



Hertfordshire Safeguarding Adults Board

Safeguarding Adults Review

‘Stanley’

Overview Report

[FINAL DRAFT]

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Executive Summary

1. Introduction

- 1.1. This review was commissioned by Hertfordshire Safeguarding Adults Board. The review seeks to understand the circumstances of Stanley who was a man in his sixties who died at his home in June 2016.
- 1.2. At the time of the review, the cause of Stanley's death was awaiting the Coroner's inquiry. What was known was that Stanley had been discharged from hospital ten days before he was found dead in his property. He had failed to receive the services he needed.
- 1.3. Stanley had been known to a variety of agencies in Hertfordshire. This review considers how well those agencies worked together to provide care and support to Stanley and to safeguard him in relation to self-neglect.

2 Summary of the Learning Points from the Review

The review considered early opportunities to engage with Stanley, as well as examining events leading up to the sad circumstances surrounding his death. The following themes and learning were identified from the review.

- Working with self-neglect
- Communication and Coordinating Care for People who are Resistive to Care
- Wider Commissioning

2.1.

Working with self-neglect: Summary of Learning Points	
i	<p>Learning from this review reflected the research regarding best practice in working with self-neglect¹:</p> <ul style="list-style-type: none">• The importance of establishing relationships• Understanding the meaning behind behaviours• Working at the person's pace• Seeking creative ways of engaging including involvement of families• Understanding legal frameworks including the Mental Capacity Act• Honesty in exploring risks and options• Effective multi-agency working and coordination of care <p>The evidence was there was variation in how well all these factors were addressed.</p>
ii	<p>Practitioners were working hard to try and meet Stanley's complex combination of physical, psychological and mental health needs. He had some consistent relationships with practitioners but other key relationships such as with care agency</p>

¹ SCIE (2014) *Self-neglect Policy and Practice*, Available from: <http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/> [Accessed: 01/10/17]

	staff and with Social Care were less enduring. Stanley found this difficult.
iii	Payment for services was a recurrent issue in Stanley's resistance to care although he had funds above the means tested limit. While there may have been justifiable reason for the Local Authority not to apply their discretion to waive payment, it is not clear that there was a formal process for exploring this option.
iv	There was consistent evidence that practitioners applied the Mental Capacity Act, maximising Stanley's decision making, assessing his capacity to make the relevant decision and respecting his right to make unwise decisions.
v	There was also consistent evidence of services repeatedly helping Stanley to make informed judgements about the risks arising from his decisions. Unfortunately, these efforts did not lead to changed behaviours or a reduction in risks.
vii	There were limits to the practitioners' ability to involve Stanley's family as he did not consent to information being shared. Stanley did consent to his neighbour's involvement as a point of contact – however, consent was not obtained from the neighbour to assume this role. This may have put unfair responsibility on him.
viii	Practitioners and services were often struggling to know how best to work with Stanley. The use of supervision and utilising expertise, for example from advocates or psychologists, is useful to help the multi-agency team step back and try and understand behaviours and find new creative routes to help engagement.
ix	This investment of time and resources can be difficult to achieve in pressured Health and Social Care systems and there is no guarantee it would have made a difference. Nonetheless, for people with such complex needs, such an investment makes sense due to the human cost of failing to get this right and the cost to the system arising from self-neglect and repeat admissions.

2.2

Communication and Coordinating Care for People who are Resistive to Care: Summary of Learning Points	
i	There were multiple agencies involved with Stanley and a general willingness by agencies to do what they could to support his care.
ii	Despite this willingness, there was a general lack of effective communication and coordination within and between all the services involved.
iii	Though there were parts of the system where practitioners were liaising, at no point was there a multi-agency meeting that involved <i>all</i> agencies coming together to develop a cohesive and comprehensive plan. An enhanced multi-agency approach is called for in cases where there are such complex care needs and significant risk arising from self-neglect.

iv	In Stanley's situation, the Care Programme Approach should have been used to provide this coordination across all agencies involved.
v	There was a tragic and avoidable sequence of events that culminated in Stanley not receiving the care he needed in the period directly preceding his death.
vi	There was a plethora of poor communication between agencies, assumptions being made without checking facts and lack of resilient systems to provide a safety net in the event of human error.
vii	No single failure of itself was likely to have been a pivotal issue, but collectively it was.
viii	Had there been an 'enhanced' multi-agency approach, in place, this could have provided the necessary framework for coordination of care, communication of inpatient episodes and development of contingency plans - ensuring Stanley received the care he depended upon.

2.3

Wider Commissioning: Key Learning Points	
i	A combination of a lack of available care provision and care agencies declining to provide care to Stanley resulted in Adult Social Care having great difficulty in sourcing a care package for him.
ii	There was limited choice of providers and there were emerging concerns about the care agency that had been sourced. Based on the information available, the concerns were not assessed as warranting a suspension of contract with the care agency.
iii	Care services are required by their regulators and commissioners to deliver standards of care. The care agency had the primary responsibility to confirm whether Stanley had been admitted to hospital and to advise Social Care accordingly – they did not deliver on these responsibilities.
iv	The national crisis in social care provision is well documented. Local Authorities have statutory responsibilities to develop local provision to meet the population need and to provide contingency plans in the event of care provider ceasing to provide care.
v	HCS is developing a 'trading arm' to provide this contingency. Their commissioning strategy should also ensure there is sufficient specialist provision to meet the needs of service users such as Stanley who have complex needs and high level of risk arising from their self-neglect.

Main Body of the Report

3. Context of Safeguarding Adults Reviews

- 3.1 The Care Act 2014, requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together.
- 3.2 Hertfordshire Safeguarding Adults Board (HSAB) commissioned an independent author, to carry out this review. The author is an experienced chair and author of reviews and holds a professional background in mental health services and safeguarding adults. The author is independent of HSAB and its partner agencies.
- 3.3 The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again*'.²
- 3.4 A SAR enables all of the information known to agencies to be seen in one place. This is beneficial to learning but the SAR also recognises that this benefit of hindsight was not available to individual practitioners at the time.
- 3.5 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity³. The principles apply to the review as follows:

Empowerment:	Understanding how the service users were involved in their care; involving those close to the person in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

4 Terms of Reference and Methodology

² Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*

³ Ibid

4.1. Terms of Reference

4.1.1 The purpose of the SAR is to determine what the relevant agencies and individuals involved might have done differently that may have prevented Stanley's death. It is not an enquiry into how he died or to apportion blame; but to learn from such issues, and that those lessons are applied to future cases to prevent similar harm occurring again.

4.1.2. The specifics are as follows:

Terms of Reference
1. To identify the arrangements in place or due to be in place for Stanley's care and any risk assessments which had been made.
2. To identify whether any of the care or support contributed in any way whatsoever to Stanley's death or caused significant harm.
3. To consider whether the agencies involved communicated effectively and whether there was effective co-ordination amongst all agencies involved.
4. To consider whether the policies and procedures of all relevant agencies are adequate to ensure safe care in the community
5. To consider whether such policies and procedures that were in place at the time of Stanley's death were adequately followed by staff involved in the process.
6. To consider any learning from this situation and make recommendations to improve policies or future working practices.
7. To consider whether Stanley's family and friends were appropriately involved in the arrangements for his care

4.1.3. The review has focused on the immediate period leading up to Stanley's death. However, the review has also considered the period from 2010, and examined how agencies worked together to support Stanley following his diagnosis of Parkinson's disease.

4.2. Methodology

4.2.1 The methodology applied for this SAR combined narrative reports and a chronology from each agency with a learning event.

4.2.2 The learning event brought together managers and frontline practitioners from the agencies to draw out learning and recommendations for improvement.

4.2.3 Understanding the experiences of those receiving support from agencies is central to learning.

4.2.4. Stanley was part of a supportive family who tried hard to help him. The involvement of Stanley's

family to this review has aided our understanding of him from the perspective of those closest to him.

- 4.2.5. The independent author is grateful to Stanley’s sisters for their contribution to this SAR. They wished to contribute in order that services may learn and improve and, crucially, make a difference to others.
- 4.2.6. A pseudonym has been used to protect Stanley’s privacy and dignity. His sister chose the pseudonym of Stanley that we have adopted for this review.
- 4.2.7. Stanley’s sister reviewed the final draft of the report. She felt the report had answered questions she had and supported the findings and recommendations.
- 4.2.8. Participating agencies were encouraged to apply a systems approach⁴ to the review i.e. explore all contributory factors in order to identify changes needed at an organisational level as well as at individual practice level.
- 4.2.9. The role of the contributing agencies is outlined in the table below

Participating Agencies and Context of Involvement	
<i>L&M Care Limited trading as Caremark (X locality).</i>	<p>This is a franchised company trading under the Caremark brand. Each office is under their own limited company and is responsible for their businesses. However, Caremark Limited (the national company) monitor and offer advice to each franchisees to ensure that they are compliant. During the scope period Caremark Limited were working with Caremark (X locality) as they were aware that there were problems within the business.</p> <p>The company is referred to throughout this review as L&M Care Limited</p> <p>Commissioned by Hertfordshire County Council Adult Social Care to provide Stanley with a package of care from 16th June 2016. L&M Care Limited ceased trading in July 2016. The parent company contribute their perspective to this review.</p>
East of England Ambulance Service NHS Trust (EEAST)	EEAST covers the east of England providing a range of services including 999 emergency services. Between 2013 and 2016, Stanley had 86 contacts with EEAST.
East and North Hertfordshire NHS Trust (ENHT)	<p>An NHS Trust that provided Stanley with a range of medical services including:</p> <ul style="list-style-type: none"> • Accident and Emergency • Inpatient care

⁴ SCIE, *Learning Together*, Available from: <http://www.scie.org.uk/children/learningtogether/about.asp>

	<ul style="list-style-type: none"> • Neurological Care • Therapies <p>In the last 6 months of Stanley's life, he attended ENHT A&E on 27 occasions.</p>
GP	Stanley had received Primary Care from the same GP practice for many years and was very well known to his GP.
Hertfordshire County Council – Health and Community Services (HCS)	<p>HCS offered services to Stanley from 2013.</p> <p>HCS provided social care to Stanley that included community based social work and hospital discharge arrangements.</p> <p>HCS as a Local Authority, is also the lead agency under the Care Act 2014 for Safeguarding Adults, working in collaboration with other agencies. HCS was responsible for leading the multi-agency response to safeguarding adult referrals regarding Stanley.</p> <p>Between December 2013 and June 2016, Stanley had involvement from 14 Adult Social Care workers from hospital, community and safeguarding services.</p> <p>HCS also commissions providers to meet service users' care and support needs. HCS commissioned Care Homes and care agencies to support Stanley, including Care Mark.</p>
Hertfordshire Community NHS Trust (HCT)	<p>Provide adult and children's health service in their homes, community settings and community hospitals. HCT provided Stanley with a range of services including</p> <ul style="list-style-type: none"> • Integrated Community Team including therapies • Nutrition and Dietetics team • Neuro Rehab Service including Parkinson's Disease Specialist Nurse (PDSN) and therapies
Hertfordshire Independent Living Service (HILS)	<p>HILS provide a range of support services within service users' homes including meals on wheels.</p> <p>HILS was initially commissioned directly by Stanley and then by HCS, to provide Stanley with meals on wheels service. HILS first began providing this service to Stanley from 2013.</p>
Hertfordshire Partnership Foundation Trust	HPFT provide mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire.

