THE TRAGIC GAP

We live in very broken times, times with lots of gaps between the difficult realities of life and what we know to be possible, humanly. One of the most important qualities a person can have in our time – a person who wants to make this a better world – is the capacity to **‘stand in the tragic gap’** between corrosive cynicism and irrelevant idealism, between what is and could be. We need the inner strength to hold both the reality and our hope at the same time.

Parker J Palmer couragerenewal.org. chapter-10-standing-in-the-tragic-gap

S|E|W
Consultancy Ltd

Adult Roy

The learning highlighted in this review is still being experienced by Roy's family. Roy sadly died as the review was completed.

With appreciation to Roy and his family, and the staff of both Gateshead and Durham who grapple with the 'Tragic Gap' daily.

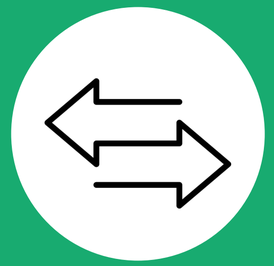
“How does your organisation speak to mine?”

WHAT WE WILL COVER

- The necessity of working to the multiagency safeguarding framework and understanding escalation pathways when safeguarding older adults with complex care and support needs.
- The many examples of good practice across all organisations and yet the system collectively lost sight of Roy. This led to a gap in understanding about what had happened to bring him to this point in his life and therefore how to work with family to find a solution.
- Improvements via a Host Authority Protocol to share intelligence, strengthen commissioning and assurance of placements in care homes out of area.
- The importance of having discharge plans from inpatient mental health settings with clear sign up from all parties especially when there is a placement out of area/cross boundary.
- Relationships matter at every level and although policies and protocols matter it is the activity of getting to know one another and the families we work with that makes the difference.

Our Time Frame:
Oct 2023-July 2024

What we have been asked to think about:



Learning from Roy's life and the whole system response when:

Transition is taking place and there is cross boundary working and transfers across services.

What is helping and hindering organisations to achieve safe and person-centred care when:

A person has complex vulnerabilities in both physical and mental health needs which might lead to a focus on one more than the other.

The Gateshead Health NHS Trust should revisit its safer discharge process:

How families are involved and what is truly in the best interests of a person.

What human factors might have influenced what happened?

“Didn’t feel joined up in the care home”

- Clinician

ROY’S STORY

- We are here to look at the reliability of the multiagency safeguarding system through the experiences that Roy and his family faced between October 2023 and July 2024 and continue to face as Roy is still receiving health and social care support. We will look at the challenges of placements across boundaries including when organisations may have improvement measures.
- Roy is 77 years old and has for at least 5 years experienced very complex mental health needs which have made it difficult for him to remain at home. Alongside these changes he has serious and enduring physical health needs.
- The period of this review is looking at what happened as he was discharged from the mental health hospital and moved to a Care Home in a neighbouring local authority, and then with deteriorating health, transferred to a local NHS trust in the same area as the Care Home for both mental health and physical healthcare, including amputation of two toes.

WHO IS ROY?

Roy has more than a spectrum of complex health and behavioural needs:

- Roy has eligible needs for care and support under the Care Act 2014. He is unable to independently meet his own needs and requires ongoing support.
- He was sectioned under Section 3 of the Mental Health Act and was then eligible for after care under S117 (which he currently still receives).
- Roy has a diagnosis of Recurrent Depressive Disorder and severe episodes with psychotic symptoms.
- A number of health needs such as diabetes, ileostomy, hypertension and swallowing problems.

- Husband and father
- Quirky sense of humour
- Worked all his life
- Suffered the loss of a son at a young age which traumatised both parents
- Number of health conditions prior to mental health deterioration
- Roy may seem challenging and communicates sometimes via his daughter
- Roy has views on what works for him and wants to be part of decision-making
- Roy is still waiting to move to long term care and his family are struggling to find a suitable facility and a care home that has the resources to support him

ROY & FAMILY FACING MANY LIFE CHANGES

What is life like in their shoes?

- Began to experience depression pre Covid but worsened during Covid. Roy became more frustrated at home and this included self-harm such as banging his head and pulling his finger nails.
  In the care home he would kick his feet on the bed. He had high levels of pain.

- Spent long periods in a mental health unit and was sectioned.
  Spent less time at home as physical and mental health deteriorated but still occasionally visits home. Care packages were tried at home and mental health support was provided
  to support family.

- **Question for the SAB:**
  What was understood about the reasons?
  What was known about family dynamics that might have helped?
  What other accommodation options are available?

Oct 2023 to Feb 2024 Discharge

TRANSITION KEY POINTS

Activity

- Roy is in TEWV in Durham under Section 3 of the Mental Health Act. He has had a long hospitalisation and it is agreed that his long term care needs cannot be met at home. It is not clear how this decision was made and what options were explored.
- Contact is made with Gateshead Health to access SLT, Podiatry and mental health teams.
- Section 117 is initiated for post discharge support.
- Personalised Care planning and early discharge planning as per national guidance.
- Family and Roy choose and visit a Care Home with support from a Social worker.
- Registered Manager (Care Home) visits Roy in hospital and attends MDT.

