Independent Investigation Final Report

20 March 2018

Author:

Dr Susan Mary Benbow, MB, ChB, MSc, FRCPsych, PhD, GMC 2382872
Director of Older Mind Matters Ltd, Visiting Professor, University of Chester, Psychiatrist and Systemic Psychotherapist

This page is intentionally blank.

Contents

	Page
Executive Summary	5
1. Background to the Independent Investigation	6
2. Objectives of the Independent Investigation	8
3. Process: The process followed in the Independent Investigation	9
4. Individual Investigations and outcomes as far as the Phase 2 report	14
Table 1: Summary of Investigation Process up to end of Phase 2 report	15
5. Individual Medical Case Reports and outcomes following the Phase 2 report	20
Table 2.1: Summary of IMA and I3 involvement in cases	20
Table 2.2: Summary of events following the Phase 2 Report	21
6. Summary of recommendations from Individual Investigations and Medical Case Reports and Action List	24
Table 3: Recommendations listed by the cases they relate to	24
Table 4: Recommendations arising from cases, numbered and listed by locality, with Agency status as of 10/5/2017	38
Table 5: Completed and outstanding recommendations arising from cases, numbered and listed by locality	76
7. Improvements made within the Health and Social Care Services within Dorset, Bournemouth and Poole. Report for the Advocare Oversight Group and Dorset, Bournemouth and Poole Safeguarding Adult Boards	102
8. Safeguarding Thematic Review Report, 25 August 2016 partially updated January 2018	123
Appendix to Safeguarding Thematic Review Report	138

	Safeguarding Thematic Review Report: Source documents	143
9.	The Investigation and the Terms of Reference	145
	Table 6: Information extracted from Annual Reports	147
	Box 1: You said – we did. Examples of how Safeguarding has responded to feedback from carers (provided by the Borough of Poole).	148
10.	Additional recommendations (including from Safeguarding Thematic Review)	150
	Table 7: Additional recommendations and evidence to be supplied	150
11.	Summary of outstanding actions as of July 2017	154
	Table 8: outstanding recommendations as of July 2017	155
12.	Conclusions	160
Appendix 1: Abbreviations/ acronyms used in the text		161
Appendix 2: Terms of Reference for Large Scale Independent Investigation into concerns raised on behalf of carers by Advocare		163
Appendix 3: Independent Investigation Terms of Reference for Independent Medical Assessors		169

Executive Summary

This Report is version 11 and has been longer than I would have wished in its gestation. For that I would like to apologise to the carers, and to everyone else affected by the delay.

This final version of the Investigation Report takes account of information that unfortunately came to light late in its genesis – information that has altered my understanding of the Investigation. As a result, as Author, ***I have decided to include in this Final Report only information that I can vouch for in terms of factual accuracy*** and have omitted feedback and opinion with apologies to those who provided feedback to me.

Previous versions of the Report were circulated to people involved in order to develop the content in confidence but they are superseded by this version. Previous versions are invalid and flawed: only this version is accurate within the limitations that follow. The Investigation itself has taken far longer than expected and includes cases that go back a number of years. The timeframe has been a major limitation in writing this Report, as, due to the lengthy timescale involved, the people involved in the Investigation have inevitably changed. The Author has relied on Advocare for the majority of documents, and is fully aware that access to the views of health and social care agencies has been limited. The Author was originally commissioned to draw together the Report within six days of work, an additional limitation.

The background, objectives and process followed by the Investigation and how it evolved are set out in the Report (chapters 1 to 5). The Investigation and its associated reports have generated a lot of recommendations from a variety of sources. The majority aim to improve healthcare, social care and safeguarding practice (summarised in chapter 6). Seventy-one recommendations were made in connection with the cases (Table 5, chapter 6); ten recommendations came out of the Safeguarding Thematic Review (chapter 8); and there are seven additional recommendations (chapter 10). The recommendations and information about how organisations had dealt with them by mid 2017 are set out in detail in the body of the Report. Some recommendations remain to be enacted (chapter 11). Alongside the Investigation there have been profound changes in health and social care. Chapter 7 (dated May 2017) was written by, and contributed on behalf of, the officers and directors of Bournemouth Borough Council, the Borough of Poole, Dorset County Council and Dorset Clinical Commissioning Group and captures some of the major changes that have taken place in health and social care over recent years.

1. Background to the Independent Investigation

1.1 The Independent Investigation was initiated in response to concerns raised by Advocare, an organisation for carers based in Poole, Dorset. Advocare was originally set up in 1999 by a small group of former carers with the aim of helping fellow carers of older people with dementia and improving local social services. By November 2008 Advocare – Caring for Carers, as the organisation became known, had acquired charitable status and broadened its remit to include support for unpaid carers of frail, sick or disabled people with any condition. Advocare's stated aim is to empower unpaid carers to speak openly about their needs and concerns.

1.2 In a letter dated 10 August 2009, Advocare brought a number of cases involving concerns unpaid carers had in relation to the health and social care services provided in Poole, Bournemouth and Dorset to the attention of the then MP for South Dorset, requesting an independent inquiry. The letter was copied to the Chair of NHS South West Strategic Health Authority (SHA), who was in the process of retiring, and came to the attention of the Chief Executive of the South West SHA. This started a process leading to a two stage Independent Investigation ranging across healthcare, social care, continuing healthcare, and safeguarding.

1.3 This Final Report brings together the findings of that investigation and is organised as follows:

1. Background to the Independent Investigation

2. Objectives: the agreed aims and objectives of the Investigation

3. Process: The process followed in the Investigation

4. Individual Investigations and outcomes as far as the Phase 2 report

5. Individual Medical Case Reports and outcomes following the Phase 2 report

6. Summary of recommendations from Individual Investigations and Medical Case Reports and Action List

7. Evidence of changes in health and social care arising from the Investigation: This chapter embeds a report produced in May 2017 for the Advocare Oversight Group and Dorset, Bournemouth and Poole Safeguarding Adult Boards and

included by kind permission. The Author asked to include it as the report sets out the current health and social care context.

8. Safeguarding thematic review Report: this report was written as a stand alone Report by the Author, dated August 2016, and has been updated and embedded as a chapter within this Final Report. It includes ten recommendations arising from that report.

9. Review against the Terms of Reference

10. Additional recommendations: this includes a Table listing the recommendations from the Safeguarding Thematic Review and some additional recommendations from one IMA report.

11. Summary of outstanding actions

12. Conclusions

2. Objectives of the Independent Investigation

2.1 The aims of the investigation were:

- to answer the questions raised by carers to their satisfaction relating to the care and treatment of their relative/loved one taking into account what carers want and don't want in relation to their concerns, see *Independent Investigation Terms of Reference*[1] Appendix 2;
- to make recommendations for improvements across health and adult social care and
- to make improvements in safeguarding practice, policy and procedures.

2.2 The stated objectives were:

- To conduct an Independent Investigation into the cases agreed
- To interview all carers to ensure that each individual carer's concerns are fully understood; to identify the desired outcomes of the investigation for each carer; to identify and consider issues of consent to the investigation process in each individual case and to identify the individual agencies that need to be involved in the investigation process.
- To answer specific questions raised by individual carers; clearly identifying any thematic issues.
- To make recommendations that maximise the potential for improvements in multi-agency working;
- To make proposals that will improve the quality of services for the future including methods for issues or concerns to be raised and resolved to a satisfactory outcome.

2.3 The full Terms of Reference for the Investigation are included as Appendix 2.

[1] Words in italics added for clarity

3. Process: The process followed in the Independent Investigation

3.1 *Agreeing terms of reference and cases to be included*

3.1.1 A South West SHA Associate Director was tasked with mediating between the statutory agencies and Advocare to secure Terms of Reference (ToR) for an independent investigation, and after two and a half years of negotiations, ToR were agreed for a two-stage independent investigation (see Appendix 1 for the full ToR). A monitoring and coordinating body was set up, called the Oversight Group (OG), and NHS England's then Chief Nurse for the Southern Region, was appointed as OG Chair and served in that capacity until November 2013.

3.1.2 The terms of reference for the OG were:

1. *Agree Terms of Reference for the independent investigation.*

2. *Procure an independent organisation to undertake the investigation.*

3. *Hold the independent investigators to account for delivery of their Terms of Reference within the agreed timescales and budget.*

4. *Ensure that the two relevant Safeguarding Adults Boards are informed of this potential large-scale investigation and they receive the final report.*

5. *Ensure that all relevant agencies involved in the investigation receive the final report.*

6. *Formally request that the two relevant Safeguarding Adults Boards following receipt of the report :*

    a. *adopt any recommendations*
    b. *develop an action plan with timescales for delivery*
    c. *ensure lessons are learnt*

3.1.3 Advocare put forward cases for inclusion in the Investigation to the group that became the Oversight Group and it was agreed initially that 18 cases should be included. Subsequently additional cases were added to give a total of 22 cases investigated (numbered in this Report 2-4, 5a/5b, 7-24). Advocare obtained consent from carers for the first time, for cases to be included in the investigation and for contact details to be passed to the investigator.

3.1.4 On 15 July 2011 Advocare and the OG Chair agreed the final versions of the investigation and OG ToR.

3.2 *Selection event*

3.2.1 Four NHS-approved organisations were invited to tender for the work and a Selection Event was held on 21 October 2011. The Acting Chief Executive Officer of Bournemouth and Poole Primary Care Trust led on the commissioning of the investigation and one of the bidding organisations was commissioned.

3.2.2 A contract was signed on 30 January 2012 and contact details of each carer plus a résumé for each case were passed to investigators – a document confirming this is dated 30 January 2012.

3.2.3 A letter dated 14 February 2012 to the carers stated that:

"*Your narrative will be treated as evidence for our detailed inquiries in Phase 2 into the reasons for your concerns*."

3.3 *Investigation Phase 1*

3.3.1 The aims of Phase 1 as set out in the report produced at the end of Phase 1 were to:

- interview all carers to ensure that their concerns are fully understood;
- identify the desired outcomes of the investigation for each carer;
- identify and consider issues of service user and/or carer consent in each case;
- identify the individual agencies that need to be involved in the investigation process.

3.3.2 Twenty-two cases were identified for interview but this reduced to 21 in April 2012 when the carer in case Number 12 withdrew from the process of his own volition.

3.3.3 The carers and/or service users involved were interviewed between 29 February 2012 and 10 April 2012 plus one interview by Skype in early June 2012, and those involved were provided with a summary of their session.

3.3.4 A draft Phase 1 report was produced for an OG meeting on 12 June 2012 and a final draft was circulated for an OG meeting on 22 August 2012.

3.3.5 Agencies involved with each case were identified and for each case five possible “scenarios” that might apply were considered:

1. *The issue requires immediate resolution for the benefit of the health and wellbeing of the service user. This does not preclude an investigation, at a later point, into the issues raised.*

2. *There is an historic issue, but the incident/problem may have occurred too long ago for any investigation to be able to identify adequately, or accurately, what happened and why. Each case will still require closure for the individual concerned.*

3. *The issues identified, whilst distressing to the individual, may not be directly to do with statutory services. However each case will require a degree of resolution and closure.*

4. *The case may still be within a three year time frame for making a complaint and a complaint may or may not have already been raised. Statutory services should, therefore, be given the opportunity to manage the complaint in accordance with the established policies and guidance.*

5. *No complaint has been made and or resolution achieved; the case falls outside the time frame for making a complaint or a complaint has been made and managed poorly leaving individuals ‘timed out’ of the system. Further independent investigation at Phase Two is required. These cases will require resolution during Phase Two as there has been a breach of trust and confidence in statutory services; this represents the only opportunity to have their concerns addressed.* (Section 12 of Phase 1 report, p.18-19, note pages in my copy are not numbered).

3.3.6 Seven cases were identified where there were “current concerns” (cases 2, 5b, 7, 13, 18,19 and 22), and it was requested that these cases should be fast tracked to prevent further distress to those involved.

3.3.7 Other points of importance to the evolving investigation were:

- The years in which concerns were raised spanned 1997-2011;
- The lack of trust between carers and statutory agencies was noted.

3.3.8 Advocare obtained consent for a second time from each carer for their contact details and the Phase 1 summaries to be passed to the relevant statutory agencies. Fast track meetings took place with relevant statutory

agency representatives and an Advocare representative attended each one at the carers' request.

3.4 *Investigation Phase 2*

3.4.1 An independent investigator (I1) was commissioned for Phase 2 in January 2013, and the OG Chair stipulated that work should be completed by September 2013. The independent investigator applied to be assisted by an additional person (I2) in view of the number of cases to be investigated.

3.4.2 The aims for Phase 2 as set out in the ToR and in the Phase 1 report were to:

- complete a detailed chronology of the care and treatment received by the individuals involved in the cases to be investigated;
- examine whether the care and treatment plans were adequate and appropriate and within the local and national guidelines and whether the actions of agencies were proportionate at the time to the concerns raised;
- identify which agencies need to be engaged to enable co-operation and assistance with the investigation:
- examine the extent and adequacy of the communication and collaboration between the agencies involved;
- undertake an audit of the individual's care and treatment records:
- raise any urgent concerns identified during the investigation with the nominated link at the relevant lead NHS or Local Authority commissioning organisation and notify Advocare.

3.4.3 The process followed in Phase 2 was:

- Meet with commissioning local authority and NHS
- Meet with the carers and/or service users "where possible"
- Examine written and computer files relevant to the cases
- Meet staff with knowledge of the case
- Prepare a draft report
- Circulate for factual comments
- Produce final report with added conclusions, findings and recommendations

3.4.4 I1's Summary (Phase 2) Report dated 20 Nov 2013 dealt with a total of seven cases and refers to an eighth as "pending completion". The Summary Report is sub-titled non-medical assessments and excluded investigations of health care. The author lists a number of "barriers" to the investigation:

- The length of time elapsed since the relevant events
- Reliance on written and computer records
- “absence of notes kept by some carers”
- “failure to previously bring genuine concerns into the formal complaints process”.

3.4.5 The Phase 2 Investigator excluded health care cases and as a result Independent Medical Assessors (IMAs) were involved to look into specific cases and produce reports. Advocare sought a third consent from carers in order that health records could be released to the IMAs.

3.4.6 In some cases, following reports produced in Phase 2, IMAs were involved or a further investigation of the case was initiated.

3.4.7 A Safeguarding Thematic Report (STR) was also commissioned. During the final stages of preparing this Final Report questions were raised about cases included in the STR. The cases to be included in the STR were agreed by the OG and the question of carers who withdrew from the Investigation had been addressed in the initial Investigation ToR:

“In circumstances, where carers decide not to continue with the investigative process, the investigator will advise the Oversight Group on the best way to deal with this.”

3.5 *Evolution of the Investigation*

3.5.1 Thus the investigation evolved, rather than proceeding in line with initially agreed process (see the Flow Chart in Appendix 2).

3.5.2 In addition it appears that there was no agreement between those involved regarding at what stage and with whom reports and recommendations should be shared, and there has been inconsistency in how this has been done, so that in collating recommendations to produce this report it is unclear which reports have been shared and which have not.

4. Individual Investigations and outcomes as far as the Phase 2 report

4.1 In total 22 cases were included at the outset the investigation. Table 1 summarises the investigation process by case as far as the Phase 2 report.

4.2 Seven cases (2, 5a/5b, 13, 16, 18, 19 and 20) were assigned to investigator 1 (I1). One of these (case 13) was not actioned. Another (case 2) was assigned to fast tracking and clinical assessment since it did not involve adult social care, so this case was not included in the Phase 2 report.

4.3 Nine cases (4, 7, 8, 11, 15, 17, 22, 23 and 24) were assigned to investigator I2. Seven of these cases were not investigated by I2. Reports were produced on cases 11 and 15, but subsequently another investigator (I3) was allocated to re-investigate these cases (11 and 15).

4.4 Thus the Phase 2 report (dated 20 November 2013) dealt with seven cases: five (5a/5b, 16, 18, 19, and 20) were investigated by I1, and two (11 and 15) investigated by I2. One case (18) was “still under investigation” at that point, so recommendations relating to six of these cases (ie excluding case 18) were included in the Phase 2 report.

4.5 A later report was produced for case 18, dated 13 March 2014.

4.6 In one of the six cases the investigator made no recommendations (case 19) in the Phase 2 report. The recommendations made in the remaining five cases (5a/5b, 16, 20, 11 and 15) are set out in Table 1 by case together with the recommendation made in the later report on case 18.

4.7 Three of the five cases with recommendations included in the Phase 2 report were subsequently assigned to be re-investigated (cases 5a/5b, 11 and 15).

4.8 5a and 5b are separated in the Table although they were regarded as one case.

4.9 I1’s Summary Phase 2 Report was received by the OG at a meeting in November 2013.

Table 1: Summary of Investigation Process up to end of Phase 2 report

Case No.	Health care	Socl care	Phase 2 investigator () not actioned	Locality	Information from text of Summary Report	Recommendations from Phase 2 Summary Report (copied verbatim)
2	√	X	I1	Poole	"… case 2 … was rated to be fast-tracked is now solely for a clinical assessment and does not involve adult social care."	None
3	√	X	X	Poole	n/a	n/a
4	√	√	(I2)	Dorset	n/a	n/a
5a	√	√	I1 Then I3	Dorset	"No evidence of poor social care practice…"	It would be helpful if the NHS were able to write to *person b* (and *person a*) to give some reassurance that his medical records are fully recorded, complete and networked on systems in the event of *person b* being admitted to any hospital in the future – especially if *person a* is in some way involved in that admission.
5b	√	√	I1 Then I3	Dorset	"No evidence of poor social care practice…" "Clinical issues in 5b to be examined independently…"	There are no recommendations in this case. The investigator wishes *person b* well for the future.
7	√	√	(I2)	Poole	n/a	n/a
8	√	√	(I2)	Bournemouth	n/a	n/a

Case No.	Health care	Socl care	Phase 2 investigator () not actioned then I3	Locality	Information from text of Summary Report	Recommendations from Phase 2 Summary Report (copied verbatim)
9	√	X	X	Bournemouth	n/a	n/a
10	√	X	X	Poole	n/a	n/a
11	√	√	I2 Note: this report was rejected by the carer. Case re-examined by I3	Dorset	"The home's formal complaints policy was not used… complaints were not upheld. It is possible that the motivation around the process was to widen the debate to other issues…"	1. That Advocare be encouraged to advise its carers to engage with the formal complaints process in Residential and Nursing Care Homes. 2. That Advocare be encouraged to advise its carers to make contemporaneous records where possible of incidents/issues they are not happy with. 3. That (carer/s) considers asking the Registered Manager for an opportunity to inspect the records held at (the Care Home involved, Care Home A) in relation to (resident).
12	√	X	X	Poole	n/a	n/a
13	X	√	(I1)	Poole	n/a	n/a
14	√	X	X	Poole	n/a	n/a
15	√	√	I2 Note: this report was rejected by the carer. Case re-examined by	Dorset/ Poole	"The home's formal complaints policy was not used… complaints were not upheld. It is possible that the motivation around the process	

Case No.	Health care	Socl care	Phase 2 investigator () not actioned	Locality	Information from text of Summary Report	Recommendations from Phase 2 Summary Report (copied verbatim)
			I3		was to widen the debate to other issues…"	
16	√	X	I1	Poole	"Findings support overall concerns, subject to independent clinical assessment."	1. (Carers) say they wish any maladministration to be exposed to ensure that changes are made to prevent other vulnerable people suffering harm and their carers experiencing distress. 2. The investigator recommends that the hospital and other agencies need to respond to these issues by informing (carers) of how situations have changed since the events subject of this investigation and what measures have been put in place to safeguard vulnerable patients both in Hospital care and on discharge under care plans. This recommendation should await the result of the independent clinical assessment. 3. It is acknowledged that all services are under huge pressure with the large numbers of vulnerable elderly people but they, and their families/carers, are entitled to safe care and support. There are disturbing, albeit historic, omissions in this case and the perception of those involved is of failure and neglect.
17	√	√	(I2)	Dorset/ Poole	X	X

Case No.	Health care	Socl care	Phase 2 investigator () not actioned	Locality	Information from text of Summary Report	Recommendations from Phase 2 Summary Report (copied verbatim)
18	√	√	I1	Poole	"pending completion" "still under investigation"	It is reasonable that Adult Services … write to (the carer) tendering an appropriate apology for the period of time that elapsed before this new approach was adopted.
19	√	√	I1	Bournemouth	"Finding does not support a general failure by social care… case is pending a clinical independent assessment…"	There are no recommendations arising from this report.
20	√	X	I1	Poole	"Finding was that complaints against Poole hospital were partially upheld and upheld against adult services."	1. Poole Hospital and their PALS be made aware of the findings of this report and to be satisfied that due consideration is made to record-keeping of patients' property and the needs of patients and carers on discharge. 2. Adult social care to review their stance when complaints are made to their staff about domiciliary services for which they have a commissioning responsibility and in particular the way in which concerns and complaints are recorded, actioned and monitored. 3. The Chief Nursing Officer and Chief Executive, who have offered to listen to carers in person be invited to meet with (carer). She welcomes this and believes it would help her to

Case No.	Health care	Socl care	Phase 2 investigator () not actioned	Locality	Information from text of Summary Report	Recommendations from Phase 2 Summary Report (copied verbatim)
						achieve closure of these issues which continue to trouble her.
21	√	X	X	Poole	X	X
22	X	√	(I2)	Bournemouth	X	X
23	√	X	(I2)	Poole	X	X
24	√	X	(I2)	Bournemouth / Poole	X	X

KEY

Social care	No shading	
Health care	Light grey shading	
Safeguarding	Hatched	
Health AND social care	Dark grey shading	

5. Individual Medical Case Reports and outcomes following the Phase 2 report

5.1 Table 2.1 and 2.2 summarise the process of the investigation following the Phase 2 report.

5.2 Table 2.1 lists those cases in which an Independent Assessor produced a report and those in which a further Investigator was involved. Six different IMAs were involved and have been designated IMA 1-6. The terms of reference for the IMAs are set out in Appendix 3. One person was involved in some cases as an IMA and some as an investigator and Table 2.1 has been checked against OG minutes in order to clarify their role in the various cases as this person was not initially sent the Investigator ToR.

5.3 Table 2.2 summarises in more detail events following the Phase 2 report, indicating which cases were fast-tracked, the involvement of an IMA or a reinvestigation/ investigation; in which cases a letter of apology was sent; what formal meetings took place; and which cases are included in the Safeguarding Thematic Report. Recommendations were produced in the Phase 2 report but also by IMAs, during re-investigation by I3, and sometimes as a result of formal meetings. From the column headed meetings it is evident that assessments and meetings included in this part of the process first took place in autumn 2012 and ran through until mid 2016.

Table 2.1: Summary of IMA and I3 involvement in cases

Case number	Assessment by IMA Individual IMAs designated numbers 1-6	Reinvestigated following Phase 2 report
2	IMA1	-
3	IMA2	-
4	IMA2	-
5a	IMA3	I3
5b	IMA4	I3
8	-	I3
9	IMA5	-
10	-	I3
11	IMA2	-
14	-	I3
15	-	I3
16	IMA4	-
17	IMA2	-
19	IMA3 & 6 (jointly)	-
21	-	I3
22	-	I3

Table 2.2: Summary of events following the Phase 2 Report

Case No.	Fast track-ed?	Invest-igator	IMA	Included in STR	Meetings	Letter of apology	Recommendations (X=not included)			
							Phase 2	From IMA/ investigator	In STR	Formal meeting
2	√	X	√ 1	X	1. Fast track meeting 8/10/12 2. IMA1 on 12/12/13 3. Senior staff Poole Hospital 28/8/14	√	None	√ **	X	X
3	X	X	√ 2	X	1. IMA2 on 3/12/13 2. Visit to Alderney Hospital 9/12/15	n/a	X	√	X	√
4	X	X	√ 2	√	1. IMA2 on 4/12/13 2. Re Safeguarding report 10/12/14 3. ASC Director 29/6/15	√*	X	√	√	X
5a	√	I3	√ 3	X	1. Fast track meeting 12/11/12 2. I1 on 15/4/13 3. Assessment by IMA3 on 7/8/14 4. Investigator I3 on 9/12/14	n/a	√	√	X	X
5b	√	I3	√ 4	X	1. Fast track meeting 15/11/12 2. I1 on 15/4/13 3. Home meeting Senior Staff 29/4/13 4. IMA4 on 11/6/14 5. MDT meeting rejected specialist report 13/11/14 4. Investigator I3 on 9/12/14	n/a	None	√	X	X
7	X	X	X	√	X	n/a	X	X	√	X
8	X	I3	√ 2	X	1. I3 on 8/10/14	√*	X	√	X	X

Case No.	Fast tracked?	Investigator	IMA	Included in STR	Meetings	Letter of apology	Recommendations (X=not included)			
							Phase 2	From IMA/ investigator	In STR	Formal meeting
9	X	X	√ 5	X		n/a	X	√**	X	X
10	X	X	√ 2		1. IMA2 on 8/5/14 2. Senior staff Poole Hospital 1/7/15 and report from specialist. 3. Visit to Jersey ward 13/8/15	n/a	X	√	X	√
11	X	X	X	X		n/a	√	√	X	X
12	X	X	X	X	X	n/a	X	X	X	X
13	X	X	X	√	X	n/a	X	X	√	X
14	X	X	√ 2	X	1. IMA2 on 7/5/14 2. Senior staff Poole Hospital 1/7/15 carer unable to attend so 3. Matron visited carer 12/8/15	n/a	X	√	X	√
15	X	I3	X	X	1. re-examining investigator I3 on 9/12/2014	n/a	√	√	X	X
16	X	X	√ 4	X	1. Resolution meeting with IMA4 on 18/2/14 2. Senior staff Poole Hospital 19/10/15	n/a	√	√**	X	√
17	X	X	√ 2	√	1. IMA2 on 5/12/13	n/a	X	√	√	X
18	X	X	X	√	1. Meeting re STR 10/12/14 2. Met Safeguarding Officer 31/5/16	√	√	X	√	X
19	√	X	√ 3, 6	X	1. Fast track meeting 19/10/12 2. Assessment IMA3 & IMA6 on 8/2/14	n/a	None	X	X	X

Case No.	Fast tracked?	Investigator	IMA	Included in STR	Meetings	Letter of apology	Recommendations (X=not included)			
							Phase 2	From IMA/ investigator	In STR	Formal meeting
20	X	X	X	√	1. Met re STR 10/12/14	n/a	√	X	√	X
21	X	X	√ 2	X	1. Met IMA2 on 7/5/14	n/a	X	√	X	X
22	√	I3	X	X	1. Fast track meeting 9/10/12 2. Investigator I3 on 7/10/14	√*	X	√	X	X
23	X	X	X	X	1. Senior staff meeting 1/7/15	√*	X	X	X	None
24	X	X	X	X	1. Senior staff meeting 1/7/15	√*	X	X	X	None

* apology not accepted by person concerned
** recommendations taken from the indicated source and modified by Final Report Author.