(HPFT)	<p>HPFT and HCS have a section 75 arrangement⁵ with HCS for mental health related Social Care to be provided by HPFT.</p> <p>HPFT was first involved with Stanley in 2007, again in 2010 and then continuously from 2013 until June 2016. He had a Care Coordinator to oversee care and support plans and carry out necessary risk assessments. Stanley also was seen by a Psychiatrist throughout this period. During his attendances at ENHT, Stanley was also assessed by the HPFT Rapid Assessment Interface and Discharge (RAID) team, based at the hospital.</p>
Hertfordshire Constabulary	<p>Herts Police did not have any direct involvement with Stanley but investigated the circumstances of his death and contributed a report from their investigation to the review.</p>

5. Stanley and the Background for This Review

- 5.1. Stanley's sisters helped provide the review with a picture of him.
- 5.2. They described Stanley as a quiet, intelligent and private individual, a much loved brother who came to feel his life had little purpose.
- 5.3. During his career, Stanley worked in a highly pressured job as an insurance underwriter. He made good friends at work and had a good social life.
- 5.4. In his 40 years employment, Stanley rarely had a day off until he began to experience the early symptoms of Parkinson's disease.
- 5.5. In the last 10 years of Stanley's life, he had a number of life changing events that had a profound effect on his mental health and overall wellbeing.
- 5.6. Stanley was coping with the end of a long term relationship alongside managing a very difficult case at work that caused him great anxiety. This coincided with receiving the diagnosis of Parkinson's. The diagnosis had a huge mental and physical impact on him and his future aspirations for an active retirement.
- 5.7. Stanley's Parkinson's and his acute anxiety and depression, eventually made work impossible for him. He became increasingly isolated - a man who enjoyed good, intelligent conversation but whose illness resulted in a loss of contact from his many friends.
- 5.8. Stanley began to neglect himself and his home. He experienced the loss of a close friend and in

⁵ NHS Act 2006 provides an enabling framework so that money can be pooled between health bodies and health-related local authority services, functions can be delegated, resources and management structures can be integrated.

2016, his Mother died from dementia – Stanley had not seen her for 2 years.

- 5.9. These events affected Stanley deeply. He became more and more isolated and anxious about his developing symptoms. He came to feel his life had little purpose and could not accept his loss of freedom and independence.
- 5.10. Stanley spiralled into a sense of hopelessness, feeling unable to cope and fearing for his future.
- 5.11. He became terrified of any symptom. A series of hospital stays began, often precipitated by Stanley neglecting to take his medication and calling emergency services. He had 27 attendances to Accident and Emergency in the last 6 months of his life.
- 5.12. Stanley's family recognise he could be difficult and described a recalcitrant attitude. On the one hand Stanley sought care, while on the other hand, he rejected care, feeling it to be intrusive.
- 5.13. Stanley would become agitated and upset, feeling others did not understand his situation and that carers did not know how to help him – seeing them as in a perpetual hurry. His family felt he declined attendance at a Parkinson's support group, partly because of the cost of transport but also because he didn't want to see other sufferers who might be further progressed in their condition than he was.
- 5.13. Stanley worried greatly over money. His family commented he had an irrational fear of not having enough money to live on. This and his frustration with his life circumstances was at the root of refusal to pay for care services.
- 5.14. Stanley's sisters tried to support him but lived a long distance away – Stanley declined to move closer to be near them. His sister described in the early days, staying with him to get him through difficult times. However, as their Mother's dementia progressed, Stanley's sisters took on shared 24 hour care for her. This was exhausting for them and they were unable to leave her to support Stanley, though still managed a couple of day trips to clean his home during hospital stays.
- 5.15. For many years, Stanley had relied heavily on the kindness of an elderly neighbour but due to his own age and ill-health, had been unable to assist Stanley in recent times. He was however a contact point for the meals-on-wheels service.
- 5.16. Stanley's body was found by a Care Mark carer on 27th June 2016. He had been discharged from Accident and Emergency 10 days earlier having attended twice that day. Stanley had recently returned home having been in hospital and then a care home, interim 'step down' bed. A care package from Care Mark, had been commissioned by Adult Social Care. Stanley was also due to receive Meals on Wheels.
- 5.17. Meals and wheels did not visit as they had understood from his neighbour, that Stanley had been admitted to hospital.
- 5.18. The care agency, L&M Care Limited had last visited Stanley on the 17th June. Their visit to Stanley on the 27th June had been accidentally scheduled by L&M Care Limited.

- 5.19 The Police report notes that the condition of Stanley's body indicated that he had passed away shortly before he was found. However, at the time of the review, it had not been possible to identify when Stanley actually died.
- 5.20. The following section provides a summary of services' involvement with Stanley from 2010.

6. Summary of Events

- 6.1. **In 2010** Stanley was diagnosed with Parkinson's disease. Stanley developed depression and had a short admission to a mental health hospital with follow up by Mental Health services.
- 6.2. Mental health services continued to support Stanley until **2012**, when Stanley reported feeling less stressed and no longer in need of support.
- 6.3. **In 2013**, Stanley was receiving care from neurology services including an allocated Parkinson's Disease Nurse Specialist (PDNS). He self-referred to the CMHT with depression and anxiety.
- 6.4. By **December 2013**, Stanley's GP, CMHT care coordinator and PDSN were expressing concern about his ability to cope. Records noted *'not coping and home chaotic.'*
- 6.5. The CMHT liaised with Social Care and the PDSN also made a referral to Social Care for a care package. Following assessment, Social Care put Stanley in touch with care agencies. He was concerned about the cost but accepted Meals on Wheels.
- 6.6. Toward the end of December 2013, Stanley called an ambulance and was conveyed to hospital but not admitted *'No acute medical issues found. Medical impression was anxiety and acopia with deterioration of Parkinson's..'*
- 6.7. 3 days later, Stanley phoned 999 again with increased anxiety and low mood. Stanley was admitted for approximately 1 week. He expressed anxiety about returning home but agreed discharge with input from Meals on Wheels, Care Agency, PDNS and mental health care coordinator.
- 6.7. **January 2014.** Within 2 days of discharge, the care agency contacted Social Care, concerned about Stanley *'...is refusing to eat, sitting on the floor rocking, not allowing carers to assist him to wash or change his clothes, he has refused all meals and drinks...'*
- 6.8. Stanley was admitted to hospital and from there, admitted to a mental health hospital. During this period, Stanley was resistant to aspects of care including declining to take medication. Occasions were recorded where Stanley had *'put himself on the floor'* but described himself as having fallen.
- 6.9. Discharge planning meetings were held in **March 2014**. A care package was offered however, Stanley did not want to be discharged. He did not want to pay for the care package and refused

to give information to allow a financial assessment to be completed.

- 6.10. Stanley was discharged in **April 2014** to a care home placement funded by HPFT. During this stay, his mental health care coordinator and social worker worked with him to try and set up care at home. Stanley initially was resistant to paying for a full care package and remained at the care home until **Oct 2014** when he returned home with a care package.
- 6.11. By **November 2014**, a pattern of multiple call outs to the ambulance service began. Stanley's GP also noted an increase in call outs to the GP practice. The GP and MH coordinator were liaising and records note '*considerable somatisation⁶and psychological overlay to [Stanley's] presentation.*' During November, Stanley began to also receive support from the HCT integrated community team.
- 6.12. Throughout **2015**, this pattern of multiple call outs to the ambulance service intensified – some resulting in conveyance to hospital.
- 6.13. There were seven admissions to hospital, some within hours of being discharged and the longest being three-months duration. In addition, Stanley was admitted to a mental health hospital under the Mental Health Act for four months.
- 6.14. Records state on a number of occasions, Stanley refused to be discharged.
- 6.15. Mental health and Social Care services made repeated offers of residential care and short stay breaks aimed at supporting Stanley and reducing his anxiety. Stanley declined this. He wanted to return home but was not happy about the care provided.
- 6.16. On occasion, Stanley agreed to a package of care to support him at home but then declined to pay for it. He had informed Social Workers that he had savings above the means tested limit but repeatedly refused to allow a financial assessment to be completed⁷.
- 6.17. Concerns regarding Stanley's self-care were increasing. His living conditions and self-care were significantly deteriorating. '*Risk hypothermia as doesn't use heating, neglect, falls.*'
- 6.18. There were some instances of care agency workers refusing to go into the house due to the state of the property and of Stanley's personal hygiene. Records indicate that when care agencies visited, Stanley regularly declined to accept personal care, refused to eat or drink and could be verbally aggressive toward them. As a consequence, by **July 2015**, Social Care began to have difficulties in sourcing agencies that would provide Stanley with care.
- 6.19. Meals on wheels continued to provide services – records indicate challenges of tracking when Stanley was in hospital or at home and many 'no replies.' '*Meals restarted. No reply from client. Driver gained access to property via keysafe, confirmed that client was not there. Left message with neighbour.*'

⁶ Tendency to experience and communicate psychological distress in the form of somatic symptoms and to seek medical help for them.

