social care institute for excellence

Havering Safeguarding Adults Board

Safeguarding Adult Review

"Mr C"

Commissioned by

Havering Safeguarding Adults Board

Independent Reviewers:

Sheila Fish (SCIE) with support from Simon Bayliss

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- informing, influencing and inspiring the direction of future practice and policy.

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Havering SAB
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CONTENTS

1 INTRODUCTION 1

1.1 Why this case was chosen to be reviewed 1

1.2 Succinct summary of the case 1

1.3 Methodology 2

1.4 Structure of the report 5

2 APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE 6

2.1 Brief timeline of the period under review 6

2.2 Appraisal synopsis 7

3 SYSTEMS FINDINGS 8

3.1 In what ways does this case provide a useful window on our system? 8

3.2 FINDING 1 ENGAGEMENT with housing of hospital services 9

3.3 Context 9

3.4 How did the finding manifest in this case? 9

3.5 How do we know it's underlying AND not a one-off? 10

3.6 How widespread is this systems finding and how many people are actually or potentially affected? 10

3.7 So what? Why should the SAB and partners care? 10

3.8 Questions for the SAB to consider: 11

3.9 FINDING 2 - TRIAGING shortcuts within ASC (HAT team and Community Team) 12

3.10 Context 12

3.11 How did the finding manifest in this case? 13

3.12 How do we know IT IS underlying AND not a one-off? 13

3.13 How widespread is this systems finding and how many people does it actually or potentially affect? 14

3.14 So what? Why should the SAB and partners care? 14

1 Introduction

1.1 WHY THIS CASE WAS CHOSEN TO BE REVIEWED

1.1.1 The Care Act (Para. 44) states as follows

44 Safeguarding Adults Reviews

(1) An 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.

(2) 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).

(3) 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.

(4)An 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).

1.1.2 This case had a legal mandate for a Safeguarding Adult Review (SAR) on the basis that Mr. C had died. There were concerns about self-neglect and a reasonable cause for concern about how agencies had worked together to safeguard him.

1.2 SUCCINCT SUMMARY OF THE CASE

1.2.1 Mr. C was in his early 60s. He had an established diagnosis of bipolar affective disorder and was known to mental health services in earlier years; he was diabetic and had a pinned hip, which had been described as restricting his mobility somewhat. At the start of the period of this review, Mr. C had moved from living with one of his sons (in multiple occupancy housing) to his own room in a shared council house, with three younger men. He had

lost his own tenancy after falling into rent arrears. The Police investigate alleged financial abuse. This did not result in no charges being brought.

1.2.2 Shortly after moving in, and over a three-week period, Mr. C took himself to the Hospital Emergency Department three times, and each time led to an inpatient stay. This was due to non-blanching rash, and later open wounds on his legs and extreme leg pain. His sons were involved and also shared concerns about a general decline in his functioning.

1.2.3 Havering Housing Services Tenancy Support had planned to reassess his support needs, following complaints from other people living in the house about his personal hygiene and ability to care for himself. However, the date coincided with his first hospital admission and so it did not take place.

1.2.4 After the second hospital stay, District Nursing visits were arranged to provide wound care. These efforts were severely hampered, often by Mr. C's refusal of treatment due to the pain he was experiencing. There was liaison with the GP and safeguarding advice was sought.

1.2.5 After the third hospital stay, some care and support was agreed through an emergency reablement package. The carers immediately contacted Havering Adult Social Care highlighting the unsuitability of his accommodation. Later they requested an urgent Social Work review as well as an urgent Occupational Therapy review because Mr. C could not use the stairs needed to get to the toilet as well as raising issues related to his basic needs and self-care. The carers also requested an urgent District Nursing visit due to the smell and seepage through his leg bandages.

1.2.6 The day after the urgent review was requested, and a week after his third hospital discharge, Mr. C was admitted for the fourth and final time, having suffered multiple strokes from which he later died. The day after his fourth admission, the allocated social worker responded to the carers' request for an urgent review by contacting them seeking Mr. C's contact details in order to book a meeting in four weeks' time.

1.3 METHODOLOGY

1.3.1 The purpose of a SAR is to provide findings of practical value to organisations and professionals for improving the reliability of safeguarding practice within and across agencies (Care Act Guidance Para 14.178), in order to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect.