KEY

Social care	No shading	
Health care	Light grey shading	
Safeguarding	Hatched	
Health AND social care	Dark grey shading	

6. Summary of recommendations from Individual Investigations and Medical Case Reports and Action List

6.1 Table 3 lists the recommendations made by case, indicating where the recommendation was made (source and date) and which locality it applies to. Some recommendations are duplicated, ie the same recommendation was made in respect of more than one case. Also there was variation in practice so it has been necessary sometimes to edit the wording to make the recommendation clear or to take recommendations from the conclusions drawn by the author of the report, as they were not separately listed.

6.2 Table 4 lists the recommendations by locality and was circulated to the agencies involved with a request that they update the Author on the status of each recommendation by 10 May 2017. Their responses are listed in the column headed status. In some cases the Author has added information as indicated.

6.3 From the responses of 10 May 2017 it was difficult to be sure whether or not many recommendations have been acted on. The Author sent out the Table a second time, now Table 5, with columns as follows:

- Yes the recommendation has been completed
- No the recommendation has NOT been completed
- IF NOT COMPLETED name of person responsible for enacting the recommendation
- IF NOT COMPLETED date by which the recommendation should be enacted.

6.4 Responses from agencies in Table 5 are from July 2017. The Table does not take account of actions taken since that date and the Author is aware that some recommendations listed in Table 5 as outstanding have been completed since then.

Table 3: Recommendations listed by the cases they relate to

Case	Source & date	Applies to locality	Recommendations/ action points
2	Taken from IMA report Jan 2014 – modified by this Author.*	Poole	**2.1** That the service user be informed whether the surgeon has undertaken **Advanced Communication Skills training**, which is now recommended for all clinical staff involved in the treatment of cancer, and if the surgeon concerned has not undertaken the training that this should be expedited urgently.
			2.2 Records: The service user has requested that his records should include a note to the effect that there was a misdiagnosis. This does not seem unreasonable, should be done and confirmation that it has been done sent to the service user.
3	IMA 17/1/14	Poole – Alderney Hospital	**3.1 Culture of care:** If the wards at Alderney Hospital are not already involved in the AIMS-OP programme then involvement in the programme could be considered as a way to demonstrate that inpatient care meets appropriate standards, and as a way of reassuring carers who have been through bad experiences that things are changing.
			3.2 Anti-psychotic drugs and psychological/ psychosocial interventions: Other possible actions might include auditing the use of anti-psychotics (this may have already been done); auditing what training staff have undertaken relating to psychological/ psychosocial interventions as a prelude to identifying future training priorities and arranging necessary training; auditing the availability and range of activities on the wards.
			3.3 Smoking policy: When a person with dementia who smokes is admitted to hospital the care plan needs to include appropriate management of their smoking which will include measures to deal with any withdrawal symptoms if they are in a non-smoking environment, eg nicotine replacement treatment.
			3.4 Relationship with carers: It is good practice to encourage the involvement of

Case	Source & date	Applies to locality	Recommendations/ action points
			carers and to ask them to give routine regular feedback about ways to improve the environment where their relative is being cared for. Simple things can be built into the system to help carers stay fully informed and involved, and should be considered eg meeting them regularly; involving them in review meetings; copying letters relating to their relatives care to them (with their relative's consent); giving them copies of treatment and discharge plans (with their relative's consent). Enquiring about LPAs and recording their existence should be routine practice.
			3.5 Commissioners should **review services to support carers in the community** including respite/ rotational respite and out-of-hours services.
			3.6 CHC funding reviews: Funding organisations should audit whether regular review of CHC funded placements is taking place; whether review includes the issue of whether care needs are being met as well as continuing eligibility for funding; and whether there are processes in place to ensure that timely reviews take place. Funding organisations need to have an agreed way of dealing with concerns about unsatisfactory care in those people receiving CHC, eg by drawing them to the attention of the regulator and/or by moving the person receiving care to a placement which meets their needs.
			3.7 Safeguarding: Dorset's Multi-Agency Safeguarding Adults Policy and Procedures should be reviewed to ensure that where carers have been alleged to have caused harm they have the right to know what has been alleged; a right to give their account of what happened; and a right to appeal against the outcome of the safeguarding process.
			3.8 Services for people with early onset dementia should be reviewed to ensure that people are not disadvantaged by virtue of developing dementia at a young age, and that the carers of younger people

Case	Source & date	Applies to locality	Recommendations/ action points
			with dementia have access to community support.
			3.9 Assessment: An admission care pathway with agreed criteria for admission of people with dementia should be considered (if not currently in operation).
4	IMA 17/1/14	Dorset	Recommendations/ action points for cases 3, 4 and 17 were listed in one report – see under case 3.
	STR	Dorset	See STR recommendations Chapter 8
5a and 5b	Phase 2 report	Dorset	**5.1** It would be helpful if the NHS were able to write to person b (and person a) to give some reassurance that his medical records are fully recorded, complete and networked on systems in the event of person b being admitted to any hospital in the future – especially if person a is in some way involved in that admission.
5a and 5b	Investigator report 31/3/16	Dorset	**5.2 Psychological assessment/ treatment:** In respect of case 5a: (carer) to be seen and assessed at home by an independent person with appropriate expertise and qualifications in psychological treatments and with a commitment to follow (and where necessary fund) the recommendations of that independent person.
			5.3 Specialist recommendations: In respect of case 5b: the recommendations made in (a specialist) report regarding (service user's) follow up care and treatment to be enacted at the earliest opportunity and, because of the complexity of (his) needs and (carer's) needs, this to be done in the community.
			5.4 Review practical and emotional support for carers available in the community with particular attention to how carers might better experience continuity of care over the course of caring for someone with a chronic illness and how carers might be supported in attending to their own needs.
			5.5 Senior member/s of staff at Social Services and the CCG to prepare **evidence and explanation for (the carer)** about how services have learned (or propose to learn) from her experiences, in

Case	Source & date	Applies to locality	Recommendations/ action points
			order to improve services for future carers by answering the eleven questions as set out on page 20 (of the Report).
			5.6 If not recently done, CCG to **audit how families/ carers are involved in the process of assessing eligibility for NHS CHC funding** with particular attention to how families/ carers might have confidence that their voice has been heard.
			5.7 If not recently done, **CCG to review the appeal process** relating to assessments for NHS CHC funding with particular attention to how families/ carers might have confidence that their voice has been heard.
			5.8 If not recently done, CCG to review the **training undertaken by health and social care staff involved in eligibility assessments** with particular attention to their training in working with service users and carers and how to ensure a person-centred approach.
			5.9 In the case of each of the above Action Points (5.4-5.8) **evidence of improvement** should be provided to (the carer, service user,) and Advocare in order to address the aims set out earlier.
			5.10 In respect of the recommendations that the person leading the CHC Multidisciplinary team meeting about the Decision Support Tool ratings on 13/11/2014 should have **training in conflict management and communication skills** (in response to their complaint); (the carer and service user) would like to know whether this was carried out and they should be informed whether it was or not.
7	STR	Poole	See STR recommendations Chapter 8
8	Investigator report	Bournemouth	**8.1 Review practical and emotional support for carers available in the community** with particular attention to how carers might better experience continuity of care over the course of caring for someone with a chronic illness and how carers might be supported in attending to their own needs.
			8.2 Carer vulnerability: Review in what

Case	Source & date	Applies to locality	Recommendations/ action points
			circumstances a carer might be regarded as vulnerable. Is practice in Bournemouth the same as elsewhere, or are there areas of the country where (this carer's) vulnerability might have been acknowledged and, if so, how would he have been approached differently?
			8.3 Review what Trust policies influence **how healthcare staff members work with and involve carers/ family**, and how communication with carers and their involvement in their relative's care might be improved.
			8.4 It may be appropriate to consider whether some wards at RBH should apply for the **Quality Mark for Elder-friendly Hospital Wards.**
			8.5 Review of discharge planning process at the Royal Bournemouth Hospital with particular reference to people with dementia, how their carers are involved in the process, and how their carers' views are taken into account.
			8.6 Carer involvement in training: Ensure that carers are involved in the training of health and social care staff.
9	IMA 5/3/15	Bournemouth	The IMA concluded that "in my opinion, there should have been an Inquest as this was a death arising directly as a result of a failed attempt at ERCP."
10	IMA 31/7/14	Poole	**10.1** Senior members of staff at the hospital (Alderney) to prepare a **detailed response** to the points raised by (the carer), concentrating on how Alderney Hospital proposes to improve the care of people using services in future, what can be learned from (the spouse's) experience, and what has changed since (the) admission; response to be produced in partnership with an Independent Medical Assessor to act as an impartial third party. It is likely that production of the response will need to include a senior member of nursing and of medical staff in order to address all the questions raised.
			10.2 Working with carers/ families: Review what Trust policies influence how healthcare staff members work with and

Case	Source & date	Applies to locality	Recommendations/ action points
			involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.
			10.3 In respect of vulnerable older people, the Trust might consider using a **letter of authorisation for information sharing** in order to ask patients who are capable of deciding to specify with whom they want information about them to be shared.
	Meeting at Poole Hospital 1/7/15	Poole	**10.4 Visit:** A senior staff member kindly offered to take (the carer) to visit the ward and meet the ward sister and (the carer) was pleased to accept this offer. If possible (subject to their agreement and practical arrangements) (she) would like to talk with patients and relatives whilst she is there.
			10.5 A senior staff member will check whether relatives/ carers are made aware that **care plans** relating to the treatment of their relatives are available.
			10.6 Staff training: Advocare will give (the carer's) contact details to the named senior staff member so that (the carer can be contacted with a view to recording experiences/ story for use) in training staff.
			10.7 The senior staff member has agreed to **feed back to (the specialist they approached for an opinion)** the specific comments and views of an Advocare representative that (the carer) i) did not have poor recollection of events as the investigator states in his report ii) was bullied by the OT and this was not a negative misinterpretation (only the carer can say what the experience was). Good communication on behalf of staff would have prevented both of these.
			10.8 An Advocare representative and a senior staff member have agreed to meet and explore **how Advocare might work with the Trust** in the interests of carers and patients.
			10.9 Audit: A senior staff member referred to the PDS audit 'get it on time' and will check whether it is being undertaken.
11	Phase 2	Dorset	**11.1** That Advocare be encouraged to

Case	Source & date	Applies to locality	Recommendations/ action points
	report 20/11/13		advise its carers to engage with the **formal complaints process in Residential and Nursing Care Homes**.
			11.2 That Advocare be encouraged to advise its carers to make **contemporaneous records** where possible of incidents/issues they are not happy with.
			11.3 That (carer/s) considers asking the Registered Manager for an opportunity to **inspect the records** held at (a named Home) in relation to (resident).
	IMA 21/7/15	Dorset	**11.4 Complaints:** Encourage relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and routinely give them information about how to complain, and how to access support in making complaints.
			11.5 To **review the involvement of service users and carers in social care staff training/ continuing development** at all levels and to consider ways of increasing their involvement.
			11.6 Involvement of Carers in ASC: To review how carers are currently involved in adult social care and consider whether they could be more involved in order that their voice is heard at all levels and in all relevant fora.
12	***STR***	***Poole***	***This case whilst included in the investigation appears not to have been investigated.***
13	STR	Poole	See STR recommendations Chapter 8
14	IMA	Poole	**14.1 Recording Next of Kin.** The Trust might review their practice regarding how NOK is recorded and how difficult issues regarding NOK might be addressed; for example, through information management training for staff and/or audit of NOK recording practices.
			14.2 Relationship with carers/ families: Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.

Case	Source & date	Applies to locality	Recommendations/ action points
			14.3 In respect of vulnerable older people, the Trust might consider using a **letter of authorisation for information sharing** in order to ask patients who are capable of deciding to specify with whom they want information about them to be shared.
			14.4 Audit basic standards of care eg nutrition, communication.
			14.5 It may be appropriate to consider whether some wards at Poole and Alderney Hospitals should apply for the **Quality Mark for Elder-friendly Hospital Wards** (Royal College of Physicians, 2014).
			14.6 Senior member/s of staff at the Hospitals to prepare an **explanation for (the carer)** about what happened to her husband and how the Hospitals propose to learn from her experience and to improve the care of people using services in future. This explanation would be best offered to (the carer) through a neutral third party, or in writing, and perhaps in partnership with Advocare. This approach might be equally appropriate in the case of other carers who have had similar experiences.
15	Phase 2 Report 20/11/13	Dorset/ Poole	15.0.1 That Advocare be encouraged to advise its carers to engage with the formal complaints process in Residential and Nursing Care Homes.
			15.0.2 That Advocare be encouraged to advise its carers to make contemporaneous records where possible of incidents/issues they are not happy with.
			15.1 That Advocare be encouraged to advise its carers to consider alternative approaches when confronted with an issue such as persistent urinary infections.
	IMA 27/1/15	Dorset/ Poole	**15.2 Complaints:** Encouraging relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and ensuring that information about how to complain, and how to access support in making complaints, is included.
			15.3 To **review the involvement of service users and carers in social care staff training/ continuing development**

Case	Source & date	Applies to locality	Recommendations/ action points
			at all levels and to consider ways of increasing their involvement.
			15.4 To **review how carers are currently involved in adult social care** and consider whether they could be more involved in order that their voice is heard at all levels.
16	Phase 2 Report 20/11/13	Poole	16.1 (Carers) say they wish any maladministration to be exposed to ensure that changes are made to prevent other vulnerable people suffering harm and their carers experiencing distress.
		Poole	16.2 The investigator recommends that the hospital and other agencies need to respond to these issues by informing (carers) of how situations have changed since the events subject of this investigation and what measures have been put in place to safeguard vulnerable patients both in Hospital care and on discharge under care plans. This recommendation should await the result of the independent clinical assessment.
		Poole	16.3 It is acknowledged that all services are under huge pressure with the large numbers of vulnerable elderly people but they, and their families/carers, are entitled to safe care and support. There are disturbing, albeit historic, omissions in this case and the perception of those involved is of failure and neglect.
	IMA 27/3/2014 NOTE: these points (16.4-16.6) were not couched as recommend-ations but formed conclusions to the report and are best understood as such.	Poole	16.4 The care offered to (the patient) in the Poole NHS Trust was not of the standard expected and there are significant differences between the family's account and that recorded in the medical record. The carers wish to: 1. Understand who took the decision to put the Medicines Management Team out to Tender; a. Why they were not provided with any warning or made aware of the consultation. b. Was the new service specification identical to the existing service. c. Why were they not informed that the service had ceased

Case	Source & date	Applies to locality	Recommendations/ action points
			during his admission.
			16.5 The carers wish to: d. Have copies of the relevant PIC's community care notes; e. Have copies of documentation (which may include the relevant Poole PCT Board minutes) relating to the decision to tender the Medicines Management service f. Meet with the appropriate person to discuss these issues which may be the Chief Executive at the time.
			16.6 The carers wish to be provided with reassurance that there have been changes to the hospital process to; g. ensure all injuries to patients are recorded on incident forms. h. that there has been an improvement in communication with families regarding the use of DNAR and Liverpool Care Pathway (or its equivalent). i. That staff are reminded to complete and correctly time all entries into the medical notes. (The IMA) would also suggest that the nursing Kardex is reviewed as at times he found it almost impossible to follow the flow of information.
17	IMA 17/1/14	Dorset/ Poole	Included in recommendations/ action points above (case 3)
	STR	Dorset/ Poole	See STR Chapter 8
18	STR	Poole	See STR Chapter 8
	Phase 2 report	Poole	It is reasonable that Adult Services … write to (the carer) tendering an appropriate apology for the period of time that elapsed before this new approach was adopted.
19	IMA assessment 28/2/2014	Bournemouth	(A named specialist Psychotherapy) Centre provides a 2 year consultancy Service focused initially on the patient.

Case	Source & date	Applies to locality	Recommendations/ action points
	Recommendations in letter dated 6/5/2014 from IMA to Psychiatrist, Christchurch.		A therapist (either a Clinical Psychologist or other NHS therapist) is to be identified within the trust who is willing and able to take on (the person's) therapy. Therapy would need to be seen as requiring a minimum of four years. This would start at once a week but provision needs to be made for twice a week therapy in due course. The therapist would need to be part of the Multi Disciplinary team and be freed up to take on the extra training and supervision required. Provision will also need to be made for (the patient's spouse) to be given regular support by a support worker who becomes familiar with (the patient's) condition.
20	Phase 2 Report 20/11/13	Poole	**20.1** Poole Hospital and their PALS be made aware of the findings of this report and to be satisfied that due consideration is made to **record-keeping** of patients' property and the needs of patients and carers on **discharge**.
			20.2 Complaints about domiciliary services: Adult social care to review their stance when complaints are made to their staff about domiciliary services for which they have a commissioning responsibility and in particular the way in which concerns and complaints are recorded, actioned and monitored.
			20.3 Face to face meeting: The Chief Nursing Officer and Chief Executive, who have offered to listen to carers in person be invited to meet with (carer). She welcomes this and believes it would help her to achieve closure of these issues which continue to trouble her.
	STR	Poole	See STR Chapter 8
21	IMA 31/7/14	Poole	**21.1 Detailed response for carer:** Senior members of staff at the hospital to prepare a detailed response to the points raised by (carer), concentrating on how the Hospital proposes to improve the care of people with dementia in future and what can be learned from the service user's experience, and with reference to the recommendations below.
			21.2 Review of discharge planning process

Case	Source & date	Applies to locality	Recommendations/ action points
			at Poole Hospital with particular reference to people with dementia, how their carers are involved in the process and how their carers' views are taken into account.
			21.3 The CHC assessment and decision making process: (a) Clarify what the role of the mental health service is in the CHC assessment and decision making process (particularly in relation to people with dementia in acute care) and when the mental health service might contribute to the overall assessment. (b) Review how staff teams ensure that carers/family are kept fully informed and able to contribute to the process.
			21.4 Involvement of carers/ families: Review of how carers/family members are involved in the care of people with dementia
			21.5 Audit of staff training in dementia care: Has Poole Hospital audited their staff against this Quality Standard (NICE Dementia Quality Standard Statement 1)? If so, how did they perform and what mechanisms are in place to ensure that this Standard is met? If not, then an audit of staff training in dementia care is recommended.
			21.6 It may be appropriate to consider whether some wards at Poole Hospital should apply for the Quality Mark for Elder-friendly Hospital Wards (Royal College of Physicians 2014).
22	Investigator report 20/1/15	Bournemouth	22.1 Audit information given to service users and carers to ensure that is it honest and open about the effect that cuts in budgets are having on services and how the funding agency is dealing with the financial pressures it is under.
			22.2 To review the process of reviewing service users and their carers with particular attention to the suggestions (this carer) has made about how the process might be improved.
			22.3 To review the supervision of student social workers in order to ensure that they are taking on tasks commensurate with their level of training and support.

Case	Source & date	Applies to locality	Recommendations/ action points
			22.4 Explanation and apology: In the spirit of the Duty of Candour senior managers at social services to prepare an explanation for (the carer) of how it came about that a student social worker believed her son's services should be cut regardless of his needs assessment and how they will avoid a similar occurrence in future, and to offer her an unqualified apology for the distress she and her son have gone through.
			22.5 To review the involvement of service users and carers in social care staff training at all levels and to consider ways of increasing their involvement.

* recommendations taken from the indicated source and wording modified by the Report Author.

Table 4: Recommendations arising from cases, numbered and listed by locality with Agency status as of 10/5/2017

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
BOURNEMOUTH				
1	Bournemouth – Health Care RBH	8	8.3 Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	Patient and public engagement and involvement is a key part of the Royal Bournemouth Christchurch Hospital (RBCH) Quality strategy. There has been a focus on proactively working with patients and families, for example working with Healthwatch, 'carers cafes', using patient and carer stories to shape services and learning. Specific examples which relate to the Older Peoples Medicine (OPM) directorate at RBCH are: All wards are signed up to 'Johns Campaign'[2]. The 'this is me' booklet has been implemented Our dementia specialist team have been working proactively with patients and carers. With our patient experience lead they have further developed this approach with a carers survey/focus group which has been scheduled during carers week (11th -18th June 2017). Further actions will be developed on the basis of this. Our Older Persons assessment and liaison team (OPAL) proactively screen all emergency admissions of frail older people. As part of their assessment process they ensure a clear collateral history is obtained from both patient and carer/nok as required and following assessment ensure optimum communication levels are maintained.

[2] See http://johnscampaign.org.uk/#/resources

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				Communication and engagement with patients, carers and families is one of the Trust objectives for 2017-18 and is incorporated in the objectives for all our staff.
2	Bournemouth – Health Care RBH	8	8.4 It may be appropriate to consider whether some wards at RBH should apply for the Quality Mark for Elder-friendly Hospital Wards.	Our OPM wards have completed the first level Quality Mark for Elder-friendly Hospital wards. The Day Hospital has completed the Bournemouth University accredited programme for Practice Development Unit and has been awarded PDU status.
3	Bournemouth – Health Care RBH	8	8.5 Review of discharge planning process at the Royal Bournemouth Hospital with particular reference to people with dementia, how their carers are involved in the process, and how their carers' views are taken into account.	As a Trust we recognise the need to continually improve our discharge processes for all patients and have signed up to the NHSi SAFER care bundle which is driven at an executive level whilst ensuring there is engagement at all staff levels. We have developed robust measurements which monitor improvements against this however they do not specifically identify dementia as a sub category. In September 2017 RBCH introduced a new frailty pathway for our patients ensuring that our frail patients have a comprehensive geriatric assessment initiated at the earliest point of their admission. This assessment encompasses a fully holistic patient centred assessment which incorporates carers views (if indicated) and what is required to support a safe discharge. To maximise a person centred approach the OPAL team have newly incorporated an 'I wish statement' which ensures that the patients voice and wishes are heard and responded to.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				Our dementia nurse specialist team support patients throughout their hospital admission and if appropriate offer an outreach service or referral to the relevant community follow up team. The Trust has identified patient flow and discharge planning as one of our three quality improvement priorities for 2016-17 and this work stream is overseen by a transformation steering board chaired by the Director of Nursing and Midwifery and reported to the Board of Directors.
4	Bournemouth – Health Care	19	19 Therapy for DID: (A named specialist Psychotherapy) Centre provides a 2 year consultancy Service focused initially on the patient. A therapist (either a Clinical Psychologist or other NHS therapist) is to be identified within the trust who is willing and able to take on (the person's) therapy. Therapy would need to be seen as requiring a minimum of four years. This would start at once a week but provision needs to be made for twice a	(The named person) was granted funding for treatment for DID through the CCG's Individual Treatment Panel in 2014 and subsequently started receiving treatment locally.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			week therapy in due course. The therapist would need to be part of the Multi Disciplinary team and be freed up to take on the extra training and supervision required. Provision will also need to be made for (the patient's wife) to be given regular support by a support worker who becomes familiar with (the patient's) condition.	
5	Bournemouth – Health & Social Care	8	8.6 Carer involvement in training: Ensure that carers are involved in the training of health and social care staff.	Proposal that this point is put on the agenda for the next Pan Dorset Academy Meeting for all Partner agencies to consider opportunities to involve carers and gather information of how this already occurs.
6	Bournemouth – Social Care	8	8.1 Review practical and emotional support for carers available in the community with particular attention to how carers might better experience continuity of care over the course of caring for someone with a chronic illness and how carers might be supported in attending to	The themed report covers improvements made for carers. Adult Social Care has a duty under the Care Act to assess a person who provides necessary care to another adult. Where Adult Social Care provides support to a Carer, they must review at least annually that the eligible needs of the Carers continue to be met. The Assessment and the Review must also take account of the Carer's wellbeing and emotional health. There are a variety of services available that may support the Carer, but these will be dependent upon their needs.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			their own needs.	
7	Bournemouth – Social Care	8	8.2 Carer vulnerability: Review in what circumstances a carer might be regarded as vulnerable. Is practice in Bournemouth the same as elsewhere, or are there areas of the country where (this carer's) vulnerability might have been acknowledged and, if so, how would he have been approached differently?	The themed report covers improvements made for carers. Safeguarding Board policies and procedures have been updated. Adult Social Care seeks to respond to support Carers who may be deemed as vulnerable as detailed above or if there are Safeguarding concerns. Adult Social Care has recently had a Safeguarding Peer Review, led by the Local Government Association and was felt to be compliant with the Care Act.
8	Bournemouth – Social Care	22	22.1 Audit information given to service users and carers to ensure that is it honest and open about the effect that cuts in budgets are having on services and how the funding agency is dealing with the financial pressures it is under.	Part of the project to implement the Care Act included reviewing Adult Social Care's Factsheets and Website content. These sources of information describe in what circumstances Clients or Carers may receive paid for services from the Council, i.e. if they have eligible desired outcomes.
9	Bournemouth – Social Care	22	22.2 To review the process of reviewing service users and their carers with particular attention to the suggestions (this carer) has made about	The themed report covers improvements made for carers. Please see point 6 above.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			how the process might be improved.	
10	Bournemouth – Social Care	22	22.3 To review the supervision of student social workers in order to ensure that they are taking on tasks commensurate with their level of training and support.	Adult Social Care has had to utilise 'off site' Practice Educators in the past, due to low numbers internally. Adult Social Care do not have a duty to provide Practice Educators, however, they have sought to train additional Practice Educators to increase the number of placements available to Social Work Students, but to also improve the quality of their placements and the teaching and assessment that occurs. Practice Educators have a responsibility to monitor that a student is not being given work to undertake that is inappropriate for their skill level and must challenge it if they are; this is to protect both the customer and the student. This is more difficult to achieve if 'off site', which is one of the reasons for training more internally.
11	Bournemouth – Social Care	22	22.4 Explanation and apology: In the spirit of the Duty of Candour senior managers at social services to prepare an explanation for (the carer) of how it came about that a student social worker believed her son's services should be cut regardless of his needs assessment and how they will avoid a similar occurrence in future, and to	The manager responsible for this action has left the organisation and in the timescale given to complete this table it has not been possible to establish if this has taken place, If it has not, it will be undertaken.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			offer her an unqualified apology for the distress she and her son have gone through.	
12	Bournemouth – Social Care	22	22.5 To review the involvement of service users and carers in social care staff training at all levels and to consider ways of increasing their involvement.	See point 5 above.
DORSET				
13	Dorset – Health Care	17	3.6 CHC funding reviews: Funding organisations should audit whether regular review of CHC funded placements is taking place; whether review includes the issue of whether care needs are being met as well as continuing eligibility for funding; and whether there are processes in place to ensure that timely reviews take place. Funding organisations need to have an agreed way of dealing with concerns about unsatisfactory care in those	Regular audit now takes place for CHC. There is a clear process for raising concerns/complaints and escalation to the Ombudsman if people are not happy with the outcome. There is a new Quality Assurance Tool for CHC which the CCG is signed up to - this is monitored by NHS England. Policies and procedures have been reviewed and updated for the appeals process and this is in line with the National Framework.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			people receiving CHC, eg by drawing them to the attention of the regulator and/or by moving the person receiving care to a placement which meets their needs.	
14	Dorset – Health Care	5a, 5b	5.1 It would be helpful if the NHS were able to write to person b (and person a) to give some reassurance that his medical records are fully recorded, complete and networked on systems in the event of person b being admitted to any hospital in the future – especially if person a is in some way involved in that admission.	Not able to confirm if this has been done. The individual will need to check with his GP. The Dorset Care Record is being progressed. Some GP systems are compatible with hospital systems and all records are visible across the system, but this is not the case for all areas at present.
15	Dorset – Health Care	5a	5.2 Psychological assessment/ treatment: In respect of case 5a: (carer) to be seen and assessed at home by an independent person with appropriate expertise and qualifications in psychological treatments and with a commitment to follow	Psychological support has been offered to case 5a. Individual Treatment Request application was not approved for specialist treatment as the person had not followed the usual NHS pathway of care and other options were available for her. However, she has been informed, in January 2016, that the panel would be willing to review a further request if evidence is supplied that all local mental health treatment pathways have been followed by her prior to the referral. Her GP is aware of the situation and offering referrals as deemed appropriate.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			(and where necessary fund) the recommendations of that independent person.	
16	Dorset – Health Care	5b	5.3 Specialist recommendations: In respect of case 5b: the recommendations made in (a specialist's) report regarding (service user's) follow up care and treatment to be enacted at the earliest opportunity and, because of the complexity of (his) needs and (carer's) needs, this to be done in the community.	Case 5b has been discussed with his GP and GP is aware of (the specialist's) recommendations. GP has offered referrals accordingly.
17	Dorset – Health Care	5a	5.6 If not recently done, CCG to audit how families/ carers are involved in the process of assessing eligibility for NHS CHC funding with particular attention to how families/ carers might have confidence that their voice has been heard.	This is now part of the regular CHC audits and CHC Quality Assurance Tool (as described under 13)
18	Dorset - Health	5a,5b	5.7 If not recently done, CCG to review the appeal process relating to assessments for	Appeal process has been reviewed and policy updated. It is in line with the National Framework for CHC.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			NHS CHC funding with particular attention to how families/ carers might have confidence that their voice has been heard.	
19	Dorset – Health Care	5a,5b	5.8 If not recently done, CCG to review the training undertaken by health and social care staff involved in eligibility assessments with particular attention to their training in working with service users and carers and how to ensure a person-centred approach.	A full programme of training for staff involved in eligibility assessments has taken place over the past two years. This involves both health and social care staff. It has been well evaluated.
20	Dorset – Health Care	5a,5b	5.10 In respect of the recommendations that the person leading the CHC Multidisciplinary team meeting about the Decision Support Tool ratings on 13/11/2014 should have training in conflict management and communication skills (in response to their complaint); (the carer and service user)	Not able to confirm this due to historical nature and no evidence of this specifically taking place. However, a full programme of training for staff involved in eligibility assessments has taken place over the past two years. This involves both health and social care staff. This includes training around communication and conflict when undertaking assessments.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			would like to know whether this was carried out and they should be informed whether it was or not.	
21	Dorset – Health & Social Care	4,17	3.5 Commissioners should review services to support carers in the community including respite/ rotational respite and out-of-hours services.	The themed report describes the improvements made to support carers A carers Vision has been co-produced with carers and wider stakeholder Pan Dorset. All carers services are being reviewed in line with the requirements and objectives set out within the vision and in line with a local reviews of needs and services in each local authority area. Respite is a key component of the review and in additional to traditional options such as the Domiciliary sitting service and residential care, other community based options are being explored. The new Dorset Care framework is currently being commissioned which provides opportunities to better meet respite options in both domiciliary care and residential through block contracts but is opening up opportunities for alternative forms of respite from the voluntary sector and community groups.
22	Dorset – Health & Social Care	5a	5.4 Review practical and emotional support for carers available in the community with particular attention to how carers might better experience continuity of care	The themed report describes the improvements made to support carers A carers counselling service has recently been commissioned and went live 1st April 2017 to meet the emotional support needs. Training for carers is being reviewed to develop local co-