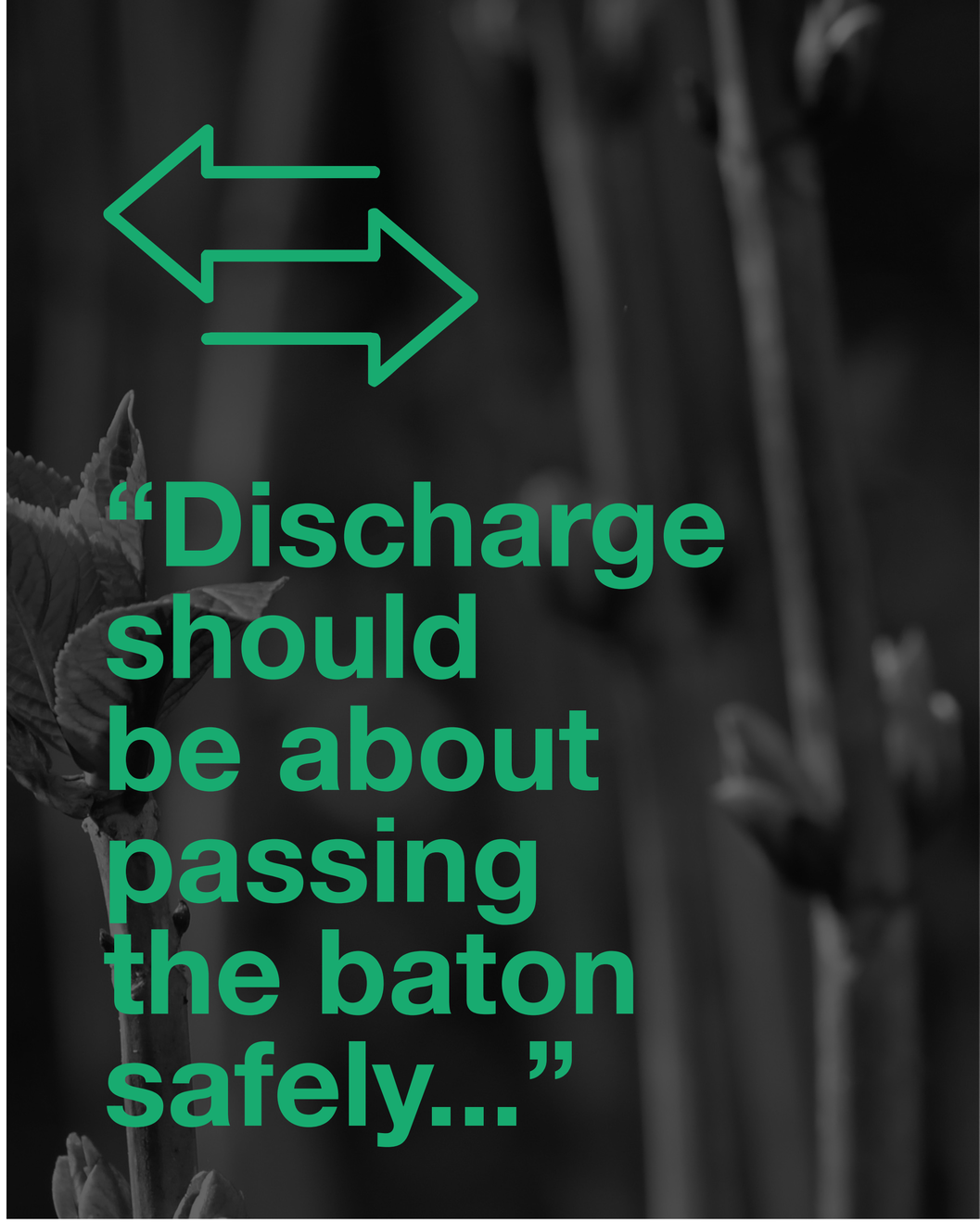
Outcome

- Discharge planning process starts as per national guidance – pathway 3 specialist residential nursing care placement.
- Communication is not reciprocal and Gateshead teams do not attend final pre discharge MDT.
- Discharge date set and Handover and Formulation plan given to Care Home.
- Care Home agree that Roy's needs can be met.
- There is communication with the placing local authority and concerns are shared about the care home. This is not communicated to family or either placing or receiving organisations.

QUESTIONS

- What is the contingency when the receiving authorities/organisations have not engaged?
- The Mental health TEVW team escalate their concerns about lack of contact with Gateshead – and it is not discussed at a senior level across boundaries.
- S117 – what joint assessments took place? How was physical health factored in?

- There is no evidence that contact was made with the host local authority to gain intelligence about the chosen care home. Were assumptions made by the host local authority that it was common knowledge of concerns about the care home organisation?
- Contact was however made with the placing local authority who disclosed concerns. However, this was not relayed to as part of the Personalised Care Planning and not to the family.
- What other long term housing options are available? Is a care home the right place?



KEY SYSTEM PARTNERS FOR DISCHARGE

Valuable information about the care home missing as well as a wider thematic review.

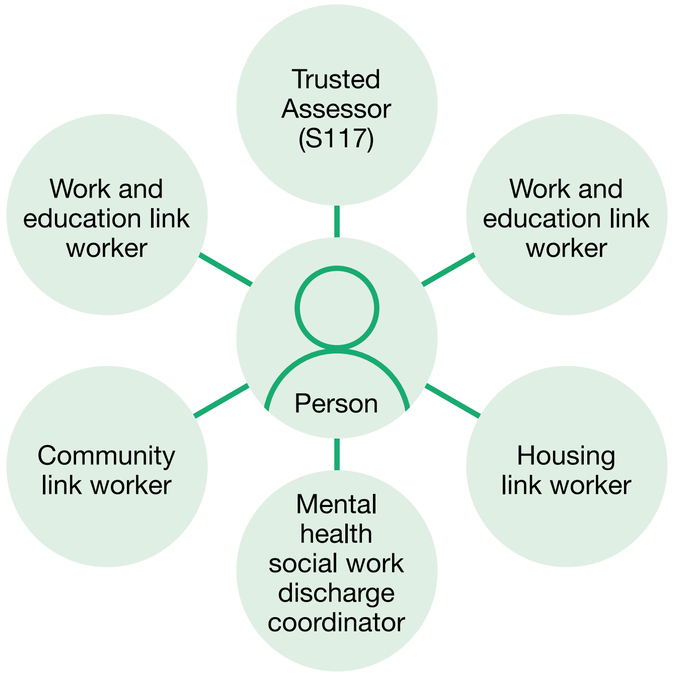
How might the Care Home, Gateshead Community Nurse Practitioner (CNP) and GP be involved in future preparations?