- To promote effective learning and improvement to services and how they work together;
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm;
- To understand what happened and why.

1.3.2 The SAB decided to use SCIE's tried and tested Learning Together model for reviews to conduct this SAR (Fish, Munro & Bairstow 2010). Learning Together provides the analytic tools to support both rigour and transparency to the analysis of practice in the case and identification of systems learning.

A PROPORTIONATE APPROACH.

1.3.3 Learning Together allows a proportionate approach that builds on any internal agency investigations that have already been completed and revolves around a one-day workshop with practitioners and managers involved in the case.

A COLLABORATIVE, SYSTEMS-FOCUSED WORKSHOP

1.3.4 Participants are involved through the workshop in considering identified Key Practice Episodes (KPE), evaluating what went well and where there could have been improvements in practice in the case through each episode. Crucially, they would also be involved in identifying a range of different social and organisational factors, what helped and what hindered them in their work at the time.

1.3.5 From that basis, the lead reviewer supports the group to move from thinking about the case, to identify if there are any generalisable issues that impacted on practice in this case and impact on other cases more widely. By this means they draw out underlying systemic issues, features of the system that can help or hinder good practice beyond the individual case that is subject of the SAR.

BUILDING SENIOR LEVEL OWNERSHIP OF SAR SYSTEMS FINDINGS THROUGH THE PROCESS

1.3.6 In order to support the identification of systems learning, the Learning Together approach requires two face-to-face meetings with senior representatives from the agencies who were involved in the case. This "review team" plays an important role in bringing wider intelligence to the SAR process in order to ascertain which issues are case specific only, and which represent wider trends locally. Their ownership of the review findings is crucial.

1.3.7 We also sought to engage with family members to talk through the analysis, answer any queries and gain their perspectives.

TIME PERIOD

1.3.8 It was agreed that the review would focus on responses to Mr. C becoming homeless to his final admission to hospital – Feb 2019 till end June 2019.

1.3.9 It was decided not to include the alleged financial abuse of Mr. C within the scope of the time period under review. Given that it had been reported to and investigated by the Police, resulting in no charges being brought against any individual, there was no cause for concern about professional practice in relation to this aspect of the case.

RESEARCH QUESTIONS

1.3.10 The use of research questions in a 'Learning Together' systems review is equivalent to Terms of Reference but focused on the generalisable systems learning that is sought. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of

systems findings. The research questions provide a systemic focus for the review, seeking generalisable learning from the single case. The research questions agreed for this SAR were as follows.

1.3.11 What can this case tell us about what is helping and hindering:

a) Assessment and placement decision making process and practice by the Housing Solutions Team for adults with physical and mental health needs and self-neglect, facing immanently homeless to provide appropriate housing
b) Agencies to work together to support someone vulnerable, notice someone's deterioration and respond appropriately
c) Hospital discharge planning including delivery and effectiveness of reablement support

INVOLVEMENT AND PERSPECTIVES OF THE FAMILY

1.3.12 Information from agencies about their involvement with Mr. C indicated that he had two sons, a daughter and a sister who were all present in his life.

1.3.13 Following efforts to contact all four family members, the SAB Business Manager was successful in reaching one of Mr. C's sons and his sister by phone and was able to have a conversation with each of them during which they shared their experiences and reflections on the support provided to Mr. C.

1.3.14 In summary, Mr. C's son felt that services could have done more to encourage and promote his father's self-care and, after his deterioration, taken steps to care for him. As referenced later in this report in more detail, Mr. C's son raised concern about his father's fitness for discharge from hospital. Mr. C's son also expressed his dissatisfaction with Police for discontinuing the investigation into alleged financial abuse. On a positive note, Mr. C's son described how his father, before his deterioration, had been happy with the shared accommodation he was placed in by the Housing Solutions team.

1.3.15 In summary, Mr. C's sister felt that the quality of service her brother received from agencies in Havering was extremely poor and that, although they appeared to have his best interest at heart, they did not always prioritise him. Mr. C's sister described her brother as appreciative of anyone who helped him. Like her nephew, Mr. C's sister was dissatisfied with the Police's investigation into the abuse. Mr. C's sister also expressed dissatisfaction with Adult Social Care and Queen's Hospital and their responsiveness to her brother's needs.

