Paper Summary Sheet

NHS Wiltshire Clinical Commissioning Group

Presented to:	Governing Body - Public
Date of Meeting:	24th July 2018
For:	To Note

Agenda Reference:	GOV/18/07/15
Title:	Summary of Recommendations from the Safeguarding Adults Reviews A and B
Executive summary:	
This report summarises the key findings from the Safeguarding Adult Reviews into two separate cases which were referred in 2017. Both cases underwent a Significant Incident learning Process (SILP) which was intended to fully investigate the specific details of each case in terms of what happened and why but also to include the front line staff in those agencies to ensure that they were fully involved in the review. Each agency involved provided a report and Learning Events took place attended by authors, managers, practitioners and safeguarding leads from the organisations involved. Following this a Recall event took place which tested out the learning and gave opportunity for participants to give their perspectives. Family involvement with both reviews also took place and both reports were shared with the families for comment and review. The report identifies the key learning and recommendations for the Governing Body to note. The CCG will ensure that it gains assurances that all recommendations made to the multi-agencies specifically the health providers it commissions have been completed. It will also ensure that as a key statutory partner of the WSAB it supports all multi-agency recommendations.	
Recommendations:	The Governing Body is asked to note this report and the recommendations which have been made to the Wiltshire Safeguarding Adult Board of which NSH Wiltshire CCG is a statutory partner.
Previously considered by:	The outcome of the Safeguarding Adult Reviews for Adult A and B have been discussed at the Safeguarding Adult Board and the Health and Wellbeing Board.
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Sponsoring Director / Clinical Lead/ Lay Member:	NA

Risk and Assurance:	Risk that the recommendations are not completed and imbedded within agencies involved. Completion of the individual agency recommendations for health providers will be monitored by CCG through contract route.
Financial / Resource Implications:	Not Applicable

Legal, Policy and Regulatory Requirements:	Mental Capacity Act 2005 Care Act 2014 Safeguarding Adults : Roles and Competencies for health staff-Intercollegiate Document 2016
Communications and Engagement:	No decision required
Equality & Diversity Assessment:	☐ No decision required

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Summary of Recommendations from the Safeguarding Adults Reviews A and B

1. Background

1.1 The Wiltshire Safeguarding Adult Board commissioned two Safeguarding Adult Reviews in 2017. Section 44 of The Care Act 2014 places a statutory responsibility upon Safeguarding Adults Boards (SAB's) to conduct Safeguarding Adults Reviews (SAR's) in cases where 'there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or others, worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse'. The Care Act 2014 Statutory Guidance states that the process for undertaking SAR's should be determined locally according to the specific circumstances of individual cases. The safeguarding adult board agreed that the criteria were met to undertake both reviews and the methodology used was the Significant Incident Learning Process (SILP), a learning model which engages the frontline staff and their manager's in reviewing cases and focussing on why those involved acted in a certain way at the time. The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners involved at the time.
- Engaging with families
- Systems methodology
- Avoidance of hindsight bias

2. Adult A

2.1 Adult A (aged 84) was admitted to hospital in December 2015 after having been found on the floor of her flat by paramedics. They raised a safeguarding alert about the condition of Adult A's flat, which indicated possible self-neglect and neglect. Adult A told the paramedics that there was money missing. Adult A was admitted to an intermediate care bed and then discharged home. In mid-January, Adult A activated a care line. The paramedics reported that Adult A was found in a situation of serious self-neglect, sitting in a cold, dark flat and was severely hypothermic. There was no fresh food in the flat and Adult A had not been taking her medication.

2.2 Adult A died in hospital the following day. At the time of death, Adult A was suffering from hypothermia, bronchopneumonia, left ventricular hypertrophy, hypertension, diabetes, kidney disease and dementia. The coroner concluded that Adult A would not have died at that time had she not been discharged home.

2.3 Key Themes and Learning Points

Good Practice

- Ambulance staff recognised possible safeguarding around Adult A's living situation
- Early assessment of care and support needs attempted to offer support based on her wishes
- Intermediate care team OT attempted to understand reasons for Adult A's behaviour
- Care Home provided a good level of care for 21 days.
- Evidence of robust assessments within short time frame in care home
- Access to care service identified an intermediate care bed within 20 mins of referral from hospital.
- Although process was not well understood the Agency nurse recognised safeguarding issues and put an alert in
- Care Coordinator role in primary care appeared to be positive role and they had been aware of Adult A for some time, making numerous requests for further support.

