



Liverpool
Safeguarding
Adults Board

Safeguarding Adults Review (SAR) Executive Summary Report 'June'

LIVERPOOL SAFEGUARDING ADULTS BOARD

INDEPENDENT LEAD REVIEWERS: SARAH WILLIAMS & FIONA BATEMAN

Publication Date: 22nd November 2024

Contents

1. Introduction	3
2. Scope of Review	4
Purpose of a Safeguarding Adult Review	4
Themes.....	4
Methodology	4
Contributing agencies	5
Involvement of June’s family	5
3. Analysis of Agencies’ Actions.....	5
Application of the Mental Capacity Act 2005	5
Professional curiosity during health appointments.....	9
Support for informal carers and identifying carer strain	11
Understanding of elder abuse	13
Use of the safeguarding process to mitigate risk.....	14
Impact of the pandemic.....	16
4. Glossary	17

1. Introduction

- 1.1 In May 2023 this case was referred in by Liverpool City Council, Adult Social Care to Liverpool Safeguarding Adults Board for consideration of a Safeguarding Adults Review. Following multiple screenings to consider the Care Act 2014 criteria, Liverpool Safeguarding Adults Board ['LSAB'] took a decision in September 2023 to commission a Safeguarding Adults Review in respect of 'June' an older, white British woman who had a diagnosis of vascular dementia.
- 1.2 June was cared for by her daughter at home. Various health and care professionals attended the family home approximately every other month, primarily to provide June's healthcare and although there were a number of occasions when practitioners were told June was not available for these appointments, these were often successfully rescheduled and no significant concerns were noted in respect of the home conditions or June's presentation, although her dementia was deteriorating.
- 1.3 Following an anonymous call in May 2021 alleging concerns at the property, police conducted a welfare check finding very poor home conditions and that June presented as physically neglected, so made a referral which was triaged to both Children's and Adult's Social Care. Children's Social Care (CSC) visited and took the view that the children needed to stay elsewhere while the home was cleaned. June was visited by Adult Social Care (ASC) the following day and found to be in squalid conditions, unable to mobilise, doubly incontinent and infested with head lice. June was noted to be without the necessary equipment to assist with the various needs brought about by her significant cognitive decline. After being assessed by her GP, who spoke to June's daughter about the fact June required more care, June was taken by ambulance to Royal Liverpool University Hospital (RLUH) for assessment and treatment. June was discharged to a nursing home after this was assessed as being in her best interests. Sadly, June died from aspiration pneumonia in August 2021 while living in the nursing home.
- 1.4 It was difficult to get a sense of June as a person during this review. Annual care assessments from 2016 to 2018 described June as chatty and social but showed a marked progression in her dementia from being 'muddled' in 2016 to increasingly confused and confabulating during assessments and starting to show aggression towards daughter. However, June's personality and values are not captured in these documents. Little insight could be gained through other agency records, as these tended to reference information provided on June's behalf by her daughter, rather than June's own views. Unfortunately, only one practitioner who had worked directly with June was still employed by the agencies involved but sadly, by the time they met her during her time in hospital, June's dementia was advanced, and she had very limited meaningful verbal or non-verbal communication. It was clear that best practice was followed in respect of the efforts to support June to express her wishes and feelings during her hospital stay, including involving a healthcare assistant who had built a rapport with June to support the Best Interest assessment. Although June's daughter was invited to participate in this review, no response was received.
- 1.5 It is important to acknowledge that although some concerns had previously been raised in respect of carer strain, there was little prior evidence that June was experiencing significant neglect during visits to the family home by a number of agencies and care assessments showed that daughter was determined to care for June in her own home, even as her needs grew increasingly complex. One practitioner commented that by the time of her hospital admission, June's needs were so great that few family carers would have the ability to meet these without an enormous amount of support and that realistically, this could only be provided in a care setting. When the home situation was discussed with June's daughter during June's hospital admission, they were very distressed about the allegation of neglect and said that June did not comply with any care (and this non-compliance could be observed at times in hospital). It appears that daughter had become overwhelmed by the situation and a practitioner described

'a family on the edge of survival', who clearly loved each other but lacked the skills or understanding to cope with June's escalating needs.

2. Scope of Review

Purpose of a Safeguarding Adult Review

- 2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:
 - To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
 - To review the effectiveness of procedures (both multi-agency and those of individual organisations).
 - To inform and improve local interagency practice.
 - To improve practice by acting on learning (developing best practice); and
 - To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- 2.2. There is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect June from harm. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

Themes

- 2.3. The LSAB prioritised the following themes for illumination through the SAR:
 - Was an appropriate level of professional curiosity exercised during health contacts, including in respect of missed appointments and episodic interactions with the family by other agencies?
 - How do practitioners inform carers of the nature of their duties to meet needs to a safe standard and what mechanisms do they use to assess whether informal carers have sufficient skills or capability to meet necessary care? How are abuse and neglect distinguished from carer strain and financial pressures?
 - How effectively do safeguarding systems in Liverpool respond to elder abuse and neglect?
 - Is the safeguarding process (s42 Care Act) used effectively to escalate concerns and secure multi-agency risk management to reduce risks where concerns are raised about neglect or unsafe informal care?
 - Were the principles of the Mental Capacity Act 2005 applied in determining whether June and her daughter's decision to decline a care package to meet June's care and support needs or the daughter's response to her health needs were consistent with her Best Interests?
 - How did the Covid-19 pandemic impact on the family, practitioners' ability to respond and what can be learned in respect of system-wide resilience to adverse events in respect of carers' needs?

