Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review
6 Step Briefing
SAR002 - Claire

The Background

Claire was a 57 year old woman who sadly died in a support service in Northamptonshire after a history of mental health illness and self-harming.

Safeguarding Concerns

A high level of care and attention was given to planning the transition for Claire to the support service in Northamptonshire, however, this detail and confidence was lost in the initial stages of transition without the plan being implemented within Claire's first month in the support service.

The Incident

During autumn 2014, Claire was admitted to a mental health in-patient ward in Northamptonshire. Claire was in mental health crisis and had been significantly self-harming. During her admission, Claire required three admissions to hospital for dehydration and injuries from self-harm. Claire was admitted again to hospital following a respiratory arrest where she remained until she died approximately one month later.

The Review

This Safeguarding Adults Review was undertaken with the full co-operation with Northamptonshire agencies and those agencies who previously provided care for Claire out of county. The family engaged with the review and contributed their views to the Author of the Overview Report.

The Findings

Physical Health Needs

*There are significant health inequalities for people with severe mental illness and a lack of financial incentive to change mental health practice. There needs to be a clear pathway of mapped needs and a shared care ethos.

Culture of Care

* The culture of care is intrinsic to the success or failure of any Care Plan. Clinical leadership, values and attitudes of staff and robust systems and processes with defined models of care are essential.

Safeguarding Responses

* Professional curiosity is important and all safeguarding concerns, incidents and enquiries should be fully reviewed.

Components of Effective Transfer of Care

* Time and attention given to detailed transition planning is essential and the views of the service user and their family/carer must be sought and heard.

Behavioural Support and Responses to Claire's Mental Health Crisis

*There needs to be a robust risk assessment of historic and current factors and detailed person centred Crisis Plan. Those involved in the plan need to be able to readily access the necessary information for clinical decision making.

* Mental Health Services need to be flexible enough to revolve around the person than around each services' criteria.

*GP's and providers of community services, need to have clear escalation routes where there are concerns.

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Recommendations

1. The Northamptonshire Safeguarding Adults Board should seek assurance from NHS Nene and Corby Clinical Commissioning Groups and Northamptonshire Adult Social Care that the strategic plans for investment of additional Government funding for mental health takes into the account the learning from this Adults Review.
2. The Northamptonshire Safeguarding Adults Board, through the Health and Wellbeing Board, should be sighted on the implementation of the Northamptonshire Crisis Care Concordat and whether the action plan is delivering improved experiences for service users.
3. With regard to the physical health care provision of patients inpatient care, NHS Nene and Corby Clinical Commissioning Group should provide information about how they exercise their duty to assure the quality of care commissioned and that the targets set are achieving the expected outcomes for patients.
4. Northamptonshire Healthcare Foundation Trust should provide evidence that the processes and systems in place are delivering effective outcomes to patients' physical health care across all services within their Trust.
5. Northamptonshire Healthcare Foundation Trust and Northampton General Hospital must develop a working protocol based around shared care and collaboration where a patient is presenting with complex presentation and mental and physical health comorbidity. The protocol should include joint responsibilities for services and responsible Consultants and set out clear expected standards of communication.
6. Northamptonshire Safeguarding Adults Board should review and update current guidance relating to safeguarding enquiries alongside serious incident investigations. This should take into account the latest NHS England serious incident reporting guidance and the Care Act 2014 statutory guidance to consider how these processes can be managed in a robust and proportionate way.

Good Practice and Evidence as a Result of this Review

Northampton General Hospital (NGH) has re-designed their Emergency Department to include access to mental health services and Northamptonshire Healthcare Foundation Trust have implemented a 24/7 mental health liaison service within NGH.

Listening to families/carers is obtained by Northamptonshire Healthcare Foundation Trust Carers strategy, working in partnership with Northamptonshire Carers to seek feedback from service users and carers. The feedback is reported through to wards/services on a monthly basis.

A CQC inspection of Northamptonshire Healthcare Foundation Trust in January 2017 commented on "effective leadership" with staff being "well led and supported".

Serious Incident investigations undertaken within health now have an allocated Principal Social Worker to ensure continuity and consistency across the key partners.

The Northamptonshire Safeguarding Adults Board has developed a Quality and Performance Sub Group who will review the serious incident process and ensure the reports are available and reviewed by Northamptonshire County Council's Safeguarding Adults team.

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