⁷ Social care is means-tested and individuals with funds above £23,000 are asked to pay in full for services.

- 6.20. Similarly, there were many occasions when community staff visited and there was no reply – follow up calls found Stanley was in hospital.
- 6.21. Inpatient and Community Health services worked with Stanley to try and address his health needs and the presenting problems leading to admissions. Many attendances at A&E were precipitated by Stanley not taking his prescribed medications and/or struggling with mobility.⁸ Occupational therapy assessments recommended aids and adaptations in his home but these were declined by him, as was a dosette box to help manage medication.
- 6.22. Stanley was consistently assessed as having capacity to make all decisions about his care, (albeit that his decisions were viewed as unwise by others).
- 6.23. Professionals meetings were held, including a hospital based meeting in **September 2015** to develop a ‘frequent attender management plan.’ At this time, Stanley’s primary needs were assessed as being mental health related, rather than neurological – the Parkinson’s illness was not far advanced and Stanley did not need to rely on equipment for mobility. Stanley’s presentation was seen to arise from the psychological reaction to his physical condition, referred to by his GP as a conversion disorder.
- 6.24. In **October 2015**, a Safeguarding Adults referral was made due to concerns of self-neglect. As the hospital social work team was already involved with Stanley around his discharge planning, the referral was not progressed through Safeguarding Adult procedures.
- 6.25. By **November 2015**, Social Care was experiencing significant problems sourcing a care agency that would provide care to Stanley. Stanley had voiced his intention to take his own discharge from hospital, despite a care package not being in place. Stanley was discharged following a four week admission – meals on wheels was in place but no care package. His call outs to ambulance services restarted almost immediately.
- 6.26. By **December 2015**, Social Care was still not able to source a care agency. There were substantial concerns about Stanley’s state of self-neglect. A hospital admission was offered on this occasion but refused by him. A care home placement was also offered but Stanley refused to pay or have a financial assessment. There is a record of the social worker consulting with their manager and being advised ‘...*nothing more we can do. He has capacity and is making an unwise decision.*’
- 6.27. Further brief admissions to hospital followed in quick succession. Meals on wheels visited but got no response. Records indicate some instances when follow up on ‘no reply’ was not made – their record stating ‘*assume in hospital*’
- 6.28. Following debate between Adult Social Care and Mental Health services regarding funding i.e. whether needs were primarily mental or physical health, the agencies agreed to joint work.
- 6.29. This pattern of behaviour continued between **January and May 2016**. During this period, Stanley had multiple attendances at A&E. Fourteen resulted in admission, many within 24 hours of

⁸ People with Parkinson’s can experience ‘Freezing’ - temporary, involuntary inability to move that can occur when medication is due.

discharge.

- 6.30. The records indicate ongoing difficulties in coordinating care packages and communication between agencies, with various workers not clear about when Stanley was inpatient and having aborted home visits. There were further instances of meals on wheels records stating *'no reply. presume in hospital'* or *'Neighbour informed that client back in hospital, suspend meals until further notice.'*
- 6.31. In **March 16**, Social Care arranged for short stay funding for Stanley to be admitted to a care home as conditions in Stanley's home and his self-care were dire. During this stay, Stanley refused personal care the care home reported significant challenges with his behaviours associated with personal hygiene. Stanley was insistent he wanted to return home so was discharged. Call outs to ambulance quickly resumed and the ambulance service made 'frequent caller' referral to GP, requesting all non-life threatening calls to be triaged.
- 6.32. In **April 2016**, a further Safeguarding Adult referral was made regarding Stanley having been found on the floor at home. This was responded to during the hospital admission that followed. In addition to the ongoing concerns about self-care and falls, the Social Worker noted the risk of fire due to the clutter in his home environment and Stanley's impaired mobility.
- 6.33. The Social Worker liaised with Stanley's sister who voiced some frustration that Stanley would not accept care. She offered to fund a deep clean of his property while he was in hospital, though recognised that Stanley would not like it.
- 6.34. At this time, Stanley stated his intent to self-discharge although there was no package of care in place. He was assessed by the RAID team clinical psychologist who carried out a mental capacity assessment regarding his ability to understand care needs and risks of discharge with no care in place.
- 6.35. On this occasion, Stanley was assessed by the psychologist as not having capacity to make this decision. *'[Stanley's] responses demonstrated cognitive inflexibility, and an impairment both in abstract reasoning and perspective taking. All of these are executive functions that are essential in making a capacitous decision. Further, [Stanley] has been diagnosed with bradyphrenia⁹ secondary to Parkinson's, a condition that can affect thought processing as well as the speed of thought.'*
- 6.36. A multidisciplinary meeting was held, attended by hospital staff and RAID. However, neither the community Social Worker or the mental health care coordinator were aware of the meeting. The hospital made Stanley subject to an urgent Deprivation of Liberty authorisation.¹⁰ When further assessment under the provisions of the Deprivation of Liberty Safeguards 2007, was carried out, Stanley was deemed to have capacity and therefore could not be compelled to remain in hospital. He returned home only to be readmitted within 24 hours.

⁹ Bradyphrenia is a neurological term referring to the slowness of thought common to many disorders of the brain.

¹⁰ A hospital may grant an 'urgent' Deprivation of Liberty Authorisation where they believe a person lacks capacity for arrangements for their care and treatment, the care is so restrictive as to deprive them of their liberty but that is required in their best interests. Further assessment is then carried out under the Deprivation of Liberty Safeguards 2007.

- 6.37. The PDNS requested a safeguarding multiagency case conference. Various multi-disciplinary meetings were held though none brought together all the professionals involved.
- 6.38. **In May 2016**, the ambulance service had eleven call outs. Many resulted in Stanley being treated at home. The ambulance service referred onto other agencies such as Social Care and Stanley's GP. A new care agency had been sourced but they were having difficulties in working with Stanley.
- 6.39. Following a further admission, Stanley remained adamant he wanted to return home, even without a care package in place. Capacity assessments confirmed he had capacity. He was offered an interim 'step down' bed in a care home which he reluctantly accepted.

- **Events leading up to Stanley's Death – June 2016**

- 6.40. On the **10th June 2016**, Care Quality Commission, Social Care and the Clinical Commissioning Group met to hold one of their regular meetings to share information about care agencies and care homes that were causing concern. The agencies had a process called 'Serious Concerns Process' that was used when there was significant concern about a provider. The meeting attendees would discuss any agency that was subject to the Serious Concerns Process and discuss other providers of care where there were emerging concerns about care.
- 6.41. At this professionals meeting on the **10th June**, the attendees discussed a care agency called L&M Care Limited. This was due to an increased number of complaints and high levels of staff sickness. As L&M Care Limited had been performing well up until Easter 2016, attendees agreed not to suspend new placements or place L&M Care Limited under their Serious Concerns Process. Their plan was to meet with the Director of the L&M Care Limited franchise to seek urgent improvement.
- 6.42. Stanley was discharged to the 'step down' care home bed on the **11th June 2016**.
- 6.43. On the **13th June 2016**, the hospital social work team sourced a care package from L&M Care Limited, agreed to begin from 16th June. The care package was to attend four times per day to assist Stanley with personal care, meal preparation and prompt him to take medication.
- 6.44. The hospital social worker visited Stanley on the **15th June** to talk through the plans for his return home. A care coordination meeting was set up for the **16th June**. Stanley was invited but declined to attend.
- 6.45. The meeting on the **16th June** was attended by Stanley's Psychiatrist, Care Coordinator and hospital discharge team social worker. Mental health services confirmed an earlier decision to discharge Stanley from their care. This was based on their assessment that he did not have depression and his needs arose from his Parkinson's and that he had capacity to make decisions albeit unwise ones. It was anticipated that Stanley would need ongoing support and that this would be sought through the Social Care Extended Involvement Team.
- 6.46. The plan was for Stanley to be discharged home on the afternoon of **16th June 2016**. A food

package was due to be delivered to the care home for Stanley to take home with him and a visit from L&M Care Limited was scheduled for that afternoon. Meals on wheels were contacted by the hospital social worker to start from **17th June 2016**. However, the Meals on Wheels service then received a separate notification from the hospital discharge team to start on the **18th June 2016**.

- 6.47. On the **17th June 2016**, the hospital social worker emailed the Social Care Extended Involvement Team, asking for their involvement with Stanley and to provide care during her absence. The Social Worker then went on annual leave for 2 weeks.
- 6.48. While the hospital social worker was away, the Extended Involvement Team had emailed back to say they were unable to allocate a worker. This email was not read until the hospital social worker returned from leave 2 weeks later and began to follow up on Stanley's care, not aware that Stanley had died the day before.
- 6.49. At 9am on the **Friday 17th June 2016**, an ambulance was called out by Stanley. He was conveyed to hospital but then returned home. Stanley's clinical record stated that his care agency was to be called on discharge. A Doctor from the hospital duly phoned L&M Care Limited and spoke with Ms Y who confirmed L&M Care Limited was due to visit that afternoon and evening.
- 6.50. The ambulance made a referral to Stanley's GP for clarification about his care arrangements and for a home assessment by Social Care.
- 6.51. On the **17th June 2016**, the Meals on Wheels service tried to contact Stanley to confirm his discharge date. They got no response so called his neighbour who informed them that Stanley was back in hospital. Their record was, *'Called Neighbour who informed HILS that client back in hospital - suspend meals until further notice.'* Social Care was not informed of this.
- 6.52. On the **17th June 2016**, Ms Y from L&M Care Limited called Social Care to speak to someone about Stanley. A message was left asking for a call back. The hospital duty social worker tried to call back on numerous occasions but got no response so passed the task through to their weekend team.
- 6.53. At 5pm on **Friday 17th June 2016**, the ambulance was called out by L&M Care Limited carers, concerned about Stanley's mobility and that he was not speaking, eating or drinking. The ambulance attended and found Stanley to be fully mobile. The ambulance crew were very concerned about the state of the property and concerned about the state of the house. However, they did not feel Stanley needed to be conveyed to hospital. The ambulance made a referral to Stanley's GP for clarification about his care arrangements and for a home assessment by Social Care.
- 6.54. The L&M Care Limited carer was in Stanley's property throughout the ambulance attendance. The ambulance crew informed police in their subsequent investigation, that they were confident that the carer who was present, was aware that Stanley would not be going to hospital. However, the L&M Care Limited supervisor's record states, *'Spoke with ambulance, they are looking into things and will admitted to hospital.'*
- 6.55. On **Saturday 18th June 2016**, Stanley made two calls to the ambulance service. The ambulance

crew attended and found Stanley to be alert and orientated, requiring minimal assistance to stand upright and be mobile. The crew assisted Stanley with giving medication, personal care, observed him mobilise downstairs and make food.