2.4 Learning Points

2.4.1 Ineffective use of the Mental Capacity Act (2005)

The Mental Capacity Act (MCA) is designed to empower people to make decisions about their own care; even if others think those decisions may be unwise. However the MCA principles clearly state that if a person repeatedly makes decisions that put them at significant risk, despite advice to the contrary, then this should be reviewed.

Historically Adult A had been deemed to have mental capacity but it did not appear that as time went on this was re-visited. In Adult A 's case, professionals reported at a learning event held as part of the SAR that Adult A seemed to understand the decisions she was making and was very sure of these. The review found that no agencies challenged these decisions, suggesting a systemic lack of understanding of appropriate application of the Mental Capacity Act 2005.

2.4.2 Lack of Understanding of neglect

The issues surrounding the Mental Capacity Act are directly related to those of self-neglect. Since the Care Act (April 2015), self –neglect has been a recognised category of abuse that requires safeguarding interventions. A Care and Support Assessment was made whilst Adult A was in hospital, instead of a safeguarding referral, as her self-neglect issues were not judged to be evident. None of the professionals working with Adult A raised any concerns about self-neglect, despite there being several factors indicating that this may be an issue. There was a lack of professional curiosity about some of the decisions Adult A made which contributed to her self-neglect.

2.4.3 Impact of self-funding on care assessments

Adult A was assessed as being a self-funder in 2012, due to the amount of care provided being under the threshold for social care funding. Following subsequent referrals for increased care, her financial status was not reviewed, and some types of support were refused as a result. A care and support assessment by Adult Social Care was not undertaken for this reason, a missed opportunity to identify increased support needs.

2.4.4 Application of safeguarding procedures

The issue of mental capacity also applies to safeguarding concerns, in considering whether an individual can make decisions that allow them to keep themselves safe. The initial safeguarding referral was made due to concerns around this, but it was made second hand, not by the attending paramedic, and so there were gaps in the information passed on. There were also discrepancies over the extent of the financial abuse that Adult A had reported to various agencies. The Acute hospital safeguarding referral was made by an agency nurse who did not understand the safeguarding procedures, so it did not go to the correct place in order to join up with other safeguarding information. A number of measures have already been put in place to address these and other concerns relating to safeguarding.

2.4.5 Effective discharge planning

Effective discharge planning should involve good planning to anticipate potential problems, and resolve these barriers using a multi-disciplinary approach. Therefore it is important to consider what Adult A died less than 48 hours after she was discharged from hospital. It was noted by a number of professionals that Adult A had significant mobility difficulties, and was unable to independently use the stairs leading to and from the flat, rendering Adult A housebound. It could be argued that the property was not suitable, but considerations about an assumption of mental capacity apply here, as Adult A's decisions were not challenged. There was a lack of communication between the Intermediate Care Team and the Care Agency upon discharge, as the latter had no knowledge of Adult A's discharge from hospital. Although Adult A's elderly sister and neighbour were informed of her discharge, an assumption was made that they would be supporting Adult A, despite having health issues of their own, which made this difficult. Adult A's nephew was also not informed of her discharge.

2.5 Recommendations and next steps re Adult A

The SILP report has identified a number of recommendations which have been identified as either single agency recommendations as well as multi-agency recommendations and these have been agreed and endorsed by the Wiltshire Safeguarding Adult Board (WSAB).

The progress by the agencies against these recommendations will be assured through the WSAB and by the three statutory agencies which make up the Board.

2.6 Multi-Agency Recommendations

- WSAB must assure itself that agencies can evidence how they will address the shortfalls in understanding and application of the Mental Capacity Act that this review has evidenced.
- WSAB should produce Multi-Agency Self Neglect guidance to support practitioners in managing self-neglect. This should include all learning points related to self-neglect.
- WSAB should seek assurance from agencies that clients (where appropriate) and practitioners are supported to understand financial status under which acre is being provided and are cognisant of the learning points in the review.
- WSAB should refresh and re-launch the SAR learning and Improvement Policy and publish this on Board website.
- WSAB should seek patient stories and undertake an audit showing evidence of the effectiveness and safety of discharge planning processes for people with care and support needs.