Discharge Planning Pathways

NATIONAL GUIDANCE PROMOTING SYSTEM PARTNERSHIPS

Hospital admission is triggered by a crisis and/or deterioration in mental mealth and requires admission to mental health in-patient unit either as formal or informal patient.

Strengths-based recovery focused on discharge planning from admission - with minimum weekly multi-disciplinary team meetings.



Wellness and recovery action plan (WRAP)

PATHWAY 1 — Home with support (including supported living)

PATHWAY 2 — Specialist step down recovery/ rehabilitation beds

PATHWAY 3 — Specialist residential/nursing care

QUESTIONS

- Do MDT meetings include cross border organisations once discharge agreed?
- Does planning include gathering information about care homes so family and individual make informed decisions?
- If concerns are known in one area how is this information exchanged?

A PAUSE FOR REFLECTION

What is the contingency when the receiving authorities/ organisations have not engaged prior to discharge? How does it affect the discharge process? Could the need to ask commissioners about any concerns about Care Homes be included in the planning process?

The Mental health (TEVW) team escalate their concerns about lack of contact with Gateshead Health – and it does not appear to have been escalated at a senior level across boundaries. Who should pick this up? Who are the Single Points of Contact?

There is a good physical health strategy in place in TEVW and this forms part of Section 117 preparation for discharge. In Roy's case there was a handover to the care home and yet perhaps Roy's very complex needs may not have been fully understood by care home staff and the gap in communication across health agencies meant that his needs were not prioritised after discharge.

Gateshead Health NHS Foundation Trust have a specialist health team linked to each Care Home. How is this communicated beyond Gateshead? How are they involved in pre admission and initial arrival at care home?

Feb 2024 to May 2024: Care Home Placement

TRANSITION KEY POINTS

Activity

- Family concerned about potential chest infection pre and post admission.
- Mental Health nurse starts 6 week transition handover with at least weekly visits up to 3rd April with transfer or care/discharge meeting at Care Home.
- No contact with SLT and podiatry in Gateshead at first.
- Community Nurse Practitioner Gateshead (Care Home Team) liaises with GP linked to Care Home.
- Took to his bed 'Hitting his feet on the bed'.
- Safeguarding concern by Care Home in March 2024.
- Family seek emergency podiatry help and bone is visible.
- Speech and Language Therapist (SLT) concerned about care home not following plan as is family.

Outcome

- **March** Safeguarding concern did not provide sufficient information with hindsight - MDT by professionals and Care Home would have been useful.
- April **investigation of transfer of care** by Consultant (Gateshead) Note: Consultant expressed concerns about care home's ability to provide care for adult Roy. 'Worry about the patients that Care Home accepts' (Clinician)
- Roy 'struggling massively with his mental health' and intensity of pain. (Family comment) Family concerned that Roy's stoma bag 'bursts' and he is not cleaned in a timely way.
- 'Skin and bone' by May (6KG weight loss since Nov 2023).
- Family called the Crisis Team as they were concerned about Roy.
- MDT did not take place until the week Roy was admitted to hospital following deterioration in mental and physical health.

QUESTIONS

- Roy's complex behavioural challenges were evident immediately which may have been exacerbated by the transition or potential staffing needs.
- What advice was given to family to enable them to seek help?
- What monitoring took place of diabetes?
- Were expectations clear of the Care Home?

- Lots of professionals in and out and no MDT/conversations.
- High number of agency nurses and limited mental health nursing cover in the care home.
- There is no evidence that any of this was escalated via safeguarding.
- Did Health staff know about concerns previously in the care home?
- What is the level of knowledge and understanding of safeguarding by Registered managers?
- What other questions might the receiving adult safeguarding team have asked to gain more information?

“Roy was struggling massively with his mental health & intensity of pain in the care home”

- Family

WE HEARD…

- The care home was part of a group that was investigated following national media reports in December 2023 that had raised allegations of poor quality of care and safeguarding concerns in another care home.
  The SAB commissioned a thematic analysis which was published during this inquiry. The care home as part of this review was classed as needing improvement by the CQC in Aug 2023.

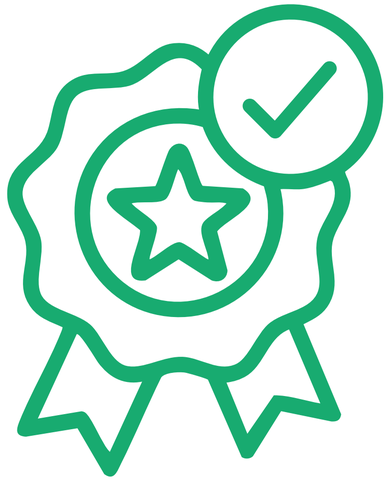
  During the course of this review concerns about the care home’s ability to keep people safe were flagged. What stopped a closer review of the care home in light of learning from the thematic analysis and local concerns?

- There is no evidence that contact was made with the host local authority to gain intelligence about the chosen care home. There is some evidence that contact was made with Durham commissioners who passed on concerns about the care home. It is unclear what happened to this information.
  It was not passed onto family or MDT.