- 6.56. Stanley informed the crew he had a care package but had not seen anyone that day. The ambulance crew contacted L&M Care Limited and spoke with a supervisor. L&M Care Limited informed the ambulance crew that no care package was in place and nothing was available until Monday 20th June. A discussion took place between the crew and L&M Care Limited supervisor. In the Police investigation that followed, L&M Care Limited reported they were left with the impression that Stanley was going to be taken to hospital. However, he remained at home.
- 6.57. The ambulance crew contacted the EEAST Single Point of Access to make a safeguarding referral to Social Care. EEAST emailed a referral to the Social Care safeguarding inbox asking for a care package.
- 6.58. On **Saturday 18th June 2016**, the hospital discharge weekend team were trying to contact L&M Care Limited to return Ms Y's call. Several attempts were made and then a message left giving a contact name for that weekend and that the team duty worker would be available from Monday.
- 6.59. On **Monday 20th June 2016**, the Social Care point of access 'See and Solve' service reviewed the referral from the ambulance service. The worker checked the electronic record that showed Stanley already had a package of care in place and did not progress as a safeguarding adult enquiry. The referral was sent to the hospital discharge team for the social workers to follow up. The referral remained in the intake tray and was not followed up.
- 6.60. **Monday 27th June 2016**, Stanley was found deceased on his sofa by a L&M Care Limited carer. Their visit had been accidentally scheduled by L&M Care Limited and was their first visit since 17th June 2016. L&M Care Limited informed Stanley's sister.
- 6.61. On the **28th June 2016**, the Social Care Early Intervention team manager contacted the hospital social worker with a plan to arrange a joint visit and transfer of Stanley's care. It was not until the **29th June 2016** that Social Care became aware of Stanley's death, following being informed by Stanley's sister.
- 6.62. Stanley's sister informed Social Care that L&M Care Limited had told her that they were refusing to visit Stanley due to state of his property and lack of food in property. L&M Care Limited informed her they had not been contacted about restarting Stanley's care following his discharge from hospital on the 17th June 2016.
- 6.63. Subsequent Police investigation was not able to establish the time of Stanley's death. Nor was it possible for the Police to establish if prior to his death, he had been able to care for himself or been unable to move due to his Parkinson's associated with medication non-compliance. A toxicology report was negative for traces of medication but due to Stanley's pattern of non-concordance with medication, it is not possible to establish whether he stopped taking medication prior to his death.
- 6.64. The cause of Stanley's death was recorded as 'Sudden Adult Cardiac Death Syndrome.'

7. Analysis and Learning

The following section provides analysis of the events – both in relation to working with Stanley in a preventative capacity as well as the events directly preceding his death. The analysis and learning is grouped under three themes:

- Working with self-neglect
- Communication and coordination of services
- Wider commissioning

7.1. Working with self-neglect

7.1.2. The records demonstrate that there were many agencies and individual practitioners who were working hard to try and meet Stanley’s complex combination of physical, psychological and mental health needs. The following is not an exhaustive list:

Figure One: Practitioners and Services Involved

7.1.3.

GP	Occupational Therapy	Physiotherapy	Neurology	Specialist Parkinson's Nurse	Clinical Psychology
Meals on Wheels	Social Worker	Support Worker	Psychiatrist	MH Care Coordinator	Integrated Care Team
Acute Inpatient	A&E	Home Care Agency	Hospital Discharge	MH Inpatient Liaison (RAID)	MH Inpatient

7.1.4. Care was available - the challenge for these agencies was how to help Stanley make best use of this care.

7.1.5. There was a shared agreement across agencies that Stanley was self-neglecting,¹¹ that is:

- Lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- Lack of care of one’s environment – squalor and hoarding, and/or
- Refusal of services that would mitigate risk of harm

7.1.6. The Department of Health commissioned research into self-neglect, published by the Social Care Institute for Excellence (SCIE) in 2015¹². This research identified the significant challenges that individual practitioners, agencies and safeguarding partnerships have in responding to self-neglect. The research highlighted factors that led to more successful self-neglect practice,

¹¹ Definition: <http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/>

¹² Ibid

summarised in the table below.

7.1.7.

Practice Factors Most Successful in Self Neglect	
1.	Time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement
2.	Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history
3.	Working at the individual's pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small
4.	Creative and flexible interventions, including family members and community resources where appropriate
5.	Understanding the nature of the individual's mental capacity in respect of self-care decisions
6.	Having an in-depth understanding of legal mandates providing options for intervention
7.	Being honest, open and transparent about risks and options
8.	Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals.

7.1.8. The response to Stanley is evaluated against these factors.

7.1.9

SCIE: Practice Factors Most Successful in Self Neglect	
1.	Time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement and

7.1.10 At the learning event, practitioners reflected on how well agencies had been able to establish relationships and offer continuity of care to Stanley.

7.1.11 Stanley did have some long established and consistent relationships – with his GP; his mental health Care Coordinator, his Psychiatrist and his Parkinson's nurse. For other Health services, their roles and relationships with Stanley were much more transient and task orientated.

7.1.12. Stanley's sister commented on the numbers of different Social Workers involved in his care. Between December 2013 and June 2016, there were fourteen different Social Care workers from hospital discharge, community and safeguarding services, the longest involvement being three months.

<p><i>‘they tried the best they could but they needed time to build a relationship with him. He found this very frustrating – he was quite exacting and lacked patience.</i></p> <p style="text-align: right;">Stanley's Sister</p>
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7.1.13. Stanley's sister also commented on Stanley's difficulty in forming relationships with carers from the care agencies. He felt they were always rushing and didn't understand him.

- 7.1.14. Records do indicate a high turn-over of different care agencies and many reports of carers struggling to engage with Stanley.
- 7.1.15. This does not imply that individual care workers were not caring or did not try to engage with him. Their ability to form relationships is likely to be impeded by consistency of worker allocated, length of visit, and the personal care tasks that they were being asked to complete which Stanley may have found demeaning.
- 7.1.16. Notably, there were no difficulties experienced within the Meals on Wheels service in their relationship with Stanley. This may have been because Stanley had originally contracted with them and felt more under control. It may have been due to the nature of the service being less intrusive. It may have been due to how individual staff approached him or a combination of these and other factors.
- 7.1.17. Stanley's sister also recalls positive relationships during a period of time Stanley spent in one care home in 2014. Stanley's sister felt he was given the space and time to recover and jobs to help with so that he felt valued.
- 7.1.18. Stanley's response reflects the research. The quality and consistency of the relationship is key to effecting change in self-neglect. This requires investment of time – time that in the current climate of efficiencies for Health and Social Care, is often not available.
- 7.1.19. For people with complex needs such as Stanley's, investment in these relationships makes sense due to the human cost of failing to get this right. Moreover, there is a resource cost to the system arising from self-neglect and repeat admissions.

[Recommendation 1]

7.1.20.

SCIE: Practice Factors Most Successful in Self Neglect

2. Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history

- 7.1.21. During the review learning event, attendees reflected on the multiple losses affecting Stanley and the psychological impact on him - his frustration, anger and sense of hopelessness.
- 7.1.22. Attendees discussed whether Stanley's challenging behaviour toward agencies, his changeable views and seemingly irrational responses, may have been a mechanism for him to exert control in one area of his life and perhaps make others experience some of the frustration he was living with.
- 7.1.23. There was some indication within the records of this frustration. There were multiple accounts of care agency workers declining to work with Stanley. There was one instance recorded in 2016 when A&E Doctors threatened Stanley with legal action due to his number of attendances and non-compliance with medication.

- 7.1.24. However, there was also substantial evidence of compassionate care by staff from the different agencies. One example was the ambulance crew, buying and preparing food for Stanley following another 999 call-out.
- 7.1.25. There was also evidence of attempts within Stanley’s care planning to understand his behaviours and to help him adjust to his difficult life circumstances.

‘Impression is that [Stanley] may be experiencing depression/isolation on top of Parkinson’s. Plan: Home base support is to be facilitated by CC. He will be reviewed by psychiatrist/Dr [X] on D/V He will probably benefit from support worker/ or even a befriender, due to social isolation. May need psychological therapy, due to maladaptive behaviour.’

HPFT Chronology Nov 2015

- 7.1.26. Clinical Psychology was offered through the HCT Neurological service however Stanley declined this. Practitioners who knew Stanley felt he may not have found talking therapies or support groups easy.
- 7.1.27. The SCIE self-neglect research highlights that supervision is an essential function to help practitioners step back and evaluate their practice and disentangle some of the frustration and blocks when working with self-neglect.
- 7.1.28. There were some references to practitioners seeking guidance from managers on the risks associated with his ‘unwise decisions.’ It was less clear how supervision was used to unpick motivations behind his behaviours and to help practitioners constructively manage the emotional impact this had on them.
- 7.1.29. Stanley declined support from psychologists. However, a psychologist’s perspective could have been an asset within a multi-agency approach, providing a consultative role to practitioners. This could help agencies work with the complexities associated with self-neglect; both in terms of exploring the functions of Stanley’s behaviours and helping practitioners to explore different approaches.
- 7.1.30. Clearly with stretched resources, this is not a realistic option for most cases. However, it may be a cost-effective use of specialist expertise in the small number of complex self-neglect cases. **[Recommendation 1]**

7.1.31.