- WSAB should provide a learning briefing to all agencies regarding all the learning points from this review.

3. Adult B

3.1 Adult B (aged 72) died after being struck by a car whilst out walking alone, something he did often. Following two referrals to Adult Mental Health Care by his GP between 2013 -2015, Adult B was diagnosed with Alzheimer's disease. He was give medication which stabilised his condition. In October 2013, Adult B move into independent living accommodation, after separating from his wife. In May 2015, it became apparent that Adult B was struggling, and his ex-wife offered to support him. Between March and September 2016, Adult B's memory and cognitive functioning further decreased. He was not managing his medication well, and support from his ex-wife had broken down. He was often out walking when staff arrived for his care package visits.

3.2 In early November 2016, Adult B was found by a friend walking in the middle of the road, carrying his washing, and he was taken home. A safeguarding referral was made but not accepted. Four days later, paramedics were called after he fell asleep in a pub, and he was taken to hospital. A second safeguarding referral was made and accepted. On 21st November 2016, Adult B was found on private military ground, 10 miles from his home, inappropriately dressed for the cold weather. He was taken home and then, after getting very distressed, to the police station. His care package was increased, with more home visits but he was not in for any of them. On 27th November 2016, Adult B was struck by a vehicle whilst walking alone on an unlit road, and alter died of his injuries.

3.3 Key Themes and Learning Points

Good Practice

- Accommodation manager and care agency went beyond what was required of them. They had a good understanding of Adult B and provided consistent support.
- Ambulance staff made a safeguarding referral following first November incident
- Police officer on 21st November did the right thing by keeping Adult B at police station and worked hard to find a solution for him.
- The GP record system which is available Out of Hours was able to be accessed and people were aware of the issues re Adult B
- Care Coordinator received good information from the care agency
- Care Coordinator communicated with several agencies to try and move things forward for Adult B
- Practitioners were working hard to ensure Adult B could maintain a level of independence and focussed on his right to a private life
- Care Agency recognised that the care package was not enough and challenged the level of support provided
- There were 41 entries on the GP system regarding Adult B, indicating a good level of input.
- Adult B was dealt with compassionately and with empathy, and practitioners wanted the best for him.

- The Care Coordinator consistently monitored Adult B's physical health and undertook to ensure that any physical health deterioration that could have explained deterioration in memory was ruled out.

3.4 Learning points

3.4.1 Assessment (including risk assessment)

There was little standardisation of risk assessments, so any being completed informally were not obvious to other agencies, an issue now being addressed. A lack of risk assessment around Adult B 's drinking was also evident. Whilst not viewed as a problem on its own, memory loss may have caused Adult B to drink more than he intended to. It also may have interfered with his medication. The biggest risk was Adult B's love of walking, with his dementia diagnosis making it more likely that he would become lost or confused. As Adult B lived independently, no-one knew if he had gone out, and the report advises that a risk assessment could have been undertaken sooner. The Learning Event, held following Adult B's death, also identified points where multi-agency meetings may have been useful, but highlighted the lack of a clear process for initiating them. High-Risk Behaviour Policy is in development which will help to address this issue.

Absence of staff team meetings and ineffective supervisions were also cited as an area for improvement, as the issue of Adult B being out for many appointments was not identified by managers sooner and therefore could not be risk assessed. Professionals also did not communicate Adult B's ex-wife's wishes to withdraw from supporting him. She continued to be contacted by professionals, and the erroneous belief that she was still supporting him meant that an advocate was not sought, nor the risk of reduced support adequately assessed.

3.4.2 Communication and Co-Ordination

The report cites a number of missed opportunities for communication between agencies. For example, officers could not respond to a local pub's concerns about Adult B's behaviour in early November 2016, due to a lack of resources. Pub staff deemed he was safe to take himself home but neither Adult B's GP nor the manager of his living accommodation were notified that these concerns had been raised. Communication over medication was also an issue. Adult B's medication was halted due to the risk of accidental overdose until a care package could be implemented, but this took a long time, potentially affecting Adult B's level of memory function. Also many assumptions were made relating to beliefs that Adult B was being safeguarded by other agencies. Referrals were made assuming that they would lead to more support, specifically respite care but this was not the case. Furthermore, there were no arrangements to ensure Adult B was home for appointments, as it was not always shared that he liked walking and therefore may be out. This led to many missed appointments, delaying support.