- There is good practice in Gateshead A Care Home Model – a Community Nurse Practitioner (CNP) linked to every care home across 5 localities, and able to prescribe. Yet – the model and role was not known or shared?

- Quality Assurance and Safeguarding visits took place in the care home between October 2023 and February 2024 by the Integrated Care Board (ICB) in light of wider media concerns about the wider company.
  Visits were not maintained due to resources.

GOOD PRACTICE TO BUILD ON



Gateshead Health NHS Foundation Trust provides an enhanced care model in all care homes in Gateshead.

Key features are:

- Named General Practice support.
- Timely access to emergency out-of-hours support.
- Regular access to specialists and healthcare professionals.
- Focus on proactive support and engagement from the wider health and care system.

May 2024 to July 2024 Move to the Hospital

TRANSITION KEY POINTS

Activity

- Roy is admitted to the local NHS Trust and moves between surgical and medical wards and the mental health unit. He is transferred on a Section 2 of the Mental Health Act.
- Family continue to experience some challenges in terms of conveying Roy's preferences.
- Physical health very poor for the first few weeks.

Outcome

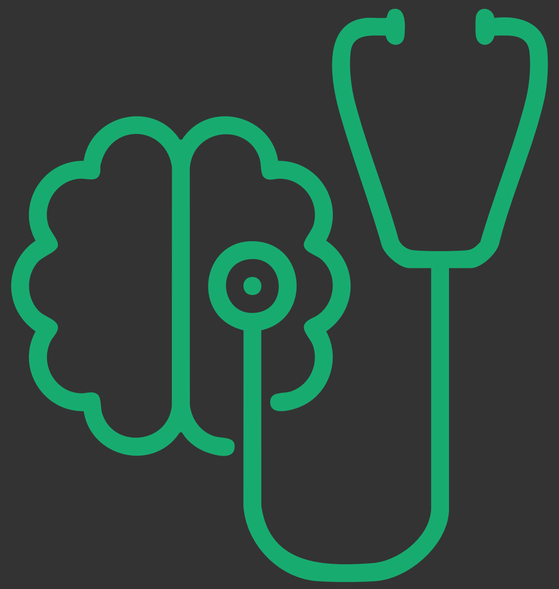
- The transfer is not easy and he is ill with an infection, leading eventually to amputation of two toes.
- After a while Roy is discharged from mental health care and is under Care of the Elderly.
- MDTs take place and the ward follows formulation plans to de-escalate. Family have been asked to search for a Care Home.

QUESTIONS

- During this period the family are again perceived as challenging?

- What was discussed with family?

DIAGNOSTIC OVERSHADOWING: FOR CONSIDERATION



- The impact of a serious mental illness is pervasive and cannot be separated for example from diabetes and other health conditions.
- Diabetes is 2-3 times more common amongst people with a serious mental illness.
- Was there an overlapping impact on Roy's mental health because of the symptoms of diabetes such as neuropathic pain? Was this missed because of how family were seen?
- Was the diabetes overshadowed in discharge planning and in decisions about placements plus in the care home by the mental illness?

WHAT DO WE KNOW TO HELP US?

Gathered intelligence about a care home organisation recently in the media was not shared prior to discharge to the care home. Concerns about the care home were not followed up or at least discussed with the care home.

Escalations about coordination pre and post discharge were not flagged at the highest leadership level across organisations, and to the care home.
The care home 'took the lead'.

Safeguarding concerns were not fully recognised either by the Care Home or by other professionals leading to a delay in the full picture emerging.
Again, 'niggling' concerns did not translate into escalation.

Family perceived as 'challenging' by some professionals – did this lead to bias which masked serious concerns about Roy's deteriorating health and disjointed care.
Was there an attempt to understand their perspective and trauma?

Serious physical deterioration and pain reported by family was not appropriately escalated.

Unclear if the care home could ever support Roy's needs.
Some doubts were expressed by professionals and this was not shared.

What have we seen and heard that impacts on the reliability of Safeguarding in Gateshead?

1

The desire to discharge should not supercede safe planning and should be reassessed when the receiving providers have not reciprocated.

2

Challenges in joint-working and handover led to coordination issues and a further emergency hospital readmission.

The GP link to care homes needs to be formally reviewed to ensure a consistent process.

3

A lack of a whole system response and conversation meant that vital safeguarding information was missed such as increasing self harm and physical deterioration and pain. The early identification of safeguarding concerns by Care Homes is vital and by the professionals working with them.

4

Little is known about...

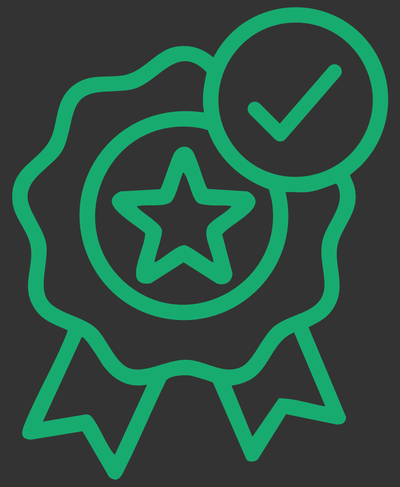
Predisposing factors:
What factors might have made Roy vulnerable to developing these difficulties?

Precipitating factors:
What events or situations might have triggered the onset of the difficulties?

Perpetuating factors:
What factors are currently maintaining the difficulties?

(This is part of the 5 Ps of Formulation in mental health)

GOOD PRACTICE TO BUILD ON



TEVW Personalised Care Planning Policy January 2025

Key features are:

- Co produced care plans
- Specific reference to Section 117 and prevention of readmission
- Trauma informed principles
- Integrated multiagency focus

SURFACING THE TENSION IN THE SYSTEM

Commissioning of cross border placements means that there is limited communication between the host authority and the placing authority. The new protocol is much needed.