SCIE: Practice Factors Most Successful in Self Neglect

- 3. Working at the individual’s pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small and**
- 4. Creative and flexible interventions, including family members and community resources where appropriate**

- 7.1.32. The chronology highlights the tensions in the system in trying to work with people at their pace, but needing to manage huge pressures to discharge from hospital beds.
- 7.1.33. There were repeated accounts of Stanley being assessed as ready for discharge but this being delayed while the discharge team tried to gain his agreement to accept a package of care.
- 7.1.34. From the information available, there was evidence that workers tried hard to negotiate with Stanley, and tried to work at his pace within the confines of a pressured hospital environment.

'Long discussion was held with [Stanley] regarding the concerns there are about returning home without the appropriate care and support being available. Talked at length regarding continence care, lack of engagement with the care staff prior to being admitted to hospital this time and concerns regarding falls and frequent admissions to hospital.'

Integrated Hospital Discharge May 2016

- 7.1.35. Opportunities were used when Stanley was potentially more amenable to change, to talk with him about managing his medication and accepting services such as respite care or using aids and adaptations.
- 7.1.36. However, there was limited evidence that these efforts were leading to sustained change. The records convey a sense of going around and around and a continuous sense of battling with Stanley.
- 7.1.37. Though Stanley's needs may not have met the statutory criteria for involving advocacy¹³, there may have been merit in offering advocacy to help Stanley have a greater sense of his voice being heard and to reach a more constructive solution. There is no record that this was considered.
- 7.1.38. There may not have been any clear solution. However, there were missed opportunities for *all* agencies to come together to try and generate creative approaches to changing this negative cycle, for example, using techniques well tested within mental health Assertive Outreach.¹⁴
- 7.1.39. Adopting this approach *may* have made a difference, for example, working on agreed small changes; shifting the focus of intervention, working through people that did have a more constructive relationship, such as the Meal on Wheels service. The involvement of HILS as provider of Meals on Wheels is discussed further in section 7.2. below.
- 7.1.40. One ongoing battle was in relation to Stanley refusing to pay for services. This was a recurrent issue in his resistance to care.
- 7.1.41. Paying for social care is nationally an area of much political debate¹⁵. Local Authorities have tight budget restraints. Under current national policy, applying a means test is necessary to be able to meet the social care needs of the population.

¹³ Care Act 2014 An advocate must be appointed where a person has substantial difficulty in being involved and if there is not an appropriate individual to support them

¹⁴NICE evidence Assertive Outreach

<https://www.evidence.nhs.uk/search?q=Assertive+Outreach+Team>

- 7.1.42. The Care Act 2014 set out national eligibility criteria for access to adult care and support and the ability (or willingness) to pay does not remove the Local Authority's duties of care.
- 7.1.43. HCS has a 'waiver' finance form that practitioners can submit for approval where exceptional circumstances indicate that a person who has financial means, should not pay for their care. This waiver, is assessed on a case by case basis.
- 7.1.44. There is no record that this waiver form was considered in relation to Stanley. One was not submitted for approval and had it been, there may well have been justification for declining it.
- 7.1.45. Views from the review learning event were that there needed to be a clearer protocol, criteria and senior sign off around use of the finance waiver and for front line Social Care staff to be aware of this. It was also noted that multi-agency information would help inform a justifiable and equitable decision around approving the waiver or not.
- [Recommendation 2]**
- 7.1.46. A further key factor in interventions, was how the agencies were able to involve Stanley's family and other social supports.
- 7.1.47. Stanley was fortunate to have supportive sisters. However, they were having to offer assistance from some distance.
- 7.1.48. Agencies reported talking with Stanley to seek consent to contact his family – this was declined. As he had capacity in relation to this decision, professionals would not be able to breach his confidentiality unless in Public Interests.
- 7.1.49. There were some occasions when practitioners were able to have discussion with Stanley's sisters and make plans regarding a deep clean of his property. HPFT acknowledged that their records were not clear about whether Stanley's consent was explicitly sought when they contacted his sister, and identified learning for their agency in relation to this.
- 7.1.50. There was also learning for HILS regarding the involvement of Stanley's supportive neighbour, Mr A. Stanley had given Mr A's name as a contact point for the Meal on Wheels service. However, HILS had not confirmed with Mr A whether he was happy to be used in this capacity. (Section 9 notes how HILS has now acted on this learning.)
- 7.1.51. It transpired that Mr A was regularly contacted regarding missed calls which may have been a burden for him. He was highly distressed and felt a sense of responsibility (though misplaced), in relation to the miscommunication in the events surrounding Stanley's death. This miscommunication is discussed further in section 7.2 below.
- 7.1.52.

SCIE: Practice Factors Most Successful in Self Neglect

¹⁵ The Kings Fund: Paying for Social Care, Beyond Dilnot
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/social-care-funding-paper-may13.pdf

5. Understanding the nature of the individual's mental capacity in respect of self-care decisions
and
6. Having an in-depth understanding of legal mandates providing options for intervention
and
7. Being honest, open and transparent about risks and options

7.1.53 Nationally, there has been concern regarding poor application of the Mental Capacity Act.¹⁶ However, there was no evidence of this in this review.

7.1.54. There was consistent evidence of all agencies repeatedly considering Stanley's mental capacity as part of ongoing care planning and providing him with information to make informed decisions.

'Therapist explained was at high risk of falls and fractures. Discussed respite which he had previously refused in hospital. Patient highly intelligent man who has demonstrated capacity, however he continues to take risks and make unwise decisions about his care.'

HCT Integrated Care Team Sept 2015

7.1.55. Case law¹⁷ has warned practitioners against taking an 'outcome' approach to assessments i.e. the assessment of capacity is swayed by the gravity of the risk involved in the decision.

7.1.56. On all but one occasion, the outcomes of the assessments was that Stanley had capacity and practitioners accepted his right to make unwise decisions.

7.1.57. The fact that a capacitous person is making an unwise decision, does not negate a duty of care on all professionals to do what is reasonable to help the person understand and reduce risks associated with their decision.

7.1.58 From the information submitted, it appeared clear that significant efforts were taken by all agencies to help Stanley explore risks and options.

'[Stanley] expressed a strong wish to return home form hospital and made it clear to myself and [X] that he was not going to be transferred anywhere else. He told us that it is his legal right and he will manage without carers if he has to. Discussed concerns regarding him managing his medication, He denied this and told us that he takes his medication regularly including sinemet. I explained that carers have raised concerns regarding medication mismanagement prior to being admitted. [Stanley] again denied this.

When asking how he will manage to arrange his shopping and meal prep when he gets home he replied "that is a concern". discussing this further [Stanley] told me that he still wishes to return home with or with out carers and will not be discharged anywhere else..'

Integrated Hospital Discharge May 2016

¹⁶ House of Lords Post legislative Scrutiny Committee, Mental Capacity Act 2005
<https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm>

¹⁷ Court of Appeal PC and NC v City of York Council 2013 EWCA Civ 478

- 7.1.59. On one occasion when Stanley was intending to take self-discharge, a capacity assessment was carried out around this decision. This assessment was carried out by someone with expertise in assessing capacity who provided a detailed record of that assessment.
- 7.1.60. The follow-on assessment under the provisions of Deprivation of Liberty Safeguards¹⁸ found Stanley did have capacity and therefore no authority to prevent him self-discharging.
- 7.1.61. There was also an occasion in 2015 when the Mental Health Act 1983 (2007) was applied as a legal framework for assessment and treatment of Stanley’s mental health. By June 2016, he was assessed as not having a mental disorder so the Mental Health Act would not apply.
- 7.1.62. It therefore appears that practitioners were considering and applying the relevant legal framework. They were working to help Stanley understand risks but had no authority to compel him to receive care.

7.1.63.

SCIE: Practice Factors Most Successful in Self Neglect

8. Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals.

7.1.64. This factor is a substantial area of learning and is examined in more detail in the following section.

7.2. Communication and Coordinating Care for People who are Resistive to Care

- 7.2.1. This section considers communication and coordination of care in two key episodes:
1. Pre-June 2016
 2. June 2016 – the period leading up to Stanley’s death
- 7.2.2. **• Coordination and Communication of Stanley’s Care: Pre-June 2016**
- 7.2.3. As noted in figure 1, there were multiple agencies involved and a general willingness by agencies to do what they could to support Stanley’s care.
- 7.2.4. In some situations, there can be dispute regarding whether the mental health services or physical health services should lead and fund¹⁹. While there was debate about Stanley’s primary needs, there was good joint working between HPFT and HCT and agreement to share funding.
- 7.2.5. However, despite this willingness by different services to be involved, records dating back to 2013, demonstrate a general lack of effective communication and coordination within and between all the services involved.
- 7.2.6. At the learning event, practitioners highlighted that not all the agencies were aware of who was

¹⁸ Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice

¹⁹ Rethink, (2012) 20 Years Too Soon, https://www.rethink.org/media/511826/20_Years_Too_Soon_FINAL.pdf

involved, what their roles were or who was coordinating.

- 7.2.7. There were multiple occasions of aborted calls as community health staff visited, only to find Stanley had been admitted to hospital. Community health managers, commented on the waste of scant resources in doing this.
- 7.2.8. Given the frequency and short turn-a-round of hospital attendances/admissions, it is perhaps understandable that tracking and communicating Stanley's whereabouts was challenging. However, the lack of coordination was not just based around these short turn arounds.
- 7.2.9. HPFT observation was that communication blocks seemed to be mainly between inpatient and community services, even within their own agency.