REVIEWING EXPERTISE AND INDEPENDENCE

1.3.16 The review was led by Dr Sheila Fish, Head of Learning Together at SCIE, with support from Simon Bayliss, Senior Practice Development Manager, SCIE. Both are independent of all services in Havering. Sheila is an experienced reviewer across children's and adults. She also trains, accredits and supervises reviewers. Simon is SCIE's safeguarding lead. With a practice background in the education sector, Simon brings significant

operational and strategic safeguarding experience.

METHODOLOGICAL COMMENT AND LIMITATIONS

1.3.17 This is the first time that Havering has commissioned a review using the Learning Together methodology and the SAB was particularly interested in its ability to deliver systems findings.

1.3.18 Identifying the right operational staff to participate in the Case Group was challenging, and unfortunately very few of the people who contributed had actually met Mr. C. Reasons for this included the time that has passed since his death, which meant that some people had changed roles and moved agencies, as well as capacity issues of hospital staff, especially in the Covid context. This created a need for a second case group workshop as well as some follow-up conversations. It also meant we were missing some of the clinical staff involved in discharge planning at the Emergency Department and the hospital proper.

1.3.19 The collaborative process and Learning Together tools nonetheless worked well to enable operational staff to check factual inaccuracies, explain the rational for actions and inactions, and help the reviewers understand some of the contributory factors. Some participants commented, for example, that the case group workshop had allowed a false assumption to be identified and rectified swiftly, in contrast to experiences using different methodologies for SARs. Previous learning from a Havering SAR had included concerns at the start of this review, about the outcomes of medical assessments conducted by an outsourced service to Havering Housing services regarding the vulnerability of people who have made homelessness applications. There was therefore a concern that assessments had underplayed Mr. C's health needs and related vulnerability contributing to his being provided inappropriate housing. The workshop structure created conducive conditions for Housing staff to be able to share the actual sequence of events, that clarified that the medical assessment had had no bearing at all on the accommodation provided. Workshop participants also commented positively on the Early Analysis report structure, and how the Key Practice Episode structure helped to keep the conversation focused.

1.4 STRUCTURE OF THE REPORT

1.4.1 There are two main sections to the report. The Appraisal of Practice Synopsis is presented first. This gives a summary evaluation of the timeliness and effectiveness of responses to Mr. C and his family. It captures the case findings, detailing where practice was below or above expected standards and, where possible, explaining why.

1.4.2 The second part of the report draws out the wider learning. Systems findings are presented that impacted on practice in Mr. C's case and hold true more broadly, continuing to impact on cases today. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in this case

2.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW:

4 Mar - 11 Mar (1 week)

- 1st Safeguarding alert from NELFT (allegations of financial abuse, and being evicted so will be homeless and s.42 by Havering Access, Assessment and Brief Intervention Team HAABIT

13 Mar - 09 May (2 months)

- Havering Housing Services arranging of suitable accomodation, including Housing Now Medical assessment

09 - 13 May (4 days)

- Settling in visit and support from Havering Housing Services. Another visit in response to concerns and complaints from other residents and date set to update Support Plan

28 - 31 May in hospital (4 days)

- 1st hospital admission for rash all over lower chest, abdomen and lower limbs. Family report general decline in his function and unable to do daily tasks himself. Mr C behaves strangely on the ward so seen by Psychiatric Liaison Team
- Discharged to receive CT and dermatology related blood screening results as outpatient

31 May - 5 June at home (5 days)

- Mr. C home

5 - 14 June in hospital (10 days)

- 2nd hospital admission by ambulance-self referral due to leg pain. Rashes look infected, ankles swollen no active bleeding. Declines memory clinic.
- from 10th reporting pain, removing dressings as a result refusing to have legs redressed. Once less pain keen to go home.
- Discharged with referral to NELFT District Nursing.

14 - 19 June at home (5 days)

- NELFT District Nursing Service beginning visiting for wound care
- Issues with removing dressing again and refusing to be redressed due to pain. DN contacts 111 and hospital. Seeks advise from team leader and NELFT Safeguarding and raises High Level Risk Report

19 -21 June in hospital (3 days)

- 3rd hospital admission. Mr. C refuses to go home before legs are healed
- OT assessment, Reablement package agreed

21- 27 June at home (6 days)

- CW at home. District Nursing agrees visits every second day. Raises High Level Risk Report. Joint visit with Tissue Viabilty Nurse. Email sent to GP.
- Reablement from Lodge Group and referral to Adult Scoial Care for review of unsuitable accomodation.

