Learning Together From Safeguarding Adult Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Adult A

Adult A: The East Sussex Safeguarding Adults Board (SAB) recently published the findings of a Safeguarding Adult Review (SAR), which evaluates multi-agency responses to the death of a man aged 64 (Adult A), from Kent, who was living in a care home with nursing in East Sussex, commissioned by NHS West Kent Clinical Commissioning Group (CCG).

Adult A died as a result of systemic sepsis, infection of his legs, diabetes and cirrhosis. He was subject to Deprivation of Liberty (DoL) in his best interests as he was deemed to lack mental capacity to decide where to live. There were concerns of self-neglect as he often refused care and treatment.

Sharing learning is a key priority of the East Sussex SAB. This includes developing strategic learning across agencies, boards and borders, learning from national best practice and Safeguarding Adult Reviews (SAR). This short briefing summarises the key findings and recommendations from the SAR. All staff and managers are encouraged to discuss this briefing and the key learning and reflection points at the end of the briefing, to ensure that the learning outcomes are used to consolidate existing best practice and make improvements where required.

If you work with vulnerable adults in East Sussex, there may be additional specific actions and recommendations for your agency and your role. You can also read the full report on the SAB website.

The Review: The SAR was led by independent reviewers Suzy Braye and Michael Preston-Shoot and examined the following areas:

1. How care placements were organised and reviewed;
2. How health and social care professionals worked together across geographical borders;
3. How Adult A was engaged with;
4. How Mental Capacity and Deprivation of Liberty were assessed;
5. How the interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) were understood and applied by professionals and,
6. How care and treatment plans were agreed and followed.

The review covered the period of 25th August 2015 from Mr A's admission to Maidstone hospital, until his death in the nursing home on 24th July 2016. 23 recommendations were accepted by the SAB following the review, and a joint action plan with the Kent & Medway SAB is now in place to ensure learning outcomes are achieved and to try and avoid similar cases occurring again in the future. The recommendations and the action plan can be found online along with the report. The East Sussex SAB is committed to taking the learning forward to safeguard adults, and hopes the findings will inform policies and practices elsewhere in the UK.

Key findings:
Finding 1: Placement

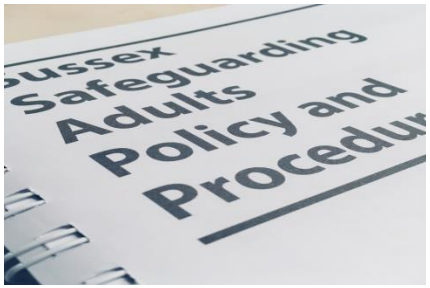
Difficulties finding somewhere where Mr A's care and treatment could be managed started well before the period under review, while Mr A was living in Kent. The review identified a shortfall of placements suitable for people, like Mr A, who have highly complex needs.

The SAR recommended that the SAB:

- Promotes the development of a database of specialist placements capable of managing people with complex needs and challenging forms of behaviour.
- Promotes work between relevant CCGs to address the commissioning/market shaping gap regarding services for people with complex needs and challenging forms of behaviour.
- Seeks reassurance that commissioning processes are robust in identifying the degree to which recommended placements have the capacity and resources to meet an individual's identified care and support needs.

Finding 2: Case Coordination and inter-agency communication

The unsuitable nature of the placement was compounded by a lack of proactive follow up by NHS West Kent CCG, and a resultant failure of case coordination. Challenges of working across borders and therefore at a distance may have added to the difficulties.



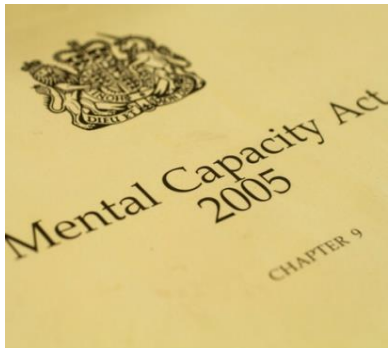
On no occasion did all relevant agencies and professionals come together to agree a plan to intervene in Mr A's best interests. Without strong leadership across the system, the efforts that individual agencies made to secure care and treatment for Mr A took place in isolation.

The SAR recommendations included that the SAB:

- Seeks reassurance regarding systems in place for notification and monitoring of out of county placements both where East Sussex is the placing organisation and the receiving organisation.
- Undertakes an audit of out of county placements to evaluate whether there are systemic patterns to be addressed.
- Reviews complex case procedures to ensure that all agencies are aware of procedures for multi-agency reviews of complex cases, with particular reference to ensuring that:
    - all available information is shared across the agencies involved,
    - all agencies have access to advice and guidance from legal practitioners,
    - all agencies agree and follow through on a multi-agency action plan.
- For all care and nursing home residents, promotes the use of one shared record held at the care home by all professionals involved, to ensure that all practitioners are aware when visiting a resident of the key issues within the chronology of the case.
- Establishes a task and finish group to review record-keeping and information-sharing between agencies; to make proposals regarding the transfer of information, including reference to hospital discharge planning and admissions to care homes, and complex cases involving concerns about self-neglect and mental capacity.

