“Martha”

Safeguarding Adult Review

May 2022

Nicola Brownjohn

Independent Safeguarding Reviewer

1 CONTENTS

2 Reason for Review 3
3 Methodology 3
3.1 Key Lines of Enquiry (KLOE) 4
3.2 Evidence used 5
3.3 Family involvement 5
4 Martha 6
5 Timeline 7
5.1 Key aspects of timeline 7
6 Analysis of Practice: Why were decisions made? 14
6.1 Information sharing between hospital and Care Home 14
6.2 Involvement of external agencies in care home 15
6.3 Covid Impact 17
6.4 Safeguarding 17
6.5 Martha's deterioration 18
6.6 Effective Practice 19
7 Findings 19
7.1 Practitioner reflections 19
7.2 Reviewer's conclusions 21
8 Considerations For The SSAB 22

2 REASON FOR REVIEW

Martha had been living independently at home with minimal care support prior to admission to hospital with a fractured ankle. She was White-British and was nearly 90 years old.

Martha was discharged from hospital to a care home with nursing for a 5–6-week episode of respite care. She was admitted to the Care Home with an air cast boot in situ on the fractured ankle. The air cast boot is a medical device used to support limb injuries.

A safeguarding referral was made when Martha attended an outpatient appointment at hospital in relation to the fractured ankle and where it was recognised that the air cast boot had been in situ for 6 weeks without removal and had resulted in category 3 and category 4 pressure injuries.

The Care Home has undertaken an investigation and concluded that there were failures in the care of this resident and that her pressure ulcers were preventable. They have advised that it was clear that staff were treating the boot as a Plaster of Paris cast rather than a removal medical device. The identified learning for the care home, from the investigation, has been followed up as part of the large-scale safeguarding enquiry process which is now concluded. The Southampton SAB Case Review Group recommended that this case met the criteria for a Safeguarding Adult Review on 22nd February 2021. The timeframe for the period under review is 23rd May 2020 to 27th November 2020.

3 METHODOLOGY

It was agreed by the Southampton Safeguarding Adult Board Case Review Group that this would be a focussed review looking at the wider system issues raised within the large-scale safeguarding enquiry.

The methodology used is based on a system and learning from cases approach[1]. The main aspect of this methodology is to engage with practitioners to view the situation

[1] Social Care Institute for Excellence Learning Together Model

from their perspective. This enables practitioners to talk about what drove their practice at the time. There are three lenses: individual, organisational, and wider system, which informs this methodology. This requires a safe environment for practitioners to talk about what happened to facilitate them to gain maximum learning and to inform the wider learning for the SAB to take forward.

3.1 KEY LINES OF ENQUIRY (KLOE)

Wider issues identified in the large-scale safeguarding enquiry include:

1. The Care Home stated that they had spoken to the nurses on the ward who assured that all the discharge information would be included within the discharge summary, however, the discharge summary did not contain any information about the air cast boot. Due to COVID, the admission assessment process at the time was completed by phone which presented challenges. Under normal circumstances, the client would have been seen in person and any medical device would have been identified pre-admission.

2. The initial outpatient appointment 3 weeks post discharge to review the fracture was cancelled/delayed, causing the resident to wait an additional two weeks to be seen.

3. Whether Martha's health care plan was appropriate for a diabetic patient? Which health services were involved in the support and management of the injuries?

4. Was there evidence of professional curiosity and were there opportunities for intervention from other professionals who may have been involved in the care of the individual

5. The timely sharing of safeguarding concerns that are raised in the community with other agencies involved e.g., acute settings.

6. Consideration of the wider impacts of COVID -19. For example, family visits to Martha; how was contact maintained between Martha and their family members and professionals.

3.2 EVIDENCE USED

- Rapid review notes from Solent Community Team and Southampton University Hospital
- Merged scoping document
- Admission and discharge documents from Southampton General Hospital
- Care Home documentation: admission, care plan, decisions made, policies
- CCG/Local Authority quality and safeguarding documents regarding monitoring of Care Homes
- Practitioner event
- CQC Incident Progress log

A brief timeline of events is included at 5.1, with the main element being the analysis of practice which will inform the themes for wider system learning.

3.3 FAMILY INVOLVEMENT

The family have been informed about the review and invited to participate.

A telephone conversation was held between the reviewer and Martha's daughter on 09 December 2021. It was agreed that the family would receive a copy of the final report, once signed off by the SSAB and that a further conversation with the reviewer would be offered to the family.