The lack of suitable accommodation nationally and locally for older adults with the most complex mental health needs and long term conditions leads to potential risk.

Staff pressures and lack of experience may mean that specialist care homes are not as observant or vigilant in safeguarding the most vulnerable.

Families can be perceived as “difficult”, which may lead to barriers in commuication, potentially hindering shared decision-making and impacting patient care outcomes, including reduced trust.

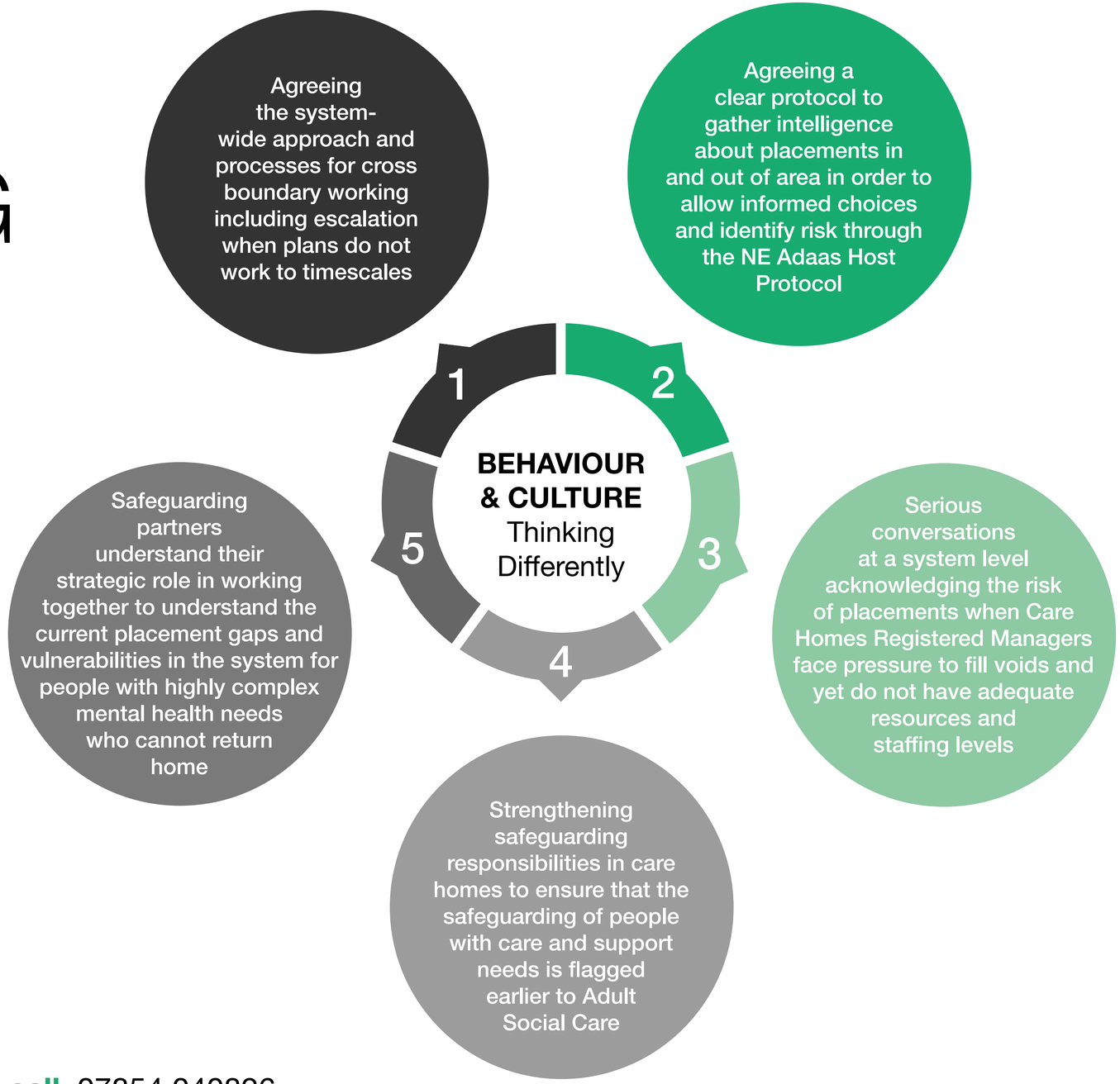
Registered managers face pressure in care homes to fill voids. Care homes may have high use of agency staff and people who do not have English as a first language, and insufficient RMN on duty when needed.

Practitioners spoke about the importance of **formulation** at all stages of the timeline and yet what was the impact? What was conveyed to family?

Relationships matter always – especially cross boundary and when when working across different areas such as independeent providers.