'Clinical notes indicate that HPFT were rarely informed of [Stanley's] admission or discharge from hospital. ... The Care Co-ordinator often had to chase and 'cold call' different hospital and agencies to find out if [Stanley] had been admitted. This was usually triggered by the fact that [Stanley] wasn't at home for a planned visit. From the HPFT perspective, the main communication issues appear to be between inpatient and community services, specifically around discharge and discharge planning.'

'At times, there is evidence that RAID did not liaise directly with their HPFT colleagues in the community. For example, on 11/4/16 there was a multidisciplinary meeting attended by hospital staff and RAID but it appears that the Herts County Council Social Worker or HPFT Care Co-ordinator were not aware of this meeting. This meeting was significant as RAID Psychologist's capacity assessment (8/4/16) was discussed. She had found that [Stanley] lacked capacity to make decisions about his care. Nothing in the clinical notes indicates that the Care Co-ordinator was aware of the meeting (or that [Stanley] was in hospital) until he locates RAID notes on [IT system]'

HPFT report

- 7.2.10. From the records, it appears there were parts of the multi-disciplinary and multi-agency system that were liaising regularly, for example:
- Hospital based multi-disciplinary professionals meeting to discuss frequent attender plan
 - Safeguarding Adult Meetings involving HPFT and HCS that tried to involve Stanley
 - Liaison between EEAST and the GP practice regarding 'frequent caller' plan
 - Six monthly mental health Care Co-ordination reviews, usually attended by Herts County Council Social Worker.
- 7.2.11. However, at no point was there a multi-agency meeting that involved all agencies coming together to develop a cohesive and comprehensive plan. Key players in Stanley's care such as the ambulance service and HILS as daily provider of Meals on Wheels were never involved in multi-agency meetings.
- 7.2.12. Had such a multi-agency meeting been held, this would have offered the opportunity to:
- i) Coordinate a holistic care plan through a lead professional
 - ii) Develop a communication strategy between all involved including how to communicate attendances and admissions
 - iii) Be clear about roles and responsibilities of services and practitioners.

- iv) Bring together wider perspectives on Stanley's care needs and associated risks
- v) Explore different approaches to working with Stanley including the role of his family
- vi) Agree crisis and contingency plan with a shared approach to managing risk
- vii) Access specialist opinion for the whole multi-agency team, for example, Psychology, legal advice, fire safety advisor
- viii) Seek commitment that no agency pulls out without discussing/informing others.

- 7.2.13. The Care Programme Approach (CPA) is a way that services are co-ordinated and reviewed for someone with complex mental health needs²⁰. The CPA Care Coordinator is responsible for developing the care plan, coordinating involvement of others and reviewing whether care (and risks) are being addressed.
- 7.2.14. The HPFT CPA policy specifies that individuals who have complex needs, are receiving care from multiple agencies, experiencing self-neglect, have physical health needs and are reliant on carers should be on CPA. However, Stanley was placed on Standard Care rather than CPA.
- 7.2.15. The author of the HPFT report commented that this may have been an administrative error and that in practice, CPA was in place - his allocated worker was referred to as 'Care Coordinator' and reviews with HCS Social Worker and Stanley, were held 6 monthly, double the minimum frequency required for reviews.
- 7.2.16. While the high level of input and regular reviews were good practice, the CPA should coordinate across all agencies, not just Mental Health and Social Care. HPFT identified learning in relation to this point.
- 7.2.17. There is call to develop a structure where an enhanced multi-agency approach is committed to by all involved agencies when certain circumstances apply, i.e.
- i) the person has complex care needs *and*
 - ii) multiple agencies involved *and*
 - iii) significant risks arising from self-neglect *and*
 - iv) those risks are not reducing
- 7.2.18. Where existing fora such as CPA is already in place, it can perform this function.
[Recommendation 1, Recommendation 3]
- 7.2.19. Subsequent to Stanley's death in 2017, Hertfordshire Safeguarding Adults Board commissioned an audit of HSAB partners responses to self-neglect. This audit highlighted the importance of a coordinated multi-agency approach in managing self-neglect.
- 7.2.20. The report arising from the audit made a number of recommendations. In summary:
- Develop a strategy to manage self-neglect
 - Develop a pathway for self-neglect including when it is best managed under Safeguarding Adults' procedures
 - Provide practitioners with a resource pack of guidance on self-neglect

²⁰

http://webarchive.nationalarchives.gov.uk/20130124042407/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

- Provide training and supervision across the agencies
- Audit the efficacy of the self-neglect pathway once it is in place

7.2.21. The HSAB had already begun working on the recommendations at the time of this review. The findings from this review should inform this work.

[Recommendation 1]

7.2.22. **• Communication and Coordination in June 2016 -the Period Leading up to Stanley's Death**

7.2.23. The review identified a tragic sequence of events that created something of a perfect storm.

7.2.24. Stanley had been receiving support through his mental health Care Coordinator. Just prior to his return home from the care home, his HPFT Psychiatrist determined that he did not have a mental disorder that met criteria for their services and he was discharged from their care.

7.2.25. Stanley had also recently been discharged by the HCT Neuro Rehab Service as there had been no response to telephone calls or written requests for him to make contact. The PDNS was informed but it is not clear if other agencies were made aware. The PDNS last recorded attempted contact with Stanley was in April 2016 – this was a 'no reply.' There was no other Community Health service involvement.

7.2.26. The plan for Stanley's discharge from the care home was that Stanley would receive a care package four times a day and meals on wheels. A HCS Social Worker would oversee this care package to ensure it met his needs.

7.2.27. HILS Meal-on-Wheels were well used to responding to the somewhat chaotic picture that surrounded Stanley's care as he moved in and out of hospital. The records indicate they had begun to slip into a pattern that did not follow their 'no reply' procedures.

7.2.28. As a comparison, entries in March 2015 record *'No reply. Driver entered property using the key safe, and confirmed client was not at home. Left message with neighbour.'*

7.2.29. By 2016, records indicated *'presume in hospital'* and an ever-increasing reliance on Stanley's elderly neighbour, Mr A, to inform them of his whereabouts.

7.2.30. HILS had received conflicting dates from the hospital discharge team regarding when to start Meals-on -Wheels (16th and 18th June). Having tried without success to check directly with Stanley, they contacted Mr A who informed them that he was in hospital when in fact he had returned home. This was not rechecked with the hospital discharge team. As this was done by phone, previous safety nets of using Stanley's key-safe to physically check his home, were not carried out.

7.2.31. The contact numbers that HILS held did not differentiate between the purpose of the contacts i.e. emergency contacts; contacts to coordinate care etc. At that time, HILS also did not have a specific procedure for re-starting suspended care.

[Recommendation 3]

- 7.2.32. HCS had the task of commissioning a care package.
- 7.2.33. HCS had significant pressures at this time in sourcing home care providers. This was partly due to care agencies declining to provide care to Stanley. However, there was also a general shortage of home care agencies available.
- 7.2.34. Some months earlier, HCS had suspended their contract with a large care agency due to concerns about their service. This agency would ordinarily offer care to service users with more complex needs such as Stanley. The loss of this provider meant capacity within the system was very stretched.
- 7.2.35. As outlined in the chronology, HCS, the NHS Clinical Commissioning Group and the Care Quality Commission had met on the 10th June 2016 to discuss emerging concerns about L&M Care Limited. At this time, the judgement was that concerns did not warrant suspending the HCS contract with L&M Care Limited. The plan was to meet with the L&M Care Limited Director to require improvements.
- 7.2.36. What is *now* known is that L&M Care Limited, the agency that was commissioned for Stanley's care, was an organisation in chaos. They had staff shortages and difficulty in meeting their service agreements.
- 7.2.37. The Police investigation report noted that this L&M Care Limited branch actively recruited staff from overseas. What is not known is whether the staff involved in the events between 16th and 27th June, used English as a second language and if so, whether this was a contributory factor in the miscommunication.
- 7.2.38. There were several strands of miscommunication. The first was a record from the hospital Doctor that records the name of a L&M Care Limited supervisor who was informed of Stanley's return home on the 17th June and that care was needed from that afternoon. This is at odds with the account that L&M Care Limited gave to Stanley's sister following his death. Stanley's sister recalls L&M Care Limited informing her that they had not been contacted about restarting Stanley's care following his discharge on the 17th June. The evidence indicates this was not true.
- 7.2.39. A further strand of miscommunication was during the second ambulance call-out on the 17th June. EEAST reported that the carer in Stanley's home was clear he was to remain at home. The supervisor however, recorded *'Spoke with ambulance, they are looking into things and will admitted in hospital.'*
- 7.2.40. The communication on the 18th June was equally confused. The Police investigation report notes the ambulance staff appearing to debate with the L&M Care Limited supervisor what to do if no care agency were available and whether Stanley would need to go into hospital. However, assumptions were then made by L&M Care Limited about Stanley's admission that were not confirmed.
- 7.2.41. A key message that needs to be reinforced across agencies is:

**Ambulance attendance does not equal conveyance
Ambulance conveyance does not equal admission**

- 7.2.42. The next strand of miscommunication was between the Ambulance Service and Social Care.
- 7.2.43. On the 18th June 2016, the ambulance crew sent a referral through to Social Care and to Stanley's GP regarding his care arrangements.
- 7.2.44. The ambulance crew had tried to resolve Stanley's predicament, providing practical help, buying some food and then contacting L&M Care Limited – as noted, this appeared an excellent example of compassionate care.
- 7.2.45. In trying to seek a solution, they made a referral through their EEAST regional Single Point of Contact to generate a referral. However, the wording on this referral did not flag the seriousness of the circumstances and specify that the care package had been withdrawn.

'Patient lives alone and suffers from parkinson's. He is well known to local health authorities for being non-compliant with his medications. He has frequent episodes of muscle stiffness because of this. His house is very cluttered and untidy. Patient would benefit from care package to help with him with daily living.'