The family want learning to be achieved from their loved one's death to prevent future deaths of elderly people in such circumstances. Martha's daughter emphasised that

she does not consider the Covid pandemic to have been a causative factor in her mother's death.

4 MARTHA

This review considers the circumstances leading to the death of Martha to draw attention to the Southampton system in relation to how the care and support needs of elderly people are met. Her daughter reflected that Martha would be satisfied if even just one other person's death could be prevented due to this review.

Martha lived in Southampton throughout her life. As a child, during World War 2, she was one of many in Southampton who suffered from the bombings across the city. This meant that her family moved within the city, to a road where Martha met her future husband.

Martha married and the couple were together for 62 years until he died in 2016. They were an active couple who used public transport and cycled. Martha continued to cycle late into her seventies.

Martha loved helping people. She would give, anonymously, to charity and would invite people in for Christmas dinner to ensure no one was alone. She was an active church member and was a Southampton football fan, enjoyed cricket and going to the theatre.

Before the fall that led her to be admitted to hospital, Martha had hired a bed that would enable her to move from the bed to a standing position. but owing to difficulties using it alone, she stopped. This led to further reduced mobility and Martha used furniture to move around her home. Her daughter explained that, by this time, her mother was not enjoying a good quality of life. She had significant underlying health conditions, which had led to her experiencing significantly reduced mobility. Martha was approaching her 90th birthday when she died.

5 Timeline

5.1 Key aspects of timeline

Episode	Key Timeline	Events	Outcomes
1.	23 May - 29 May 2020	Admitted to hospital following a fall at home. Medical diagnosis was collapse / fainting episode with loss of consciousness, closed fracture of left ankle, back slab applied. Admitted under Orthopaedics for ongoing fracture & falls management Martha was seen by Therapy team. She had a fractured left malleolus and a back slab in-situ, not weight bearing requiring hoist transfer from bed to chair. Martha normally lives alone with twice a day package of care Monday to Friday and meals on wheels. Aim was for interim placement on discharge as non-weight bearing. Discharge officer made request to Integrated Discharge Bureau for a complex needs assessment. Referral made to hub for interim placement. Hospital discharge sheet given to Martha.	Electronic request made for discharge care bundle. These are system generated requests created for inpatients with a diabetes diagnosis or comorbidity. This allows the diabetes team to record some details related to the patient which are then included in the discharge summary for the GP. Nursing assessment records that Martha was assessed as at moderate risk of developing skin pressure damage. Pressure ulcer prevention plan implemented which included 2 hourly repositioning and heel offloading. Complex discharge planning electronic records note complex needs assessment completed and sent to Southampton hub for placement sourcing. The assessment documents Martha had a fractured lateral malleolus involving ankle (closed), in a cast therefore will be non-weight bearing for 6 weeks. Unable to use wheeled zimmer frame, therefore required hoist transfer. This assessment was completed prior to Martha having an aircast boot fitted.

Episode	Key Timeline	Events	Outcomes
		Care Home virtual assessment- Enquired about Martha's care and informed that she had a splint in place. Reviewed by a physiotherapist, air cast boot fitted (diabetic) and patient informed of use. Small broken area of skin noted on first metatarsal, nursing staff informed and dressed wound.	This was one of the first admissions that the Home dealt with over the phone as part of the system for discharge during the initial phase of the Covid-19 pandemic. This reflected the CCG policy for phone assessments and to ensure quick assessments for discharge. It was reported that Martha was informed about how to use the boot and that nursing staff would need to manage it. There was no record of Martha's response or understanding of the information.
2.	29 May 2020	Discharged from hospital. Admitted to Care Home with nursing for respite.	Discharge summary from UHSFT to Martha's GP was completed by a doctor. The management plan is documented as "Analgesia as required, aircast boot 6/52, OPC 2/52 to check alignment, Appointment and X-ray in 2 weeks to check alignment and ensure no need for intervention". Home received the discharge summary but no instructions regarding the aircast boot. Daily records written at the time of admission indicated an aircast boot in situ. Admitting nurse did not note actions required for an air cast boot. No mobility plan in place.
3.	02 June– 08 June 2020	Care Home visits by the Solent East Community Nursing Team, Community Health Care Team Physiotherapist and GP.	Care Home recorded that Martha was non weight bearing due to fracture and needed to be assessed for her mobility. The staff not able to plan exercises until shown by the Physiotherapist.