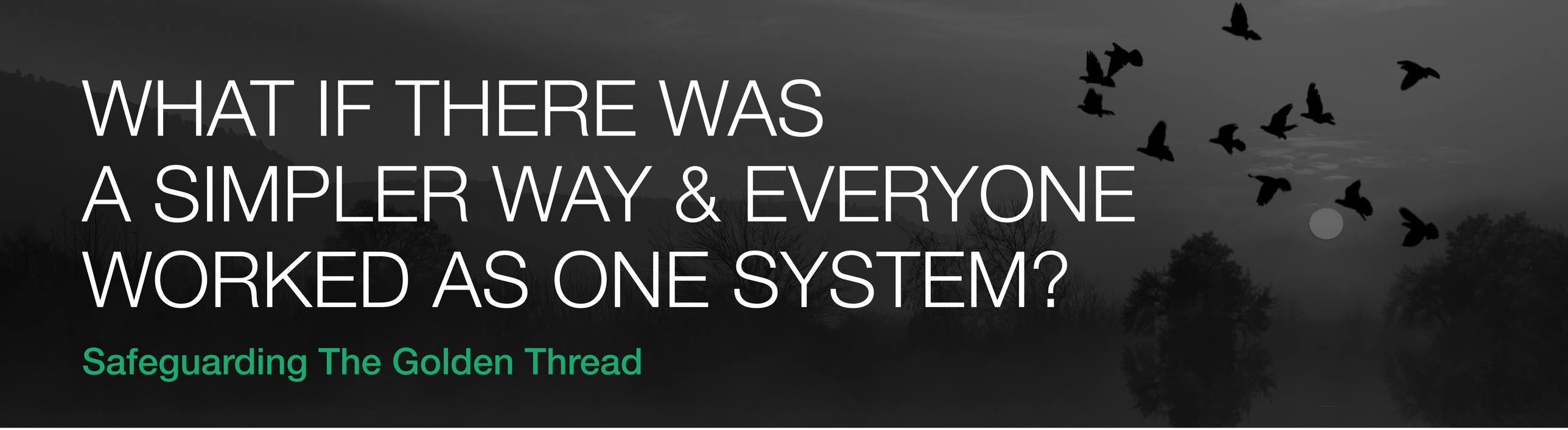
Good physical health strategies are in place in TEWV. Yet, is there a need to review Section 117 planning and ensure that physical health concerns are not overlooked?

A SYSTEM SAFEGUARDING THE MOST VULNERABLE



QUESTIONS FOR GATESHEAD SAB

- What is the potential for an improved joint protocol for cross border working across Mental Health Trusts?
- What provision might you need to think about to support older people more effectively who have such complex physical and mental health needs and need care for both?
- The Enhanced Health Model for Care Homes in Gateshead Health is good practice and covers all care homes. What if the team were part of all admissions processes?
- What agreements are needed to ensure there is escalation when discharge plans are not working and contact not made with new organisations? Should discharge take place at all without the full cooperation of receiving authorities?
- What needs to happen for more effective assurance of safeguarding processes in care homes? What is the relationship between commissioning and safeguarding? How does this influence contract monitoring? What is the ICB role?
- How might our assumptions about families affect how we hear the voice of their family member?



WHAT IF THERE WAS A SIMPLER WAY & EVERYONE WORKED AS ONE SYSTEM?

Safeguarding The Golden Thread

- A local authority protocol that means that information is known quickly where there are improvements needed in care homes.
- Discharge plans only take place if there is confidence that the person is safe; and includes the enhanced care home model.
- Families are made to feel integral even when conversations are difficult.
- Referral process across boundary is clear and simple, no matter whether Durham or Gateshead.
- Specialist placements exist for people like Roy staffed by the right people, that enable the person to live as fulfilled a life as possible.
- Discharge Planning into Care Homes includes the right people such as the Gateshead Care Home health model and more time is spent assessing risk, getting to know families and people who are being discharged into their care.

Whilst safeguarding is indeed everyone's responsibility, we need to go further to ensure that this responsibility is a collective one. Underpinning this review is a reminder that conversations matter.

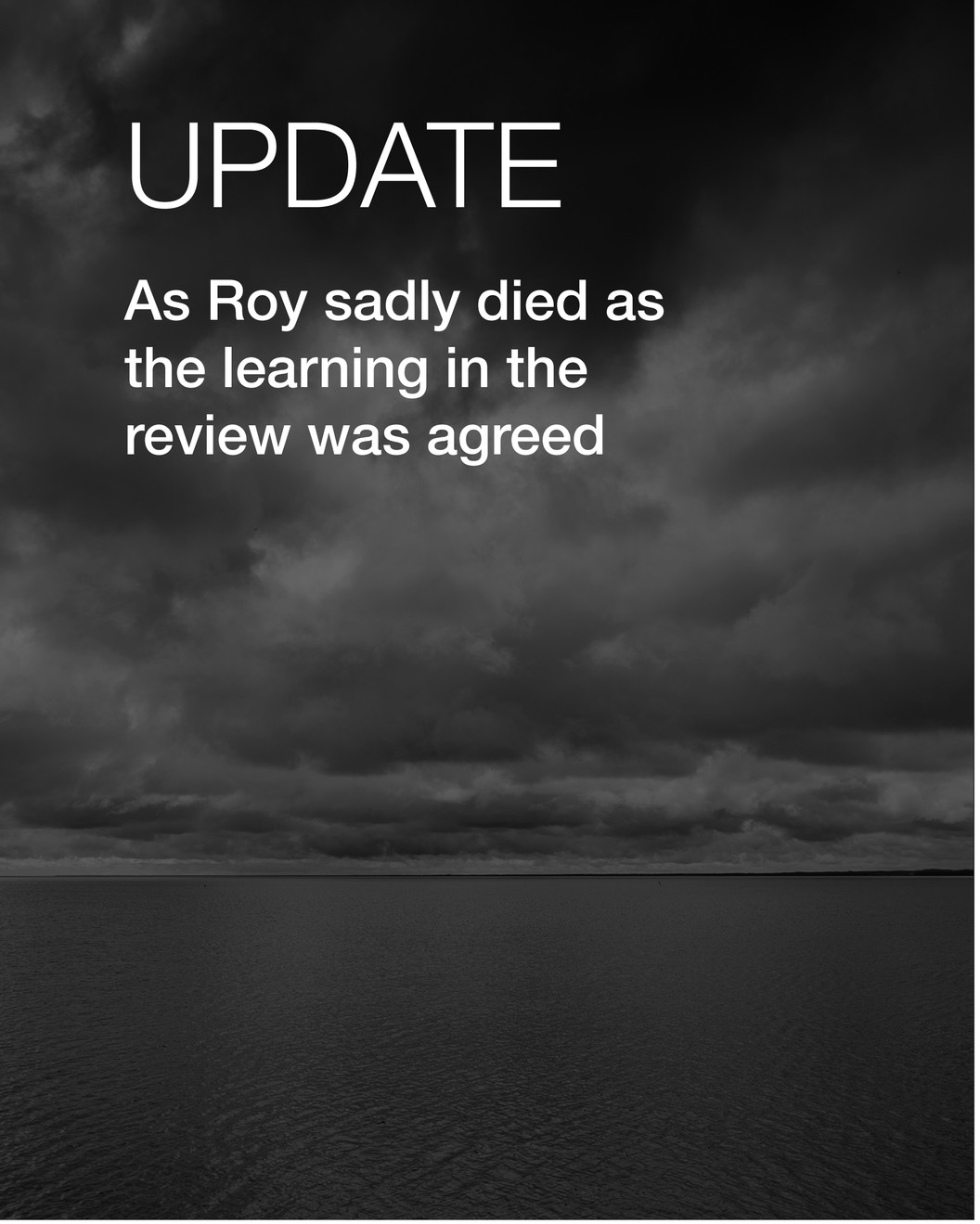
2024/01/12Cs-Collective-Safeguarding-Responsibility-MMU-Dec-23.pdf