Methodology

- 2.4. The LSAB commissioned independent reviewers, Sarah Williams and Fiona Bateman to conduct a SAR using the Social Care Institute for Excellence Learning Together methodology with tools from the SCIE SAR in Rapid Time methodology. This was to enable learning to be turned around more quickly than usual through a SAR, but with a more detailed report than

would typically be produced for a SAR in Rapid Time. The initial SAR Panel took place in May 2023 and the report was approved by the LSAB in December 2023.

- 2.5. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.
- 2.6. The review covers the period from June 2018 – May 2021, although additional background information has been included for context.

Contributing agencies

2.7. The following agencies provided documentation to support the SAR:

- Liverpool City Council's:
 - Adult's Services
 - Children's Services
- Liverpool University Hospitals NHS Foundation Trust (including Royal Liverpool University Hospital, RLUH)
- Mersey Care NHS Foundation Trust representing:
- Cheshire and Merseyside Integrated Care Board (Liverpool Place) representing:
 - the GP Surgery,
- Merseyside Police
- North West Ambulance Service (NWAS)

2.8. Multi-agency learning events took place, both with front-line practitioners who worked in the services that support June and the leaders who oversaw the services.

Involvement of June's family

2.9. Liverpool Safeguarding Adults Board invited members of June's family to participate in the review, however, no response was received to the correspondence sent on two occasions. Liverpool Safeguarding Adults Board have notified June's family this report will be published.

3. Analysis of Agencies' Actions

Application of the Mental Capacity Act 2005

- 3.1. The provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the Mental Capacity Act 2005 (MCA) and the Human Rights Act 1998 (HRA).
- 3.2. Mental capacity is always decision specific, and professionals are expected to take steps to empower people to take decisions, for example by ensuring an appropriately calm environment and communicating in a manner that the individual can understand. The MCA sets out that a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain, which includes conditions such as dementia. A person is unable to make a decision for themselves if they are unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the decision-making process, or to communicate their decision by any means. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision and capacity may fluctuate over time, for example as dementia advances people

may have periods of lucidity and confusion. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise.

- 3.3. The principles embedded in s4 MCA require that any decision taken on behalf of a person who lacks capacity to make it, follows the least interventionist approach, and is taken in the person's best interest. This is not just the person's medical best interest, but rather their welfare in the widest possible sense, considering the individual's broader wishes and feelings, values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible, and those who know them best should be consulted. Section 4B allows that a person can be deprived of their liberty for the purpose of life sustaining treatment or treatment to prevent a deterioration in their condition in an emergency if there is a 'reasonable belief' (on the basis of 'reasonable steps' having been taken to establish) that the person lacks capacity to consent. Section 5 likewise sets out that acts of care and treatment will not incur liability if there is a reasonable belief that the person lacks capacity to consent being carried out.
- 3.4. Section 9 of the MCA also enables people to take a decision, while they still have capacity to do so, to appoint a Lasting Power of Attorney (LPA) to one or more individuals (the donees), to take decisions on their behalf if they lose the capacity to do so. This can either be in respect of their property and finances (which can take effect before or after the person loses capacity, depending on their wishes) or their personal welfare (which can only take effect if the person loses capacity to take decisions in respect of their own care), or both. This will only be legal if it is registered with the Office of the Public Guardian, and professionals are required to have sight of the registered document rather than relying on assertions by daughter that this has been made. If an LPA is in place and the person loses capacity to take decisions in respect of their property and/or welfare, the donees have the authority to take those decisions on behalf of the individual, but only in accordance with the terms of the LPA and in the person's best interests.
- 3.5. June was regularly seen and assessed by practitioners from 2016 onwards, but no formal mental capacity assessments were carried out until she was admitted to hospital in May 2021. Annual care assessments were primarily completed in consultation with June's daughter, who was her informal carer rather than June. These tracked the deterioration of June's cognition, initially presenting in 2016 as 'muddled' but able to communicate with some support from her daughter, needing substantial help to make decisions and help 1-2 times each day to meet her basic care needs but with no behavioural issues. June's daughter was noted to hold a 'POA' ('power of attorney') in respect of June's finances within the assessment, but it does not appear that the assessor had sight of a copy of this (or during subsequent reviews), and it is not clear that consideration was given to whether this included a welfare LPA or authorised decisions in respect of her property and finance. Although the assessment concluded that June would benefit from accessing a day centre for socialisation, when she trialled this, daughter reported that June had not enjoyed this and did not wish to return. June's daughter refused a carers assessment.
- 3.6. Referrals were made to ASC in May and July 2017 identifying that there was a significant risk of care breakdown due to carer strain as June's needs placed pressure on June's daughter, but no assessments were completed until her annual review in September. During the care review in 2017, June was presenting as able to communicate but "*very confused and continually confabulates*", she could become agitated and at times reluctant to accept care and was occasionally verbally (but not physically) aggressive to daughter, and now required help with all of her personal care needs. She was recorded as requiring help to make important decisions, although she could still make basic decisions such as what she wanted to eat, wear or do.