Question: Is self-neglect/environmental concern the primary reason for referring the person

Answer: Yes

Question: Describe the person's home environment/living conditions

Answer: cluttered, rugs everywhere, dirty clothes, paperwork all around

Extract from Referral to HCS Social Care from EEAST

- 7.2.46. The method for EEAST making the referral was by e-mail. Though it went through to the safeguarding secure inbox, the reason on the referral form was Adult Social Care. The urgency of the referral was not clear or whether this was a safeguarding or social care referral.
- 7.2.47. There is learning for the ambulance service in relation to this and in specifying the nature of concerns more clearly, e.g. *'care package has been withdrawn, immediate assistance required.'*
[Recommendation 2]
- 7.2.48. The result was that the HCS intake team 'See and Solve' reviewed the email on the 20th June, checked the system and noted that Stanley was recorded to be receiving a care package from L&M Care Limited. An assumption was made that this was still in place.
- 7.2.49. The referral was passed through to the hospital discharge team for follow up – it sat in their in-tray and was not followed up.
- 7.2.50. At the learning event, HCS and EEAST explored communication difficulties between their agencies, particularly out of hours. HCS state they are not able to process email referrals out of hours and referrers needed to contact by phone if they had an urgent safeguarding referral or

any urgent social care referral.

- 7.2.51. EEAST described the pressures and complexities of an emergency service crew covering a whole region and their Single Point of Contact being a robust means of making referrals.
- 7.2.52. What is clear is that EEAST and HCS need to come together to find a resolution that takes account of pressures on both agencies but ultimately delivers robust communication out of hours.
[Recommendation 2]
- 7.2.53. The third element in this sad sequence of events was the involvement of Social Care in overseeing the package of care.
- 7.2.54. The hospital discharge team had been aware that L&M Care Limited had tried to contact them on Friday 17th June, and had tried without success to return their call – this was then passed to their weekend team who also had no success.
- 7.2.55. There appeared to be no follow up on this, post the weekend and no link up with the EEAST referral that came through from See and Solve regarding Stanley -as noted, it was left in the team in-tray.
- 7.2.56. There was also no follow up on the new package of care from L&M Care Limited as should have been the standard of practice.
- 7.2.57. The hospital discharge social worker had tried to hand over to the HCS community Extended Involvement Team (EIT) before going on leave. This was done by email. There was an assumption EIT would allocate though there had been no confirmation of this. The response from EIT declining input, went back to the discharge team social worker's email with the assumption that this would be read and acted on. It is not clear whether an 'out of office' message indicated the social worker would not be back for 2 weeks.
- 7.2.58. There is learning for HCS in relation to systems for continuity and resilience
- Communication and transfer of tasks between their day time and weekend services
 - Oversight and prioritisation of referrals into their service
 - Resilient systems when allocated staff are away
- [Recommendation 3]**
- 7.2.59. Overall, between and within agencies, there was a theme about poor communication and assumptions being made without checking facts.
- 7.2.60. This was a catalogue of unfortunate, and avoidable events. No single failure of itself was likely to have been a pivotal issue, but collectively it was.
- 7.2.61. Stanley had had previous periods where he had returned home without a care package in place but others were aware of the risks surrounding this. On this occasion, Stanley was also not receiving daily meals-on wheels, his supportive neighbour did not know he was at home, Social Care thought he was receiving a care package, he had no Social Worker following up and he no

longer had a Care Coordinator.



7.2.62. Had there been an ‘enhanced’ multi-agency approach, as detailed in 7.2.12, this could have provided a robust structure with a lead coordinator and deputy in their absence; a crisis plan with up-to-date contacts; current care package and ‘flags’ on care records to highlight risk and priority responses.

[Recommendation 1]

7.2.63. It is not possible to say whether this would have averted the sad circumstances of Stanley’s death. We don’t know how Stanley was managing after he was last seen on the 18th June.

7.2.64. What is known, is that over the nine-day period before his body was found, he had no contact from any of the agencies involved in his care.

7.3. Wider Commissioning

7.3.1. This final section considers wider factors relating to commissioning care providers.

7.3.2. Commissioned care services are required by their regulators, the Care Quality Commission, to meet fundamental standards.²¹ These standards cover a range of elements including quality of care plans, recording, staffing and management.

²¹ Care Quality Commission <http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards>

- 7.3.3. In addition, care providers have specific requirements set out through contractual arrangements with their commissioning bodies, such as Adult Social Care.
- 7.3.4. Such contracts routinely include service specifications about the quality of care and expectations on the service relating to such aspects as continuity of care; staffing; business resilience and period of notice before terminating care.
- 7.3.5. HCS had such a contract in place and had carried out a series of monitoring visits to L&M Care Limited.
- 7.3.6. L&M Care Limited had been under the Hertfordshire ‘Serious Concerns Process’ from October 2014 – May 2015 and had a suspension on new packages. Having made improvements, the suspension was lifted in August 2015.
- 7.3.7. HCS continued to monitor L&M Care Limited and carried out a full compliance visit in October 2015 where a ‘good’ rating was given. However, by January 2016, L&M Care Limited was beginning to be unable to meet service demands and gave notice to reduce its services in another area.
- 7.3.8. This created further pressures on the availability of care providers. The shortage of providers resulted in something of a provider led market. It was more difficult to find a provider who was willing to meet Stanley’s complex needs and challenging behaviours and no choice was available.
- 7.3.9. Nonetheless, L&M Care Limited had contracted to deliver care to Stanley and with that, their obligation to meet their regulatory and contractual standards.
- 7.3.10. In a report written to Social Care by the L&M Care Limited franchise owner regarding Stanley’s death, he concluded:

[L&M Care Limited] ‘reasonably concluded that [Stanley] was in hospital and so the suspension was reasonable. However, the company should have followed up with the hospital on Monday 20th or shortly afterwards to determine the current status of [Stanley].....I found there were various multi-disciplinary agencies, including our own, that may have detected the whereabouts of [Stanley] but did not do so.’

L&M Care Limited Franchise Owner

- 7.3.11. The findings from this review, as described in 7.2, are that assumptions were made by L&M Care Limited that should not have been.
- 7.3.12. L&M Care Limited had the primary responsibility to confirm with the hospital whether Stanley had been admitted and to advise Social Care accordingly – they did not deliver on these responsibilities.
- 7.3.13. At the review learning event, the Operations Manager from Caremark Limited which acts as the franchisor, reinforced their expectation that the onus was on the care agency to be proactive and to follow up on the person, communicating with Social Care.
- 7.3.14. The circumstances that HCS was in in relation to the quality and capacity of care providers is not

uncommon.

- 7.3.15. National media²² and research bodies²³ document the crisis of social care provision, characterised by insufficient capacity in the system, difficulty in recruiting and retaining staff, reliance on overseas staff that may have communication difficulties and businesses closing as they become financially unviable.
- 7.3.16. Under the Care Act 2014, Local Authorities have wider duties relating to market shaping, market oversight and contingency planning²⁴ so that people continue to receive the care and support they need should their care provider cease to provide services.
- 7.3.17. At the review learning event, HCS discussed their plans to develop a 'trading arm' of their Local Authority that could provide some direct service provision. This would provide additional capacity and offer greater resilience and contingency where a provider is failing.
- 7.3.18. This may address some of the learning from this review. However, the HCS commissioning strategy should also ensure there is sufficient specialist provision to meet the needs of service users such as Stanley who have complex needs and high level of risk arising from their self-neglect
- 7.3.19. The learning from this review should feed into the development of the HCS strategy for market development and contingency planning.
[Recommendation 3]

8. Conclusions

- 8.1. The review has examined the sad circumstances surrounding Stanley's death.
- 8.2. Stanley had complex needs and lots of services and practitioners were working hard to try and meet those needs. Stanley's resistance to care meant it was more challenging for those practitioners to do so.
- 8.3. Such circumstances call for a higher level of coordination and collaboration between services, working together to try and reduce the risks to health and safety that arise from self-neglect.

²² <https://www.theguardian.com/society/2016/dec/12/social-care-crisis-funding-cuts-government-council-tax>

²³ The Kings Fund and Nuffield Trust (2016) Social Care for Older People: Home Truths
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

²⁴ Department of Health (2017) Guidance on Social Care Market Shaping
<https://www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping>

- 8.4. Though there were some elements of good multi-agency liaison, there was not a unified multi-agency plan in place. This would have enabled all practitioners to work together more cohesively. Such an arrangement may have delivered better care for Stanley as well as making better use of stretched Health and Social Care resources by reducing multiple admissions and missed appointments.
- 8.5. The events surrounding the days leading up to Stanley's death were a catalogue of miscommunication, misplaced assumptions and poor coordination of care. It is less likely this would have occurred had robust multi-agency working been established at an earlier point.
- 8.6. Stanley died of Sudden Adult Cardiac Death Syndrome. It is not possible to say whether this could have been prevented.
- 8.7. It is conceivable that a timely care agency visit or a call from meals on wheels could have provided him with responsive care and the opportunity to summon medical assistance. Ultimately however, this is conjecture.
- 8.8. What is evident is that there are substantial areas of learning for agencies to address in order to lessen the risks for other dependent adults accessing the care services that they rely upon.
- 8.9. From the outset, Stanley's sister expressed her willingness to contribute to the review to help agencies learn and improve, and to make a difference to others. The recommendations below are aimed at achieving this.

9. Acting on Learning

9.1 Since June 2016, agencies have made a number of changes that are relevant to the circumstances of this review, some as a direct consequence of the learning.

9.2 The HSAB, as part of its governance role, should seek assurance from the agencies around how these changes have made a positive impact on the learning from this review and led to improved responses to people in Hertfordshire.

[Recommendation 3]

9.3 These changes include (but not limited to) the following:

9.2

- HSAB commissioned a thematic review of self-neglect. The findings were presented to the HSAB in August 2017. The HSAB has a task and finish group that is working on developing the partnership responses to self-neglect.

9.3

- HILS' referral will be revised to differentiate between different contacts. They have re-trained their teams around 'no reply' procedures, strengthened record keeping, and have introduced a new "re-starting suspended clients" procedure.