RECOMMENDATIONS

Four Steps to Improvement

- The SAB is asked to consider not only the four recommendations but the questions running throughout the review.
- The SAB is requested to consider the findings in light of the *'Thematic analysis of safeguarding enquiries within a residential care setting in Gateshead'* Feb 2025.
- Consideration and reflection should be given to the impact on both Roy and his family of not sharing concerns known about the care home and the fact there were known serious concerns about a care home that was part of the same company.

"How can we improve communication between commissioning and safe-guarding?"



UPDATE

As Roy sadly died as the learning in the review was agreed

- Roy was discharged from hospital in Gateshead and into another care home. A discharge planning meeting was held prior to Roy's family starting the search for a care home that would be able to meet Roy's needs.
- The family did not feel supported in the discharge process from hospital and into the care home. They felt pressured to find a suitable placement for Roy.
- Several care homes undertook assessments but then refused to accept Roy. When a care home did agree to accept Roy, the family had concerns about about their ability to care for Roy.
- This did not delay the process and he was discharged within 2 days of the care homes acceptance. No meeting was held between the home, nursing staff, and the social worker to ensure all equipment was in place for Roy and that all relevant information about his care had been shared.
- The care home was unsuitable for his needs, and he deteriorated mentally and physically. He had frequent admissions back to hospital because of infections. Diabetes care was not foremost in care plans all the way through the review and latterly.
- The family still experienced the feeling that they were too challenging.
- This is why this update is added before the recommendations. It is a timely reminder of the urgency of the recommendations and the need to take action during a review.

RECOMMENDATION 1

Safeguarding Process and Pathways

There should be a joint review and audit between the Care Home, ICB and Gateshead Council of the Quality Assurance and Safeguarding processes in the care home to determine not only training provision but governance and accountability. This links directly with Recommendation 4 and 5 of the Thematic Analysis.

https://www.gatesheadsafeguarding.org.uk/media/45478/Gateshead-SAB-Thematic-Review/pdf/Gateshead_Thematic_SAR_final_report.pdf?m=1743625592460

An audit of referrals April 2024-April 2025 to determine timeliness and content. A previous review was not continued because of resource and capacity issues.

The SAB should consider the following:

Who becomes the coordinator when a Section 117 is in place and a care home placement is agreed across boundaries?

This is a gap and impacts on decisions making. It led to lack of clarity about who was leading between the Care Home and professionals. This may have contributed to late escalation of safeguarding concerns. It is a current concern for the family.

RECOMMENDATION 2

Building on Good Practice – Strengthening the System

Gateshead Health NHS Foundation Trust provides an enhanced health care model in all care homes in Gateshead. This should be shared across neighbouring authorities and team members should be part of admission processes.

Functioning MDT processes are known to be important for communication and information/intelligence sharing and encouraging a collective response, and a clear care plan. This might also include decisions on the suitability of placements.

What role does the Care Home Model have on influencing MDTs?
What might need to be strengthened?

The ICB should review arrangements for Primary Care links with Care Homes and consider a review of the enhanced care provision in care homes.
This should include the conduct of weekly ward rounds, gathering health information; assessments and MDTs.

What are the protocols in place for information sharing and shared governance?

RECOMMENDATION 3

Safe Discharge

Both Gateshead and Durham NHS Mental Health Trusts have clear guidance on Section 117 and discharge planning for after care.

Clarity is needed on what happens when the receiving organisations/services are not in place at point of discharge. The organisations should provide the SAB with assurance that there is guidance and process in place to ensure safe discharge including family involvement.

TEWV and neighbouring mental health trusts should agree a protocol for cross boundary working which includes an escalation pathway for delays and disagreement and this should be shared with Gateshead SAB.

Policies and protocols exist under Section 117 for inclusion of physical health conditions. Monitoring of health conditions such as diabetes are vital and need to be in place at discharge.

RECOMMENDATION 4

Host Protocol for Care Homes

The Adass Host protocol will need time to embed. The SAB will require assurance that it is not only shared across the NE local authorities but that there is an overarching monitoring process to close any gaps.