June's daughter also completed a carers assessment, which identified that she was tired, stressed and needed a break.

- 3.7. In early 2018, a further care review recorded that June "*lacks mental capacity to make decision with regard to care and support*", that she was "*confused and disorientated to time, place and person.*" She could become agitated and at times physically aggressive towards daughter. June's daughter was not in agreement with having domiciliary carers in the home, but reluctantly accepted care vouchers. The social worker identified that a Best Interest decision would need to be taken if June attended a day centre as she would need to be prevented from leaving due to the risk of wandering but did not use the Best Interest process to weigh whether daughter's decision to refuse domiciliary care was in June's best interest. When June had a brief hospital admission in mid-2018, this was revisited, and again daughter refused to consider a care home, although daughter claimed that they were making use of the carer's vouchers. The assessor advised that daughter should consider respite in a care home, but this was not progressed, and no further care assessments were carried out until June was admitted to hospital.
- 3.8. Although these assessments evidence that the impact of June's dementia was recognised and that her capacity to take decisions in respect of her personal care was considered, the fact that a formal mental capacity assessment was not completed was a missed opportunity to explore her best interests and in particular, to distinguish her best interests from the wishes and needs of her daughter in respect of the decision to refuse care and support. Whilst June, her daughter and other interested persons would obviously need to be consulted with as part of this process in accordance with the requirements of the Mental Capacity Act 2005, this would have facilitated a discussion about her holistic needs, including any risks that could arise if her daughter was unable to consistently meet June's needs in the future. This process may also have better supported June's daughter to understand the potential benefits of a day centre or respite in a care home, both for June and daughter in terms of reducing the strain they reported to be under. Further, a formal Best Interests process requires all of the realistic options to be explored in weighing the person's best interests, which may have supported practitioners to consider a broader and more creative range of care options, which may have better met June's needs, or been more palatable to daughter, which could in itself have been in June's best interest if this meant care was more likely to be accessed.
- 3.9. Similarly, although medical practitioners were regularly visiting the home to attend to June's health needs, there was no record that her mental capacity was assessed, either in respect of her treatment or her missed appointments. It is a legal requirement to obtain a person's consent to medical treatment, yet there is no clear record that this was obtained, nor that if June was assessed as lacking capacity to consent to treatment, the decision to provide this was taken in her best interest. Whilst this process should be proportionate to the decision being made, it is very important that clear records are maintained in circumstances where an individual's cognition is clearly impaired.
- 3.10. As a result, throughout the period from 2016-2020, when it appears that June was still communicating with practitioners, albeit in a confused manner, June's voice is lost. Many of the records appear to capture assertions made on June's behalf by her daughter and there are few occasions when June's own views or wishes are reported. The focus of the documentation is primarily on daughter's needs. This also meant that later, when more complex decisions needed to be taken, a clear record of June's express wishes and feelings was not available from a period when she still had capacity.
- 3.11. Although a formal mental capacity assessment and best interest decision were not carried out in respect of the decision to take June to hospital, given the urgent nature of her circumstances, ambulance staff acted appropriately in doing this without delay. In a fast-moving situation where professionals have limited information, and in circumstances where not taking action could

endanger the person's life, the threshold for concluding that the person lacks capacity to consent to treatment is going to be low.

- 3.12. Good understanding of the Mental Capacity Act 2005 and quality multi-agency practice could be seen in respect of June's discharge from hospital. The GP who recommended her hospital admission contacted the ward to ensure that her safeguarding concerns were clearly understood, and she explicitly asked to be invited to any Best Interest meeting. This proactive safeguarding approach is highly commended. In assessing that June lacked capacity in respect of her hospital discharge destination, the Best Interests assessor complied with best practice, undertaking the assessment over a number of sessions, breaking down the issues in an effort to support June to understand the decision she was being asked to take, and involving a healthcare assistant who had built up a rapport with June, to help her feel as comfortable and supported as possible when attempting to ascertain her capacity, wishes and feelings. Because the s42 enquiry was ongoing, an Independent Mental Capacity Advocate was appointed to represent June's interests, rather than relying solely on her daughter's views to promote her welfare. In addition to the medical team at the hospital, the GP, social worker, daughter (with a family friend to support) participated in the Best Interest meeting, to allow for a holistic discussion about June's needs. The care plan agreed was appropriate as this was for a short-term placement in a care home, while the safeguarding enquiry was completed and June's needs and her daughter's ability to meet those needs were assessed. The plan was therefore minimally interventionist in accordance with MCA principles. The benefits of this process also enabled daughter to understand why practitioners believed that June's needs could only be met in a formal care setting, as these were so advanced that the round-the clock care she required could only be provided by a team of carers.
- 3.13. Senior managers in ASC reported that since 2018, significant steps have been taken to strengthen practice around the Mental Capacity Act and use of the Best Interest framework to support good decision-making and empower practitioners during difficult conversations with individuals or their families. The balance sheet proforma for Best Interest meetings included consideration of the carer's ability to meet the person's assessed needs. Better managerial scrutiny also enabled gaps in MCA practice to be identified more quickly. However, they acknowledged that this tended to focus on 'big' decisions, such as when people needed to move into care homes or if someone needed to be kept under constant supervision in a day centre. Practice could be less consistent in respect of more day-to-day decisions, and leaders were not confident that a refusal to accept a service such as an offer of respite at a day centre would necessarily trigger a Best Interest discussion.