27 June 4th and final hospital admission

- 4th hospital admission after being found collapsed at home unresponsive, with query stroke

2.2 APPRAISAL SYNOPSIS:

This section has been redacted to ensure that details of the individual and their family remains anonyms and thereby enabling publication of the report.

3 Systems Findings

3.1 IN WHAT WAYS DOES THIS CASE PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

Two systems findings have been prioritised from Mr. C's case for the SAB to consider. These are:

	Finding
1	FINDING 1: **Engagement with housing of hospital services** In situations where a person has changing medical/mobility needs and has only recently been housed by the council after being homeless, there is currently no routine liaison between Hospital Assessment Teams and Housing's Tenancy Sustainment Teams, leaving Reablement packages being commissioned in isolation from knowledge held by housing staff, including information about self-neglect. This runs the risk that opportunities to assess individuals who are at risk of self-neglect and who are admitted to hospital are missed and the options for reassessment and provision of alternative, more suitable accommodation, too (professional norms and culture).
2.	FINDING 2. **Triaging shortcuts within ASC (HAT Team and Community Team)** Efforts in the HAT Team to expedite urgent responses by liaising directly via email with the allocated social worker in the Community Team, unintentionally leave responses by both the HAT initial contact worker and the allocated SW without the senior oversight provided by the standard triaging systems. This makes it less likely that errors will be picked up, such as a social worker wrongly assuming a request is for a routine re-assessment at the end of a reablement package, rather than something requiring a more urgent review, including of safeguarding concerns (Professional norms and culture)

3.2 FINDING 1 ENGAGEMENT WITH HOUSING OF HOSPITAL SERVICES

FINDING 1: **In situations where a person has changing medical/mobility needs and has only recently been housed after being homeless, there is currently no routine liaison between Hospital Assessment Teams and Housing's Tenancy Sustainment Teams, leaving Reablement packages being commissioned in isolation from knowledge held by housing staff**, including information about self-neglect. This runs the risk that opportunities to assess individuals who are at risk of self-neglect and who are admitted to hospital are missed and the options for reassessment and provision of alternative, more suitable accommodation too (professional norms and culture)**. (Professional norms and culture)**

3.3 CONTEXT

Housing services and arrangements. Roles and processes exist in council housing services to assess the support needs of residents in order to maximise the chances that they are able to sustain their tenancies and avoid homelessness. In Havering these include a Settling In visit, Support Plan with the potential of review and also visits.

Reablement, is generally provided in the person's own home or care home as an intensive, time-limited assessment and therapeutic work over a period of up to six weeks (but possibly for a shorter period). It aims to 'enable people to be and to do what they have reason to value'. Since 2010 the UK Government has substantially invested in reablement services through NHS funding. It is now set within the context of the Government's broad prevention agenda, which aims to promote wellbeing and help reduce unnecessary hospital admissions, re-admissions and delayed discharges. In England, reablement is seen as a core element of intermediate care that promotes faster recovery from illness; prevents unnecessary acute hospital admissions and premature admissions to long-term care; supports timely discharge from hospital; maximises independent living and reduces or eliminates the need for an ongoing care package.

Broadly there are two models of delivery.

Intake and assessment services tend to operate a 'de-selective' model, where all those referred for home care undergo reablement unless it is agreed they will not benefit. For example, if someone has end of life care needs, they will be de-selected.

In comparison, hospital discharge services usually operate on a more selective basis. They support only those people who are judged likely to benefit from reablement. For example, discharge from hospital of someone who lacks confidence in their abilities following a fall which resulted in injury.

In recent years some of the hospital discharge services have broadened their role and evolved into a 'de-selective' model – and, similarly, some intake and assessment services have become more selective (perhaps due to financial pressures). For more information see **https://www.scie.org.uk/reablement/what-is/principles-of-reablement**

3.4 HOW DID THE FINDING MANIFEST IN THIS CASE?

A poignant fact of this case was a catch-22 which saw the meeting to review Mr. C's

support plan by the Tenancy Sustainability Team, deferred due to the very decline in his physical heath and mobility that made the need for that review pressing. The Tenancy Sustainability Officer at Havering Housing Services received a call from one of Mr. C's son's cancelling the appointment to update his father's support plan because Mr. C had been admitted to hospital with vasculitis.