At a learning event, it was suggested that having a lead worker as one point of contact would have improved communication and coordination. Additionally, the National Institute for Clinical Excellence (NICE) guidelines around assessment and care plans were not adequately followed, which if they were, may have helped. Other issues for consideration here are ; lack of access to an advocate in the absence of close family, delays in assessments , lack of risk assessment, and the limitations of some roles leading to a reliance on other services.

3.4.3 Escalation

Adult B lived in independent living accommodation, with no 24 hour monitoring and only basic care checks. The accommodation manager didn't feel able to challenge other agencies about his care package. When the care agency met Adult B, five weeks after he was referred, they thought his needs exceeded what they had been asked to provide but did not feel able to escalate these concerns. In both cases, there were no clear processes for escalation. Lack of escalation was often due to limitations of roles and perceived difficulties in how to challenge other agencies 'decisions without being seen as 'difficult', potentially highlighting a cultural issue in this area.

Adult B was referred for an assessment of care and support needs on 9th September 2016. It took almost two months before he received further care, and weeks more until he was allocated a social worker. This delay could have been escalated much sooner, an issue that may be addressed with the implementation of the Wiltshire Adult Multi-Agency Safeguarding Hub (MASH) which has just been set up. Safeguarding decisions here are made by a multi-agency group, making information sharing easier, as well as providing a clearer route for challenge and escalation. The MASH will also be able to more quickly address outstanding actions such as , for Adult B, the lack of a Mental Health Social Worker referral, and a delayed Community Mental Health Team Assessment.

3.4.4 Application of the Mental Capacity Act (2005)

The report suggests that some of the areas highlighted above would have been helped by robust application of the Mental Capacity Act (2005). The Act requires an assessment of capacity before any treatment or care is carried out, if there is reasonable belief that someone lacks the capacity to make decisions about treatment themselves. If Adult B was deemed not to have capacity to understand his own needs, a best interest decision could have been made and could also have led, if necessary to the application of a Deprivation of Liberty Safeguards authorisation, to keep him safe. For Adult B, there was a belief that a social worker should do the Mental Capacity Assessment , with other agencies citing a lack of confidence or resources to do so themselves. It was decided that Adult B should not have possession of his medication, as he didn't know what it was for or when to take it. A Mental Capacity assessment could have been done here by the Care Coordinator and the GP, with the outcome formally recorded as evidence. Discussions about providing tracking his whereabouts were dismissed as an infringement of his human rights. The MCA could have been applied here to support Adult B to continue doing an activity he loved, more safely.

3.5 Recommendations and next steps re Adult A

There are as with Adult A individual agency recommendations which the WSAB will seek assurance that action plans are underway and outcomes are assessed within those organisations.

3.6 Multi-Agency Recommendations

- WSAB should seek assurance that all agencies consider the elements of NICE Guidance for supporting people with dementia that would have made a difference in this particular case. There should be consideration of an agreed approach to identifying a lead worker role when multiple agencies are working with an individual at risk and an agreed approach to shared planning.

- WSAB Quality Assurance Sub-Group should seek information from commissioners regarding their assessment of the risk of resource and capacity issues pose to the safety and well-being of Adults with care and support needs who are at risk of harm. There should be an expectation and agreed process for commissioners to raise any significant risk with the Board Chairman.
- WSAB should assure itself that all agencies and providers have robust structures in place for support and supervision of staff.
- WSAB should consider the learning from this review and undertake to ensure that there is guidance to all agencies on the importance of professional curiously and challenge and of escalation where required to mitigate risk.
- An agreed multi-agency approach is required for managing risk in adults who have care and support needs. WSAB should seek assurance that this approach is developed and embedded through audit.
- WSAB should add the learning from this review regarding understanding and application of the Mental Capacity Act, to the previously made recommendation in the Adult A SAR.