Systems finding

- 3.14. Knowledge and application of the Mental Capacity Act 2005 across partner agencies is inconsistent and in particular, the importance of conducting mental capacity and Best Interest assessments in circumstances where an individual or family/carer is refusing or not engaging with a service that is necessary to meet the person's care needs. Greater focus on protective, low-level interventions (such as befriending services) during assessments and care planning for those who lack capacity and are resistant to care would increase opportunities to monitor changes in needs over time and prevent overreliance on referrals at times of crisis.

Recommendation 1: Ongoing programmes by partner agencies to strengthen practice in respect of the Mental Capacity Act 2005 and Best Interest decisions should be used to reinforce that proportionate assessments and best interest decisions should be carried out and recorded in respect of all significant decisions about a person's care, in particular when a care package has been refused by the individual or their carer.

Recommendation 2: Guidance for Adult Social Care practitioners on completing the Best Interest balance sheet when taking decisions about care and support needs should explicitly

prompt analysis of the carer's ability to meet the person's care and support needs if the person remains at home or a formal care package is not provided, and whether it may be appropriate to utilise existing legal powers (including under s42(2) Care Act) to provide protective, low-level interventions (such as befriending services) for those who lack capacity and are resistant to care, but at risk of harm.

Recommendation 3: *Partner agencies should ensure that forms or guidance which ask practitioners to consider whether the person has a Lasting Power of Attorney prompt them to enquire whether this relates to finance or welfare matters, and to request a copy of the LPA from the Office of the Public Guardian if the person or their carer/donee cannot provide a copy, recording when this has been seen.*

Recommendation 4: *The LSAB, working with relevant parties responsible for delivery of the local dementia strategy, should develop guidance on the practical application of legal principles applicable to support people with degenerative cognitive conditions. The dementia strategy should incorporate clear pathways for informal carers to seek support for the person they are providing care to, in particular as needs start to escalate or stressors arise within the home. A publicity campaign should be run to ensure that this is accessible all carers, including those not currently receiving support from statutory agencies or the care navigator service.*

Professional curiosity during health appointments

- 3.15. From 2018 - 2021, health professionals regularly attempted to carry out visits to June at home, but they were frequently told by family members that June was unavailable. The podiatry team had 9 missed appointments and 9 successful appointments. The phlebotomy team was only able to take blood on one occasion with 8 unsuccessful visits. All of the successful appointments took place downstairs in the living room.
- 3.16. This was discussed during the learning events and practitioners advised that as June was still mobile at this time, no concern would be raised about the fact she was always seen in the living room. Plausible explanations were provided for most of the missed appointments with the podiatry team and these were then followed by a successful appointment within a couple of weeks as the family would rearrange the appointments. When June was seen, there was only one occasion, in December 2020, when any concerns were recorded, as June's feet were noted to be unkempt and soiled, and advice was given about this to her daughter. On occasions, different excuses were given for the same missed appointment to the same podiatrist, but this was not picked up on. Practitioners felt that had several appointments in a row been missed, or hygiene issues continued to be noted, that would have been likely to trigger a discussion at the podiatry team's safety huddle. It was noted that for patients such as June, who were only being seen once every 3 months, staff would have limited opportunity to get to know them or their families and that they would not necessarily see 'behind the curtain'. During the pandemic, visits became increasingly task-focussed, as practitioners tried to complete the treatment quickly to minimise the risk of exposure for vulnerable patients.
- 3.17. In respect of phlebotomy, managers explained that this service was episodic in nature, with the GP making ad hoc referrals for blood to be taken when health concerns arose. The team's policy after receiving the referral was to carry out two home visits, then discharge the patient back to the GP if those attempts had been unsuccessful. It is possible that the reason that far more phlebotomy home visits were missed than podiatry visits is that phlebotomy visits tended to be unannounced and while this may have meant that June was less likely to be available, it is also possible that the family would ensure that June and the home were more presentable for planned visits and did not want professionals to see her at other times. While this is speculative, greater professional curiosity about disguised compliance during this period would have enabled this possibility to be explored.