Gateshead Council should provide the SAB with a timeline for implementation and review.

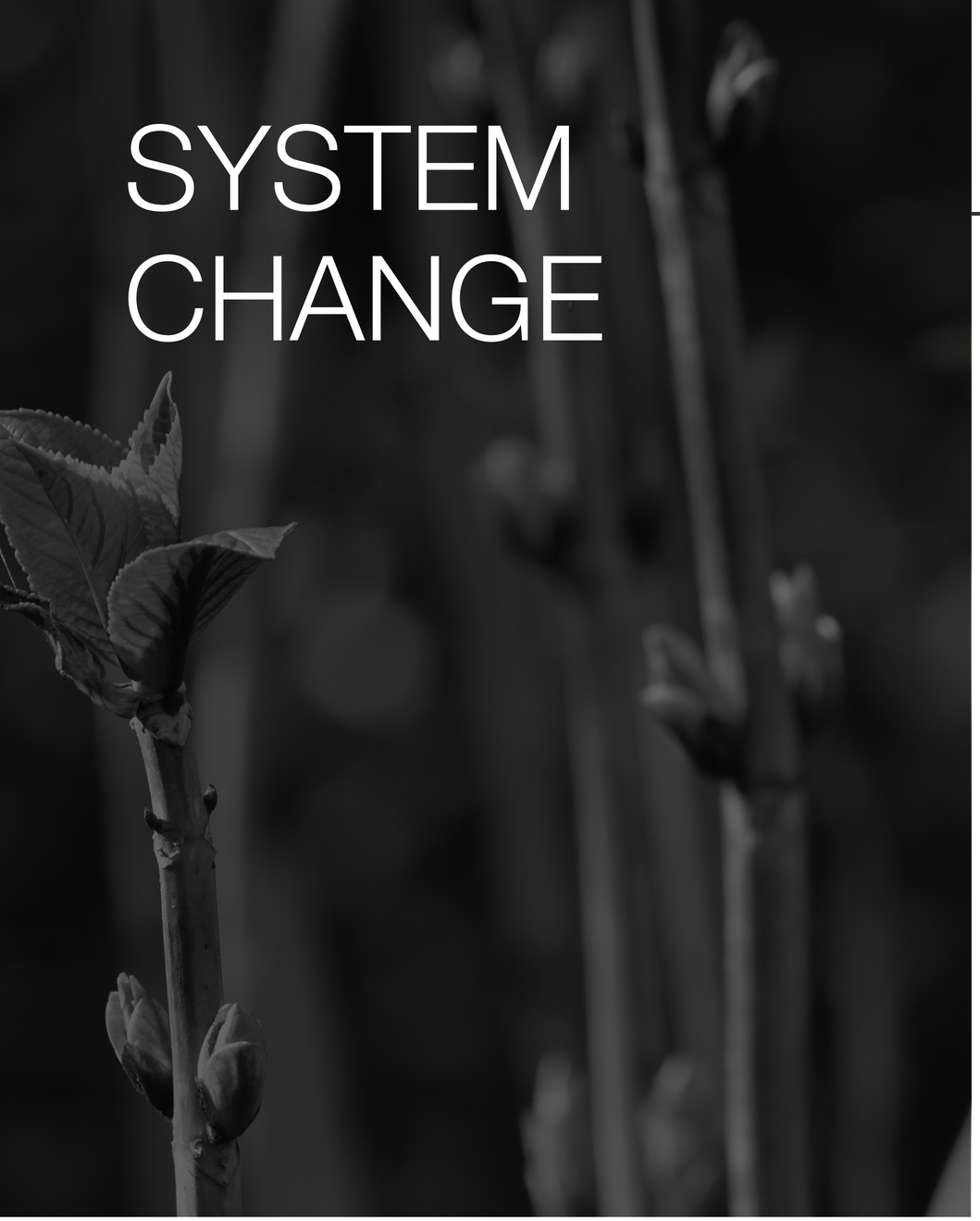
Until the new Host Protocol for cross boundary placements is agreed there is no formal protocol in place. Each LA would expect that professionals seek information about care homes from LA Commissioners. However, this is not guaranteed. What is an interim arrangement?

What conversations take place at a system level acknowledging the risk of placements when Registered Managers face pressure to fill voids and yet do not have adequate resources and staffing levels?

FINAL REFLECTION

Underlying everything we see the family struggling and a gap between them and professionals.

- Roy's journey to find a suitable place to call home is not over. The learning highlighted in this review applies today.
- His family continue to experience the difficulties of navigating a system that struggles to be able to fully address and meet his needs.
- They experience challenges in being heard.
- They have raised ongoing concerns about the need to think more widely about housing options.



SYSTEM CHANGE

Heart of the Art

This means the real activity that encourages systems change is not analysis, or programme planning or project management. It is a relational activity that asks us to engage widely and openly, including with those who trouble us.

It asks us to enquire into their motive and means. It means we must be ready to listen more than to tell, to connect and not to direct, to propagate and not to control.

GUIDANCE

- https://www.tandfonline.com/doi/full/10.1080/09638237.2021.2022611#d1e353
- https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/
- https://www.ombudsman.org.uk/sites/default/files/Discharge%20from%20mental%20health%20care%20making%20it%20safe%20and%20patient-centred_10.pdf
- https://www.local.gov.uk/publications/framework-achieving-excellence-mental-health-discharge#:~:text=The%20three%20discharge%20pathways&text=If%20a%20person%20needs%20access,and%20recovery%20services%20at%20home
- Section 117 of the Mental Health Act 1983 is a legal provision that mandates the provision of free aftercare services to individuals who have been detained under specific sections of the Act.