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			over the course of caring for someone with a chronic illness and how carers might be supported in attending to their own needs.	produced options to provide practical advice and training as well as access to health and wellbeing training through Public Health funded courses. The focus of the service review and development of a new picture of services is to ensure that carers gain back control of their lives through advice, support and training that will enable them to successfully manage their caring role and provide time for their own needs and welfare.
23	Dorset – Health & Social Care	5a	5.5 Senior member/s of staff at Social Services and the CCG to prepare evidence and explanation for (the carer) about how services have learned (or propose to learn) from her experiences, in order to improve services for future carers by answering the eleven questions as set out on page 20 (of the Report).	The themed report describes the improvements made to support carers This case, as with all cases that have an impact on the work in this area, will be considered by the Carers Board[3] and appropriate steps put in place to implement key lessons learned. This case will form an agenda item for the next meeting.to check that all could have been done has been done.
24	Dorset – Health & Social Care	5a,5b	5.9 In the case of each of the above Action Points (5.4-5.8) evidence of improvement	The themed report describes the improvements made to support carers See response to recommendation 23.

[3] The Author is informed that this refers to the Dorset Carers Steering Group which supports the implementation of the Joint Pan Dorset Carers Strategic Vison 2016-2020, “Valuing Carers in Dorset”.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			should be provided to (the carer, service user,) and Advocare in order to address the aims set out earlier.	
25	Dorset – Social Care	11	11.4 Complaints: Encourage relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and routinely give them information about how to complain, and how to access support in making complaints.	Complaints information is available. It is a CQC requirement for homes to provide this to people moving into a home. Quality assurance visits now take place to care homes- residents and their carers are listened to during these visits and encouraged to raise concerns. The attached complaint leaflet has been in place since August 2014. The expectation is that complaints are made with the home in the first instance and if service users remain unhappy they can contact the Council's complaints team.
26	Dorset – Social Care	11	11.5 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.	The themed report covers improvements made for carers. The carers vision has an objective in respect of training to professionals. Plans to be drawn up by individual stakeholders i.e. CCG, LAs and Health Trust to evidence this work. This is monitored by the Dorset Carers Steering Board which has representative carers as members.
27	Dorset – Social Care	11, 15	11.6 Involvement of Carers in ASC: To review how carers are currently involved in adult social care and consider whether they could be more	The themed report covers improvements made for carers. Dorset ASC has a carers reference group that is consulted on changes in services and their views on what is important, what works and what needs improving. It is currently used by the commissioning team but could be open to other colleagues in

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			involved in order that their voice is heard at all levels and in all relevant fora.	social care if they wish to engage with carers. A database of carers is held for wider consultation purposes. The Dorset Carers Steering Board which developed the Pan Dorset Carers Vision is made up of key stakeholders and carers that represent specific local authority areas and caring types
28	Dorset – Social Care	15	15.2 Complaints: Encouraging relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and ensuring that information about how to complain, and how to access support in making complaints, is included.	The current leaflet is being updated in June 2017 to reflect changes in corporate policy. Support is available to relatives in making a complaint through local advocacy services including Dorset Advocacy, Dorset Mental Health Advocacy and the CAB. Complainants may be supported to make a complaint through the complaints team members who are willing to meet with service users or take complaints over the telephone.
29	Dorset – Social Care	15	15.3 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.	See response to recommendation 26 above. The creation of the Making it Real Board[4] is the opportunity to start building in a co-production approach moving forward. Contact has been made and this is being actively followed up. Service users and carers are currently involved with recruitment onto qualification training for social workers and it is recognised that they make an invaluable contribution to the process. The

- [4] The Author is informed that the Making it Real Board is part of the “think local act personal” initiative and, in line with national guidance, involves working together with community members in Dorset to make services more person centred.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				workforce development group recognise that this good practice needs to be expanded to other areas of training and continuing professional practice. We intend to incorporate learning from complaints into the design and development of learning and development opportunities. We are keen to extend the involvement from service user led organisations such as People First Dorset and the Shaw Trust.
POOLE				
30	Poole Hospital	2	2.1 That the service user be informed whether the surgeon has undertaken Advanced Communication Skills training, which is now recommended for all clinical staff involved in the treatment of cancer, and if the surgeon concerned has not undertaken the training that this should be expedited urgently.	In June 2015, the former Director of Nursing confirmed that the surgeon involved had met with the service user and reflected on his communication skills. Due to the passage of time and change of Director, it has not been possible to identify the individual surgeon involved. However, the Trust has a clear framework for conducting annual appraisals for all consultants and non-training grade medical staff. During this appraisal, professional development needs are identified and appropriate training/skill development put in place. This will include advanced communication skills training, where this is appropriate. This system of appraisal and revalidation meets the external standards set out by the General Medical Council, Medical Royal Colleges and the Department of Health. As part of the Building on the Best work, the Trust is proposing to survey patients at the end of life. This survey will incorporate questions relating to meeting service users information needs, open communication and opportunity to ask questions. The

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				results of the survey will help the Trust identify any gaps in the way we communicate with this patient group, carers and others, and actions will be identified as appropriate..
31	Poole Hospital	2	2.2 Records: The service user has requested that his records should include a note to the effect that there was a misdiagnosis. This does not seem unreasonable, should be done and confirmation that it has been done sent to the service user.	It would be helpful if Advocare is able to share the conclusions of their investigation so the Trust can understand any misdiagnosis identified and respond to the request to amend records. Alternatively, the Trust is able to add a note to the service user healthcare records, explaining that the service user believes there has been a misdiagnosis. Please contact the Patient Experience Team at Poole Hospital for this action to be progressed.
32	Poole Hospital	20	20.1 Poole Hospital and their PALS be made aware of the findings of this report and to be satisfied that due consideration is made to record-keeping of patients' property and the needs of patients and carers on discharge.	Any report findings will be shared with the Patient Experience Team/PALS. Record keeping, including records kept about patient property, is a high priority for all nursing staff. Any concerns raised about lost property are investigated thoroughly by the senior sister of the ward and a member of the PALS team. The Patient Property Policy is currently being reviewed and updated and will continue to reflect the requirement for accurate record keeping. The appointment of a Carer Support Lead, who works closely with the Trust Discharge Team, has made a significant difference to the quality of care offered to carers, both throughout their loved ones stay in hospital, and support on discharge.
33	Poole Hospital	20	20.3 Face to face meeting: The Chief Nursing Officer and Chief Executive, who	The Trust welcomes the opportunity to meet with patients and carers, to hear first-hand, their experience of Trust services. This is reflected in our Board meetings that all begin with a patient

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			have offered to listen to carers in person be invited to meet with (carer). She welcomes this and believes it would help her to achieve closure of these issues which continue to trouble her.	story. A carer has recently shared their story at a training session with medical staff and this will also be shown to Board. The offer to meet this carer and to hear their experience remains open.
34	Poole Hospital	21	21.1 Detailed response for carer: Senior members of staff at the hospital to prepare a detailed response to the points raised by (carer), concentrating on how the Hospital proposes to improve the care of people with dementia in future and what can be learned from (the service user's) experience, and with reference to the recommendations below.	The Trust is able to review the points raised regarding improving the care of people with dementia, although would not necessarily be able to comment on any historic care issues unless these are documented in the service user's healthcare records. A key project for the Trust this year is Dementia and significant work has already taken place to improve quality of care, including the care environment and the level of training offered to all staff. The Trust has a Dementia Nurse Specialist and a Carer Support Lead in post, both working to deliver improvements in care and experience. The Trust has participated in the Kings Fund Enhancing the Healing Environment for people with Dementia and successfully refurbished one of the wards within the Philip Arnold Unit to embrace these principles. Further environmental improvements form part of our charity priorities this year. The Trust would welcome the opportunity to share this work with the service users involved. Please contact the Patient Experience Team at Poole Hospital for this action to be

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				progressed.
35	Poole Hospital	21	21.2 Review of discharge planning process at Poole Hospital with particular reference to people with dementia, how their carers are involved in the process and how their carers' views are taken into account.	The Trust has improved processes to identify and support carers throughout their stay, including robust discharge planning. Last year, we launched a Carers Commitment and now have an on-going active carers project that involves a care partnership document (similar to a carers passport), to help staff understand to what extent, and how, a carer wants to be involved in their loved ones care. This ensures that carers feel welcome, are orientated to the ward and are recognised as experts in care. We can also offer discounted parking and meals for active carers.
36	Poole Hospital	21	21.4 Involvement of carers/ families: Review of how carers/family members are involved in the care of people with dementia	Further work is planned as part of the Dorset Carers Strategy 'Valuing Carers in Dorset'.
37	Poole Hospital	21	21.5 Audit of staff training in dementia care: Has Poole Hospital audited their staff against this Quality Standard (NICE Dementia Quality Standard Statement 1)? If so, how did they perform and what mechanisms are in place to ensure that this Standard is met? If not, then an audit of staff training in dementia care is	The Trust induction now includes dementia training for both employed staff and volunteers. This training is now mandatory. A formal audit of compliance has therefore not been considered necessary, but the Trust will review this in light of this recommendation.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			recommended.	
38	Poole Hospital	21	21.6 It may be appropriate to consider whether some wards at Poole Hospital should apply for the Quality Mark for Elder-friendly Hospital Wards (Royal College of Physicians 2014).	The Trust has participated in the Kings Fund Enhancing the Healing Environment for people with Dementia. Further consideration will also be given to the Quality Mark for Elder-friendly Hospital Wards at Poole Hospital.
39[5]	Poole & Alderney Hospital[6]	14	14.1 Recording Next of Kin. The Trust might review their practice regarding how NOK is recorded and how difficult issues regarding NOK might be addressed; for example, through information management training for staff and/or audit of NOK recording practices.	See attached letters and action plans from Dorset Healthcare Trust
40	Poole & Alderney Hospital	14	14.2 Relationship with carers/ families: Review what Trust policies influence how healthcare staff members	See attached letters and action plans from Dorset healthcare Trust

[5] For recommendations 39-44 feedback received was “See attached letters and action plans from Dorset Healthcare Trust” where the author could locate the status of the recommendation this has been inserted in the appropriate column. Letters and action plans were included with the response but are not included here.

[6] DHUFT is now responsible for Alderney Hospital and has provided the relevant responses.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	
41	Poole & Alderney Hospital	10, 14	14.3 In respect of vulnerable older people, the Trust might consider using a letter of authorisation for information sharing in order to ask patients who are capable of deciding to specify with whom they want information about them to be shared.	See attached letters and action plans from Dorset Healthcare Trust
42	Poole & Alderney Hospital	14	14.4 Audit basic standards of care eg nutrition, communication.	See attached letters and action plans from Dorset Healthcare Trust
43	Poole & Alderney Hospital	14	14.5 It may be appropriate to consider whether some wards at Poole and Alderney Hospitals should apply for the Quality Mark for Elder-friendly Hospital Wards (Royal College of Physicians 2014).	See attached letters and action plans from Dorset Healthcare Trust
44	Poole &	14	14.6 Senior member/s of staff	Author: this was done.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
	Alderney Hospital		at the Hospitals to prepare an explanation for (the carer) about what happened to her husband and how the Hospitals propose to learn from her experience and to improve the care of people using services in future. This explanation would be best offered to (the carer) through a neutral third party, or in writing, and perhaps in partnership with Advocare. This approach might be equally appropriate in the case of other carers who have had similar experiences.	
45	Poole – Alderney Hospital	3,4,17	3.1 Culture of care: If the wards at Alderney Hospital are not already involved in the AIMS-OP programme then involvement in the programme could be considered as a way to demonstrate that inpatient care meets appropriate	Dorset University Healthcare Foundation Trust - In regard to the Elder friendly Ward we are formally on this program and have introduced it into 9 of our community hospitals and rolling it out to the others this year.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			standards, and as a way of reassuring carers who have been through bad experiences that things are changing.	
46	Poole – Alderney Hospital	3,4,17	3.2 Anti-psychotic drugs and psychological/ psychosocial interventions: Other possible actions might include auditing the use of anti-psychotics (this may have already been done); auditing what training staff have undertaken relating to psychological/ psychosocial interventions as a prelude to identifying future training priorities and arranging necessary training; auditing the availability and range of activities on the wards.	All wards have a nominated pharmacist and pharmacy technician to review drug charts and advise nurses and doctor in regard to medication options. The Trust participates in the national medication audits and undertakes local audits. Staff identify any training needs during their appraisal and line management supervision. Ward activity co-coordinators are now present on the wards to support activity planning and interventions with the patients and consider a wide variety and diversity of activities. (information received 19/5/2017)
47	Poole – Alderney Hospital	17	3.3 Smoking policy: When a person with dementia who smokes is admitted to hospital the care plan needs to include appropriate management of their smoking	Dorset HealthCare went 'smoke free' on 1 April 2017 across all our inpatient units (mental health and community health). Staff have been trained in brief intervention and there is a stop smoking champion on each ward trained to a higher level. NRT is available for patients who do smoke and are supported not to use tobacco whilst an inpatient.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			which will include measures to deal with any withdrawal symptoms if they are in a non-smoking environment, eg nicotine replacement treatment.	(information received 19/5/2017)
48	Poole – Alderney Hospital	3,4,17	3.4 Relationship with carers: It is good practice to encourage the involvement of carers and to ask them to give routine regular feedback about ways to improve the environment where their relative is being cared for. Simple things can be built into the system to help carers stay fully informed and involved, and should be considered eg meeting them regularly; involving them in review meetings; copying letters relating to their relatives care to them (with their relative's consent); giving them copies of treatment and discharge plans (with their relative's	Poole Hospital The Trust has improved processes to identify and support carers throughout their stay, including robust discharge planning. Last year, we launched a Carers Commitment and now have an on-going active carers project that involves a care partnership document (similar to a carers passport), to help staff understand to what extent, and how, a carer wants to be involved in their loved ones care. This ensures that carers feel welcome, are orientated to the ward and are recognised as experts in care. We can also offer discounted parking and meals for active carers

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			consent). Enquiring about LPAs and recording their existence should be routine practice.	
49	Poole – Alderney Hospital	3,4,17	3.9 Assessment: An admission care pathway with agreed criteria for admission of people with dementia should be considered (if not currently in operation).	Dorset University Healthcare Foundation Trust - In regard to the Elder friendly Ward we are formally on this program and have introduced it into 9 of our community hospitals and rolling it out to the others.
50[7]	Poole – Alderney Hospital	10	10.1 Senior members of staff at the hospital (Alderney) to prepare a detailed response to the points raised by (the carer), concentrating on how Alderney Hospital proposes to improve the care of people using services in future, what can be learned from (her husband's) experience, and what has changed since (his) admission; response to be produced in partnership with	Author: a copy of a letter which contained the response requested in this action point was supplied to the author.

[7] For recommendations 50-57 feedback received was "See attached letters and action plans from Dorset Healthcare Trust". Where the Author could identify the status of the recommendation this has been inserted in the appropriate column. Letters and action plans were included with the response but are not included here.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			an Independent Medical Assessor to act as an impartial third party. It is likely that production of the response will need to include a senior member of nursing and of medical staff in order to address all the questions raised.	
51	Poole – Alderney Hospital	10	10.2 Working with carers/ families: Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	Author: the answer to recommendation 48 addresses these points.
52	Poole – Alderney Hospital	10	10.4 Visit: A senior staff member kindly offered to take (the carer) to visit the ward and meet the ward sister and (the carer) was pleased to accept this offer. If possible (subject to their agreement and practical arrangements)	Author: the carer's visit took place on 13 August 2015.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			(she) would like to talk with patients and relatives whilst she is there.	
53	Poole – Alderney Hospital	10	10.5 (A senior staff member) will check whether relatives/ carers are made aware that care plans relating to the treatment of their relatives are available.	See attached letters and action plans from Dorset healthcare Trust
54	Poole – Alderney Hospital	10	10.6 Staff training: Advocare will give (the carer's) contact details to (a senior staff member) so that (the carer) can be contacted with a view to recording her experiences/ story for use in training staff.	Author: a meeting took place to arrange this.
55	Poole – Alderney Hospital	10	10.7 A senior staff member has agreed to feed back to (a specialist who provided a report) the specific comments and views of (an Advocare representative) that (the carer) i) did not have poor recollection of events as he states in his report ii) was bullied by the	Author: this was done.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			OT and this was not a negative misinterpretation (only she can say what her experience was). Good communication on behalf of staff would have prevented both of these.	
56	Poole – Alderney Hospital	10	10.8 (An Advocare representative) and (a senior staff member) have agreed to meet and explore how Advocare might work with the Trust in the interests of carers and patients.	Author: a meeting took place on 17 September 2015.
57	Poole – Alderney Hospital	10	10.9 Audit: A senior staff member referred to the PDS audit 'get it on time' and will check whether it is being undertaken.	Author: feedback received was that wards undertake ward based audits and reviews of medicines management and timeliness of medications.
58	Poole – Health Care	3	3.6 CHC funding reviews: Funding organisations should audit whether regular review of CHC funded placements is taking place; whether review includes the issue of whether care needs are being met as well as continuing eligibility	Regular audit now takes place for CHC. There is a clear process for raising concerns/complaints and escalation to the Ombudsman if people are not happy with the outcome. There is a new Quality Assurance Tool for CHC which the CCG is signed up to- this is monitored by NHS England. Policies and procedures have been reviewed and updated for the appeals process and this is in line with the National Framework.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			for funding; and whether there are processes in place to ensure that timely reviews take place. Funding organisations need to have an agreed way of dealing with concerns about unsatisfactory care in those people receiving CHC, eg by drawing them to the attention of the regulator and/or by moving the person receiving care to a placement which meets their needs.	
59	Poole – Health Care	16	16.4 The care offered to (the patient) in the Poole NHS Trust was not of the standard expected and there are significant differences between the family's account and that recorded in the medical record. The carers wish to: 1. Understand who took the decision to put the Medicines Management Team out to Tender;	The Trust would welcome the opportunity to investigate any outstanding issues the family may have, where it is possible to undertake an investigation and reach a conclusion. This will depend on the specific concerns raised and any associated time lapse. If these concerns cannot be adequately investigated, the Trust would welcome the opportunity to invite the family in to discuss, understand and learn from the issues that arose at the time. Author: a meeting took place on 19 Oct 2015 and a response was produced by a senior member of staff, which to some extent addressed these three points. It may not be possible to achieve

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			a) Why they were not provided with any warning or made aware of the consultation? b) Was the new service specification identical to the existing service? c) Why were they not informed that the service had ceased during his admission?	greater clarity.
60	Poole – Health Care	16	16.5 The carers wish to: d) Have copies of the relevant PIC's community care notes; e) Have copies of documentation (which may include the relevant Poole PCT Board minutes) relating to the decision to tender the Medicines Management service f) Meet with the appropriate person to discuss these issues which may be the Chief Executive at the time.	Author: the meeting on 19 Oct 2015 brought the carers together with senior staff to discuss issues of concern and further documentation was provided following that meeting. It may not be possible to achieve greater clarity.
61	Poole – Health Care	16	16.6 The carers wish to be provided with reassurance	The Trust has a robust electronic system of recording all incidents, including all injuries that occur on hospital premises.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			that there have been changes to the hospital process to; g) ensure all injuries to patients are recorded on incident forms. h) that there has been an improvement in communication with families regarding the use of DNAR and Liverpool Care Pathway (or its equivalent). i) That staff are reminded to complete and correctly time all entries into the medical notes. j) (The IMA) would also suggest that the nursing Kardex is reviewed as at times he found it almost impossible to follow the flow of information.	This relates to patients, carers and the wider public. The Trust has undertaken various service improvement initiatives regarding end of life care, and communication of DNACPR. We would welcome the opportunity to share this with the carer concerned. Please contact the Patient Experience Team at Poole Hospital for this action to be progressed.
62	Poole – Health Care	21	21.3 The CHC assessment and decision making process: (a) Clarify what the role of the mental health service is in the CHC assessment and	Mental health teams are involved in providing information on individuals in order for a full assessment of care needs and a complete DST to be undertaken. They are involved in MDTs as appropriate. Families and carers are now integral to the process- this is

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			decision making process (particularly in relation to people with dementia in acute care) and when the mental health service might contribute to the overall assessment. (b) Review how staff teams ensure that carers/family are kept fully informed and able to contribute to the process.	monitored by audits and the CHC Quality Assurance Tool. Dorset Clinical Commissioning Group together with the 3 Local Authorities have produced a protocol to ensure staff working within NHS Borough Of Poole up date. Dorset CCG, together with contracted providers are clear about the case management responsibilities relating to people who are in receipt of NHS funded Continuing Healthcare. It also sets out the transfer arrangements between organisations when a person becomes eligible for CHC or is reviewed and found to be no longer eligible. The protocol also ensures that patients and their families/carers know who is managing their care arrangements when funded by any of the organisations referred to above.
63	Poole – Health & Social Care	3,4	3.5 Commissioners should review services to support carers in the community including respite/ rotational respite and out-of-hours services.	The themed report covers improvements made for carers Borough of Poole Update. Commissioners have reviewed services available for carers in the community as a result there is a wide range available including the Carers Information Service. Carers in Crisis -Emergency Back up System. Home based sitting service. Carers Support Programme run by St John's ambulance. Focus befriending scheme. A fully equipped static caravan has been purchased to offer short respite breaks and holidays for carers. A Carers Reference group is being run independently from Social Services. Reps from this group sitting on the Joint Commissioning Board. There is a Home from Home respite day service. Across the 3 Local Authorities there is an out of hours service for members of

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				the public to contact if they require assistance , the OOH officers would be able to identify appropriate support in an emergency should this be required by the Carer.
64	Poole – Health Care	3	3.8 Services for people with early onset dementia should be reviewed to ensure that people are not disadvantaged by virtue of developing dementia at a young age, and that the carers of younger people with dementia have access to community support.	The themed report covers improvements made for carers. Memory Support and Advisory Services have been commissioned for early help, at any age. Borough of Poole Update Carers of younger people with dementia are able to access support in the community. There are a range of generic service that carers access, and many of these can include the cared for person, because it is well known that carers are not always able, or want to leave the person they care for without them being present. There is also respite services commissioned for people with learning disabilities. The sitting service for replacement care in order to have a short break does not need to be as passive as the title suggests. The agency will carry out a risk assessment so they can support the person in the way that suits them best, such as going for a walk, or undertaking activities, this ensures the carer is reassured that the person they care for will be happy in their absence. There is training available for carers of people with dementia and this includes early onset dementia. The Home Safely bracelet is also suitable for younger people with dementia who may become lost. Dementia services are currently under review across the system

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
65	Poole – Health & Social Care	16	16.2 Evidence of change: The investigator recommends that the hospital and other agencies need to respond to these issues by informing (carers) of how situations have changed since the events subject of this investigation and what measures have been put in place to safeguard vulnerable patients both in Hospital care and on discharge under care plans.	Borough of Poole Update Over recent years a number of safeguarding enquires have been undertaken in relation to hospital discharge at Poole Hospital. The hospital compiled an action plan that was over seen and monitored by the Hospital Safeguarding Lead, the Safeguarding Lead from the CCG and the Safeguarding Coordinator from BoP. As a result new discharge procedures have been put in place and are being monitored to ensure safe discharges from PGH wards. PGH have also introduced “My Ticket Home” which is a planning document completed from the start of the admission to PGH and is fully completed prior to discharge. This helps staff, the patient & family involved in the patient’s care to ensure they are updated on progress and engaged in planning to discharge to home in a safe manner as soon as the patient is medically stable to leave hospital. In addition PGH have introduced a Welcome to Poole Hospital letter which outlines what the patient can expect from their admission. PGH has also produced a best practice document compiled with staff, partners and patients. Plus they have introduced a card system “Hello my name is” which includes the date the patient is due to be discharged, their name and address to avoid any potential mistakes - especially important for patients who have communication concerns or dementia. Social Workers are available 7 days a week. Step up step down beds are available to facilitate speedy safe discharge for short term respite and assessment to enable suitable ongoing support and placements to be identified.