- 3.18. It was acknowledged by the GP surgery that during this period, these discharge letter would be filed on the patient's records by an administrator without being flagged on the system or highlighted to the GP. Consequently, there was limited oversight of a pattern of missed appointments. Further, both phlebotomy and podiatry are commissioned by Mersey Care and can access each other's records, but the practitioners involved do not appear to have reviewed June's files to see that there was a pattern of missed appointments across both services, which may have triggered a safeguarding discussion.
- 3.19. Leaders identified that the notes from these visits were quite superficial and that June's capacity to consent to treatment was not recorded, despite the fact she was fully dependent on her daughter for her care needs, which, as set out above, meant that consideration was not given to whether her Best Interest were being met by these repeated missed appointments, in particular as to whether her health needs were being met when the necessary blood tests were not being taken. There was concern that potential risks in the environment were not flagged for colleagues' safety, in particular the fact that there was a dog in the home that the police later reported to be aggressive. Although the incident in December 2020 when June's feet were noted to be dirty appears to have been a one-off, but these concerns were superficially documented and good practice would have been for a follow-up appointment to be offered within a shorter period, but instead, a normal 3-monthly appointment was scheduled.
- 3.20. Disguised compliance could also be observed in the daughter's interactions with the care navigator service. The care navigator service is Mersey Care's specialist service for people with dementia, to support them and their families through the health service as their condition develops and will generally make contact approximately every 6 months, or more often as required. Although this is primarily a virtual service, the care navigator demonstrated persistence and good practice after becoming concerned by the fact they had not received a response to several telephone calls and letters over a number of months, so took the unusual step of visiting the home. Whilst she accepted the family's explanation that they could not invite her into the home of a problem with their fridge, she explored some of the difficulties the family was experiencing in trying to care for June and took proactive steps to help them resolve these, for example providing contact numbers for the occupational therapy service to see if a banister could be installed to reduce the risk of falls, and the bladder and bowel service for incontinence support.
- 3.21. Practitioners noted that since the start of the pandemic, multi-disciplinary team meetings (MDT) to discuss challenging cases or lower-level concerns had fallen into abeyance, which limited opportunities to identify patterns of behaviour observed by different agencies. However, even if this had taken place, the fact that practitioners were able to gain entry to the home on occasion, and that no safeguarding issues were identified on those occasions, would probably have ameliorated those concerns. Although June's condition when she was discovered in May 2021 was very serious, the fact that she was assessed as not having any pressure ulcers on admission to hospital may indicate that she was not left sitting in urine for a prolonged period, as this would be likely to damage her skin. The nurse from the GP surgery who saw June in February 2021 for her Covid-19 immunisation reported that the home was unkempt, cluttered and stale smelling, but nothing marked. As Adult Social Care had not had any contact with the daughter since 2018 when the daughter had declined care and support or respite, an MDT may have triggered a review of June's care needs.
- 3.22. The GP Surgery has since been taken over by a new provider that has a different procedure for recording outcome letters from the phlebotomy service, which means that the system will automatically flag to the GP that the blood tests ordered have not been undertaken when they attempt to issue a prescription. This will enable a pattern of missed appointments to be identified more quickly and safeguarding issues can be taken forward by their dedicated safeguarding nurse.

Systems finding

3.23. Health partners lacked effective systems to monitor patients who missed repeated appointments, relying on individual practitioners to identify patterns. Records of visits were transactional and lacked the detail about the person and their home circumstances that would support analysis of developing concerns.

Recommendation 5: *Partner agencies should review their 'was not brought' or 'missed appointment' policies for adults who are unable to attend appointments without support due to their care needs or mental capacity, to identify trigger points for practitioners for a discussion with their designated safeguarding leads and to seek intelligence from other agencies working with the individual. Where possible, ICT systems should contain measures to automatically flag missed appointments at least internally, but ideally to other partner agencies.*

Support for informal carers and identifying carer strain

3.24. Section 10 of the Care Act 2014 gives anyone who is looking after another adult with care and support needs the right to a carer's assessment. These assessments should address the carers' mental and physical health, their ability and willingness to care, and their relationships with others. Section 9 of the Care Act 2014 clarifies that an assessment of a person's eligibility for care must consider all of the person's care needs, regardless of any support being provided by a carer, and that this informal care must not influence the eligibility determination. In addition, s20 places a duty on local authorities to meet carers' needs in accordance with a national eligibility threshold.

3.25. In May and July 2017, Mersey Care sent two referrals to ASC in respect of concerns that daughter was 'at breaking point', identifying that daughter was experiencing carer strain as a result of caring for June. Although ASC noted that a social worker should be allocated, it is unclear why no assessment was carried out in respect of either daughter or June until September 2017, when a carer's assessment was completed at the same time as June's annual care and support review. The carer's assessment identified that daughter was feeling tired and stressed and felt they needed a break. Although daughter had not wanted to use a day centre offered following the previous care assessment in 2016 as June had trialed this once and did not like being separated from her family, daughter felt that June may be willing to engage with this now that her needs had increased, and she was placed on a waiting list. However, June never used the service. A referral was also made for an occupational therapy assessment to determine whether modifications could be made to the home to make it easier to care for June safely, but this was put on hold as family advised that they were considering moving to a new property and this was not subsequently followed up.