Episode	Key Timeline	Events	Outcomes
		Martha was complaining of pain in her left knee but not much pain in her left ankle.	Care plan put in place for Martha to carry on exercises to stretch her left knee into extension regularly as at risk of contracture. Staff also advised to hoist Martha out of bed as she was able to sit in a recliner chair. Physio team to review in 1-2 weeks. Of note, the Physiotherapist knew Martha pre-admission and continued to see her due to the circumstances of the pandemic. Noticed the left knee pain and that Martha was more distressed and confused. She refused to do some of the exercises. Physio contacted her daughter to discuss.
4.	10 June 2020 29 June 2020	Due a follow up outpatient's appointment Physio at the Care Home for pain in left knee. Noted to be in low mood A further Outpatients Clinic appointment was carried out by phone.	Delayed by a month due to no escort being available from Care Home due to pandemic, and family unable to assist. The letter went to Martha's daughter before being shared with the Care Home. A further appointment was arranged with the Care Home. Care plan for Martha to carry on the knee extension exercises. Physio also noted that Martha had still not been hoisted out of bed into a chair. Staff advised to hoist Martha out of bed and if problems occurred to contact the team. Risk of skin breakdown. Home reported that this was not an appointment but to confirm details for the face-to-face appointment. Did Not Attend follow up letter for Martha's next appointment on the 08/07/20 was sent. Orthopaedic clinic letter from the

Episode	Key Timeline	Events	Outcomes
		Seen by GP at the Care Home	Consultant Orthopaedic Surgeon to GP- not able to reach the Care Home. Advised on need for x-ray to check progress. At this time, there were two GP rounds a week with some physical visits, if necessary, otherwise virtual. This was a change of GP for Martha, due to her moving into the Home Prescribed painkillers for pain in left leg.
5.	08 July – 29 July 2020	Outpatients Clinic attended. Boot removed, pus noted, smell and brown liquid. The Care Home informed Solent East Tissue Viability (TV) Team that Martha had developed pressure ulcers to her dorsum, medial malleolus, and her heel. These had occurred from an air cast boot Martha had been wearing for a fractured left ankle.	Clinic sent letter to GP. View that ulcers probably developed later due to poor movement and care for the leg. Wounds dressed and boot removed as it had been around seven weeks from the injury and was now safe for her to be out of the boot. For referral to Tissue Viability, Physiotherapy and Diabetic team. The home noted the need to follow up with the GP due to diabetes. Nurse contacted Care Home to provide education about air cast being able to be removed daily as would be expected for this medical device to allow personal care to be provided. Team advised GP, who was present at the home, to make a referral to the podiatry team. This referral was not received by Podiatry and at the time the team were concentrating on acute referrals.

Episode	Key Timeline	Events	Outcomes
		The Care Home made a safeguarding referral and CQC notification. Solent East Tissue Viability Nurse visited, and a wound assessment was carried out. Martha's daughter-in-law called Solent East Community Health Care Team Physiotherapists. Seen in OPC	Safeguarding action commenced by CCG. Leading to a provider led enquiry as requested under the legal duties of the Local Authority. Police initiated their investigation in August 2020. TV Nurse advised the Care Home staff that a podiatry referral was needed. Staff at Home shown how to off load Martha's heels correctly. The TV team also noted that Martha's bandage had been applied poorly and advised staff that the knotting was not good practice. Team discussed the importance of good skin care with staff. Pressure ulcer prevention advice was given verbally. No further visits were planned, and staff advised to contact team if any concerns. Review of ulcers found they were healing well. Seen at the Care Home for follow up assessment and exercises three times between July and September 2020. Discharge to Care Home.
6.	September 2020	Solent East CIS Team, Community Health Care Team Physiotherapist called Martha's next of kin to update them on Martha's status.	Family informed that Martha did not have any rehab potential and had shown no improvements over the Physiotherapy team's visits. The team advised that Martha was happy in the Home and was happy to stay as her quality of life was much better. Martha was discharged from the team.