9.4

- HCS Commissioners are planning a 'trading arm' of the Local Authority to build resilience for home care provision and contingency where a provider has ceased to deliver services.

9.5

- HCT and EEAST have the ability for a 'flag' to be shown on the district nurse clinical record where the ambulance service has attended a patient known to their service.

9.6

- New resources are being made available under the new GP Commissioning Framework to help facilitate multidisciplinary team working involving community teams to work with patients who are at risk of admission. This more proactive case management should help promote closer working between all agencies.

9.10 From the 24th June, HCS stopped commissioning new packages of care from L&M Care Limited. By 22nd July, the L&M Care Limited ceased trading.

10. Recommendations

- 10.1 In addition to the developments noted in section 9, some of the agencies made recommendations for their agency. These are detailed in appendix 1.
- 10.2 The author has taken these into account and made some additional recommendations for the partnership to take action on.

Recommendations

1. The **HSAB** partner agencies should develop an enhanced multi-agency approach for people who have the most complex needs and highest risks arising from their self-neglect. This enhanced approach may include elements such as:
- i) An identified lead professional
 - ii) A multiagency care plan, coordinated and communicated across all services involved
 - iii) A communication strategy between all involved relating to the person's care
 - iv) Multi-agency risk assessment and risk management including crisis and contingency plan
 - v) Access to specialist advice for the whole multi-agency team, for example, Psychology, legal advice, fire safety advisor
 - vi) Commitment to liaise with partner agencies prior to terminating engagement

Learning from this review should inform the development of their self-neglect pathway and resource pack that is underway.

2. Agencies contributing to this review should take account of the learning from the review and address the following areas to strengthen practice.

2.1. East of England Ambulance Service Trust:

Strengthen quality of safeguarding adult referrals through providing further guidance to their crews and Single Point of Contact. Referrals should indicate whether it is an adult social care or a safeguarding response that is required and the level of urgency.

2.2. Hertfordshire County Council – Health and Community Services and East of England Ambulance Service Trust:

Work together to deliver a solution that provides effective management of any time safeguarding adult referrals. This solution will need to be negotiated between both services, with recognition of the resource constraints and pressures of both services.

2.3. Hertfordshire County Council, Health and Community Services, Adult Social Care:

Review their procedures for determining whether a financial waiver is warranted for a person who has funds to pay for their care so that:

- o Criteria is clear and equitable
- o Decision making takes account of multi-agency information and risk assessment (where applicable)

- Social Care practitioners are aware of the criteria and application process

3. The **HSAB**, as part of its governance role, should seek assurance from agencies that their own recommendations, and their improvement plans referenced within this review, are being progressed and leading to improved responses to people in Hertfordshire, specifically:

3.1. Hertfordshire County Council, Health and Community Services, Adult Social Care:

Reviewed and improved management oversight and system resilience within their Integrated Hospital Discharge Team i.e. in the management of referrals and ensuring robust systems are in place for managing practitioners' workloads in their absence

3.2. Hertfordshire County Council, Health and Community Services, HCS Commissioning:

- Has addressed the needs of people who may present challenges due to self-neglect within their market development strategy, for example, through commissioning specialist domiciliary care provision.
- Has used learning from this review in their strategic plans for contingency arrangements when a provider fails. This may include their planned development of a trading arm.
- Has shared learning from this review with providers, specifically reiterating the providers responsibility for continuity of care and establishing robust checks before suspending services to the person.

3.3. Hertfordshire Independent Living Service

- Review and assure that the existing and new procedures regarding 'no reply' and 're-starting suspended clients' are being robustly applied.
- That their revised referral form (providing a description of the role of named contacts) has been issued to all relevant parties, uploaded to HILS and HCC's website, and that the named contacts are being used appropriately in practice.

3.4. Hertfordshire Partnership Foundation Trust

- Assure the Delivery of Care and Care Programme Approach is applied consistently in conjunction with the Local Authority where people have complex needs and that the coordination of care takes account of holistic care needs and coordinates *all* agencies involved.



Sylvia Manson

Date: November 2017



Appendix 1: Recommendations made by agencies contributing to the review

East of England Ambulance Service Trust	
1.	EEAST Policy for the management of patients with defined individual needs is currently undergoing its review to ensure it remains consistent and current with the evolving needs of us as a Trust and patients that we serve.
2.	Individual learning has taken place as part of the section 42 enquiry.
3.	It is noted that there has been some excellent care given by the ambulance crews and this will be recognised as a trust. One crew went over and above the expectations of the Trust.
Health and Community Services: Adult Social Care	
1.	Review of how triaging of the Lister referral Intake takes place, including the level of staff members required to complete this task. Consistently of management oversight is needed to ensure this task is being monitored.
2.	Safeguarding managers to ensure that any learning points for social care staff in case conferences are formally noted as an action and followed up as part of the safeguarding process. Senior managers to discuss this with managers in formal management meetings
3.	'Safeguarding - Charing Meetings' training, to be reviewed by L & D to incorporate guidance in relation to managers noting learning for staff as part of the safeguarding process.
4.	Management oversight of multi-agency information produced during safeguarding investigations to ensure it is saved in correct electronic file within 3 days of safeguarding case conferences taking place.
5.	Importance of accurate recording to be raised by managers within team meetings and individual issues to be raised in supervision to reflect on accurate recording
6.	Lead Role of one agency
7.	Importance of multi-agency professionals meetings. Senior managers to discuss this with managers in formal management meetings.
Health and Community Services: Commissioning	
1.	Building further resilience within home care market. Spot accreditation to build capacity, develop specialisms.
2.	Arms-Length Trading Company to be established to support during provider failure.
3.	Communications to all contracted home care providers re following up when Service User

	taken to hospital in ambulance – no assumptions must be made that that person has been admitted to hospital.
Hertfordshire Community NHS Trust	
1.	Work with multi-agencies to develop a process to alert relevant agencies of attendance at ED, admission or discharge to Acute Hospital for vulnerable patients to keep all partners informed and minimise missed/failed visits.
Hertfordshire Independent Living Service	
1.	Referral form will be revised to explain <u>why</u> the emergency contacts are needed.
2.	Referral form will be revised to differentiate between different contacts – e.g. one person could be the emergency contact for finding the client’s whereabouts in the event of a “no reply”, and another person could be the contact for discussing any financial or safeguarding concerns.
3.	Teams have been reminded that we should always take the instruction of the hospital discharge team and visit anyway. If we get a “no reply” we can then contact the HDT to confirm whether discharge did take place.
4.	Teams have been re-trained in the use of the “no reply” procedure
5.	A new “re-starting suspended clients” procedure has been introduced to teams
6.	Teams have been re-trained in the importance of providing clear and detailed information in the client’s record on our IT system
Hertfordshire Partnership Foundation Trust	
1.	Wellbeing & Holistic Approach Assurance to be sought that there is evidence across the Trust of use of Wellbeing Plans to support full consideration of Wellbeing outcomes in keeping with the principles of the Care Act 2014.
2.	Communication between Acute and Community Services Assurance should be sought that there is evidence RAID are inviting the care co-ordinator and/or other involved professional/agencies to Frequent Attender meetings. This will ensure a holistic approach to dealing with crises when they occur in situations where a person is resistant to support.
3.	Care Programme Approach In complex cases, when more than one agency is involved, ensure HPFT are working to Delivery of Care Policy incorporating principles of the Care Programme Approach. In line with work undertaken in the East & South East Improvement Project ensure that learning from this case is shared and considered with the project lead.

4.	<p>Risk Assessment</p> <p>Review risk assessment documentation and systems on PARIS to ensure that the risk assessment is personalised and integrates the person’s perspective and their wishes throughout in keeping with the principles of the Wellbeing Plan and the Emergency Care Plan.</p>
<p>GP Practice</p>	
1.	<p>Procedures are already in place to share and disseminate information received by the hospital and other agencies. In order to make sure that clinicians get to see documents swiftly which may require action we have increased staffing and time for scanning. A new more efficient scanner is in place and our administrative staff are to be trained in a new system EZ-DOC for rationalising documents that are relevant for the doctors.</p>

Glossary

CCG – Clinical Commissioning Group, commissioners of local health care

CMHT - Community Mental Health Teams

CPN Community Psychiatric Nurse

CPA The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

Deprivation of Liberty is where the person is subject to continuous supervision and control and would not be free to leave. Where a person lacks capacity regarding arrangement for care and treatment, a deprivation of liberty may be authorised through a legal process if the care is in the person's best interests.

EEAST East of England Ambulance Service NHS Trust

EIT Extended Involvement Team

E&NHT - East and North Hertfordshire NHS Trust

HCS - Health and Community Services

HCT - Hertfordshire Community NHS Trust

HILS - Hertfordshire Independent Living Service

HPFT – Hertfordshire Partnership NHS Foundation Trust

HSAB –Hertfordshire Safeguarding Adults Board, statutory requirements under the Care Act 2014 – objective is assurance that local safeguarding arrangements and partners act to help and protect adults in its areas for whom safeguarding duties apply.

Making Safeguarding Personal - is a personalised approach that enables safeguarding to be done with, not to, people.

Mental Capacity refers to whether someone has the mental capacity to make a specific decision or not at a specific time

PDNS – Parkinson's Disease Nurse Specialist

Safeguarding Adults is used to describe all work to help adults at risk stay safe from significant harm. Safeguarding duties apply to an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse and neglect.

RAID Rapid Assessment Interface and Discharge team - a mental health team based in the acute hospital to help support safe and timely discharge

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About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care front line services and management.

Sylvia was the Department of Health NHS lead for safeguarding adults during 2010-11, developing Health guidance published by the DH in 2011 and the Safeguarding Adults principles now contained in the Care Act statutory guidance. Past roles have also included Department of Health regional implementation lead for Mental Capacity Act 2005; Deprivation of Liberty Safeguards and Mental Health Act 2007.

In addition to independent work, Sylvia Manson is Head of Safeguarding in a CCG and a specialist lay member of the Mental Health Review Tribunal



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