3.26. This was revisited in February 2018, when the ASC social worker noted during a home visit and that June's condition had deteriorated and she was assessed to be lacking capacity in respect of her care and support. June's daughter reluctantly accepted an offer of 20 carer vouchers, but did not accept the offer of respite.

3.27. Following a further referral from Mersey Care's care navigator in May 2018, ASC made a telephone call to June's daughter, where she was reluctant to place June in a care home but was willing to accept respite and acknowledged that she had received carer vouchers. The following month, a home visit was conducted where daughter reported that she felt overwhelmed at times but declined formal care despite attempts to change her view. Family member agreed to use care vouchers but refused respite again, although agreed to make contact should this view change. However, it appears that the vouchers were never used by daughter.

- 3.28. Although efforts were made to persuade June's daughter to reconsider respite in a care home, there was no clear analysis of whether daughter understood and had the skills to meet June's needs, nor the risks to June if her needs could not be met by her daughter. It was vitally important for June's needs to be kept under careful review as there was clear evidence that these were rapidly escalating and in particular, her reluctance to accept care and aggression towards daughter indicated that the situation could deteriorate quickly.
- 3.29. Practitioners explained that although care vouchers could be used to access a 'sitting service' (a service which provides a worker to mind the individual while the carer goes out to run errands or socialise etc, but does not provide personal care), the process to redeem the vouchers was complicated and could be inaccessible to many families, particularly those who may be feeling stressed and overwhelmed or have limited computer literacy. Care vouchers are provided through a commissioned service, the Carer's Development Service, rather than directly through the council, which may further complicate access. A review of the service¹ completed by Liverpool Healthwatch in 2018 found that there was a lack of capacity with care provider agencies and that the nature of the service lacked flexibility in respect of supporting users with basic personal care tasks. As a consequence of the Healthwatch review, paper vouchers were retained in line with carer satisfaction. Resources were mobilised to support carers to source an agency, so that there was understanding of market capacity, reduce administration for carers and improve the speed to which a provider could be mobilised. The providers on the Help to Live at Home contract were reproached of which the carers vouchers were an element. There are plans to further review the scheme, and it is important that this addresses the concerns that practitioners have raised in respect of the limitations of care vouchers.
- 3.30. The Carer Development Services was proactive in contacting June's daughter several times to try to engage with her during 2018, but when they closed the case due to non-engagement in November, this did not trigger ASC to reassess June's needs or care plan, or seek to determine whether daughter carer strain had been alleviated in other ways. It is unclear why ASC had no further contact with June or her daughter after November 2018 until her hospital admission in May 2021. June had been assessed as having care and support needs which had increased over the course of the 3 successive annual care assessments and could reasonably be predicted to continue to escalate. Section 27 of the Care Act 2014 requires the local authority to keep care plans under periodic review and statutory guidance requires that this should be at least annually, or more frequently if the person's needs are increasing. The fact that daughter was choosing not to engage with ASC did not change or discharge its duties to June. It is not evident that daughter's ability to meet June's care needs was ever assessed, either initially or as her needs grew. Again, practitioners needed to exercise professional curiosity and understanding of the use of the Best Interests framework to analyse safe decision making.
- 3.31. The care navigator service showed good practice during 2018, proactively contacting ASC to draw their attention to June's escalating need and daughter's resulting stress. Mersey Care advised that where people with a diagnosis of dementia do not have a formal package of care, the service contacts individuals or their carers every 3 months to monitor the progress of their needs and make relevant referrals or provide contact details to secure any additional support that may be needed. Leaders queried whether there may have been an element of disguised compliance in daughter accepting but not using the carer's vouchers, to deflect the interest of the agencies involved.

Systems finding

- 3.32. Support for carers under s10 of the Care Act 2014 needs to be flexible and care taken to ensure that this meets the needs identified in a bespoke way, rather than a generic offer which may not be accessible to all carers. There is a gap in risk analysis in respect of cases where carer strain

¹ [Carers Voucher report FINAL.pdf \(healthwatchliverpool.co.uk\)](#)

has been identified, with practitioners focussing on the carer's wishes but placing insufficient weight on the risk to the individual if the carer is unable to meet their needs, particularly if these are escalating.

Recommendation 6: *ASC should ensure, through guidance, training, supervision and audit processes, that social workers are consistently assessing the ability of informal and family carers to understand and to meet the person's needs without additional support and explicitly record this in the assessment or care and support plan. Contingency plans should be incorporated in care plans to provide clear advice to carers on how to identify that needs are escalating, how to meet those needs safely or to access timely and targeted support to address this.*

Recommendation 7: *ASC should review its processes to ensure that where potential carer strain has been identified, this triggers a review of the care and support plan pursuant to s27 of the Care Act 2014.*

Recommendation 8: *LCC should ensure that clear advice is provided on its own website and a leaflet that can be sent to carers about how to use carers vouchers and any other commissioned services regularly offered through third party providers. LCC should provide assurance to LSAB in respect of any steps taken to improve the issues in respect of provider capacity identified in the Healthwatch report.*