Episode	Key Timeline	Events	Outcomes
7.	October 2020	Care Home referred Martha to Solent East Speech and Language Therapy (SALT) Service. Martha was noted by the Home to not be eating or drinking as she had been. There was a referral to the GP due to possible wound infection and reduced oral intake. Care Home asking for Tissue viability review of pressure ulcer. Care Home became concerned about Martha's deterioration. They contacted her daughter who wanted to talk to GP. GP said to call 999. Martha admitted into hospital due to an infected pressure sore and dehydration.	Advice given around diet and consistency of food and drinks. Martha was discharged from the SALT team. Antibiotics commenced. Martha eating better with a puree diet for a short time before getting worse. Appointment made for a home visit but did not take place before admission to hospital. There was a wound care plan in place for dressings. Ambulance called; transfer summary sent with Martha identifying suspected sepsis. Martha remained poorly and, in discussion with her daughter who was her next of kin, a decision was made to for palliative care and an advance care plan was put in place. She was subsequently discharged to a different Care Home (Care Home 2), due to safeguarding concerns about her previous care. The new Home sought advice from the TV team about how to manage her wound dressings.
8.	November 2020	At Care Home 2 notes stated that Martha was now palliative end of life care. Martha died on 26 November 2020.	Assessment by Podiatrist at Care Home 2 – Osteomyelitis identified.[2] Very frail lady with a very vulnerable foot. Only options would be below knee amputation or palliative care.

[2] Osteomyelitis is a bone infection which can cause permanent damage if not treated appropriately. Those who have had fractures are more at risk of developing the infection - https://www.nhs.uk/conditions/osteomyelitis/

Episode	Key Timeline	Events	Outcomes
			Staff advised to monitor the wound for signs of infection and to seek help. Daughter called the police following the death.

6 ANALYSIS OF PRACTICE: WHY WERE DECISIONS MADE?

6.1 INFORMATION SHARING BETWEEN HOSPITAL AND CARE HOME

6.1.1 Discharge information

6.1.1.1 At the Practitioner event there was evidence provided that, normally, the ward would complete an onward care report. However, the air cast boot was put on after the discharge report had been sent. There is a specific Discharge Team that deals with the discharge of patients, but the ward staff take responsibility for sharing information on the actual day of discharge. In the case of Martha, the information was not gathered and reviewed efficiently which led to misconceptions about the treatment for her foot. Additionally, the Care Home would normally have assessed patients in person, but due to the pandemic restrictions were just commencing virtual assessments.

6.1.1.2 It is acknowledged that the practice for discharge has since changed. This includes an escalation process and developments in digital support which is improving the access to access to discharge summaries for Care Homes. The Consultant reported to the GP that he could not reach the Care Home.

6.1.2 Communication with Martha about her care

6.1.2.1 In hospital, the Physiotherapist who applied the air cast boot gave verbal information to Martha about the care required. This meant that it was not noticed that it needed to be followed through with the Care Home. There should have been a leaflet provided as well, which could then have been given to the home. It is also of concern that her family were not included in the conversation, although they would not have been allowed into the hospital due to Covid-19.

6.1.2.2 At the practitioner event it was reported that Care Homes continue to receive admissions with no discharge paperwork and medication, although there is supposed to be use of the onward care plan. There is a new role in place for the CCG, of a trusted assessor, who works within the hospital to help with discharge plans and admissions to Care Homes.

6.1.2.3 Within the group, there was a reflection that incidents of poor discharge need to continue to be escalated to the hospital to enable a full investigation to take place. It was clear that there is an ambition to improve discharge coordination, but this needs to have a framework to support real improvement for patients.

6.2 INVOLVEMENT OF EXTERNAL AGENCIES IN CARE HOME

6.2.1 There seemed to be extensive involvement of community and primary care services in the Care Home. There was good communication between the Care Home and community services, particularly once the pressure ulcer had been identified.

6.2.2 At the practitioner event there was a discussion about how there can be misconceptions about Care Homes by the acute health sector. This is in terms of what can be done for individuals once they have been discharged to a Care Home, as referrals for additional services or equipment have to go via the GP. It was considered that the acute settings need to ensure that the appropriate referrals are in place before discharge because, otherwise, Care Home staff need to refer through the GP. This can result in the individuals being placed on waiting lists for services or, as in Martha's case, gaps existing in the sharing of information regarding the treatment plan.

6.2.3 Martha needed to have rehabilitation whilst at the Home, however, staff were unable to commence exercises without having had instruction from a physiotherapist and had to await any equipment needed. Therefore, it would have been beneficial for the hospital to initiate the instruction and ensure that all equipment is provided.