However, what was also notable, was that in the course of Mr. C's taking himself back to the hospital a further two times, with his legs deteriorating and an escalation in his pain and mobility problems, there was no communication with the Housing Service generally or Tenancy Sustainability team in particular. As part of this review, we heard how the Residents Services Team could have stepped up their visits and could have easily reorganised or moved rooms so that the toilet was on the same level so removing the need to use stairs. The Tenancy Sustainability Officer has already contacted the Safeguarding Lead for housing in the MASH for a reflective discussion about who was in Mr. C's family network and could potentially support with his care needs, as well as whether sharing housing was appropriate for his circumstances.

3.5 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

As part of the review process, we explored the extent to which this was usual. These discussions surfaced how well it is working for housing staff, to have a designated housing lead in the Safeguarding Mash. We were told this role works effectively to link up housing and social work staff, that is otherwise experienced as difficult.

Similarly, we heard that about lots of recent changes targeted at improving the liaison and discharge planning for people who are homeless or there is a threat of homelessness. For example, there is a protocol between the hospital and Housing Solutions (the first point of contact for homelessness) to enable the hospital to inform them of approaching discharges. Housing Services have been doing training with the Hospital Discharge Team to encourage links and networks with housing. A named contact for housing for the hospital has been agreed. Discharge pathways have been mapped out with the hospital JAD team. This work, however, is predominantly focused on rough sleepers and crisis situations where there someone has no-where to be discharged too. What it does not cover are the whole range of tenancy support teams the Hostel Team, HMO TEAM, Sheltered Housing Team, Telecare team. This suggests that the lack of engagement with Mr. C's Tenancy sustainment officer was not a one off, but could something likely to be replicated.

3.6 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

Input the case review suggests that this finding is relevant to both hospitals in the local area: Queen's Hospital in Romford and King George Hospital in Goodmayes. It is likely to impact more on discharge process from emergency facilities than from wards. The finding would impact on all people who have recently been housed in council accommodation and are in the early stages of their 'settling in' processes and assessment of any support needs to allow them to sustain their tenancies.

3.7 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

Hospitals are making sense of someone's circumstances and wishes in pressurised settings with often limited information. Multi-agency working is therefore critical. Without established mechanisms and routines to engage with housing staff where relevant, failed hospital discharges are more likely, with the associated risks for patients, expense for services and distress for families.

FINDING 1 - ENGAGEMENT OF HOUSING IN HOSPITAL SERVICES

FINDING 1: **In situations where a person has changing medical/mobility needs and has only recently been housed after being homeless, is currently no routine liaison between hospital assessment teams and Housing's Tenancy Sustainment teams, leaving Reablement packages being commissioned in isolation from knowledge held by housing staff, including information about self-neglect. This runs the risk that opportunities to assess individuals who are at risk of self-neglect, who are admitted to hospital are missed and the options for reassessment and provision of alternative, more suitable accommodation too (professional norms and culture).. (Professional norms and culture)**

SUMMARY OF SYSTEMIC RISKS

Housing services are an important partner in efforts to safeguarding people with care and support needs in the local area. The provision of appropriate housing and housing support to people to enable them to sustain housing tenancies, are vital to the prevention of safeguarding issues, abuse and neglect, including self-neglect. This finding has highlighted a pertinent gap in multi-agency working and therefore information sharing, namely the engagement of tenancy support staff in hospital discharge planning, particularly for people who have only recently been housed. This creates risks that the resources of the whole multi-agency network are not used to best effect, and increases the chances of people being left in inappropriate housing when they need not be.

3.8 QUESTIONS FOR THE SAB TO CONSIDER:

3.8.1 Do the SAB and partners have adequate understanding about council housing services, how they are organized and what they provide?

3.8.2 How can better familiarity be enabled between Housing and Hospital Discharge Teams as regards the assessment and support provided to newly housed tenants?

3.8.3 Is there an up-to-date and functional housing/hospital discharge protocol that covers housing demand, supported housing and housing management?

3.8.4 Should Housing and the Hospital be asked to report back to the Board the outcomes of evaluations of new roles such as Housing's In-reach housing worker and the hospital's housing discharge coordinator?