Understanding of elder abuse

- 3.33. The anonymous referral to the police in May 2021 Police showed good practice by clearly identifying the risks in respect of both June and the family in the property, resulting in a VPRF which was sent simultaneously to both the children's and adults' team in Careline, LCC's triaging service and requested home visits from both departments. Adults' Careline showed good practice in contacting the police to clarify whether an urgent response was needed to the situation.
- 3.34. Practitioners and leaders observed that although in general, practitioners from adult services were vigilant in respect of children's safeguarding issues, this was not necessarily reciprocated and that it was common that elderly or vulnerable adults who lived in a household with children would be 'silent' in the children's records too, unless they posed a direct risk to a child. It is unclear whether children's practitioners were aware of the referral pathway for adult safeguarding.
- 3.35. CSC reported that currently, they are in the process of moving towards a Family Safeguarding Model, with smaller teams incorporating co-located multi-agency colleagues, including adult mental health, domestic abuse and substance misuse specialists. However, leaders welcomed the opportunity to strengthen practice in respect of a 'Think Family' approach, supporting children's practitioners to consider the holistic needs of and risks to all family members. Leaders also reflected that a more reciprocal safeguarding approach between CSC and ASC would also strengthen relationships between the departments and improve partnership working.
- 3.36. NWAS reported that they now had better pathways for referrals for early help, as previously any referral they made had to come through a safeguarding pathway which was not always appropriate. The GP surgery also reported that they had improved their training requirements for reception staff, including coding of missed appointments to ensure these are drawn to the GP's attention, to support early identification of increased care and support needs or safeguarding issues and ensure a proactive response to this.

Systems finding

- 3.37. Understanding of the signs of elder abuse were not well embedded across partner agencies and a lack of joined up working between CSC and ASC resulted in a delayed safeguarding response for June. Whilst partner agencies have taken steps to strengthen recognition and reporting of potential signs of harm, better understanding of a 'whole family' approach to safeguarding should improve outcomes for children and adults at risk.

Recommendation 9: *Learning from this review should be used as a case example during safeguarding training across the partnership, to support better reflective practice in respect of a whole family approach to safeguarding. Clear advice should be given to frontline staff in respect of the benefits of joint visits across different departments or agencies in circumstances where issues relating to multiple disciplines need to be assessed, or processes agreed in respect of information gathering and sharing between those services when actioning a referral involving multi-generational subjects.*

Recommendation 10: *Guidance, training and supervision for all relevant agencies should support analysis of the whole family circumstances, with family members living in the home clearly identified on agency records. Children's services should ensure that staff know when and how to raise an adult safeguarding concern.*

Use of the safeguarding process to mitigate risk

- 3.38. Practitioners discussed the fact that there were two pathways for referrals, police completed VPRFs which were triaged by police safeguarding officers who sat in the specialist Vulnerability Hub that determined what action should be taken, and which agencies the referral should be sent to and RAG rate the referral. Other agencies sent referrals via Careline, although practitioners commented that the response they received sometimes depended on whether Careline staff attributed status to their role as they had observed that referrals sent to the central email box could take 2 weeks for a response. One safeguarding lead reported that they received a lesser response on occasions when they did not identify that they were in a senior safeguarding role. Managers felt that exploration was needed in respect of whether there were any barriers to receiving a response from Careline, and whether the same challenges were faced by all agencies or levels of hierarchy. They felt it was important that communication was open and that there were easy pathways for frontline practitioners to chase or challenge when they felt that a more urgent response was required. Although practitioners can raise issues with a Careline manager or use the SAB escalation process, it may be that frontline practitioners do not feel confident in using this or are concerned that this will be perceived as a complaint as opposed to an opportunity to reach a shared understanding of risk in a timely way.
- 3.39. In June's case, other than as identified above, there was good practice from practitioners from all agencies, who used the safeguarding process promptly and appropriately. Police, the GP, ambulance and RLUH all made separate safeguarding referrals in respect of June's condition in May 2021, rather than making assumptions that this had been previously completed by another agency.
- 3.40. The decision by ASC to call the GP to assess June rather than arranging for her to be moved directly to hospital or seeking urgent legal advice in respect of moving her to a respite placement in a care home (which would also have required ambulance transport) was a good one. NWS acknowledged that at the time and currently, pressure on ambulance services means that unless the individual is at immediate risk of death, there may be a wait of several hours before an ambulance can attend a call if there are a lot of other priority calls. ASC were continuing to progress their plan to identify a respite placement for June either through their in-house respite home or a temporary placement in a private care home while the s42 enquiry and an assessment of June's needs were progressed. Social workers negotiated to obtain daughter's

agreement to this, but also were aware that they could obtain urgent legal advice within half an hour in the event she had continued to oppose this. However, in light of the GP's immediate concerns for June's health, transporting her to hospital using powers under s4B MCA was the appropriate safeguarding response.