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				Reablement service home care is available for a specific period to help rehabilitation. Health watch are available to assist with any health or Social Care Complaints & are independent for the Local Authority and Health Units.
66	Dorset - Safeguarding	4	3.7 Safeguarding: Dorset's Multi-Agency Safeguarding Adults Policy and Procedures should be reviewed to ensure that where carers have been alleged to have caused harm they have the right to know what has been alleged; a right to give their account of what happened; and a right to appeal against the outcome of the safeguarding process.	The Safeguarding policies have been reviewed and updated to reflect the Care Act requirements. They can be found on the Safeguarding Boards' websites. Borough of Poole Update. The Bournemouth, Dorset & Poole, Multi-Agency Safeguarding Adults policy & procedures have been completely reviewed and re-written since the implementation of the Care Act. In addition there has been the introduction of a new way of working based on a person –centred approach known as Making Safeguarding Personal (MSP). This approach is based on the need to put the person at the centre of all safeguarding interventions and support. The person and their carer are asked what outcomes they would like to see. Where an informal carer is alleged to have caused harm a risk assessment of the situation would be undertaken to establish if the person was considered to be at high risk ie: domestic violence. Based on the outcome of the assessed risks and whether the police need to be involved a decision would be made to involve the carer. The carer would be asked to give an account of any allegation. It should be noted that a significant change in practice has taken place and it has been made clear to staff working in Social Care that it is not their

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				role to prove innocence or guilt and that, if there is an informal carer, they are likely to require support in their caring role. The 3 Local Authorities all now have dedicated safeguarding teams and this has meant a more consistent and person centred approach is taken. In addition at the beginning of the safeguarding process the person and their carer are asked how they would like to be kept informed of the progress of any enquiry, including whether or not they would like to attend any or all safeguarding meetings. People are also asked if they would like to have an independent advocate present at any meetings. This is a more person centred way of engaging with people and their carers. Staff working in safeguarding have had refresher training on this new approach and at the closure of the safeguarding enquiry the person and their carer are asked about their experience of the support they have received and whether they felt safer at the end of the enquiry. Fact sheets are also available for people and their carers explaining what they can expect if there is a safeguarding enquiry.
67	Poole – Social Care	15	15.4 To review how carers are currently involved in adult social care and consider whether they could be more involved in order that their voice is heard at all levels.	The themed report covers improvements made for carers. Borough of Poole Update The Service Manager with responsibility for Carers in the BoP regular bi monthly has contact with a group of carers so they have a voice within Adult Social Care, and carers are involved in all the groups connected to the Learning Disability Partnership Board. Carers have been closely involved in the development of 'Valuing Carers' the strategic vision 2016 – 2020, and there is a well established Carers Reference Group informing

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
				commissioning in Bournemouth and Poole. Carers are increasing involved in the commissioning process, from Service specification to tendering evaluation. Carers have been involved in the Care at Home contract development, and will be involved in the tender evaluation.
68	Poole – Social Care	15	15.3 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.	Borough of Poole Update Carers have been involved in producing a number of short films to support staff training and awareness. We continue to look for opportunities to increase this. There are nine main objectives in Valuing Carers, two of these state: Develop the workforce to understand carers' needs, improve identification of carers and value their contributions. Involve carers in local and individual care planning. Poole have twice invited (a named individual) to run workshops for practitioners and he has been key to recent Carers legislation and the more recent Care Act, so has knowledge and emphasis on the importance of supporting carers
69	Poole – Social care	15	15.2 Complaints: Encouraging relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and ensuring that information about how to complain, and how to access support in	Borough of Poole Update The Quality Assurance (QA) team produce an Adult Social Care Information pack which front line operation staff (such as Helpdesk and the Assist team) give to service users. It contains copies of factsheet which give further information and signposting in areas such as charging, carers support and also includes information about the complaints process. This information is also published on the Borough website. In addition to the above:

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			making complaints, is included.	The Complaints and Improvement Officer runs regular complaints training which all social care staff are encouraged to attend, so that they can be confident they know how to advise and signpost a service user or carer wishing to make a complaint. On receipt of a complaint consideration is routinely given as to whether the service user or carer would benefit from an advocate when making a complaint and if necessary this is arranged. The QA team manager and complaints officer attend regular meetings with their opposite numbers in partner organisations such as DHUFT, local acute hospital trusts and other local authorities to ensure best practice and experience is shared, and keeps abreast of changes and developments within complaint handling within health and social care. The team also attend carers' events to be on hand to provide advice to those who may need it.
70	Poole – Social Care	20	20.2 Complaints about domiciliary services: Adult social care to review their stance when complaints are made to their staff about domiciliary services for which they have a commissioning responsibility and in particular the way in which concerns and complaints are recorded,	Borough of Poole Update All complaints notified to the complaints team are logged, monitored and actioned where necessary. If requested by the service user or their representative/carer the complaints team will assist them with making a complaint to an independent provider (where commissioned by the Council) alternatively they can complain directly to us and they will undertake a full investigation. The complaints team are also available to provide advice to self funding individuals if needed. The Service Improvement Team who monitor provider services

No.	Locality	Re: Cases	Recommendation	Status as reported by relevant Agency on 10/5/2017
			actioned and monitored.	log any complaints that are received in the team, but do not respond directly as these are dealt with by the Complaints Officer, or the care manager if the complaint has not been taken down the formal route. The themes logged are then looked by the SIT as part of the contract monitoring process.
71	Poole – Social Care/ Safeguarding	18	It is reasonable that Adult Services … write to (the carer) tendering an appropriate apology for the period of time that elapsed before this new approach was adopted.	Author's Note: Apologies. This recommendation was accidentally omitted from the version of Table 4 circulated to agencies prior to May 2017 but has been added since then.

Table 5: Completed and outstanding recommendations arising from cases, numbered and listed by locality, as of July 2017

No.	Locality	Re: Cases	Recommendation (R)	Tick below √ if R enacted	X below if R NOT enacted	If X name of person responsible for enacting R	If X date by which R will be enacted
BOURNEMOUTH							
1	Bournemouth – Health Care RBH	8	8.3 Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	√			
2	Bournemouth – Health Care RBH	8	8.4 It may be appropriate to consider whether some wards at RBH should apply for the Quality Mark for Elder-friendly Hospital Wards.	√			
3	Bournemouth – Health Care RBH	8	8.5 Review of discharge planning process at the Royal Bournemouth Hospital with particular reference to people with dementia, how their carers are involved in the process, and how their carers' views are taken into account.	√			
4	Bournemouth – Health Care	19	19 Therapy for DID: (A named specialist Psychotherapy) Centre provides a 2 year consultancy	√			

			Service focused initially on the patient. A therapist (either a Clinical Psychologist or other NHS therapist) is to be identified within the trust who is willing and able to take on (the person's) therapy. Therapy would need to be seen as requiring a minimum of four years. This would start at once a week but provision needs to be made for twice a week therapy in due course. The therapist would need to be part of the Multi Disciplinary team and be freed up to take on the extra training and supervision required. Provision will also need to be made for (the patient's wife) to be given regular support by a support worker who becomes familiar with (the patient's) condition.				
5	Bournemouth – Health & Social Care	8	8.6 Carer involvement in training: Ensure that carers are involved in the training of health and social care staff.		X	Head of Workforce Development & Training Service - Social Care (Bournemouth Borough Council)	Methods for delivering this are being considered, with consideration being given to delivering

							within the Training Plan for 2018.
6	Bournemouth – Social Care	8	8.1 Review practical and emotional support for carers available in the community with particular attention to how carers might better experience continuity of care over the course of caring for someone with a chronic illness and how carers might be supported in attending to their own needs.	√		BBC: Joint Service Manager (Long-Term Conditions) and Gateway & Enablement Services (Bournemouth) Adult Social Care; & Head of Joint Commissioning & Partnerships	
7	Bournemouth – Social Care	8	8.2 Carer vulnerability: Review in what circumstances a carer might be regarded as vulnerable. Is practice in Bournemouth the same as elsewhere, or are there areas of the country where (this carer's) vulnerability might have been acknowledged and, if so, how would he have been approached differently?	√		Bournemouth Borough Council: Joint Service Manager (Long-Term Conditions) and Gateway & Enablement Services (Bournemouth) Adult Social Care; & Head of Joint Commissioning & Partnerships	
8	Bournemouth – Social Care	22	22.1 Audit information given to service users and carers to ensure that is it honest and open about the effect that cuts in budgets are having on services and how the	√		Adult Social Care Management Team	

			funding agency is dealing with the financial pressures it is under.				
9	Bournemouth – Social Care	22	22.2 To review the process of reviewing service users and their carers with particular attention to the suggestions (this carer) has made about how the process might be improved.	√		Joint Service Manager (Long-Term Conditions) and Gateway & Enablement Services (Bournemouth) Adult Social Care	
10	Bournemouth – Social Care	22	22.3 To review the supervision of student social workers in order to ensure that they are taking on tasks commensurate with their level of training and support.	√		Joint Service Manager – Statutory Services, (Principal Social Worker – Bournemouth) Adult Social Care Bournemouth & Poole Borough Councils	
11	Bournemouth – Social Care	22	22.4 Explanation and apology: In the spirit of the Duty of Candour senior managers at social services to prepare an explanation for (the carer) of how it came about that a student social worker believed her son's services should be cut regardless of his needs assessment and how they will	√		Joint Service Manager – Statutory Services, (Principal Social Worker – Bournemouth) Adult Social Care Bournemouth & Poole Borough	

			avoid a similar occurrence in future, and to offer her an unqualified apology for the distress she and her son have gone through.			Councils	
12	Bournemouth – Social Care	22	22.5 To review the involvement of service users and carers in social care staff training at all levels and to consider ways of increasing their involvement.	√		Head of Workforce Development & Training Service - Social Care (BBC)	
DORSET							
13	Dorset – Health Care	17	3.6 CHC funding reviews: Funding organisations should audit whether regular review of CHC funded placements is taking place; whether review includes the issue of whether care needs are being met as well as continuing eligibility for funding; and whether there are processes in place to ensure that timely reviews take place. Funding organisations need to have an agreed way of dealing with concerns about unsatisfactory care in those people receiving CHC, eg by drawing them to the attention of the regulator and/or by moving the person receiving care to a placement which meets their	√			

			needs.				
14	Dorset – Health Care	5a, 5b	5.1 It would be helpful if the NHS were able to write to person b (and person a) to give some reassurance that his medical records are fully recorded, complete and networked on systems in the event of person b being admitted to any hospital in the future – especially if person a is in some way involved in that admission.	√			
15	Dorset – Health Care	5a	5.2 Psychological assessment/ treatment: In respect of case 5a: (carer) to be seen and assessed at home by an independent person with appropriate expertise and qualifications in psychological treatments and with a commitment to follow (and where necessary fund) the recommendations of that independent person.	√			
16	Dorset – Health Care	5b	5.3 Specialist recommendations: In respect of case 5b: the recommendations made in (a specialist's) report regarding (service user's) follow up care and treatment to be enacted at the earliest opportunity and, because		X	Person 5b's GP	Ongoing

			of the complexity of (his) needs and (carer's) needs, this to be done in the community.				
17	Dorset – Health Care	5a	5.6 If not recently done, CCG to audit how families/ carers are involved in the process of assessing eligibility for NHS CHC funding with particular attention to how families/ carers might have confidence that their voice has been heard.	√			
18	Dorset - Health	5a,5b	5.7 If not recently done, CCG to review the appeal process relating to assessments for NHS CHC funding with particular attention to how families/ carers might have confidence that their voice has been heard.	√			
19	Dorset – Health Care	5a,5b	5.8 If not recently done, CCG to review the training undertaken by health and social care staff involved in eligibility assessments with particular attention to their training in working with service users and carers and how to ensure a person-centred approach.	√			
20	Dorset – Health Care	5a,5b	5.10 In respect of the recommendations that the person	√			

			leading the CHC Multidisciplinary team meeting about the Decision Support Tool ratings on 13/11/2014 should have training in conflict management and communication skills (in response to their complaint); (the carer and service user) would like to know whether this was carried out and they should be informed whether it was or not.				
21	Dorset – Health & Social Care	4,17	3.5 Commissioners should review services to support carers in the community including respite/ rotational respite and out-of-hours services.	√ social care √ health care			
22	Dorset – Health & Social Care	5a	5.4 Review practical and emotional support for carers available in the community with particular attention to how carers might better experience continuity of care over the course of caring for someone with a chronic illness and how carers might be supported in attending to their own needs.	√ social care √ health care			
23	Dorset – Health & Social Care	5a	5.5 Senior member/s of staff at Social Services and the CCG to prepare evidence and explanation for (the carer) about how services	√ health care	X social care	Commissioning Manager	31 Aug 2017

			have learned (or propose to learn) from her experiences, in order to improve services for future carers by answering the eleven questions as set out on page 20 (of the Report).				
24	Dorset – Health & Social Care	5a,5b	5.9 In the case of each of the above Action Points (5.4-5.8) evidence of improvement should be provided to (the carer, service user,) and Advocare in order to address the aims set out earlier.	√ health care	X social care	Commissioning Manager	31 Aug 2017
25	Dorset – Social Care	11	11.4 Complaints: Encourage relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and routinely give them information about how to complain, and how to access support in making complaints.	√			
26	Dorset – Social Care	11	11.5 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.	√			
27	Dorset – Social	11, 15	11.6 Involvement of Carers in	√			

	Care		ASC: To review how carers are currently involved in adult social care and consider whether they could be more involved in order that their voice is heard at all levels and in all relevant fora.				
28	Dorset – Social Care	15	15.2 Complaints: Encouraging relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and ensuring that information about how to complain, and how to access support in making complaints, is included.	√			
29	Dorset – Social Care	15	15.3 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.	√			
66[8]	Dorset - Safeguarding	4	3.7 Safeguarding: Dorset's Multi-Agency Safeguarding Adults Policy and Procedures should be reviewed to ensure that where	√		Safeguarding Adults Board	

[8] Recommendation 66 had been incorrectly listed under Poole but to avoid confusion the original number is retained despite move to list under Dorset safeguarding.

			carers have been alleged to have caused harm they have the right to know what has been alleged; a right to give their account of what happened; and a right to appeal against the outcome of the safeguarding process.				
POOLE							
30	Poole Hospital	2	2.1 That the service user be informed whether the surgeon has undertaken Advanced Communication Skills training, which is now recommended for all clinical staff involved in the treatment of cancer, and if the surgeon concerned has not undertaken the training that this should be expedited urgently.		X	Not applicable[9]	
31	Poole Hospital	2	2.2 Records: The service user has requested that his records should include a note to the effect that there was a misdiagnosis. This does not seem unreasonable, should be done and confirmation		X	Head of Patient Experience	Within 1 month of service user giving consent to contact

[9] Further information is that the surgeon met with the patient and reflected on his communication skills: those involved in the meeting understood the patient involved to be happy with the outcome of the meeting and that the patient did not wish for any further action to be taken. The surgeon has since retired.

			that it has been done sent to the service user.				Southampton Hospital
32	Poole Hospital	20	20.1 Poole Hospital and their PALS be made aware of the findings of this report and to be satisfied that due consideration is made to record-keeping of patients' property and the needs of patients and carers on discharge.		X	Head of Patient Experience	One month after report shared with Poole Hospital
33	Poole Hospital	20	20.3 Face to face meeting: The Chief Nursing Officer and Chief Executive, who have offered to listen to carers in person be invited to meet with (carer). She welcomes this and believes it would help her to achieve closure of these issues which continue to trouble her.		X	Head of Patient Experience	At mutually convenient date to be arranged if carer wishes.
34	Poole Hospital	21	21.1 Detailed response for carer: Senior members of staff at the hospital to prepare a detailed response to the points raised by (carer), concentrating on how the Hospital proposes to improve the care of people with dementia in future and what can be learned from (the service user's) experience, and with reference to the recommendations below.	√			

35	Poole Hospital	21	21.2 Review of discharge planning process at Poole Hospital with particular reference to people with dementia, how their carers are involved in the process and how their carers' views are taken into account.	√			
36	Poole Hospital	21	21.4 Involvement of carers/ families: Review of how carers/family members are involved in the care of people with dementia	√			
37	Poole Hospital	21	21.5 Audit of staff training in dementia care: Has Poole Hospital audited their staff against this Quality Standard (NICE Dementia Quality Standard Statement 1)? If so, how did they perform and what mechanisms are in place to ensure that this Standard is met? If not, then an audit of staff training in dementia care is recommended.	√			
38	Poole Hospital	21	21.6 It may be appropriate to consider whether some wards at Poole Hospital should apply for the Quality Mark for Elder-friendly Hospital Wards (Royal College of Physicians 2014).	√			
39	Poole &	14	14.1 Recording Next of Kin. The				

	Alderney Hospital		Trust might review their practice regarding how NOK is recorded and how difficult issues regarding NOK might be addressed; for example, through information management training for staff and/or audit of NOK recording practices.	√			
40	Poole & Alderney Hospital	14	14.2 Relationship with carers/ families: Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	√			
41	Poole & Alderney Hospital	10, 14	14.3 In respect of vulnerable older people, the Trust might consider using a letter of authorisation for information sharing in order to ask patients who are capable of deciding to specify with whom they want information about them to be shared.	√			
42	Poole & Alderney Hospital	14	14.4 Audit basic standards of care eg nutrition, communication.	√			
43	Poole & Alderney	14	14.5 It may be appropriate to consider whether some wards at	√			

	Hospital		Poole and Alderney Hospitals should apply for the Quality Mark for Elder-friendly Hospital Wards (Royal College of Physicians 2014).				
44	Poole & Alderney Hospital	14	14.6 Senior member/s of staff at the Hospitals to prepare an explanation for (the carer) about what happened to her husband and how the Hospitals propose to learn from her experience and to improve the care of people using services in future. This explanation would be best offered to (the carer) through a neutral third party, or in writing, and perhaps in partnership with Advocare. This approach might be equally appropriate in the case of other carers who have had similar experiences.	√			
45	Poole – Alderney	3,4,17	3.1 Culture of care: If the wards at Alderney Hospital are not already		X[10]		

10

DHC has not subscribed to this programme. In 2016/17 introduced and implemented John's Campaign in Older People's Mental Health Wards. This facilitates families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed – or wish to and to assist with care.

	Hospital		involved in the AIMS-OP programme then involvement in the programme could be considered as a way to demonstrate that inpatient care meets appropriate standards, and as a way of reassuring carers who have been through bad experiences that things are changing.				
46	Poole – Alderney Hospital	3,4,17	3.2 Anti-psychotic drugs and psychological/ psychosocial interventions: Other possible actions might include auditing the use of anti-psychotics (this may have already been done); auditing what training staff have undertaken relating to psychological/ psychosocial interventions as a prelude to identifying future training priorities and arranging necessary training; auditing the availability and range of activities on the wards.	√			
47	Poole – Alderney Hospital	17	3.3 Smoking policy: When a person with dementia who smokes is admitted to hospital the care plan needs to include appropriate management of their smoking	√			

			which will include measures to deal with any withdrawal symptoms if they are in a non-smoking environment, eg nicotine replacement treatment.				
48	Poole – Alderney Hospital	3,4,17	3.4 Relationship with carers: It is good practice to encourage the involvement of carers and to ask them to give routine regular feedback about ways to improve the environment where their relative is being cared for. Simple things can be built into the system to help carers stay fully informed and involved, and should be considered eg meeting them regularly; involving them in review meetings; copying letters relating to their relatives care to them (with their relative's consent); giving them copies of treatment and discharge plans (with their relative's consent). Enquiring about LPAs and recording their existence should be routine practice.	√			
49	Poole – Alderney Hospital	3,4,17	3.9 Assessment: An admission care pathway with agreed criteria for admission of people with	√			

			dementia should be considered (if not currently in operation).				
50	Poole – Alderney Hospital	10	10.1 Senior members of staff at the hospital (Alderney) to prepare a detailed response to the points raised by (the carer), concentrating on how Alderney Hospital proposes to improve the care of people using services in future, what can be learned from (her husband's) experience, and what has changed since (his) admission; response to be produced in partnership with an Independent Medical Assessor to act as an impartial third party. It is likely that production of the response will need to include a senior member of nursing and of medical staff in order to address all the questions raised.	√			
51	Poole – Alderney Hospital	10	10.2 Working with carers/ families: Review what Trust policies influence how healthcare staff members work with and involve carers/ family, and how communication with carers and their involvement in their relative's care might be improved.	√			

52	Poole – Alderney Hospital	10	10.4 Visit: A senior staff member kindly offered to take (the carer) to visit the ward and meet the ward sister and (the carer) was pleased to accept this offer. If possible (subject to their agreement and practical arrangements) (she) would like to talk with patients and relatives whilst she is there.	√			
53	Poole – Alderney Hospital	10	10.5 (A senior staff member) will check whether relatives/ carers are made aware that care plans relating to the treatment of their relatives are available.	√			
54	Poole – Alderney Hospital	10	10.6 Staff training: Advocare will give (the carer's) contact details to (a senior staff member) so that (the carer) can be contacted with a view to recording her experiences/ story for use in training staff.	√			
55	Poole – Alderney Hospital	10	10.7 A senior staff member has agreed to feed back to (a specialist who provided a report) the specific comments and views of (an Advocare representative) that (the carer) i) did not have poor recollection of events as he states in his report	√			

			ii) was bullied by the OT and this was not a negative misinterpretation (only she can say what her experience was). Good communication on behalf of staff would have prevented both of these.				
56	Poole – Alderney Hospital	10	10.8 (An Advocare representative) and (a senior staff member) have agreed to meet and explore how Advocare might work with the Trust in the interests of carers and patients.	√			
57	Poole – Alderney Hospital	10	10.9 Audit: A senior staff member referred to the PDS audit 'get it on time' and will check whether it is being undertaken.	√			
58	Poole – Health Care	3	3.6 CHC funding reviews: Funding organisations should audit whether regular review of CHC funded placements is taking place; whether review includes the issue of whether care needs are being met as well as continuing eligibility for funding; and whether there are processes in place to ensure that timely reviews take place. Funding organisations need to have an agreed way of dealing	√			

			with concerns about unsatisfactory care in those people receiving CHC, eg by drawing them to the attention of the regulator and/or by moving the person receiving care to a placement which meets their needs.				
59	Poole – Health Care	16	16.4 The care offered to (the patient) in the Poole NHS Trust was not of the standard expected and there are significant differences between the family's account and that recorded in the medical record. The carers wish to: 1. Understand who took the decision to put the Medicines Management Team out to Tender; a) Why they were not provided with any warning or made aware of the consultation? b) Was the new service specification identical to the existing service? c) Why were they not informed	√			

			that the service had ceased during his admission?				
60	Poole – Health Care	16	16.5 The carers wish to: d) Have copies of the relevant PIC's community care notes; e) Have copies of documentation (which may include the relevant Poole PCT Board minutes) relating to the decision to tender the Medicines Management service f) Meet with the appropriate person to discuss these issues which may be the Chief Executive at the time.	√[11]			
61	Poole – Health Care	16	16.6 The carers wish to be provided with reassurance that there have been changes to the hospital process to; g) ensure all injuries to patients are recorded on incident forms. h) that there has been an improvement in communication with families regarding the use of DNAR and Liverpool Care Pathway (or its equivalent).	√			

[11] A meeting was held with relevant staff and the family in 2014.
However, the PICs and PCT Board minutes were no longer available due to organisational changes so have not been able to be shared

			i) That staff are reminded to complete and correctly time all entries into the medical notes. j) (The IMA) would also suggest that the nursing Kardex is reviewed as at times he found it almost impossible to follow the flow of information.				
62	Poole – Health Care	21	21.3 The CHC assessment and decision making process: (a) Clarify what the role of the mental health service is in the CHC assessment and decision making process (particularly in relation to people with dementia in acute care) and when the mental health service might contribute to the overall assessment. (b) Review how staff teams ensure that carers/family are kept fully informed and able to contribute to the process.	√			
64[12]	Poole – Health care	3	3.8 Services for people with early onset dementia should be reviewed to ensure that people are not disadvantaged by virtue of	√			

[12] Recommendation 64 had been incorrectly listed under Poole – Health and Social Care instead of Poole – Health Care. To avoid confusion the original number is retained despite move to list under Poole - Health Care.

			developing dementia at a young age, and that the carers of younger people with dementia have access to community support.				
63	Poole – Health & Social Care	3,4	3.5 Commissioners should review services to support carers in the community including respite/ rotational respite and out-of-hours services.				
64	Incorrectly listed as Poole – Health and Social Care moved to list under Poole - Health Care but original number retained						
65	Poole – Health & Social Care	16	16.2 Evidence of change: The investigator recommends that the hospital and other agencies need to respond to these issues by informing (carers) of how situations have changed since the events subject of this investigation and what measures have been put in place to safeguard vulnerable patients both in Hospital care and on discharge under care plans.	√			
66	Incorrectly listed under Poole – moved to Dorset but recommendation number retained						
67	Poole – Social Care	15	15.4 To review how carers are currently involved in adult social care and consider whether they could be more involved in order that their voice is heard at all levels.	√		Service Manager , Long Term Conditions & Acute Hospitals – Adult Social Care, BoP	

68	Poole – Social Care	15	15.3 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.		X	Learning & Development Manager, Commissioning Unit, Borough of Poole.	The Health and Care Academy work will be an ongoing and long term project.
69	Poole – Social care	15	15.2 Complaints: Encouraging relatives to complain when they find care in Homes to be unacceptable: review what information is given to carers of people moving into Care and ensuring that information about how to complain, and how to access support in making complaints, is included.	√		Principal Officer, Contracts & Service Improvement, Commissioning Unit, Borough of Poole	
70	Poole – Social Care	20	20.2 Complaints about domiciliary services: Adult social care to review their stance when complaints are made to their staff about domiciliary services for which they have a commissioning responsibility and in particular the way in which concerns and complaints are recorded, actioned and monitored.	√		Principal Officer, Commissioning Unit, Borough of Poole	
71	Poole – Social Care/ Safeguarding	18	It is reasonable that Adult Services … write to (the carer) tendering an appropriate apology for the period	√			Completed. A formal letter of apology was

			of time that elapsed before this new approach was adopted.				sent to the carer by Jan Thurgood (which also apologised for the delay).