6.2.4 In respect of the Care Home, it was positively reported that there are now training placements on offer for physiotherapy students, linked with the community team. This should be used to strengthen the connections between Care Homes and wider community services.

6.2.5 There was evidence of community services advising Care Home staff. The practitioner event was informed that where homes provide nursing care, there are registered nurses who would be expected to have knowledge and skills in relation to the management of pressure ulcers. To complement this knowledge there is a community Tissue Viability Nurse (TVN) who can visit the home to support learning and advise. In addition to the home being able to refer directly to the TVN.

6.2.6 For physiotherapy, homes can link directly, if they are in the area covered by individual physiotherapists, for urgent issues. However, for routine work, the homes must go via the GP. This makes Care Homes too reliant on GPs to make clinical decisions, despite the knowledge and skills of the registered nurses.

6.2.7 At the Care Home, the GP is contracted to visit twice a week, with additional calls if needed. There are also visits by Practice Nurses to give vaccinations to residents. Some individuals at the home continue to use their own GP but can register with the Home's GP, it is their choice. This leads to added bureaucracy for those individuals who may wish to receive seamless care.

6.3 Covid Impact

6.3.1 From 23rd March 2020 the Care Home was not allowed to have visitors making life difficult for both families and residents. The Care Home staff reported that families were not able to take loved ones to A&E, instead elderly people had to go to A&E on their own, which made staff at the Care Home feel very uncomfortable. It was reported that outpatients' appointments did not really start again until September 2020, and these were held by phone or online. It was reflected, at the practitioner event, that it was a lot easier for some appointments to be virtual, as face to face appointments are reliant on waiting for transport.

6.3.2 The Care Home also reported that individuals being admitted in 2021 were more likely to arrive with their own technology for use for virtual conversations.

6.4 Safeguarding

6.4.1 A safeguarding referral was made when it was found that Martha had a significant wound on her ankle due to failures by the provider to appropriately manage the medical device. This was investigated under a section 42 enquiry and led to the Care Home putting improvement measures in place.

6.4.2 However, this incident needs to be considered in a wider context, beyond the Care Home; for example: there were external professionals visiting the Care Home who seemingly did not ask about the medical device. The hospital discharge notification did not state that Martha had been fitted with an air boot cast.

6.4.3 At the practitioner event there was an honest and open discussion across agencies as practitioners reflected on their role in Martha's care. This identified the human factors of making assumptions about other professionals and the care of an individual. It was clear from the evidence that the systems in place in the hospital, Care Home and community services did not provide an adequate safety net for any one professional's misconception of the medical device. Other SARs have shown similar issues in relation to the maintenance of medical devices and equipment.[3]

6.5 MARTHA'S DETERIORATION

6.5.1 Martha had been mobile before the fall, lived alone and received mobile meals, but nevertheless, she appeared to experience rapid deterioration. When she was admitted to the Care Home, her diabetes was quite stable and her nutritional intake was reported to be quite good until the end of September 2020, when she became unwell. Martha did not have a big appetite and needed to be reminded to take fluids.

6.5.2 Martha was noted to have capacity to make her own decisions and whilst in her own home she reportedly declined equipment offered by professionals. She preferred to sleep on a recliner chair and would use the furniture to help her to walk, although her daughter explained that her mother struggled to use some of the equipment, when alone.

6.5.3 Martha would appear to have been a lady who had significant underlying health conditions and was able to say what support she wanted. She was starting to struggle at home even before the fall. Nevertheless, she was frail and should not have been exposed to the risks in relation to inappropriate care of her fractured ankle.

---

[3] Norfolk Safeguarding Adults Board (2021) *Safeguarding Adults Review: Joanna, Jon & Ben*

6.6 Effective Practice

Despite the tragic outcome for Martha, it is acknowledged that there is some evidence of effective practice, especially in the context of the crisis period of the pandemic during this time.

6.6.1 Martha was known to Physiotherapy. It was positive that she continued to be seen by the Physiotherapist who had visited her at her own home. This meant that he was able to assess the changes in Martha's demeanour.

6.6.2 There was good access to community services by the Care Home, which meant staff had access to the specialist support. An inclusive approach was evident from NHS community services, visible in visits made and telephone advice provided.

6.6.3 The Outpatients Clinic staff recognised that Martha needed to be seen and they communicated with the GP when they could not reach the Care Home.

6.6.4 There was recognition that there were potential safeguarding risks for Martha when it was realised her foot/ankle had not been appropriately care for, for several weeks. This provided the opportunity for agencies to work together to investigate and to prevent any further individuals being at risk of harm.