- 3.41. As noted, the multi-agency working in respect of hospital discharge was very good, and the GP in particular showed excellent, proactive practice in contacting the hospital directly to discuss her concerns about June being discharged home and asking to be part of the Best Interest meeting to discuss this. However, this invitation should have been made automatically when the decision was made to hold a Best Interest meeting as GPs are a vital part of the Team Around the Person in respect of hospital discharge, both in terms of providing intelligence about the person's circumstances and care in the community and ensuring that any subsequent care plan will be adequate to meet their needs, including confirming their contribution to this.
- 3.42. One of the key challenges in identifying the risks to June was that prior to May 2021, all of the teams that were seeing her were seeing her relatively infrequently and often on an ad hoc basis, so there was no obvious lead professional to triangulate the available information. Leaders noted that since the pandemic, regular neighbourhood multi-disciplinary team meetings (MDT) have been established which are hosted by Mersey Care and take place fortnightly, and provide an opportunity for practitioners to discuss cases which have become 'stuck' in an informal meeting for advice from partners across health, social care, substance misuse and other agencies. Any agency could bring a person for discussion at the MDT and the discussions could lead to onward referrals to agencies who could support to promote the person's wellbeing. For the avoidance of doubt, these neighbourhood MDTs are in addition to ordinary MDTs that can be convened by any of the agencies involved in a specific case but have the benefit of a wide spectrum of multi-agency input, rather than just the agencies currently working with the individual.
- 3.43. More generally, a Team Around the Person (TAP) approach would have been of benefit in June's case, where practitioners have the contact details for and regularly communicate with other frontline practitioners working with the individual in respect of coordinating care and discuss lower-level concerns arising in respect of the case. This mirrors the Team Around the Child approach used across children's services to support both early help and safeguarding cases. As noted, given that June was still being seen on occasion without significant concerns being reported, it is not clear that even with oversight from a MDT or lead professional, the identifiable issues would have led to a conclusion that June was experiencing neglect. However, use of the Team Around the Person may have identified earlier the concerns in respect of the family dynamic, or that her needs were increasing to the point that June's daughter required additional support through ASC. This could then facilitate an earlier multi-agency discussion in respect of her mental capacity and whether Best Interests should take place if care was declined – ideally before the matter progressed to a safeguarding issue.

Systems finding

- 3.44. Good safeguarding practice could be observed in respect of the multi-disciplinary hospital discharge planning and Best Interest meeting. Liverpool would benefit from a Team Around the Person approach to support effective communication between frontline practitioners, improve coordination of health and care and strengthening early help measures to stop safeguarding risks escalating. Steps already taken to strengthen multiagency problem solving through use of ASC's neighbourhood MDTs provide a framework for escalation for the TAP in cases which have become 'stuck' and awareness of these should be raised across all partner agencies.

Recommendation 11: LSAB should consider whether it endorses a Team Around the Person approach to improve communication pathways for frontline practitioners and improve coordination and delivery of health and care. Partners should also promote awareness of the

neighbourhood MDTs in more complex cases and ensure that staff feel confident to refer cases directly to the neighbourhood MDTs to secure a multi-disciplinary approach to problem-solving.

Impact of the pandemic

- 3.45. The frontline health services being provided to June continued to carry out home visits throughout the pandemic, with appropriate safety measures in place, although in the first few months of the first lockdown, the family were shielding to protect June. From that time, there was only one occasion when the family declined a visit due to concerns that one of the children had tested positive for Covid-19, which was not unexpected during this period, and the follow-up appointment was allowed. As discussed, it is possible that the need to shield and minimise contact when home visits resumed may have reduced opportunities to engage with June and gain a better understanding of her and her circumstances, however, this was a reasonable balance given the risk June would have faced if she had caught Covid-19 before the vaccination became available.
- 3.46. ASC was not providing a service at this time, although LCC's Covid-19 Shield Protection team contacted the family in the early days of the pandemic to determine whether they needed any additional assistance. The care navigator team was proactive during this period, writing to and attempting to call the daughter and, when those efforts were unsuccessful, carrying out a home visit to determine whether June needed additional support. Police reported that the impact on their services were minimal, although care needed to be taken to make the best use of their contacts with the public to maintain an eye to safeguarding issues, as they were mindful that many other services had minimal contact with children and adults with vulnerabilities. Ambulance staff were similarly vigilant, even as their services came under pressure due to the increased demand.
- 3.47. Whilst undoubtedly the pandemic impacted the family, as they were forced to shield in a crowded home, there is no evidence in this case that this was visible to agencies or that there was a lack of resilience across the professional network resulting from the pandemic that impacted on June's care.

4. Glossary

ASC	Adult Social Care
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CSC	Children's Social Care
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICB	Integrated Care Board
IMCA	Independent Mental Capacity Advocate
LCC	Liverpool City Council
LSAB	Liverpool Safeguarding Adults Board
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act 2005
MDT	Multi-disciplinary Team meeting
NWAS	North West Ambulance Service
OT	Occupational Therapy
RLUH	Royal Liverpool University Hospital
SAR	Safeguarding Adults Review
TAP	Team Around the Person
VPRF	Vulnerable Person Referral Form