7. Improvements made within the Health and Social Care Services within Dorset, Bournemouth and Poole.

Report for the Advocare Oversight Group and Dorset, Bournemouth and Poole Safeguarding Adult Boards

Report Author's Note: The following chapter was written by and contributed on behalf of the officers and directors of Bournemouth Borough Council, the Borough of Poole, Dorset County Council and Dorset Clinical Commissioning Group. It is dated May 2017 and is included in its entirety and with permission.

7.1 INTRODUCTION

7.1.1 This Report has been written jointly by officers and directors of Bournemouth Borough Council, the Borough of Poole, Dorset County Council and Dorset Clinical Commissioning Group. It has been written in response to concerns raised, and subsequent findings from investigations, relating to the experiences of carers, patients and service users.

7.1.2 Members of the Board of Trustees from Advocare have raised a number of concerns, on behalf of carers known to them, about the care and treatment of their relatives/ loved ones within Poole, Bournemouth and Dorset Local Authorities and Health organisations.

7.1.3 Advocare and the carers they represent have requested answers to the concerns they have raised and, where necessary, for improvements to be made across health care settings, adult social care and safeguarding practice, policy and procedures. A number of the cases raised have undergone independent investigations and further cases have had an independent medical assessment.

7.1.4 There are, however, cases that were not investigated because, either carers chose to withdraw from the process, or in some cases the individuals and carers have since passed away.

7.1.5 This report concerns the remaining cases which have not been subject to a full investigation for the reasons given above. It was agreed with the Oversight Group that issues on cases not investigated would form a 'thematic review' of learning for adult social care and health partners and any actions arising would form an action plan of improvement.

7.1.6 In this report we have detailed a number of the early themes that have arisen for the local authorities and health partners involved in this process. It should be noted that significant changes in practices have been made as a result of these issues being brought to the attention of the various agencies.

7.1.7 It should also be noted that a long period of time has elapsed since these people were being cared for and the concerns arose. Much has happened through national and local government policy to improve the standards of care across the system.

7.2 KEY THEMES

7.2.1 There are a number of key themes that have already been identified within this process. However, given that some of the cases are historic it is necessary to identify where improvements have already been made in recent years but also highlight any additional areas of improvement which are required. This demonstrates willingness for Adult Social Care and Health to improve the way in which they work alongside carers.

7.2.2 The themes arising include:

A lack of service provision for carers

Services specifically targeted at carers have seen significant improvements since 2011. The Care Act, which was fully enacted in 2015, makes further statutory provision for carers and these are already being put in place by partners in health and adult social care. Included within this is the statutory right to a carers assessment in their own right and the offer of a direct payment to meet a carers identified needs.

It should be noted that services for carers across the three Local Authorities are currently different however there is no difference now in eligibility due to the changes in legislative requirements.

7.2.3 This report does not set out to list those differences but aims to demonstrate that, since the Advocare Oversight Group was established, there have been significant improvements in the way that both Social Care and Health engage with carers.

7.2.4 Services commissioned for carers since 2011 include the following:

Services/support for all carers - Free

A carers assessment is not required to access these services **(Not Fair Access to Care eligible - this is a right set within a legislative framework)**

- **Carers Information Service** - the Information Service provides carers with a newsletter every 2 months to inform them of social events, activities, training and other useful information. The Caring Matters magazine, A –Z booklet and list of support groups is also sent out to everyone registered with the service.

- **Carers in Crisis (Emergency Back-up Scheme)** - contact only membership. Scheme will contact the nominated emergency contact to inform them of situation. No replacement care is arranged or provided.

- **Home Based Support (Sitting Service)** - Carers can access up to 15 hours subsidised care per quarter to provide them with the opportunity to take a break from their caring role to undertake other activities.

- **Carers Support Programme** - this is a training programme for Carers provided by St John Ambulance.
  Subjects covered include first aid, dealing with memory loss and the dementias, falls prevention, safer handling and care skills plus advice on how to manage stress. Transport can be provided free.

- **Dorset Advocacy** - has been commissioned to provide advocacy for carers. Help for carers to resolve problems dealing with statutory organisations.

- **Focus -** Befriending scheme for carers offers emotional support and friendship through a volunteer.

- **Reference Group for Carers** – run by Colin Feltham of Bournemouth Council for Voluntary Services (CVS) open to current and past (two-year time frame) carers from Bournemouth and Poole. This group have representation on the Joint Strategic Commissioning Board. Carers that attend can have travel and replacement care costs.

- All three Local Authorities offer training and respite service for carers.

- Dorset County Council offers a Carers Activity Service through their Access Team.

- In Dorset funding from the National Carers Strategy, channelled through NHS has enabled one off payments to be made to individual carers of up to £300 and a further £5000 has been awarded to organisations set up to support carers.

Services/Support for FACs eligible carers

7.2.5 A Carers assessment is required to establish eligibility.

- **Carers in Crisis (Emergency Back-up Scheme) -** full replacement care membership – scheme will contact nominated contacts and provides full replacement care free of charge for the first 48 hours.

- **Home Based Support (Sitting Service) -** carers can access up to 30 hours subsidised care per quarter to provide them with the opportunity to take a break from their caring role to undertake other activities.

- **Direct Payment to carer -** To provide a "carers service" directly to the carer for example: trips, driving lessons, laundry, washing machine, gardening, holiday, help with housework.

- **Complementary Therapy and Cinema Vouchers -** carers can have vouchers for free complementary therapy sessions or free admittance to Empire or Odeon cinemas; they can have a combination of both.

For Carers of older people using own funds or Direct Payment to the cared for person

- **Home from Home Day Respite** - this is a new day service in partnership with East Borough Housing Trust and Bournemouth Borough Council providing carers of older people with a break. It provides an alternative to day centres.

  Up to four people spend the day with a "Host" carer with a personalised programme of activities. It is open to people with personal budgets and people who pay the full costs of their care.

7.3 QUALIFICATIONS OF PROVIDERS TO MAKE ALLEGATIONS OF ABUSE TO SOCIAL SERVICES

7.3.1 Every registered Provider of an adult social care service must comply with regulations laid down by the Care Quality Commission (CQC). Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states that:

7.3.2 The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of:

(a) Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and
(b) Responding appropriately to any allegation of abuse.

7.3.3 In order to meet the above regulation, Providers must:

- Take action to identify and prevent abuse from happening in a service;
- Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring;
- Ensure that Government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice;
- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual;
- Only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services;
- Understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns;
- Protect others from the negative effect of any behaviour by people who use services;
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

  Residential Care Providers and Hospitals are required by law to request a Deprivation of Liberty Safeguard authorisation from the relevant Local Authority, if they consider that they are depriving a resident of their liberty within the Human Rights legislation. This is specifically important when the individual is objecting to their placement or hospital admission and it appears that they lack capacity to agree to their treatment or care plan.

7.3.4 Compliance with the above is also included within the local authority's contracts and service specification and is monitored by both health and social care agencies, in addition to CQC, for compliance.

7.4 GP'S ROLE IN UNDERTAKING MEDICAL EXAMINATIONS TO BACK UP ALLEGATIONS OF ABUSE OR NEGLECT.

7.4.1 Through the NHS transformations there has been a defined split between the commissioning and providing of health services. From April 2013, local General Practitioners as part of the Dorset Clinical Commissioning Group (CCG) have been responsible for commissioning most health services to meet the needs of their local communities. These needs have been determined by a Joint Strategic Needs Assessment, which has been produced through a multi- agency approach. Dorset Clinical Commissioning Group commissions with providers of health services across Dorset, Bournemouth and Poole Local Authorities.

7.4.2 The CCG is overseen by NHS England Wessex. The CCG also now has delegated responsibility from NHS England for commissioning GP services (as from April 2016). The NHS in collaboration with the Department of Health, Department for Education, CQC and NHS Improvement have developed a Safeguarding Accountability and Assurance Framework to support the principles of Safeguarding Adults. This Framework was developed and issued on the 2nd July 2015 and includes links to the Care Act 2014 and the Care and Support Statutory Guidance. The Framework makes specific reference to people who lack capacity, which by definition includes people who have dementia.

7.4.3 Dorset Clinical Commissioning Group is fully engaged with the local Safeguarding Adults Boards and works in partnership with local authorities to fulfil their safeguarding responsibilities. They will contribute to Safeguarding Adult Reviews (SARs- previously known as Serious Case Reviews) and develop robust processes to learn lessons from cases where adults at risk die or are seriously harmed and where abuse or neglect is suspected. A lead Safeguarding Nurse now works full time for the CCG.
The CCG now employs GP safeguarding leads who are responsible for improving adult safeguarding within Primary Care.

7.4.4 Safeguarding adults within health is now integral to:

Patient Care: Safeguarding is particularly relevant to domains 4 and 5 within the NHS Outcomes Framework - *Patient experience and protecting people from avoidable harm*.

Regulations: Safeguarding is a fundamental requirement for registration and Complying with the Care Quality Commission, Essential Standards for Quality and Safety. GPs Practices are now required to be registered with the CQC and are inspected and rated regularly.

Legislation: Duty to comply with other legislation including the Human Rights Act; Mental Capacity Act and Safeguarding Vulnerable Groups Act.

Cost Effectiveness: Quality Innovation Productivity and Prevention – harm neglect and abuse cost the NHS millions each year in avoidable admissions and care. NHS service providers are regulated through the Care Quality Commission (CQC), and NHS Improvement, a regulatory body, as well as being monitored by the CCG. All care homes that provide regulated activities as defined in the Health and Social Care Act (2008) must be registered and regulated through the CQC.

7.4.5 Therefore all NHS services, provided through Hospitals, Community Services or Care Homes must adhere to the Dorset, Bournemouth and Poole Multi Agency Safeguarding Adults Policy and Procedures. They will be accountable for the quality of care they provide, ensuring that shared decision making is the norm, and that patient safety is paramount.

7.4.6 GPs have a significant role within Safeguarding Adults and should receive appropriate training in this area. They should be able to identify adults in their care who may be at risk of potential or actual harm. They need to ensure they have processes in place to recognise and report such issues in line with the Bournemouth, Dorset and Poole Multi Agency Safeguarding Adults Policy and Procedures, as this can be a vital first step in ensuring that he or she receives necessary support. They should contribute to strategy discussions, case conferences and protection plans where appropriate.

7.4.7 Additional Resources have also been provided for GPs by the British Medical Association: Safeguarding Vulnerable Adults – a tool kit for general practitioners. Two lead GPs for safeguarding adults have been employed by the CCG to provide specific focus on this within Primary

Care. These GPs are participating in training of local GPs, raising awareness and assisting with audits.

7.5 THE ATTITUDE OF STAFF IN ADULT SOCIAL CARE WHEN APPROACHING CARERS WHO HAVE BEEN ACCUSED OF HARM/ HEAVY HANDED SAFEGUARDING PROCESSES – CARER'S VIEWS IGNORED

7.5.1 Firstly, it has been recognised by the Statutory Safeguarding Adults Board members that more work needed to be done to truly understand the impact of our safeguarding interventions, whether service users feel safer as a result and whether we met the desired outcomes of service users.

7.5.2 To ensure that the above was taken forward in a systematic and robust manner, we recruited an independent lay person to undertake semi structured interviews with service users and, where appropriate, their family/advocate to better understand whether their safeguarding needs have been met and, more importantly, how they were treated within the process. This included some people with dementia.

7.5.3 The lay person was from a Poole based, user led charity called "Prodisability". The charity provides support to adults to help them live independently, with dignity and to ensure they have choice and control over their care needs. The organisation considers the safeguarding of their clients as crucial and they subscribe to the Bournemouth, Dorset and Poole Multi- Agency Safeguarding Adults policy and procedures.

7.5.4 The organisation was pleased to take on this voluntary role to assist with obtaining feedback from people who have been the subject of a safeguarding incident that has been investigated and also believe strongly in the view that it is important to learn about people's experiences of statutory processes in order to help with the continued improvement of the process for users.

7.5.5 Since this initiative was introduced the 3 Local Authorities have adopted the National "Making Safeguarding Personal" approach to all safeguarding adults activities and interventions. This involves putting the person and their carers or families at the centre of the concern. They are asked what outcomes they would like to have help with to achieve at the end of the safeguarding enquiry. In addition, how they would like to be kept informed of the progress of any enquiry, including whether or not they would like to attend any or all safeguarding meetings. People are also asked if they would like to have an

independent advocate present at any meetings. This is a more person centred way of engaging with people and their carers.

7.5.6 Since 2010, adult social care services and the Safeguarding Boards' Quality Assurance Group have introduced an audit schedule for safeguarding work, the schedule includes the following:

- Peer audits of practice between councils;
- Multi agency audits with partners including the CCG, Police, CQC, housing and children's services;
- Case file audit of all safeguarding work on a quarterly basis;
- Case file audits of Mental Capacity Assessments and scrutiny of Deprivation of Liberty Safeguards Authorisations.

7.5.7 Any learning from the above is disseminated in team meeting and training sessions delivered across all teams within adult social care and is extended to health and CQC colleagues.

7.5.8 The Safeguarding Adults Policy was reviewed and updated in December 2016 to more robustly include safeguarding concerns in respect of carers and family members. Within the policy it is now recognised that, in cases where unintentional harm has occurred, this may be due to lack of knowledge or due to the fact that the carer's own physical or mental needs make them unable to care adequately for the adult at risk. The carer may also be an adult at risk. In this situation the aim of safeguarding adults work is to support the carer to continue to provide the support for their loved one.

7.5.9 It should be noted that the Safeguarding Adults Policy and Procedures have been completely re written to take account of both the Care Act requirements and the Making Safeguarding Personal approach already mentioned above. These were re-issued in 2016 and are being constantly reviewed and updated by the Policies and Procedures sub-group of the Safeguarding Adult Boards.

7.5.10 A carer's assessment must take into account the following factors:

- Whether the adult for whom they care has a learning disability, mental health problems or a chronic progressive disabling illness that creates caring needs which exceed the carer's ability to meet them;
- The emotional and/or social isolation of the carer and the adult at risk;

- Minimal or no communication between the adult at risk and the carer either through choice, mental incapacity or poor relationship;
- Whether the carer is not in receipt of any practical and/or emotional support from other family members or professionals.
- Financial difficulties;
- Whether the carer has a lasting power of attorney or appointeeship;
- A personal or family history of violent behaviour, alcoholism, substance misuse or mental illness;
- The physical and mental health and well-being of the carer.

7.5.11 The new Safeguarding Adults policy also makes it explicitly clear that feedback should always be sought from the adult at risk or their representative in respect of their experience of the safeguarding activity and whether they are satisfied with the outcomes of the intervention and if they feel safer as a result.

7.5.12 The revised practice guidance also covers adults who are alleged to have harmed another adult at risk and that they must be given the opportunity to provide their account of what happened during the alleged incident. Whether they are an employee, a volunteer, a relative or a carer they also have the right to be treated fairly and their confidentiality respected.

7.5.13 They have a right to know in broad terms what the allegations are that have been made against them, unless the police suggest otherwise, or it would jeopardise the intervention. A risk assessment will be undertaken and the person should be provided with appropriate support throughout the process.

7.5.14 If the person causing harm is also an adult at risk, they must also be provided with appropriate support. If the person causing harm is a young person or has a mental disorder, including a learning disability and they are interviewed at the police station, they are entitled to the support of an appropriate adult under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice.

7.6 ACCOMMODATION AND ACCESS OF LOVED ONES WHERE NEGLECT IS SUSPECTED

7.6.1 The relationship between the Clinical Commissioning Group, the Care Quality Commission and adult safeguarding is much improved and all agencies now share weekly reports on services of concern. Any

indication of neglect or abuse is shared between all agencies and a decision is jointly made on whether a service needs a 'spot inspection or indeed if all service users in receipt of a service of concern need an urgent review. Where neglect is suspected all service users and their families will be offered a review of their care regardless of how their placement is funded. If the assessment or review identifies a need to change accommodation to maintain an individual's safety, alternative placements will be found.

7.7 CARERS FEELING INTIMIDATED AT MEETINGS

7.7.1 This practice is unacceptable and carers are now routinely invited to attend or take part in meetings and can, if necessary, be accompanied by an advocate. With the implementation of Making Safeguarding Personal this ensures that both the person at the centre of the concern and their carer/relative will be kept informed and engaged throughout the safeguarding activity. In addition, formal apologies have been given to people who felt intimidated in the past.

7.8 CONCERNS ABOUT DOMICILIARY CARE AND RESIDENTIAL CARE

7.8.1 Local authorities reviewed their complaints procedures in August 2012 to ensure that they met legislative requirements which are defined in the National Health Service and Community Care Act 1990, this introduced directions under the Local Authority Social Services Act 1970.

7.8.2 They required social services to establish a formal complaints procedure to consider 'any representation, including a complaint to the Local Authority in relation to the discharge of, or any failure to discharge, any of their social services functions' in respect of a 'qualifying individual'.

7.8.3 On 1 April 2009 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 came into being, building on a culture of listening, responding to and learning from complaints in order to improve services and importantly put service users at the heart of the process.

7.8.4 The new procedure incorporates a direction and policy in respect of occasions when complaints have elements of both health and social care services. If such a complaint is received, it is forwarded to the Complaints Manager, who will look at the issues and decide whether

the Joint Protocol with health needs to be adopted and the complaint progressed through this route.

7.8.5 It should be noted that issues relating to any adult safeguarding concern identified within any complaint is dealt with through the adult safeguarding route. This entails a Statutory Section 42 Safeguarding Enquiry Planning Meeting. This includes liaison with the Local Authority contracts teams, the service improvement, CQC and adult safeguarding staff. Feedback and any updates are shared wherever possible with the person and their carers. It should be noted that, where there are employment or disciplinary issues, it is not always possible to share the full details.

7.8.6 The complaints process is now linked very closely with contract monitoring and quality assurance processes. Legislation requires local authorities and NHS organisations to record all complaints. Recording demonstrates concerns are being dealt with and complaints are taken seriously. Feedback gained from complaints, however minor, leads to improvement in service delivery, practice and policy development and ensures that resources are targeted appropriately.

7.8.7 The Complaints Managers provides monthly reporting to Managers and an Annual Report to Members/Governing Bodies which is made publicly available by publishing on the website. Learning from complaints is disseminated through regular articles in newsletters, training and management updates. Examples of this are:

- Carers to alert the CQC and Local Authority immediately if there are concerns. These will be followed up either through the complaints system or safeguarding as a result of Winterbourne View;
- Complaints process is accessible with leaflets and dedicated Complaints Managers;
- L.A. Adult Social Care routinely has lessons learnt from Complaints and policy changes are made, where appropriate, e.g. introduction of telephone reviews;
- NHS Complaints reports are received by all health trusts and CCG Governing Bodies and complaints are published on their websites.

Concerns about Care Homes with Nursing

7.8.8 It has been recognised that care homes with nursing have historically not received the same level of quality assurance or quality improvement work as the acute and community hospitals. As a result

of this, the CCG set up a Care Home Quality Improvement Team which has been in place since April 2013. This team work very closely with the Local Authorities monitoring teams and have jointly worked towards a number of quality improvements in local care homes. New standards relating to nursing care have been agreed to be included in the contracts between the Local Authorities and the CCG with care homes and domiciliary care providers.

7.8.9 There has been a marked reduction in care homes with nursing that have an inadequate or 'requires improvement' rating from the CQC.

7.8.10 Quarterly newsletters which provide best practice advice and learning from complaints and incidents, are provided to all care homes by the CCG. A leadership development programme for care home managers has commenced in 2017.

7.9 THE APPLICATION OF DEPRIVATION OF LIBERTY SAFEGUARDS

7.9.1 A fundamental Principle of Common Law and of the Mental Capacity Act 2005, is that every adult has the right to make his/her own decisions and is assumed to have capacity, or be able, to do so, unless it is proved otherwise.

7.9.2 Assessing whether someone has capacity to make decisions is complex. Some people may need help or support to be able to understand the decision they are being asked to make, to know how to make a choice, or to be able to communicate but this does not remove their right to make their own decisions.

7.9.3 Any assessment of a person's mental capacity can only be made in relation to the specific decision or proposed action in question at that particular time. A person may be capable of making a straightforward decision but less able to make a complex one. Professionals support people in understanding that decisions need to be made and why, what the effects may be and check whether there are any alternatives.

7.9.4 Professionals should use their professional judgement and skills in the most effective way to communicate and explain things in a way which can be understood. They may also know of other sources of help and advice which will enable individuals to reach a decision and express a choice.

7.9.5 The Mental Capacity Act 2005 for England and Wales was implemented in 2007 to empower and protect people who may lack the

capacity to make some decisions for themselves. The Act is underpinned by 5 key principles:

- A presumption of capacity, every adult has the right to make their own decisions and is assumed to have capacity to do so unless proved otherwise;
- Individuals must be supported to make their own decisions with all practicable help;
- Unwise decisions do not by themselves mean the person lacks capacity.
- Best Interests assessments means that anything done for or on behalf of people without capacity must be in their best interests;
- Least restrictive alternative, anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

The Deprivation of Liberty Safeguards

- The Deprivation of Liberty Safeguards is an amendment to the Mental Capacity Act 2005. They apply in England and Wales only;
- The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests;
- Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards;
- The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can be asked if a person can be deprived of their liberty;
- As previously stated, Care homes or hospitals must ask either a local authority or health body if they can deprive a person of their liberty. This is called requesting a standard authorisation;
- There are six assessments which have to take place before a standard authorisation can be given;
- If a standard authorisation is given, one of the most important safeguards is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend;
- Other safeguards include rights to challenge authorisations in the Court of Protection without cost and access to independent mental capacity advocates (IMCAs).

7.9.6 Over the past few years, there has been an increase in applications for Deprivation of Liberty Safeguards to be approved. This is the situation both locally and nationally, following case law changes. This has led to increasing investment in this service, additional Best Interest Assessors being in place and increased training for professionals.

Independent mental capacity advocates (IMCAs)

7.9.7 IMCAs provide one type of non-instructed advocacy. Their role was established by the Mental Capacity Act 2005 to provide a statutory safeguard mainly for people who lack capacity. They assist those people who do not have family or friends who can represent them or whose family & friends appear not to be making decisions in the person's best interest, by helping them to make decisions which are in their best interest. IMCAs have a statutory role in the Safeguarding Adults process.

7.9.8 There is a legal requirement to make a decision about instructing an IMCA for an adult at risk who is the focus of safeguarding adults' processes where they lack capacity to make decisions about their safety. IMCA instruction may be unnecessary if the adult at risk has adequate alternative independent representation. This could be from another advocate, or from family or friends.

7.9.9 Before making an instruction to an IMCA for safeguarding adults, it is necessary to assess the person as lacking capacity for consenting to at least one protective measure which is either being considered or has been put in place. Examples of protective measures may include (but are not limited to):

- Restrictions on contact with certain people;
- Temporary or permanent moves of accommodation;
- The police interviewing the person or collecting forensic evidence which may support a prosecution;
- Increased support or supervision;
- An application to the Court of Protection;
- Restrictions on accessing specific services and/or place;
- Access to counselling or psychology with the aim of reducing the risk of further harm.

7.10 FURTHER DEVELOPMENTS IN RESPECT OF THE KEY THEMES ARISING

7.10.1 As stated at the start of this report some of the cases within the investigation date back many years and it must be acknowledged that systems, policies and procedures have been updated and improved.

Heavy Handed safeguarding processes – carers' views ignored

- Quick guide developed and published on the 2 Local Safeguarding Adults Boards webpages;
- Introduction of Making Safeguarding Personal ensures that views and wishes of people involved are discussed and recorded;
- Training departments have been informed of the concerns expressed by carers and this has also been shared with the local university to ensure this is included in social work and nursing training. The Local Authorities have also reviewed all levels of the safeguarding training provided to ensure that this encompasses the changes in the policy and procedures and Making Safeguarding Personal. This approach to the safeguarding process ensures that the individual and any carers are involved from the start of the safeguarding intervention;
- All 3 Local Authorities now have dedicated safeguarding adults teams to ensure that a consistent approach is applied to how safeguarding interventions are managed.

Lack of follow up (written or verbal) with individual and/or carer after Community Care Assessment and/or reviews

- New IT management systems are now in place that alert the team managers if an assessment or review is not completed or is overdue. In addition, there are Performance Management systems in place to identify where workers are not completing these tasks in a timely manner.

Limited access to Carers Assessments or lack of awareness of such a service

- Changes have been made to the assessment process to ensure carers are routinely offered an assessment at the same time as the Service User. All Carers are informed about the Carers Information Service as a matter of routine good practice.
  Carers who have signed up for the Carers Information Service receive regular news letters about Carers Events, pamper sessions, voucher schemes for the theatre/cinema etc;
- Carers advised they can request an assessment or a review without waiting for contact from a social worker;

- Carers Assessment documentation has been amended to ensure it is more user friendly;
- Work is underway to ensure that carers can access a self-assessment tool on line through the Councils;
- Information is available on the Councils' websites.