7 Findings

7.1 Practitioner reflections

At the practitioner event attendees were invited to consider what they would want to see improved within practice.

7.1.1 The TVN supports Care Homes and plans to ask them to identify staff to become link nurses and to attend a group to share learning and development on a quarterly basis. This would be of benefit to Care Homes in the wider community. It would also have the potential of reducing the impact of preventable pressure ulcers, experienced by residents in Care Homes.

7.1.2 It would be helpful for Care Homes to be able to gain access to the Care and Health Information Exchange (CHIE) system which would enable barriers to be broken between acute services and Care Homes. There was recognition that IT systems between organisations are not always compatible and so the CCG and Local Authority quality team commit to share information with each other.

7.1.3 There is a need to raise awareness and deliver training with regard to the assessment of patients needing medical devices. For example, whether air cast boots need removal or not, and the need for physiotherapists to check the skin under casts or splints.

7.1.4 The Care Home reported that they have learned lessons from this incident. As they have low staff turnover, learning from Martha's case is sustainable. There are 21 nurses employed who are committed to improving the care they give to their residents.

7.1.5 The Care Home report that they can feel pushed to take patients from hospital without the appropriate equipment.

7.2 REVIEWER'S CONCLUSIONS

7.2.1 Discharge coordination is a prominent feature in SARs nationally, as well as failures to share information effectively.[4] In Martha's case there was coordination for her to be discharged to a care home. However, there were insufficient checks that the Care Home had received the accurate information regarding the rehabilitation and care she needed. Additionally, the IT system of discharge notifications was not able to facilitate the changes made to Martha's care prior to discharge. Care Homes are crucial to safe, and timely, discharge of patients from hospital who require rehabilitation prior to returning to their own homes, as the environment can provide additional support. However, there are assumptions made, about the access that Care Homes have to equipment, training, and specialist services. This can lead to delays, and risks to the individual's wellbeing. It is extremely positive that Southampton community services provide support for Care Homes, but this needs to be strengthened through greater involvement by the acute health services in order to assess the needs of individuals and plan their care with Care Home staff.

7.2.2 The national review of SARs identified how care plans can be absent or incomplete for individuals, when they are admitted to a Care Home. This leads to insufficient consideration of the expected outcomes for that individual.[5] For Martha, the care plan was incomplete due to a lack of assessment with regard to the medical device. This demonstrated the silo working between hospital, community services, and Care Home, albeit there was some liaison and communication, but a lack of joint care planning.

---

[4] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

[5] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

7.2.3 The Covid-19 pandemic had an impact on how effectively Martha was cared for across services. This review has highlighted the good practice from community services in providing continuity of care, when she first was admitted to the home. It was evident that the impact of families not being able to visit and support their loved ones was evident Martha's deterioration. Yet, there were efforts to try to adopt virtual appointments fill the gap of face-to-face outpatients not being permitted. According to the Government guidance, Homes were expected to manage their policies to ensure that there were the opportunities for visitors.[6] however, in practice this was extremely difficult for all Care Homes to achieve.

8 Considerations For The SSAB

Item	Review Finding	The SAB should consider:
1.	In relation to the Home receiving accurate information regarding Martha's rehabilitation and care, there were insufficient checks in place.	How systems for discharge to Care Homes incorporate referrals to appropriate services? How can information sharing practice be improved regarding discharged to Care Homes, to enable sharing of relevant and real time information? E.g., hospital and Care Home liaising discharge day to check through information?
2.	There are assumptions made about the access that care homes have, in relation to equipment, training, and specialist services. This can lead to risks for individuals.	What can the Integrated Care System do to ensure that individuals are discharged from hospital with specialist referrals and equipment in place?
3.	There was evidence of silo working between hospital, community services, and the Care Home with an absence of joint care planning, leading to gaps in Martha's care.	How can the Integrated Care System develop joint care planning across acute and community services, and Care Homes?
4.	It was evident that the impact of families not	How can the ICS/CCG and Local Authority facilitate a reflective review of how

[6] https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes : accessed 19 November 2021.

	being able to visit care homes and support their loved was a factor in Martha’s deterioration. Albeit there were efforts to try to adopt virtual appointments fill the gap of face-to-face outpatients not being permitted.	outpatients’ clinics can be accessed virtually for Care Homes?