Liquid Logic and notify the social worker, care co-ordinator or team.

11.3 Bolton Older Adults Community Health Team

- To share the learning from this review to ensure all staff are aware and ensure that communication channels stay open, between the care agency and Older Adults Community Mental Health Team, and to ensure that all changes are documented on the portal.
- If the request is to re-commission a care package, to request consent to look at care records to ensure things are up to date and to check if carers left any communication.
- When requested to re-commission a care package, discuss with family/friends to establish/record their thoughts and feelings and any changes.
- Routine checking for care provider daily records where this is in place, to identify any concerns at an early stage.

11.4 Bolton Commissioning Team

- Contract specification amended and directly awarded to the nine existing Tier one Framework providers – (Care provider is one of these).
- The ongoing development of new longer term contract framework for care providers in 2024.

- Consideration to align a more geographical neighbourhood specification to ensure providers can be consistent to area service delivery during 2024.
- A flowchart for the cessation of care packages for providers – The providers portal will evidence a clear audit trail of the information.
- The re-design of the specification for the new Home Care service specification is due to commence early 2024 now which will review current specification to ensure the incumbent Home Care agencies are aware of communication expectations.

12. The main learning points from this review

- There is evidence that assumptions were made about Nancy's capacity. These assumptions should not have replaced a formal assessment.
- There was a delay in completing the ACE 111 assessment, identifying cognitive impairment, and no evidence of an outcome focussed plan, and risk assessment following the assessment.
- There needs to be more evidence of effective communication and joint planning between the OACMHT care coordinator and the Care provider carers on issues such as missing keys and hiding medication.
- Conduct regular multi-agency reviews of the care plan to ensure any changes are factored into risk assessments and care plans.
- Where there are several agencies involved in delivering care to a person in the community there should be a coordinated care plan, with an identified lead professional.
- A Local Authority protocol for external care providers, outlining a clear process for the cessation of, or amendments to care packages.
- Missed opportunities for OACMHT care co-ordinator to review the carer attendance records, realise they were not attending and raise the alarm.
- Provide feedback to the hospital discharge team if it is felt that the appropriate medication has not been administered during the stay or at discharge.
- There needs to be a process for communication with the family when a care package is at risk of being re-allocated to another provider.
- A process for formal communication with a family when they request this following a complaint.
- A missed opportunity to conduct a carers assessment for Nancy's family, to ensure they would be able to continue with appropriate care in the event of a crisis.
- Nancy's protected characteristics meant that there were missed opportunities for safety planning e.g. Following burglaries and deterioration in physical and mental health.
- Development of a universal care log, to record activity at each visit with time, purpose, and date at each visit. All agencies must complete and sign to state they have the care log when they visit.

13. Recommendations/actions to effect change

1. When changes are required to a home care package, a checklist/dialogue with the relevant care management team, across all agencies to ensure the care manager, relevant professionals and where appropriate, family members, are notified.

2. BSAB to convene a working group, within 6 months of the publication of this report to consider the development of a universal care log which would be signed by agencies following a home visit.

3. BSAB to lead on a targeted audit of the updated process for agencies involved in the commissioning of domiciliary care when care packages are to cease, or changes are required. This will happen within 6 months of this report publication.

4. As part of our Care Act duties, practitioners need to ensure Carers assessments are considered as part of standard operating procedure. This will build on and embed strengths and assets-based working. Adult Social Care to ensure their case recording systems record the active consideration of carers assessments so that this can be routinely monitored via case file audits.

5. When a care provider, family member or social worker/ community assessment officer/ CPN provides concerns that the current support package is not meeting an individual's needs, a request would be made to the Social Worker (or allocated worker) to undertake an urgent review. This will take place within 28 days and form a re-assessment of the individual's needs.

6. The BSAB needs assurance that Care Act Assessments and Carers Assessments are undertaken in a timely manner resulting in an outcome focussed care plan, reviewed at least every 12 months, which responds to changing needs. The plan will be shared by all professionals and the family, in line with current protocols.

7. There needs to be consideration of Decisional or Executive capacity – as part safety planning and assessments to enable risks to be effectively managed. There needs to be clear evidence of the person's voice, wishes and feelings in line with Care Act duties - Making Safeguarding Personal.

8. The BSAB need to ensure a multi-agency training programme on discriminatory abuse is available across the safeguarding adult workforce.

9. BSAB partners will ensure that the learning from this review is shared with practitioners and the learning is embedded in front line practice.

10. The BSAB will ensure that the above recommendations are implemented within 6 months of the publication of this report and progress is formally reported back to the BSAB and its subgroups for scrutiny purposes.

14. Appendix one