Carers feeling intimidated at meetings. Inexperienced staff/trainee Social Workers undertaking review

- Carers are informed they can meet with the allocated worker before a meeting;
- Carers are advised they can have an advocate at the meeting. Carers can choose to have a meeting at the venue of their choice;
- Staff training is provided about the needs of carers and utilising listening skills as part of client centred approach.

Notes of meetings not reflecting timely actions.

- Staff are aware that before a meeting is closed they should agree any follow up actions with the carer before leaving the meeting.
- Audits of notes from meetings are included in the safeguarding Adults Boards' quality assurance processes

7.11. WORK WITH HOSPITALS

7.11.1 The concerns highlighted by the above investigations have been shared with health colleagues within the local hospitals and as a result a number of changes and improvements have been made or are under development. As such there have been a number of new partnership projects with Poole Hospital, and it may be helpful to summarise them:

- **Weekend Working:** Borough of Poole, Dorset County Council and Bournemouth Borough Council worked together to establish and provide weekend social work support to the acute hospitals in Poole and Bournemouth. This ensures that there is a 7 days per week social work role available to support the hospitals and promote rapid discharge. This new weekend social work role has been established on a pilot basis, however, subject to evaluation; there is an ambition to see the role as a permanent arrangement.

- **Extending the working day of social workers within the acute hospitals:** Using funding provided by the NHS, Borough of Poole will extend the working hours of the hospital discharge team within the hospital up to 7.30pm each week day.

Work has taken place to prevent unplanned hospital admissions and support early discharge, including the seasonal use of extended social work hours, greater integration of community social work teams with primary care services and use of interim care home beds. 2017/18 also saw the introduction of a new integrated discharge bureau at Poole Hospital, which brings together local authorities, Dorset HealthCare and hospital staff into a single joined-up service.

- **Step up step down beds**: Poole, Bournemouth and Dorset local authorities have over the last few years increased the number of "step up step down" beds used to support discharge and prevent hospital admission.

7.12 NEW FORMS

7.12.1 In Poole there has been the roll-out of new assessment and support plans for service users and carers. The form has been designed by practitioners - with staff in the Hospital Discharge Team who recognised that a more robust and thorough assessment was required to ensure safe discharges from hospital.

7.13. REABLEMENT

7.13.1 Poole, Bournemouth and Dorset local authorities have developed reablement services that focus on reablement home care for service users either at home or coming out of hospital. These services issue telecare equipment, but also provide a response to the telecare equipment when it sends an alert to the control centre. Previously, control centre staff have been able to go out but, because they are not trained as care assistants, have not been able to undertake personal care and often find that they need to call an ambulance.

7.13.2 We are also working on the integrated approach for long term conditions and older frail people - where multi-disciplinary groups of practitioners meet at GP surgeries to work together on complex cases. The local Sustainability and Transformation Plan includes major plans for further developing care 'closer to home' and full integration of health and social care services. Hubs are being developed where multi-disciplinary teams work together within localities, closely with their local hospital, to provide more 'joined up' care.

7.14. DEMENTIA CARE

7.14.1 A theme has been identified around poor care of patients with dementia whilst inpatients in hospitals. Since these original concerns arose, there have been considerable improvements in dementia care within hospitals, underpinned by the Prime Minister's Dementia Challenge in 2012. It is a priority for the CCG.

7.14.2 The NICE guidance on the use of antipsychotic drugs for people with dementia has been adopted by all local healthcare institutions, which has led to a change in prescribing practice.

7.14.3 A large amount of training on dementia has taken place in local hospitals, with 'dementia champions' and lead clinicians for dementia in hospitals now in place. Environmental work has also been undertaken on a number of wards, for example at all local hospitals; 'dementia friendly' signage is in place.

7.14.4 New services are in place for people with early dementia, diagnosis rates of dementia have improved significantly in the past year and the CCG has procured a new service for memory support and advice to people in the early stages of dementia.

7.14.5 The majority of GP Practices are now 'dementia friendly' and the CCG is continuing a programme to spread this across all Practices.

7.15 CONTINUING HEALTH CARE (CHC)

7.15.1 A number of concerns raised a common theme around the processes for assessing people for Continuing HealthCare funding and for the review of patients in receipt of CHC funding. Since the time of these complaints and concerns, the new National Framework for CHC has been adopted and embedded within the CCG CHC team. New management arrangements are in place and regular audits are undertaken. New arrangements are in place for 'fast track' approval of funding for people at the end of life which has made a significant difference for people wishing to return home to die.

7.15.2 There are integration programmes for CHC and adult social care being progressed. Dorset County Council and the CCG are aligning their CHC and adult social care budgets from April 2017 and integrating their teams with the aim of improving the experience for service users/patients. It is planned to do the same with Bournemouth and Poole from 2018.

7.15.3 The complaints process for CHC has been improved, with significant training being given to staff on ‘customer care’ and a more proactive approach to addressing concerns early.

7.15.4 It is acknowledged that there is further improvement work to be undertaken on the experience of patients and their carers; and this is a priority for the CCG as well as for NHS England.

7.16 BASIC CARE FAILINGS

7.16.1 A number of the Advocare cases highlighted failings in basic care and compassion being provided to patients and their carers. Following the Francis Inquiry report into Mid Staffordshire NHS foundation Trust, the NHS is focussing on ‘compassion in care’ and the local health community is working hard to address the issues of basic care and compassion. Much has been achieved already in relation to nursing staffing levels, ‘intentional rounding’, new standards and increase in listening to what patients and carers are saying about the services they receive.

7.16.2 The Chief Nurse for England has introduced her ‘Care and Compassion’ strategy and subsequently ‘Leading Change - Adding Value’ Framework, which have been adopted across Dorset.

7.16.3 Since 2009, ‘quality’ of care has been a requirement for all health Boards to have as their priority.

7.16.4 CQC inspections have been strengthened dramatically and regulation has extended to GPs.

7.16.5 All provider contracts held by the CCG include a large number of ‘quality metrics’ which measure the quality of care being provided and outcomes for patients. Where these fall short of what is required, remedial action is taken to address the issues.

7.16.6 Healthwatch is actively engaged with statutory bodies to ensure the patient/service user voice is heard. There is a Quality Surveillance Group in Wessex, of which all statutory agencies and Healthwatch are members. The Quality Surveillance Group shares any concerns about healthcare organisations and identifies actions that need to be taken by commissioners and other agencies.

7.17 NHS COMPLAINTS PROCESS

7.17.1 Advocare identified that carers do not feel confident to use the NHS complaints process and do not feel it is effective. There has been a lot of national focus on this as well, including a large number of actions from the Francis Inquiry around improving the complaints process so that it is accessible and meaningful for patients and carers. Locally, the CCG is working very closely with its healthcare providers to make sure the statutory complaints processes are being followed and that patients and carers are satisfied with the outcomes of their complaints. There are new requirements around this in the contracts with providers and the CCG is auditing a random set of complaints from providers on a quarterly basis.

7.17.2 Healthwatch provide an independent service for people wishing to make complaints about the NHS and have provided helpful information on feedback they have received on local health services. They undertake visits to service areas and assist with focus groups. They have requested improvements as a result of their findings and these are overseen by their governing body.

7.18. CONCLUSION

7.18.1 This report has been prepared for the Advocare Oversight Group and is a compilation of the various key themes that have emerged from the enquiries made into the concerns raised by carers.

7.18.2 The report is an overview which demonstrates the statutory agencies have listened and learned from the concerns which were highlighted to them by Advocare. There have been huge improvements made since the original concerns were raised by Advocare about the experience of carers within Dorset.

7.18.3 However, it is acknowledged that there are still times when care is not as good as it should be and when carers do not receive the support and care they deserve. There is further work to be done to make sure improvements continue to be made.

7.18.4 The three Local Authorities and health agencies believe we are well placed to continue this work together and are committed to pursuing excellent care for all patients, service users and carers within Dorset, Bournemouth and Poole.

8. Safeguarding Thematic Review Report, 25 August 2016, partially updated January 2018

8.1 Introduction

8.1.1 This is a report on a review of themes arising in six cases involving safeguarding issues. It was originally dated 25 August 2016 but has since been updated. In all cases résumés, based on the carers narratives, and context boxes, which Advocare produced to show the nature of harm or distress experienced, were supplied. The narratives were taken in good faith and the carers involved were doing their best to look after the people they cared for, but found that the system didn't support them and, in some cases, worked against them.

8.1.2 Anonymous summaries of some cases involved in this review are included as Appendix 1 with permission. The remit of the review was to produce a summary of issues raised by the cases and to recommend ways in which those issues could be addressed. One of the three aims set out in the original terms of reference of the Independent Investigation (ToRII) is “to make improvements in safeguarding practice, policy and procedures”, and the terms of reference for the Oversight Group formally request that the two relevant Safeguarding Adults Boards adopt any recommendations; develop an action plan with timescales for delivery; and ensure lessons are learned.

8.1.3 Summary of information sources

The safeguarding review cases are:

Case 4	Dorset
Case 7	Poole
Case 13	Poole
Case 17	Poole & Dorset
Case 18	Poole
Case 20	Poole

Information was gathered in telephone conversations with the carers involved, through the independent medical assessment (IMA) process in some cases, and in meetings with some carers as follows:

Case 4 IMA report; conversations 1/10/2014 and 7/1/2015; meeting on 10/12/2014
Case 17 IMA report; conversation 18/9/2014
Case 18 conversation 23/9/2014; meeting on 10/12/2014
Case 20 conversations 23/10/2014 and on 20/1/2015; meeting on 10/12/2014

In respect of case 7, in addition to the résumé and context box, additional documents were provided by Advocare including:

(i) Notes of meeting held at 24 Hamble Road, Poole on 21/6/2012 (redacted)

In respect of case 13, in addition to the résumé and context box, additional documents were provided by Advocare including:

(i) the husband/carer's signed consent
(ii) correspondence with a solicitor dated 16/11/2009
(iii) supportive letter from a third party
(iv) letters regarding a complaint about an Advocare representative dated 20/10/2009 and 17/9/2009, concerning his criticism of a Safeguarding Officer's mode of communication to a deaf and partially sighted disabled elderly carer
(v) body map and accident/incident form dated 7/8/2009
(vi) copy of various correspondence from Advocare dated 23/11/2009 and 5/12/2009 with attached statements from the husband/carer and an Advocare representative
(vii) correspondence from a registered psychotherapist who had seen the husband/ carer.

This case (13) is a particular concern. Both husband and wife have now died. The wife died in a care setting with restrictions on her contact with her husband who was distressed by the situation and his wife's care. The husband died without being able to defend himself, indeed without knowing the substance of the allegations made against him.

The carer in case 4 supplied the following additional documentation:

(i) Notes re Thematic Review of Safeguarding.
(ii) The way it goes for carers
(iii) Style of Apologies
(iv) Climbing the mountains and crossing the chasms. The Caring Process.
(v) *Extract*, Home Assessment of the carer's mother in case 4. (Ref: CPN, re my mother going out to the shops on her own)
(vi) Perception of Truth
(vii) Lord MacAlpine interview

It is important to note that there was no access to safeguarding records in respect of these cases and that they will contain additional information not accessible to the Author of this Report.

8.2 Safeguarding Context

8.2.1 Adult safeguarding is changing and has been put on a legal footing by the Care Act, which received Royal Assent in May 2014. From April 2015 local authorities must set up Safeguarding Adults Boards; make enquiries (or ensure that others do so) if an adult is believed to be subject to, or at risk of, abuse or neglect; arrange for independent advocates to represent adults who are the subject of a safeguarding enquiry or a Safeguarding Adult Review (SAR); and work with appropriate partners to protect adults who are experiencing, or at risk of experiencing, abuse or neglect.

8.2.2 Six principles of safeguarding (Social Care Institute for Excellence 2015) are recognised:

1. **Empowerment**
People being supported and encouraged to make their own decisions and informed consent.
2. Prevention
It is better to take action before harm occurs.
3. Proportionality
The least intrusive response appropriate to the risk presented.
4. Protection
Support and representation for those in greatest need.
5. Partnership
Local solutions through services working with their communities.
6. Accountability
Accountability and transparency in safeguarding practice.

8.2.3 The Dorset Multi-Agency Safeguarding Adults Policy and Procedures dated 2014 (page 12) uses the No Secrets definition of a vulnerable adult (Bournemouth Dorset and Poole Adult Social Services, Dorset Bournemouth and Poole NHS Trusts et al. 2014), that is:

> *"(a person) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"* (page 8-9) (Department of Health 2000)

8.2.4 The Dorset Multi-Agency Safeguarding Adults Policy and Procedures dated 2014 also includes a section on responsibilities to those who are alleged to have caused harm (page 108) (Bournemouth Dorset and Poole Adult Social Services, Dorset Bournemouth and Poole NHS Trusts et al. 2014): this section states:

"*Adults who are alleged to have harmed an adult at risk of harm must be given the opportunity to provide their account of what happened during the alleged incident. Whether they are an employee, a volunteer, a relative or a carer they also have the right to be treated fairly and their confidentiality respected… They have a right to know in broad terms what the allegations are that have been made against them, unless the police advise otherwise, or it would jeopardise the investigation… They should be provided with appropriate support throughout the process. "*

8.2.5 Page 58 of the same document states that:

"*Throughout the Safeguarding Adults process, people alleged to have caused harm must be treated and spoken of without prejudice."*

8.2.6 Page 116 deals with complaints:

"Complaints received from any source about the Safeguarding Adults practice and arising from the Safeguarding Adults process ***should be handled by the relevant complaints procedures of the organisation about which the complaint has been made."***

8.2.7 This document (Dorset Multi-Agency Safeguarding Adults Policy and Procedures) is dated 2014 and would not have applied when the events described in the appendices took place. However it is referred to here, and quoted from, to make the following important points:

1. Safeguarding practice must clearly comply with the four basic and generally accepted ethical principles (Beauchamp, 2009), namely:

(1) Respect for autonomy: respecting individuals' right to make their own decisions (both carers and service users with capacity to make those decisions).

(2) Beneficence: doing good/ promoting well-being.

(3) Non maleficence: avoiding doing harm.

(4) Social Justice: fair impartial treatment/ service provision.

2. It is important that allegations are properly dealt with, but at the same time:
3. People alleged to have caused harm have the right to know what has been alleged;
4. People alleged to have caused harm have a right to give their account of what happened;
5. There must be a right of appeal against the outcome of the safeguarding process – this must be an independent appeal.

8.3 Investigation Context provided by Advocare in ToRII

8.3.1 “Unpaid carers of frail, sick and disabled people who contact Advocare describe feeling sidelined, subjugated and exploited. Many feel they are regarded by paid care workers as a resource at best and as a nuisance at worst. Research studies and surveys reflect this nationally. Twenty carers have agreed for their cases to be taken forward for an independent investigation.” Some of the cases included in the investigation raised concerns about the safeguarding system.

8.3.2 Safeguarding is about making a difference in the lives of the most vulnerable people and their families (LGA, 2014). This Review aims to identify recommendations that will help to change the system for the better.

8.4 Fundamental issues raised

These are organised in relation to the six principles of safeguarding but with a broad interpretation of each.

8.4.1 EMPOWERMENT

Empowerment means that people are supported and encouraged to make their own decisions and give informed consent.

8.4.1.1 Theme 1. Listening to and respecting carers

Carers report that they are not listened to or respected, that their narratives are not believed, and that the opinion of health or social care staff (including care home staff) automatically over-rides their opinions, yet they may have known the person they care for over many years, and far better than any professional will ever know them. Carers are entitled to have views of their own – they have known the person they care for far longer than professionals involved and bring that expertise with them. They may know a lot about their relative’s care that it is important for health and social care staff to know and take into account.

The recently published report Freedom to Speak Up (Francis 2015) is a report about whistleblowing in the NHS, but it has important resonances with carers’ reports of their experiences when they speak up about poor care, things that worry them, or things that have gone wrong in the care of their relative. It talks about a number of issues, which closely match the experiences and perceptions of carers including: a “bullying” culture which suppresses

concerns; victimisation as a consequence of speaking up and a lack of action; the need for culture change. In fact the report highlights five “overarching themes” (page 11), namely the need for:

- culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups, and
- extending legal protection for those who raise concerns in the public interest.

The experiences of carers in several cases show that there is a need for effective leadership to bring about culture change, improved case handling and improved practice in local safeguarding practice, within both the NHS and social care.

8.4.1.2 Theme 2. Listening to and respecting service users

Time and patience is needed to listen properly to service users and their carers in order to ascertain and fully understand their needs and wishes. It is essential that this is done without prejudice/ judgement.

To change attitudes there needs to be change throughout an organisation at every level, from the top to the bottom.

8.4.2 PREVENTION

Prevention means that it is better to take action before harm occurs.

8.4.2.1 Theme 3. Prevention of further abuse by the system designed to protect vulnerable adults and by those operating that system

The health/ social care system response to allegations of abuse/ harm must conform to the ethical principle of non-maleficence, ie it must avoid itself doing harm. Several cases show that vulnerable adults have been abused in the community and in institutional care settings. The cases show that people in both community and institutional care settings (including hospitals) are vulnerable in respect of the response that the health and social care system takes in response to allegations of possible abuse/ harm, where the risk is that the response, however well-intentioned it might be, may lead to further and different harm to them and to those close to them and where what is written in records represents only one version of events.

Carers too are vulnerable to the health and social care system response. Thus in one case contact between husband and wife was considerably curtailed following allegations of abuse/ harm, which the husband/ carer was unable to contest at the time. In writing this report there has been no access to the wife's account or to any additional evidence available to the agency concerned because of information governance restrictions. The Author has been told that everything was done with careful and balanced thought, together with awareness of the sensitivities involved and that all the options might involve harm. Nevertheless it is my understanding, based on the information supplied to me by Advocare, that the allegations against the husband were never prosecuted or placed in the public domain and that the husband/ carer incurred psychological and emotional harm as a result of the processes involved.

In another case, involving a service user admitted to the Royal Bournemouth Hospital, there were allegations that the main carer had been verbally aggressive towards the service user and of possible neglect. A Social Worker looked into the allegations and advised that an Adult Protection Investigation would be inappropriate. "I am concerned that the allegation of verbal aggression towards the patient was made, when actually, no member of staff claimed to have observed it although (the carer) was said to be verbally aggressive to staff": the author completing the case recording sheet concluded that the allegation of verbal aggression "seems to have been made up" and writes that "the consequences of an inappropriate Adult Protection Investigation could have caused them (service user and carer) more stress in addition to the difficult circumstances they were finding themselves in already". There is no indication that action was taken against the person who "seems to have … made up" the allegation. Further the Social Worker notes that inappropriate investigation could increase their "oppression" and is a reason for staff education about adult protection. The safeguarding response in this case was measured and perceptive, and the allegations went no further, but the incident demonstrates that "misunderstandings" do occur, and that staff who perceive themselves as being personally criticised may "defend" themselves by blaming the carer. The consequences of an investigation for the people concerned in this case could have been devastating.

Caring carries costs. Becoming a family/ informal/ unpaid carer involves making sacrifices: some carers lose their sense of self by subjugating their own needs to those of the person they care for over a long period of time. Carers take on the caring role without giving informed consent. Often people over time imperceptibly/ gradually take on a caring role without any thought about where it is leading and what the consequences might be. Many may feel that they have no choice because of their relationship to the person they care for or because of what that person has done for them in the past. Carers

are not prepared for the role they take on - they don't know what to expect. They may be given very little information about what they're letting themselves in for and what the future might hold. At the same time they are not always included in the health/ social care processes relating to the person they care for and sometimes are actively excluded, perhaps on the grounds of 'confidentiality'. Some carers are vulnerable as a result of taking on the caring role, yet they may not fit the accepted definition of a vulnerable person, and, by failing to recognise and address their vulnerability, practitioners in health and social care may unintentionally increase the stress they are under. Yet when care breaks down the burden on the state and the distress caused to two people (and sometimes more) may be considerable. 'No Secrets' (Department of Health 2000) sets out a broad definition of a vulnerable adult, namely that they are a person:

> "*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation*". (page 8-9)

Some carers would meet the requirements set out here. However, when does a carer whose emotional and physical health is being compromised and who is not taking care of themselves emotionally and/or physically by virtue of their caring role become a 'vulnerable adult'? Prevention of abuse should be understood as including not only prevention of further abuse to the person alleged to have suffered harm but prevention of harm to the carer and prevention of additional harm as a consequence of the response to the alleged abuse.

8.4.2.2 Theme 4. Financial abuse

One case shows that a family was unable to protect their mother from financial abuse and statutory agencies did not intervene to support them, whether because of inability or unwillingness to do so.

What can be done to protect people from financial abuse and what can't? It is very difficult to prove abuse when the person who is allegedly being abused is not able to give a coherent account or to remember what is happening. Also, because capacity is decision specific, the individual might have capacity to decide (eg to have contact with a friend) but not have capacity to recognise that they need to protect themselves (or be protected) from financial exploitation and what the consequences of that friendship decision might be.

8.4.3 PROPORTIONALITY

Proportionality means that interventions should be proportionate to the likely risk and not result in further unnecessary disadvantage to the vulnerable person.

8.4.3.1 Theme 5. Proportionate assessment of risk

To assess risk well requires that assessment to be carried out by someone with the appropriate skills, experience and understanding of the person's health and social care needs, personality, family context and life preferences. It is not a simple administrative process. Assessment of risk is not a clear cut process – it involves weighing up the evidence, risks and benefits and different people will inevitably come to different conclusions. That does not mean that one is necessarily right and another inevitably wrong but it does mean that people need to share information and work together. Sometimes to carry out a careful thoughtful assessment will involve seeking more information from those with more expertise in a particular area. One case demonstrates the difficulties of making a risk assessment in a complex case, and another shows that different professionals involved took different views in making their risk assessments.

8.4.3.2 Theme 6. Thinking outside the box

Professionals may not know what is best – they have to work out what is best in collaboration with family members and the service user (as far as they are able to contribute) and/or their advocate. Solutions that work for one family will not work for another. Instead of falling back on established solutions there may be a need to think outside the box. One case illustrates how a son was able to provide good person-centred care for his father when given the opportunity and support to do so, despite experiencing the distress of unfounded accusations of physical abuse.

8.4.4 PROTECTION

Protection means affording vulnerable people support and protection.

8.4.4.1 Theme 7. When does poor care become a safeguarding issue? And Where does the responsibility lie for taking action regarding poor care?

A fundamental issue is: when is poor care "acceptable" (is poor care acceptable?) and when does poor care become a safeguarding issue? This applies not only to hospital care, and to care in Nursing/ Residential Homes, but also to domiciliary care. Domiciliary care which is unreliable and of an unacceptable standard may be a safeguarding issue, whilst recognising that

domiciliary carers are often untrained, under extreme time pressure, and poorly paid. If a very elderly frail person with dementia is discharged from hospital in their nightclothes in a taxi unescorted, is this acceptable care or a safeguarding issue? It can be hard for those operating the health and social care system to accept that they are not providing a satisfactory level of care, but, where care standards are unacceptable, patients/ clients need protection from harm and it becomes a safeguarding issue.

Linked with this: whose responsibility is it to take action? The carer may take responsibility to speak up on behalf of the person they care for if poor care is experienced. The report Freedom to Speak Up (Francis 2015) states its aim as being that NHS staff in England should feel it is safe to raise concerns, confident that they will be listened to and they will be acted upon. Health and social care staff have a responsibility to their patients/ clients to speak up too if they are aware of poor care. What responsibility do commissioners have for poor care and when would they raise safeguarding concerns? Commissioners have responsibility for the process of planning, agreeing and monitoring services. Part of monitoring is ensuring that services provide care of the necessary quality, which meets recognised standards. Protection of vulnerable people is a fundamental part of this.

8.4.5 PARTNERSHIP

Partnership involves people, professions, groups and communities in working together to prevent, detect and report neglect and abuse.

8.4.5.1 Theme 8. Sharing information with carers

Whenever possible, there is a need to include carers in meetings/ discussions; to regard them as part of the care team; and to integrate care across the agencies involved. Confidentiality may be an issue, and partnership working with carers may be difficult where a member of the family is alleged to have caused harm. With respect to people who may be unable to consent, the Nuffield Council on Bioethics report entitled Dementia: ethical issues (Nuffield Council on Bioethics 2009) makes the point that:

> "*Unless there is evidence to the contrary, there should be a presumption of trust in carers by health and social care professionals and care workers."* (page 120)

In the Author's view this applies to all carers, not only to the carers of people living with dementia.

Excluding carers deprives health and social care professionals of the opportunity to draw on their expertise and knowledge about their relative and that relative's wishes, and may deprive the person alleged to have suffered harm of an important source of support. Although information sharing is included here as an aspect of partnership, openness and honesty are vitally important, in order for everyone to be able to trust the safeguarding process.

The cases included in this review include examples of when partnership working failed to work.

8.4.5.2 Theme 9. Leadership and partnership

One of the risks of work that involves a number of partners is that no one takes clear responsibility for leading. This may occur at the level of an individual case or a service. Leadership responsibility involves responsibility for sorting things out when they go wrong (see honest apology below) and responsibility for changing attitudes.

There is a need for effective leadership in respect of safeguarding practice in order to bring about culture change, improved case handling and improved practice in local safeguarding practice, within both the NHS and social care.

8.4.6 ACCOUNTABILITY

Accountability means that those involved in safeguarding processes are accountable for what they do.

8.4.6.1 Theme 10. An honest apology when things go wrong

With timely genuine apologies from the agencies involved the independent investigation into some cases would not have been necessary.

The independent report recommended an apology to the carer involved in one case: in December 2014 this had not been done. The carer said in conversation "my Dad was a victim: it was my Dad's liberty that was restricted". The carer in another case shared with me a piece he has written on style of apologies. It highlighted the difference between an honest open apology, which acknowledges that things have gone wrong, and answers the carer's questions according to the Terms of Reference of the Investigation, and an apology, which merely attempts to go through the motions, without an acceptance that practice fell short in some way. The latter is not in keeping with the duty of candour and serves to reinforce injustice.