3.8.5 Is there a role for the SAB in facilitating relations between Hospital Discharge Teams and the housing safeguarding lead on the MASH?

3.8.6 What assurances does the SAB seek about hospital discharge processes

locally?

3.9 FINDING 2 - TRIAGING SHORTCUTS WITHIN ASC (HAT TEAM AND COMMUNITY TEAM)

Efforts in the HAT team to expedite urgent responses by liaising directly via email with the allocated social worker in the Community Team, unintentionally leave responses by both the HAT initial contact worker and the allocated SW without the senior oversight provided by the standard triaging systems. This makes it less likely that errors will be picked up, such as a social worker wrongly assuming a request is for a routine re-assessment at the end of a reablement package, rather than something requiring a more urgent review, including of safeguarding concerns. (Professional norms and culture)

3.10 CONTEXT

The 'front door' of Havering Adult Social care Havering Assessment Team or HAT is designed to be the initial point of contact for all adult social care. The 'front door' of Havering safeguarding is technically the Multi-Agency Safeguarding Hub (MASH) which is described on the Council website as Havering's 'Adult Social Services Safeguarding Adults Team'.

Due to the grey area between quality and/or 'welfare' concerns and safeguarding concerns related to abuse or neglect including self-neglect, clear mechanisms have been created to allow concerns to be passed between the two teams, HAT and the MASH/Safeguarding Team. If there are any welfare concerns (rather than safeguarding issues) identified by the safeguarding team, the safeguarding team send them directly to the Duty 'ladder' in the Hat Team, overseen by a Senior Practitioner and visa-versa.

The remit of HAT is to do an immediate response to issues raised and to stabilize the situation. They only do short-term, time limited work. Routine and/or longer-term assessments and work is carried out by Community Teams, arranged in geographical patches.

The HAT Team currently has 6 initial contact workers. They are unqualified staff whose role is to have a conversation with the referrer, finding out what the situation is. In the HAT Team one initial contact worker manages the emails coming into the service on a rota basis. All referrals should then be triaged by one of two senior managers in the team (which include a social worker and an OT). Each Community Team has an equivalent 'duty tray' triaging system, overseen by senior managers.

Reablement interfaces between hospital and adult social care: At the end of a hospital discharge reablement package, a Reablement Review will often be needed to assess if there are outstanding care and support needs to be addressed. In Havering, the Brokerage Team, who arrange community support services for people choosing to have their support package arranged by Adult Care, automatically notify the Adult Social Care Community Team South (at the beginning of the reablement period) of when a person's Reablement package will end in order to log that a review will need to be completed.

3.11 HOW DID THE FINDING MANIFEST IN THIS CASE?

A notable feature of this case is that requests for 'urgent' responses were not successful. This finding focuses on Adult Social Care, taking the example of the email sent by the reablement carers on day six of their engagement with Mr. C.

As we noted in the appraisal of practice above, the reablement carers sent an email to the HAT Team, in which they made two 'urgently needed' requests. One was for a review by his Social Worker linked to the issue of inappropriate housing that saw him needing to use a water bottle to urinate in or crawl painfully up the stairs to access the toilet and also linked to potential self-neglect and/or inadequate care and provisions – no bedding, no clothes or under garments or toiletries, and very limited food supplies. The 'urgent need' was explicitly specified. Yet the response it triggered was an attempt to schedule in a routine review four weeks later.

We investigated how this could have appeared the sensible thing to do at the time, as part of this review. This took us back to the point at which the Reablement packages start 21st June. At this point, the Adult Social Care Brokerage Team automatically notified the Community Team South (at the beginning of the reablement period) that the reablement would end 6th July and a review should be completed. This allowed the allocated Social Worker assigned to complete these reviews, to know that a reablement review needed to be scheduled.

When the reablement carer sent the email to the HAT Team on the 26th June 2019, it was opened by the initial contact worker on duty to manage incoming emails. The initial contact worker, in an effort to be efficient, checked if there was already an allocated Social Worker for Mr. C. Finding there was, instead of creating a 'contact' log to be triaged, she forwarded the email directly to the allocated worker for Mr. C's reablement review. The initial contact workers also put a case note on the system to that effect, as well as copying and pasting the email.