The General Medical Council and Nursing and Midwifery Council have carried out a consultation on the professional duty of candour and the consultation document (General Medical Council/ Nursing and Midwifery Council 2014) states that this means that health professionals must:

- *"tell the patient or, where appropriate, the patient's advocate, carer or family when something has gone wrong*
- *apologise to the patient (or, where appropriate, the patient's advocate, carer or family)*
- *offer an appropriate remedy or support to put matters right (if possible)*
- *explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened."*

Although the Statutory Duty of Candour (Department of Health 2014) stemmed from the Francis Inquiry into events at Stafford Hospital, it applies across health and social care. The Think Local Act Personal Partnership document on the adult social care perspective states:

> "*Regulated health and care professionals will have to be candid with patients and people using services about all avoidable harm, and obstructing colleagues in being candid will be a breach of professional codes."* (page 2) (Think Local Act Personal Partnership 2014)

The Author was involved in another case which is not included in this Safeguarding Thematic Review, but where the carer has now received a meaningful letter of apology. This would not have happened without the Investigation, but has helped him to understand why staff behaved towards him in the way they did and has had a big impact on his grievances. It demonstrates the difference a candid apology can make.

8.4.6.2 Theme 11. The opportunity to set the record straight

Several cases show why records need to be corrected and evidence of that correction needs to be supplied. One case was a powerful example of this: in the Minutes of an Adult Protection Meeting many comments were made about the carer's character and the manner in which he cared for his mother, which are reflected in the Meeting's conclusions and for which there is no substantiation.

Instead of appearing to start from a presumption of guilt, safeguarding investigations need to be investigations, which seek answers to questions. Carers may not know that allegations have been made against them or, if they

do know, they may not know the details– so how can they contribute to assessment of the situation when they are in the dark?

8.4.6.3 Theme 12. Transparency and openness

Several cases show why the safeguarding process needs to be more transparent. In the case referred to above (8.4.6.2) the carer was not informed of what had been alleged; was not given the opportunity to explain; and was unable to contest the outcome of the safeguarding process. The Minutes of an Adult Protection Meeting include many comments made about the carer's character and the manner in which he cared for his mother, which are reflected in the Meeting's conclusions and for which there is no substantiation. It was only three years after the meeting that the carer discovered the details of the allegations against him, demonstrating a complete lack of transparency in this case.

Transparency is part of accountability. The update to the statutory guidance to support local authorities to implement the Care Act 2014 states that:

> *"Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries"* (14.73)
> (Department of Health 2016)

and also that:

> *"confidentiality must not be confused with secrecy"* (14.187)
>
> *"Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation"*[13] (14.190).
> (Department of Health 2016)

If carers do not know about allegations made against them, how can they contribute to assessment/ investigation of the situation? Is the system transparent if this is the case? How could the process of safeguarding be more transparent?

---

[13] NOTE: confidentiality is the right of an individual to have personal, identifiable information about them, and particularly about their health, kept private or only shared with their consent (unless required by law). Some people argue that it can be a "screen" that organisations hide behind eg saying information is confidential when the organisation's staff wish to withhold that information in the interests of the organisation rather than those of the individual concerned.

8.5 Conclusions and recommendations

This Review aims to ensure that lessons are learned from the cases involved. Many of the nine recommendations apply equally to carers and service users. The tenth recommendation sets a timescale for an action plan following adoption of this Review Report.

8.5.1 **Multi-Agency Safeguarding Adults Policy and Procedures to be reviewed** to ensure that where carers have been alleged to have caused harm they have the right to know what has been alleged; a right to give their account of what happened; and a right to appeal against the outcome of the safeguarding process.

8.5.2 Carers involved in safeguarding processes must be **routinely signposted** to sources of support.

8.5.3 Where safeguarding processes are proven to have caused harm/ distress **a timely and honest apology** is necessary in plain jargon-free language in line with the Duty of Candour and acknowledging what has gone wrong.

8.5.4 **Records relating to a safeguarding process/ processes** which has caused harm/ distress need to record the facts and make it clear when a carer has been exonerated: this needs to include corrections to any inaccurate statements made during Adult Protection/ safeguarding Meetings.

8.5.5 When a carer seeks to **contest a safeguarding decision**, the appeal meeting dealing with that appeal must be chaired by a person who is not drawn from an organisation which might have a conflict of interest with regard to the decision of the appeal meeting.

8.5.6 When **independent advocates** are sought to represent adults who are the subject of a safeguarding enquiry or a Safeguarding Adult Review (SAR), those advocates must be seen to be truly independent of the investigatory agencies involved, and the adults involved must be able to freely choose an advocate whom they trust.

8.5.7 Produce and implement protocols to routinely seek **the views of carers** involved in safeguarding processes.

8.5.8 **Produce and implement protocols to involve** carers and service users in safeguarding training.

8.5.9 **Produce and implement protocols to involve** carers and service users in developing safeguarding policies and procedures.

8.5.10 An **action plan** with timescales for delivery of the actions set out above and identified responsible individuals to be produced within 1 month of adopting this Report.

8.6 APPENDIX TO SAFEGUARDING THEMATIC REVIEW REPORT: Brief summaries of some cases included in the review for reference and with the specific consent of the carers concerned.

Summary of case No. 4

The service user was coping at home until she had a stroke in October 2008 and was admitted to hospital. She was discharged a couple of months later and returned to her flat with her son/carer to look after her. She needed a lot of care at home: her son/carer had little support, got little sleep and became very stressed. Community services that he had been promised to help with his mother's care failed to materialise. About 6 weeks after discharge he consulted his mother's GP who prescribed haloperidol for her, but matters deteriorated and she went into a Care Home for two weeks to give him respite. There she remained anxious and difficult to reassure. After being seen by a psychiatrist at the Home, she was transferred to Alderney Hospital where she stayed for about 3 months for what was described as assessment. She then returned home to live with her son/carer. The care agency supporting her alleged some months later that she had been abused by her son. The police interviewed the son/carer at home and no immediate action was evident. Shortly afterwards she was admitted to Poole Hospital with physical problems.

As a result of the above allegation, during the admission to Poole Hospital, an Adult Protection Meeting took place: the Minutes cite a report that the son/carer had been physically and verbally abusive towards his mother; that he had been restricting her movement at home; and that he had altered her medication. The Minutes also state that the Police had found the allegations unsubstantiated: they confirm that her son's role as carer was substantial; and state that she adores her son and the cat, "they are her whole life." There are references to her son/carer being stressed. There are also many comments made about the son/carer's character and the manner in which he cared for his mother, which are reflected in the Meeting's conclusions and for which there is no substantiation. The Minutes note that the son/carer was unhappy about the safeguarding alert and investigation: the son/carer was not informed about the investigation nor what was going on in terms of the safeguarding process being followed, and was not given a chance to explain events.

Additional papers give more information about the concern expressed by the care agency that the son/carer had replaced some of this mother's tablets with different ones. This involved cocodamol replacing paracetamol: however the pharmacist, who supplied the medication, was not approached (over three years later, after discovering the contents of the Adult Protection Meeting, the son obtained an explanatory letter from the pharmacist - this could have been done at the time). The son/carer was not informed of what had been alleged; was not given the opportunity to explain; and was unable to contest the outcome of the process. The result was that an IMCA was involved in the process of making a decision about where his mother should live when she was discharged from Poole Hospital, despite the fact that his mother had signed a Health and Welfare LPA (registered that same year) in his favour. A meeting was held at Poole Hospital prior to the mother's discharge and attended by the son/carer to determine her future. He is convinced that a decision for his mother to be placed in a Home had already been made, although he and his mother wished otherwise. At the time he was not aware of the Adult Protection Meeting having taken place. He has stated since that he was conscious of the fact that others at the meeting 'appeared to know something he didn't'. The service user was deemed not to have capacity to make a decision on her future living arrangements, and was discharged from the hospital to live in a Home. Her son/carer went through a very difficult and distressing time during his mother's illness, made worse by the events described above.

Summary of case No. 17

The service user was a married man with a dementia, cared for by his wife. He went into Alderney Hospital for assessment/ respite and matters spiralled downhill from that point with a marked deterioration in his abilities. He was perceived by the staff to exhibit behaviour problems (probably mainly related to the change of environment; untreated nicotine withdrawal; absence of his wife) and treated with anti-psychotic drugs, which appear to have caused side effects that compounded his problems. He was then kept on the ward long-term as he was thought to be “too difficult” to return home to his wife or for care in a nursing home, and only moved out when his wife, aided by others, gained NHS CHC funding for him. The home he was then moved to stopped his psychotropic drugs and found no evidence of violent behaviour (Home 1). Unfortunately he was then moved to a second home which appears to have provided an unacceptable level of care, and has now stopped providing dementia care (Home 2). His wife/ carer was not aware for some time that she could move him elsewhere, but eventually did so. The third home he moved to, and where he died in 2013 (Home 3), provided dignified and person-centred care for people with dementia.

The main issues identified in the independent assessor report were:
1. how long the service user was in Alderney which his wife/ carer felt was totally inappropriate for his condition.
2. use of antipsychotics during that time and aspects of care (failure to treat nicotine withdrawal; standard of care of people with dementia).
3. standards of care at Home 2. (The wife/ carer observed worrying incidents including: human excreta left in the dining room while residents were eating their meals; a resident came to the dining table with his hands covered in faeces; the corridor always smelt of urine and often of faeces. She also noted generally poor care including: lax hand washing procedures; no communication with residents apart from during interventions with them; no stimulation apart from the activities organiser or relatives.)
4. Difficulties in complaining: the wife/ carer felt she could not communicate these concerns to the manager because of the “pre-existing institutionalised, arrogant culture of the staff” and was aware that change was not welcomed. Since the PCT was funding the service user’s care she felt it was tacitly permitting the standard of care. Efforts to complain to the Care Quality Commission were “in vain”.

Summary of case No. 18

The service user was a frail elderly man with Parkinson's Disease and digestive problems. A care agency worker found bruising under his arm, and a GP who was new and unfamiliar with his medical history was alerted. Paramedics were called, then a social worker. The Police were also involved because of an existing Adult Protection Order about which neither the carer (the service user's son) nor the service user was aware. The son/ carer was subsequently arrested on suspicion of physically abusing his father.

The son/carer was released on bail without charge, pending further enquiries, and was prevented from visiting his father in hospital except under close supervision. (Eventually it was established that the bruising had been caused inadvertently.) A Deprivation of Liberty Safeguarding Order was issued to prevent the son/carer from removing his father from hospital, and the son/carer was not left alone with his father at visiting times in hospital. His father was not fed properly in hospital nor was he encouraged to eat. His father's consultant said that "hospital is not the best place for him because of potential infection" and that "he should be at home where he would be properly cared for by a son who loves him". By this time the son/carer was convinced his father was going to die. Advocare encouraged the son/carer to accept supervision arrangements, and to continue to visit his father if only to try to feed him. Eventually his father was discharged, content and happy to be looked after by his son at home. Sixteen months on he was enjoying a relatively good quality of life, eating well, had put on weight, and his pressure sores had healed due to his son's diligence and the care he received at home. The father looked forward to going to football matches with his son.

Advocare commented that this case highlights how the son/ carer was taken over by Poole Adult Social Services Safeguarding. The safeguarding conditions were unnecessarily harsh and inflexible and not in the father's best interests. The son/carer felt as if he was under constant surveillance. Advocare representatives supported him at several safeguarding/case review meetings and witnessed incidents they regarded as tantamount to psychological abuse of two vulnerable people by professionals in positions of power, who talked down to the son/carer and disregarded his knowledge and experience of his father's preferences and wishes.

The son/carer was not permitted to see his father's Discharge Plan: safeguarding conditions were unnecessarily top heavy; care arrangements made by safeguarding officers were excessive, based on hospital care, and were not in his father's best interests or those of the son/carer. A later care package involved the son/carer from the outset and went well. This son/carer also had a very difficult and distressing experience during his father's illness.

Summary of case No. 20

The service user had a heart condition and suffered from confusion due to dementia. Her daughter and main carer is herself disabled and also cares for her husband.

Whilst her mother lived in the community, there were concerns about the standard of, and unreliability of, domiciliary care services – this placed a lot of stress on her daughter/ carer, who was told by her GP that she was shortening her own life by caring for her mother. On one occasion the daughter visited her mother, read the care log and realised the careworker had signed out earlier in the day, as if having visited that evening. This daughter visited her mother again that evening at the time a careworker was due to call and no-one did: the family felt that this was fraud. When complaints were made to the agency concerned about the standard of their service, things improved for a few days, but then went back to how they had been prior to the complaint. At one stage the family requested a meeting with the social work team. Notes of the meeting written by Social Services did not reflect the true situation, and, instead of acceding to the family's wishes, a decision was made to send someone in from the same agency at lunch time. The meals were "so awful" that in the end the family decided to arrange for lunches to be provided by two private firms.

Whilst she was living in the community, a large amount of money was stolen from her by a male friend: there was also an incident when it was thought that he may have physically abused her. The service user wanted this man's friendship but did not have sufficient insight to appreciate the consequences of having him as a friend. The Police told the family that they needed proof before they could act.

The service user was admitted to Poole Hospital, was treated for a UTI, and discharged twenty days later on a Friday. Her daughter/ carer had requested ambulance transport to take her home but she was sent by taxi, unescorted, in her nightdress, wrapped in a hospital blanket, without her walking stick and without her dentures, but with toothpaste and brush belonging to another patient. She also had with her a plastic bag containing soiled clothing. She was unable to walk. Her daughter/ carer had to ask the taxi driver to help her mother indoors. Her daughter's nephew, who lived nearby, came over to help get her onto her bed where she stayed all night, till a paid carer came to help her out of bed and into her chair in her sitting-room. The next day she was feeling unwell and her daughter stayed with her all Saturday and through Sunday, sleeping on the sofa at night. During Sunday night she got out of bed to use the commode, but her daughter could not lift her off the commode and rang the care agency, paramedic service, and social services at 3am: none of them would come out to help her daughter get her back into bed.

The following Monday morning the service user was visited by her GP, and when he saw the state the she was in, the GP arranged for her to be admitted to a nursing home immediately. She died ten days later. The family felt that the hospital treatment amounted to neglect, that their mother was not treated with due respect, and that the safeguarding mechanisms supposed to protect vulnerable people, like their mother, failed her.

8.7 Safeguarding Thematic Review Report: Source documents

Beauchamp, T. L. (2009) The philosophical basis of psychiatric ethics. In S. Bloch & S. A. Green (eds), *Psychiatric Ethics* (pp. 25-48). Oxford: Oxford University Press.

Bournemouth Dorset and Poole Adult Social Services, Dorset Bournemouth and Poole NHS Trusts, et al. (2014). "Multi-Agency Safeguarding Adults Policy and Procedures." Retrieved 17 Feb 2015, from http://www.bpsafeguardingadultsboard.com/upload/cms/multiagency_safeguarding_adults_policy__procedures.pdf.

Department of Health. (2000). "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse." Retrieved 23 December 2014, from https://http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf.

Department of Health. (2014). "Introducing the Statutory Duty of Candour. A consultation on proposals to introduce a new CQC registration regulation." Retrieved 9 January 2014, from https://http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295773/Duty_of_Candour_Consultation..pdf.

Department of Health. (2016). "Care and support statutory guidance. Safeguarding. Chapter 14." Retrieved 13 March 2016, from https://http://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding.

Francis, R. (2015). "Freedom to Speak Up. An independent review into creating an open and honest reporting culture in the NHS." Retrieved 17 February 2015, from https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf.

General Medical Council/ Nursing and Midwifery Council. (2014). "Openness and honesty when things go wrong: the professional duty of candour. A draft for consultation." Retrieved 7 December 2014, from http://www.gmc-uk.org/Openness_and_honesty___Draft_guidance.pdf_58423740.pdf.

Local Government Association (2014) Making Safeguarding Personal: Guide 2014. Retrieved 2 June 2016 from http://www.local.gov.uk/documents/10180/5854661/Making+Safeguarding+Personal+-+Guide+2014/4213d016-2732-40d4-bbc0-d0d8639ef0df.

Nuffield Council on Bioethics (2009). The needs of carers. Dementia: ethical issues**:** 114-125.

Social Care Institute for Excellence. (2015). "Adult safeguarding: sharing information." Retrieved 12 February 2015, from http://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/files/sharing-information.pdf.

Think Local Act Personal Partnership. (2014). "The Duty of Candour – an Adult Social Care Perspective." Retrieved 9 January 2015, from http://www.thinklocalactpersonal.org.uk/_library/The_Duty_of_Candour_-_an_Adult_Social_Care_Perspective_March_2014.pdf.

9. The Investigation and the Terms of Reference

9.1 Carers were invited to return feedback to the Author and to maintain confidentiality detail of that feedback is not included in this Final Report. Important themes were:

9.2 Regarding the Investigation

- the difficulty and distress of a lengthy investigative process
- Dissatisfaction with outcomes (including carers' questions not being answered to their satisfaction)

9.3 Regarding agency responses

- The importance of being listened to and believed
- The importance of unreserved/ unconditional apologies

9.4 Regarding services

- The difficulty of knowing whether change has occurred
- Need for practical and psychological support for carers

9.5 The aims of the Investigation as set out in the ToR were threefold:

1. to answer the questions raised by carers to their satisfaction
2. to make recommendations for improvements across health and adult social care, and
3. to make improvements in safeguarding practice, policy and procedures.

9.6 With respect to the first aim, the two phases of the Investigation, IMA involvement and meetings held aimed to answer carers' questions but doing so has been complicated by the length of time that has elapsed since the investigation was initiated.

9.7 The recommendations from a number of sources set out in this Report and the changes reported in Chapter 7 address the second of the aims but if the underlying aim is to improve services then there must be a process to ensure that the remaining recommendations are enacted and that evidence is produced to confirm that they have been enacted.

9.8 With respect to the third aim, the recommendations arising from the Safeguarding Thematic Review and set out in this Report aim to address safeguarding practice, policy and procedures.

9.9 Advocare requested evidence that improvements have resulted from the Investigation. The Author was sent a suggested list of evidence that could

potentially substantiate claims of improvements and this included the following:

(1) No. of Hospital admissions and readmissions of patients to
    - St Ann's
    - Poole
    - Royal Bournemouth
(2) No. and type of complaints re
    - Poole
    - Bournemouth
    - Dorset Social Services.
(3) No. and type of complaints re safeguarding in Dorset.
(4) No. and type of complaints re CHC/PHB applications in Dorset.
(5) No. and type of CHC/PHB applications granted in Dorset.
(6) No. and type of complaints re IFRs in Dorset
(7) No. and type of IFRs acceded to in Dorset.
(8) Breakdown on how money over last five years has been spent by Dorset CCG/Poole, Bournemouth & Dorset PCTs.

9.10 Table 6 sets out information extracted from reports published by Poole Hospital and the RBCH. The RBCH report gives detailed information about complaints, categories of complaint and actions that have resulted from complaints and the Trust sets an example in making this information readily available online. Of the potential evidence listed above, numbers 2-4 and 6 would provide helpful evidence of improvement if the information were to be provided for each of the last 3 years. Numbers of admissions and percentages of readmissions within 28 days of discharge are available within the reports currently. How money is spent is unlikely to be a reflection of improving service quality.

9.11 This Report adds a recommendation that the following information for each of the last three financial years is provided to the group that monitors the enactment of recommendations arising from this Report in a spirit of openness and partnership working and with the intention of furthering improvements in health and social care:

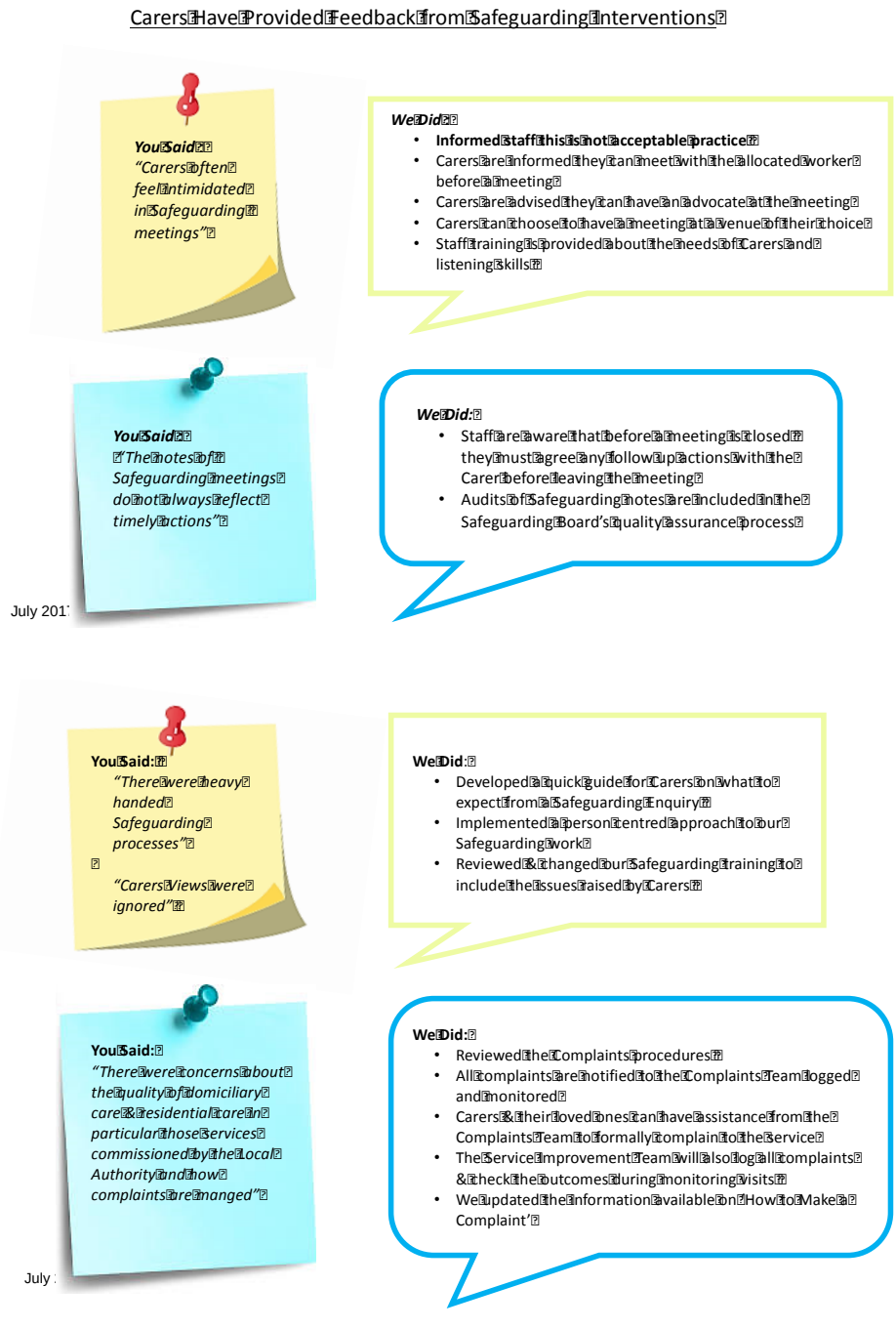
1. No. and type of complaints re
    - Poole
    - Bournemouth
    - Dorset Social Services.
2. No. and type of complaints re safeguarding in Dorset.
3. No. and type of complaints re CHC/PHB applications in Dorset.
4. No. and type of complaints re IFRs in Dorset

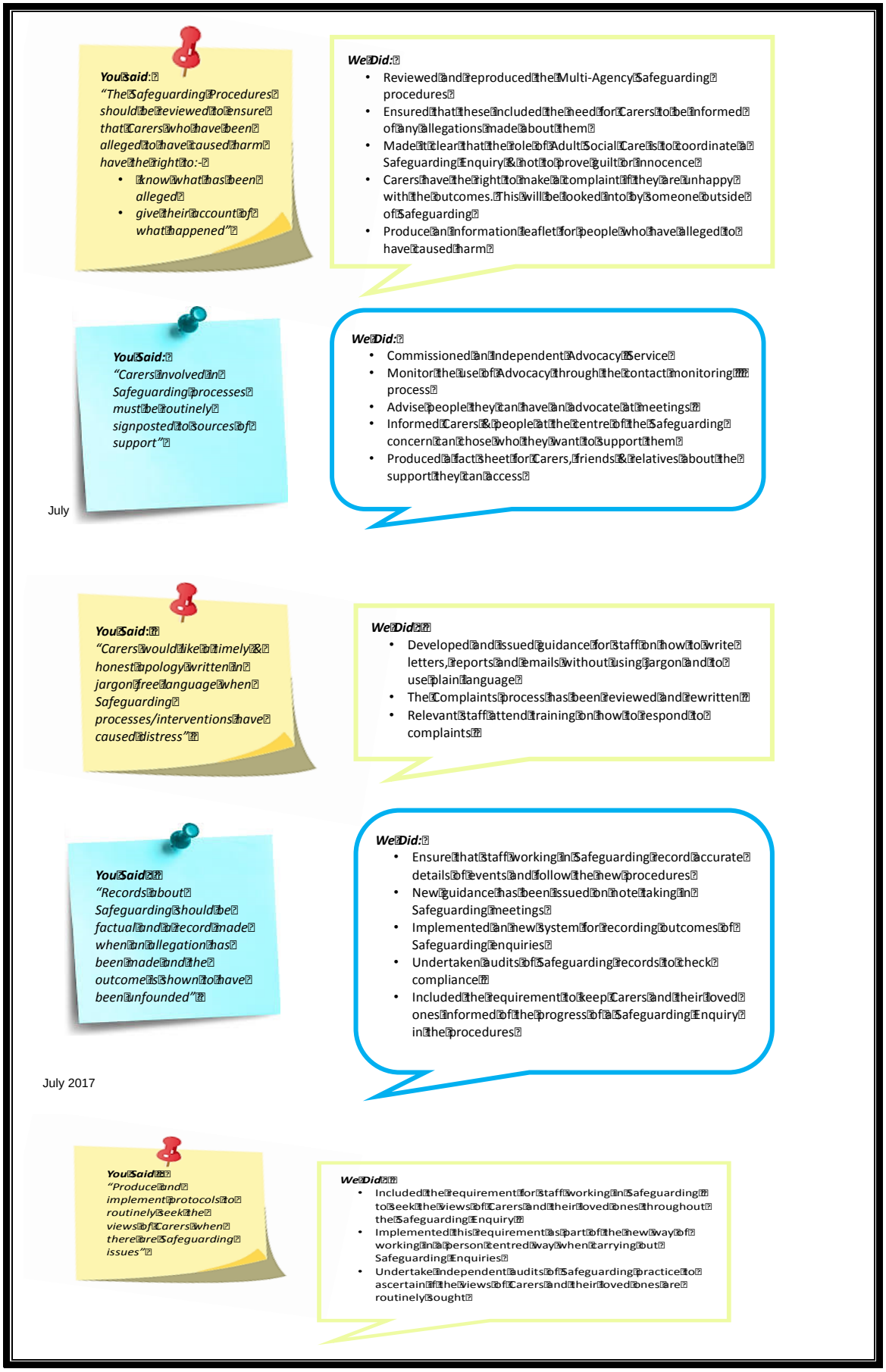
Table 6: Information extracted from Annual Reports

	2013-2014	2014-2015	2015-2016	Source
% of patients readmitted to hospital within 28 days of discharge				
Poole	10.1%	10.5%	11.8%	Annual Report
RBCH	-	10.4%	10.9%	Annual Report
Complaints information				
Poole	?	?	?	
RBCH	303	370	313	Annual Report p 118-121
RBCH complaints to Ombudsman	-	6	12	Annual Report p 118-121

9.12 At the OG meeting in June 2017 it was reported that actions have been taken in response to feedback from the carers involved in the Investigation and information about these was invited for inclusion in the Report, along the lines 'You said – we did'. The information sent is included in Box 1 below by kind agreement of the Borough of Poole.

Box 1: You said – we did. Examples of how Safeguarding has responded to feedback from carers (provided by the Borough of Poole in pictorial format and pasted below).




You Said:
"The Safeguarding Procedures should be reviewed to ensure that Carers who have been alleged to have caused harm have the right to:-
know what has been alleged
give their account of what happened"
We Did:
Reviewed and reproduced the Multi-Agency Safeguarding procedures
Ensured that these included the need for Carers to be informed of any allegations made about them
Made it clear that the role of Adult Social Care is to coordinate a Safeguarding Enquiry & not to prove guilt or innocence
Carers have the right to make a complaint if they are unhappy with the outcomes. This will be looked into by someone outside of Safeguarding
Produce an information leaflet for people who have alleged to have caused harm
You Said:
"Carers involved in Safeguarding processes must be routinely signposted to sources of support"
We Did:
Commissioned an Independent Advocacy Service
Monitor the use of Advocacy through the contact monitoring process
Advise people they can have an advocate at meetings
Informed Carers & people at the centre of the Safeguarding concern can chose who they want to support them
Produced a fact sheet for Carers, friends & relatives about the support they can access
July
You Said:
"Carers would like a timely & honest apology written in jargon free language when Safeguarding processes/interventions have caused distress"
We Did
Developed and issued guidance for staff on how to write letters, reports and emails without using jargon and to use plain language
The Complaints process has been reviewed and rewritten
Relevant staff attend training on how to respond to complaints
You Said
"Records about Safeguarding should be factual and a record made when an allegation has been made and the outcome is shown to have been unfounded"
We Did:
Ensure that staff working in Safeguarding record accurate details of events and follow the new procedures
New guidance has been issued on note taking in Safeguarding meetings
Implemented an new system for recording outcomes of Safeguarding enquiries
Undertaken audits of Safeguarding records to check compliance
Included the requirement to keep Carers and their loved ones informed of the progress of a Safeguarding Enquiry in the procedures
July 2017
You Said
"Produce and implement protocols to routinely seek the views of Carers when there are Safeguarding issues"
We Did
Included the requirement for staff working in Safeguarding to seek the views of Carers and their loved ones throughout the Safeguarding Enquiry
Implemented this requirement as part of the new way of working in a person centred way when carrying out Safeguarding Enquiries
Undertake independent audits of Safeguarding practice to ascertain if the views of Carers and their loved ones are routinely sought

10. Additional recommendations (including from Safeguarding Thematic Review)

10.1 Table 7 lists the additional recommendations that were made in the Safeguarding Thematic Review (numbering STR1-10) plus those arising from the IMA report on case 9 (numbered 72-77 to follow on from the numbering in Table 5) plus an additional recommendation about producing evidence that the aims of the Investigation have been met (numbered 78).

10.2 The Author is aware that many of the new recommendations may already have been enacted but has not formally requested feedback from the agencies involved so completed actions are not reflected in Table 7.

Table 7: Additional recommendations and evidence to be supplied

Number	Action	Evidence to be supplied to the Next Steps Group
From Safeguarding Thematic Review Report		
STR 1	**Multi-Agency Safeguarding Adults Policy and Procedures to be reviewed** to ensure that where carers have been alleged to have caused harm they have the right to know what has been alleged; a right to give their account of what happened; and a right to appeal against the outcome of the safeguarding process.	1. Copies of policies and procedures 2. Audit of their implementation in cases where carers alleged to cause harm
STR 2	Carers involved in safeguarding processes must be **routinely signposted** to sources of support.	1. Feedback from carers
STR 3	Where safeguarding processes are proven to have caused harm/ distress **a timely and honest apology** is necessary in plain jargon-free language in line with the Duty of Candour and acknowledging what has gone wrong. (See Box 2: Style of Apologies).	1. Anonymised apology letters 2. Feedback from those receiving apologies
STR 4	**Records relating to a safeguarding process/ processes** which has caused harm/ distress need to record the facts and make it clear when a carer has been exonerated: this needs to include corrections to any inaccurate	1. Audit of relevant records

	statements made during Adult Protection/ safeguarding Meetings (see Box 2: Style of Apologies).	
STR 5	When a carer seeks to **contest a safeguarding decision**, the appeal meeting dealing with that appeal must be chaired by a person who is not drawn from an organisation which might have a conflict of interest with regard to the decision of the appeal meeting.	1. Review of chairs of appeal meetings
STR 6	When **independent advocates** are sought to represent adults who are the subject of a safeguarding enquiry or a Safeguarding Adult Review (SAR), those advocates must be seen to be truly independent of the investigatory agencies involved, and the adults involved must be able to freely choose an advocate whom they trust.	1. Feedback from the relevant adults.
STR 7	Produce and implement protocols to routinely seek **the views of carers** involved in safeguarding processes.	1. Copies of protocols 2. Audits of the implementation of protocols
STR 8	**Produce and implement protocols to involve** carers and service users in safeguarding training.	1. Copies of protocols 2. Audits of involvement in training
STR 9	**Produce and implement protocols to involve** carers and service users in developing safeguarding policies and procedures.	1. Copies of protocols 2. Audits of involvement in policy/ procedure development
STR 10	An **action plan** with timescales for delivery of the actions set out above and identified responsible individuals to be produced within 1 month of adopting this Report.	Copy of action plan with timescales and names responsible individuals
Recommendations arising from case 9 (additional to the 71 recommendations		

in Table 5)		
72	For the hospital concerned to review the procedures for deciding which deaths are reported to the Coroner with particular attention to how junior doctors communicate with consultants and to post operative deaths.	Written materials to confirm this has been done eg minutes of meetings.
73	For the hospital concerned to audit what is recorded in clinical case notes regarding conversations between medical staff and the Coroner's Office.	Copy of audit materials.
74	For the hospital concerned to review their teaching delivered to medical staff on death certification and reporting deaths to the Coroner.	Written materials to confirm this has been done eg minutes of meetings.
75	For the hospital concerned to check with the local Coroner whether they have a set of guidelines on reporting deaths either available online or that could be made available on the Trust's intranet.	Written materials to confirm this has been done eg minutes of meetings.
76	For a suitably qualified person to meet with the family of the person concerned (should the family wish a meeting to take place) and explain the IMA's report to them.	Feedback from Advocare and from the family concerned.
77	To inform the Coroner that following this Investigation there is reason to suspect that death was due to post operative rather than natural causes with a view to a possible Inquest.	Written submission to the Coroner regarding a possible Inquest.
Recommendation providing evidence that the aims of the Investigation have been met		
78	That the following information *for each of the last three financial years* is provided to the group that monitors the enactment of recommendations arising from this Report in a spirit of openness and partnership working and with the intention of furthering improvements in health and social care: 1. No. and type of complaints re - Poole - Bournemouth - Dorset Social Services.	Production of the information listed to the group monitoring the enactment of recommendations by a date agreed with that group.

	2. No. and type of complaints re safeguarding in Dorset. 3. No. and type of complaints re CHC/ PHB applications in Dorset. 4. No. and type of complaints re IFRs in Dorset	

11. Summary of outstanding actions as of July 2017

11.1 Table 8 sets out the recommendations that had not been enacted according to agency responses set out in Table 5 and as of July 2017. These recommendations are included below as remaining outstanding and in each case evidence should be provided to the group overseeing the next steps to demonstrate that the recommendation has been acted upon.

11.2 Informal feedback is that some of the recommendations have been enacted, but actions occurring since July 2017 are not reflected in the Table below and the group overseeing the next steps should be asked to review the status of recommendations listed in Table 8.

Table 8: Outstanding recommendations as of July 2017 (note: the Table does not include actions taken since July 2017)

No.	Locality	Re: Case	Recommendation	Tick below √ if recommendation enacted	X below if recommendation NOT enacted	If X name of person responsible for enacting recommendation	If X date by which recommendation will be enacted
5	Bournemouth – Health & Social Care	8	8.6 Carer involvement in training: Ensure that carers are involved in the training of health and social care staff.		X	Head of Workforce Development & Training service – Social Care (Bournemouth Borough Council)	Methods for delivering this are being considered, with consideration being given to delivering within the Training Plan for 2018.
16	Dorset – Health Care	5b	5.3 Specialist recommendations: In respect of case 5b: the recommendations made in (a specialist's) report regarding (service user's) follow up care and treatment to be enacted at the earliest		X	Person 5b's GP	Ongoing

			opportunity and, because of the complexity of (his) needs and (carer's) needs, this to be done in the community.				
23	Dorset – Social Care	5a	5.5 Senior member/s of staff at Social Services and the CCG to prepare evidence and explanation for (the carer) about how services have learned (or propose to learn) from her experiences, in order to improve services for future carers by answering the eleven questions as set out on page 20 (of the Report).		X social care	Commissioning Manager	31 Aug 2017
24	Dorset – Social Care	5a,5b	5.9 In the case of each of the above Action Points (5.4-		X social care	Hann	31 Aug 2017

			5.8) evidence of improvement should be provided to (the carer, service user,) and Advocare in order to address the aims set out earlier.				
31	Poole Hospital	2	2.2 Records: The service user has requested that his records should include a note to the effect that there was a misdiagnosis. This does not seem unreasonable, should be done and confirmation that it has been done sent to the service user.		X	Head of Patient Experience	Within 1 month of service user giving consent to contact Southampton Hospital
32	Poole Hospital	20	20.1 Poole Hospital and their PALS be made aware of the findings of this		X	Head of Patient Experience	One month after report shared with Poole Hospital

			report and to be satisfied that due consideration is made to record-keeping of patients' property and the needs of patients and carers on discharge.				
33	Poole Hospital	20	20.3 Face to face meeting: The Chief Nursing Officer and Chief Executive, who have offered to listen to carers in person be invited to meet with (carer). She welcomes this and believes it would help her to achieve closure of these issues which continue to trouble her.		X	Head of Patient Experience	At mutually convenient date to be arranged if carer wishes.
63	Poole – Health & Social Care	3,4	3.5 Commissioners should review				

			services to support carers in the community including respite/ rotational respite and out-of-hours services.				
68	Poole – Social Care	15	15.3 To review the involvement of service users and carers in social care staff training/ continuing development at all levels and to consider ways of increasing their involvement.		X	Katrina Keenan	The Health and Care Academy work will be an ongoing and long term project.

12. Conclusions

12.1 The next steps following receipt of this report by the commissioning organisations will involve ensuring that the additional recommendations and outstanding recommendations from Table 5 as of July 2017 (set out in chapters 10 and 11) are followed up, and that, for each recommendation, evidence is produced to show that it has been acted upon.

12.2 With respect to the additional recommendations (chapter 10) the Report lists examples of what might constitute evidence that the recommendations have been enacted in order to avoid uncertainty about their status.

Appendix 1: Abbreviations/ acronyms used in the text

ASC	Adult Social Care
AIMS-OP	Now the Quality Network for Older Adults Mental Health Services
BoP	Borough of Poole
CCG	Clinical Commissioning Group
CHC	NHS Continuing Healthcare
CQC	Care Quality Commission
DID	Dissociative Identity Disorder
DNAR	Do Not Attempt Rescusciation
DST	Decision support tool (in relation to CHC)
ERCP	Endoscopic Retrograde Cholangio-Pancreatography
GMC	General Medical Council
I	Investigator
IFR	Individual Funding Requests
IMA	Independent Medical Assessor/ Assessment
LPA	Lasting Power of Attorney
MDT	Multi-disciplinary team
MP	Member of Parliament
NHS	National Health Service
NHSi SAFER	NHS Improvement SAFER Patient Flow Bundle
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NOK/ NoK	Next of Kin

NRT	Nicotine replacement therapy
OG	Oversight Group
OOH	Out of hours
OPAL	Older Persons Assessment and Liaison
OPM	Older People's Medicine
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PCT	Primary Care Trust
PDS	Parkinson's Disease Society
PDU	Practice Development Unit
PHB	Personal Health Budgets
PIC	Poole Intermediate Care Services
QA	Quality assurance
RBCH	Royal Bournemouth and Christchurch Hospitals
RBH	Royal Bournemouth Hospital
SHA	Strategic Health Authority
STR	Safeguarding Thematic Report
TDA	NHS Trust Development Authority
ToR	Terms of Reference

Appendix 2: Terms of Reference for Large Scale Independent Investigation into concerns raised on behalf of carers by Advocare

1. The aims and aspirations

The aims of the investigation are:

to answer the questions raised by carers to their satisfaction relating to the care and treatment of their relative/loved one taking into account what carers want and don't want in relation to their concerns, see Appendix 1;

to make recommendations for improvements across health and adult social care and

to make improvements in safeguarding practice, policy and procedures.

2. Terms of reference for the independent investigator

2.1 The independent investigator will subject always to the consent of the carer:

- interview all carers to ensure that each individual carer's concerns are fully understood; to identify the desired outcomes of the investigation for each carer; to identify and consider issues of consent to the investigation process in each individual case and to identify the individual agencies that need to be involved in the investigation process.

- on the basis of the information gathered through interviews with all carers, the investigator will draft out proposals for the conduct, scope, themes and scale of the full investigation and present these to the Oversight Group for approval to proceed to the next stage.

- It is expected that for each investigation, the investigator will:

  - complete a detailed chronology of the care and treatment received by the individuals involved in the twenty cases to be investigated

  - examine whether the care and treatment plans were adequate and appropriate and within the local and national guidelines and whether the actions of agencies were proportionate at the time to the concerns raised

  - Identify which agencies need to be engaged to enable co-operation and assistance with the investigation

  - examine the extent and adequacy of the communication and collaboration between the agencies involved

  - undertake an audit of the individual's care and treatment records.

- raise any urgent concerns identified during the investigation with the nominated link at the relevant lead NHS or Local Authority commissioning organisation and notify Advocare (see section 5.1 of Governance/Accountability Framework).

2.2 In circumstances, where carers decide not to continue with the investigative process, the investigator will advise the Oversight Group on the best way to deal with this.

2.3 The independent investigator will produce a report on the findings from this investigation to include:

- answers to specific questions raised by individual carers; clearly identifying any thematic issues .

- recommendations that maximise the potential for improvements in multi-agency working;

- make proposals that will improve the quality of services for the future including methods for issues or concerns to be raised and resolved to a satisfactory outcome.

3. Setting up the independent investigation

The process for the independent investigation is as follows.

3.1 The Oversight Group agrees the terms of reference for the independent investigator.

3.2 The independent investigator will be drawn from the list of independent people held by the SHA. The selection process will be overseen from a procurement perspective by the NHS Bournemouth, Poole and Dorset procurement team and from the investigation's perspective by the Oversight Group.

3.3 The Oversight Group will interview and appoint him or her.

3.4 The selected applicant will agree their terms of reference (see section 2).

3.5 Advocare will give all pertinent information including contact details (with carers' permission) to the independent investigator only.

3.6 Advocare will discuss the cases in strict confidence with the independent investigator only.

3.7 The investigator will interview all carers and on the basis of the information obtained, make recommendations to the Oversight Group on the conduct, scale and scope of the investigation.

3.8 The independent investigator will interview all carers and agree the scale and scope for the investigations with the Oversight Group, but maintain confidentiality case information and contact details will not be divulged.

3.9 The independent investigator will:

- be free to determine his/her own approach to the investigation giving full consideration to human rights criteria and in accordance with the frameworks, legislation and guidance set out in 5.1.

- Record and report to the Oversight Group details of any organisation not willing to share requests for information outlining their reasons

- be given full assistance by the commissioning agencies to enable access to staff, documents, and care and health records which he/she feels are pertinent to the investigation.

4. Governance/accountability framework for the independent investigation

Introduction

4.1 To support the independent investigation, it will be important that there is an accountability and governance framework to ensure that the Independent Investigator has a clear mandate for the investigation and should it be necessary that recognised procedures can be triggered during the investigation to ensure the welfare and safety of individuals.

Accountability

4.2 The investigation is to be commissioned jointly by the Chief Executives of NHS Bournemouth, Poole and Dorset and Directors of Social Care in Bournemouth, Poole and Dorset.

4.3 An Oversight Group will be established to oversee the independent investigation process.

4.4 This Oversight Group will be Chaired by the Director of Patient Care, Nursing and Workforce, NHS South West.

4.5 The Oversight Group will comprise Advocare Trustees and their Chief Executive, senior representatives of NHS Bournemouth and Poole, NHS Dorset and the Directors of Social Care for Bournemouth, Poole and Dorset or their representative.

4.6 The Directors of Adult Social Care will be responsible for ensuring that all relevant partners, including the two relevant Safeguarding Adults Boards are informed of this large-scale investigation.

4.7 Accountability for delivering any resulting action in a timely way will be led by the appropriate health and social care lead commissioning organisations and all relevant agencies including, the two Adult Safeguarding Boards will be formally requested to ensure that lessons are learnt and action plans implemented.

4.8 The Chief Executive of the Cluster Primary Care Trust and the three Directors of Adult Social Care for Dorset, Bournemouth and Poole will be accountable for ensuring delivery of resulting action.

4.9 All organisations included within the investigation will be advised of the protocol for the investigation by the appropriate health and social care lead commissioning organisations.

5. Governance

5.1 It is recognised that during the course of the investigation the Independent Investigator will be exposed to detailed information about patient/service users/carers which may necessitate triggering processes to ensure the welfare and safety of an individual. As such, the Independent Investigator will familiarise themselves and act within the following:

- Data Protection Act 1998;
- Access to Health Records Act 1990;
- Dorset Multi-Agency Policy and Procedures for Adult Protection (Bournemouth, Dorset and Poole 2007) Procedures;
- No Secrets;
- Local Authority Social Services & NHS Complaints (England) Regulations 2009;
- Making Experiences Count including role of Ombudsman.

Subject to and in accordance with

- The Human Rights Act (1998) and proposed amendments (2000)

5.2 Where any priority actions are required, they will be reported on the same day to the nominated link at the relevant lead NHS or Local Authority commissioning organisation as follows:

- NHS Bournemouth, Poole & Dorset — Suzanne Rastrick
- Bournemouth Borough Council — Barbara O'Brien
- Borough of Poole — Hayley Seymour
- Dorset County Council — Glen Goucoul

Context for the investigation provided by Advocare

Unpaid carers of frail, sick and disabled people who contact Advocare describe feeling sidelined, subjugated and exploited. Many feel they are regarded by paid care workers as a resource at best and as a nuisance at worst. Research studies and surveys reflect this nationally. Twenty carers have agreed for their cases to be taken forward for an independent investigation for the following reasons:

What carers have said they want:

- Carers want to be believed.
- Carers want the perpetrators of neglect or abuse of their loved ones to be made accountable for their actions.
- Carers want closure.
- Carers want truthful answers to their questions, not excuses or lies.
- Carers want a positive, radical change in the culture of care.
- Carers want their status enhanced so that they are listened to.
- Carers who are sole advocates for vulnerable people want recognition of their role.
- Carers want a real understanding by so-called professionals of conditions such as Parkinson's and Alzheimer's and others which render individuals unable to communicate their own needs.
- Carers want a rapid response strategy via a suitable conduit that is effective and not blocked by a bureaucracy that acts as a comfort blanket for poor practice in hospitals, care homes, sheltered housing, community services, domiciliary support and respite services.

What carers have said they don't want:

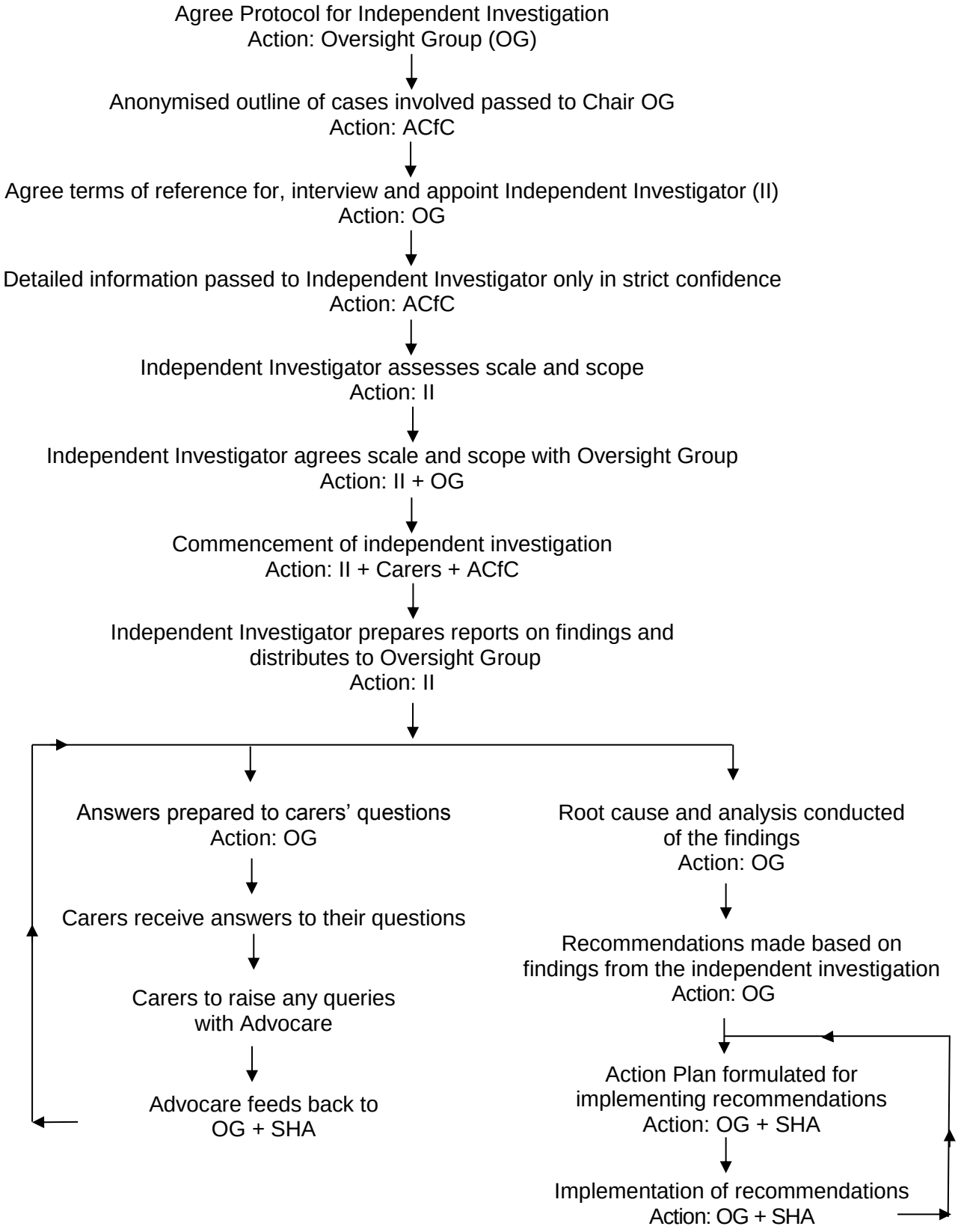
- Carers don't want to have to face a panel of thirteen people at Continuing Health Care reviews.
- Carers don't want to expend time and energy on the complaints process.
- Carers don't want to have to ask Advocare to E-mail Chief Executives, to write to their MPs or to report their case to the Parliamentary Ombudsman.
- Carers don't want to have to go to the expense of engaging a solicitor to get what they or their loved ones are entitled to.
- Carers don't want to have to resort to banging on the door of the press to be heard.

What Advocare wants:

- Advocare wants a timeline introduced and maintained to show where we are starting from and why, the progress being made and end goals.
- Advocare suggests the new monitoring body should be run by an independent body (or representative of one) [redacted] and that the Advocare Charter for Carers forms part of the framework for its guiding principles.
- Advocare wants measures introduced for all of the above in order to make itself redundant.

(Revised 1.06.11)

INDEPENDENT INVESTIGATION
Flow Chart Showing Process Outlined in the Protocol



Appendix 3: Independent Investigation Terms of Reference for Independent Medical Assessors

1. Introduction

An independent investigation is underway into allegations of malpractice, maltreatment, abuse and neglect of vulnerable people in Bournemouth, Poole and Dorset. Commissioned by NHS England (South) with I1 as the lead investigator for Phase Two, the aims of the investigation are:

1.1 to answer the questions raised by carers to their satisfaction relating to the care and treatment of their relative/loved one and that of themselves taking into account what carers want and don't want in relation to their concerns;
1.2 to make recommendations for improvements across health and adult social care and
1.3 to make improvements in safeguarding practice, policy and procedures.

2. Aim

The purpose of an Independent Medical Assessor is to assist I1.

3. Actions required by the Independent Medical Assessors

3.1 To meet with the patient and/or their carer to listen to the medical history as appropriate.

3.2 To examine evidence in the medical records of the relevant individuals.

3.3 To produce a report of their findings. This must be sent simultaneously to I1 and the patients/carers concerned so they can agree, accept or question the IMA's findings before their report is circulated to the Oversight Group by I1.

4. Governance Arrangements

4.1 The Independent Medical Assessor will be registered with the General Medical Council, have a licence to practise medicine in the UK and their name should be included on the specialist register.

4.2 The patient or their carer/relative/next of kin, will provide written consent for the Independent Medical Assessor to access the relevant records

4.3 The Independent Medical Assessor will follow the GMC "Duties of a Doctor" including recording their findings in the clinical record and any recommended treatment.

4.4 The Independent Medical Assessor's report must be verified by a statement of truth in the following form:
"I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed

represent my true and complete professional opinions on the matters to which they refer".

4.5 Decisions concerning funding of recommended treatment that is not normally commissioned by the NHS (or available locally) will need to be considered through an Individual Funding Request (IFR) to the Wessex Area Team in line with the national IFR framework.

4.6 If the patient wishes, their GP will maintain ongoing responsibility for their treatment and/or care.

- - -

29.07.13