The allocated Social Worker in the Community Team, responded promptly but erroneously to the communication the next day. Because she had already been alerted by the Brokerage Team for the need for a reablement review, assumed this was another request for the same. She did not notice that it was in fact an 'urgent review' being requested, so she put a contact in her diary for a review on 19th July 2019 as in normal circumstances this would have been the review date. She called the reablement carers the following day to get contact details for Mr. C in order to be able to confirm the reablement review date, only to be told that the day before he had been readmitted to hospital.

3.12 HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE-OFF?

As part of the review process, we explored the extent to which such a misjudgement about the urgency of response needed is usual. This revealed the way in which, sharing the email directly with the allocated worker inadvertently bypassed the oversight mechanisms that are designed into the triaging systems in both the HAT Team and Community South Team.

Within the HAT Team, if the standard process had been followed, a 'contact' should have been recorded by the unqualified initial contact worker, to be triaged by the qualified

managers. Good practice in this instance, would have been either for the HAT Team to respond as a matter of urgency as is their remit, and/or to raise a safeguarding concern with the MASH which may have led to a Section 42 enquiry, with the benefits of moving discussion and planning into a multi-agency space.

Even if the contact had erroneously been passed on to the Community Team via the duty system (rather than by direct email to an individual worker), there would have been a second level of oversight through the triaging system there.

Use of direct emails across teams within Adult Social Care therefore represents a systemic vulnerability of effective decision making and the timeliness of responses when concerns are shared, rather than just a one-off anomaly in Mr. C's case.

3.13 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

The HAT is set up and advertised as the single point of contact for Havering Adult Social Care; a 'front door' through which all concerns and requests flow in. If they require an urgent, time-limited response they receive it, otherwise referrals are passed on to the longer-term Community Teams or for adult safeguarding concerns to the MASH. Therefore, this systems finding will potentially affect information sharing about any and all the individuals referred in to the HAT Team.

3.14 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

With Havering Adult Social Care set up to have a single 'front door', the reliability with which concerns raised get the right response, depends on the robustness of the triaging system. This finding highlights a weakness that increases the possibilities of safeguarding concerns not being correctly identified and urgent care and support needs not getting the speed of response required.

FINDING 2. TRIAGING SHORT-CUTS WITHIN ADULT SOCIAL CARE

Efforts in the HAT Team to expedite urgent responses by liaising directly via email with the allocated social worker in the Community Team, unintentionally leave responses by both the HAT initial contact worker and the allocated SW without the senior oversight provided by the standard triaging systems. This makes it less likely that errors will be picked up, such as a social worker wrongly assuming a request is for a routine re-assessment at the end of a reablement package, rather than something requiring a more urgent review, including of safeguarding concerns.

SUMMARY OF SYSTEMIC RISKS:

Under pressure of work, people create 'work arounds' in an effort to be more efficient than the usual or planned processes allow. In addition, staff use 'rules of thumb' or heuristics as mental shortcuts to allow them to make judgments quickly and efficiently without needing to stop and think. Both these mechanisms have benefits but also

drawbacks. This finding has revealed how the workaround in the HAT Team, of using direct emails to pass on referrals where there is already an allocated worker, inadvertently by passes mechanisms for senior oversight of decision making both in the HAT Team, but also in the Community Team. This leaves no chance to pick up errors, when 'rules of thumb' that might usually work, lead to errors in decision making. Mr. C's case illustrates how this can lead to a lack of urgency of response, even when it is explicitly requested.

Questions for the SAB and partners to consider:

- Has the SAB recently asked Havering Adult Social Care to share updates about arrangements for processing referrals and insights about strengths and vulnerabilities and drivers of any identified work-arounds?
- The language on Havering Council's website does not reflect the terminology used by partners and creates confusion. E.g. there is no reference to the Adults MASH nor to the HAT team. Are there plans underway that will resolve all these issues? How can the findings from this SAR be fed into any website updating process?
- Has the use and oversight of emails been previously recognized as a potential risk by the SAB and/or partners?
- Can the SAB be confident that issues raised with the HAT rather than the Safeguarding Service/Adults MASH get the same level of service in terms of recognition and response to adult safeguarding issues?
- Can the SAB be confident that staff in the HAT team are able to recognise when issues brought to their attention should be passed on to the Safeguarding Service/Adults MASH?
- How will the SAB know if the potential gap in oversight arrangements for decision making in response to contacts with the HAT team, has been addressed?