Finding 3: Mental Capacity

At most points at which capacity was assessed, Mr A was found to lack capacity to make decisions relating to his living situation, his care and treatment. One such assessment by a doctor at Maidstone Hospital resulted in a decision to place him in a nursing home in East Sussex. A decision was subsequently made to authorise the deprivation of his liberty to ensure that he remained there.



Paradoxically, Mr A's refusal of care and treatment on a daily basis in the nursing home was respected by staff, and endorsed at a best interests meeting in January 2016.

Best interests interventions using the protections of the Mental Capacity Act were not actively pursued, and no consideration was given to referring Mr A's case to the Court of Protection, when such a referral would have been entirely appropriate at various points during the final six months of his life.

The SAR recommendations included that the SAB:

- Reviews the effectiveness of training in raising awareness and strengthening knowledge with respect to the Mental Capacity Act 2005, referrals to the Office of the Public Guardian and the Court of Protection.
- Conducts an audit of cases to evaluate the outcomes of best interests decision-making, with particular reference to assessing multi-agency involvement and clarity about leadership responsibility.
- Reviews guidance on mental capacity assessment to include a process for securing multidisciplinary capacity assessment in complex cases where multidisciplinary teams are responsible for decision-making.
- Reviews guidance for staff on working with those holding LPA.

Finding 4: Interface between mental capacity, mental health and physical health

There were missed opportunities to engage proactively with Mr A's mental health, despite the recognition that it affected his ability to allow others to care for him. No community mental health referral was made at the time of his discharge from Hospital, and no referral was made during the early months of his home placement, nor following the best interests meeting in January 2016.

Despite advice from a consultant psychiatrist that assessment could be considered of whether Mr A met the grounds for hospital admission under the Mental Health Act 1983 (which could have facilitated his physical treatment), no such assessment took place.

This was not proactively followed up by the nursing home, GP or the psychiatrist. This was a significant omission as the impact of his mental health as a potential underlying cause of his refusal of care and treatment was not tested.

The interface between physical health, mental health and mental capacity is complex, and required more explicit interagency discussion than it received in Mr A's case.

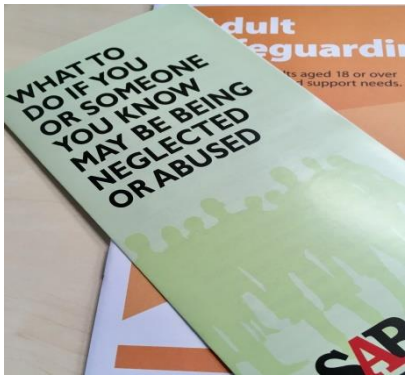
The SAR recommended that the SAB:

- Reviews guidance on legal options for intervening in self-neglect, with and without capacity, to include consideration of the interface between the Mental Health Act 1983 and the Mental Capacity Act 2005, and the use of the Court of Protection and of inherent jurisdiction.
- Reviews with commissioners and providers of advocacy services (including PRPRs and IMCAs) measures to address shortfall in the number of available advocates, and monitors further developments in advocacy provision.

Finding 5: Safeguarding

..

The review showed that safeguarding processes were not effectively used in Mr A's case. A safeguarding referral was not made until the weekend he died, whereas safeguarding referrals could and should have been made at numerous earlier points by any of the people involved in his care and treatment.



The SAR recommended that the SAB:

- Produces briefings to promote and refresh safeguarding literacy in the context of the Care Act 2014, with particular reference to the referral pathways and thresholds for section 42 safeguarding enquiries and the use of complex case procedures and multi-agency meetings in challenging cases, as well as awareness of, and confidence in, understanding factors contributing to self-neglect.
- Seeks reassurance that practitioners and managers across agencies understand and use pathways for seeking advice from, and escalating concerns to, safeguarding leads within their own organisation, and are able to use safeguarding referral pathways appropriately.

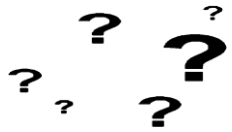
Finding 6: Involvement

Although Mr A was placed in a location to which he and his attorney were opposed, his consistent refusal of intervention was respected, despite the view that he lacked capacity to make that decision. Instead of being one of a number of factors to be taken into account in determining his best interests, his wishes were allowed to determine the actions that professionals took (or omitted to take). To comply with best interests decision-making requirements, a more nuanced balance of a range of factors, including the risk to his life, was required.

The person who held Lasting Power of Attorney (LPA) on behalf of Mr A was known to find this role difficult, both because of the distance to Mr A's placement and because she was struggling anyway to make decisions in his best interests. Not all agencies were aware of her existence. No consideration appears to have been given to whether her difficulties should have been notified to the Office of the Public Guardian, which has responsibility for overseeing the work of those holding LPA.

The SAR recommendations with regard to this area are covered under Findings 3 and 4 above.

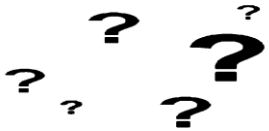
Key points for learning and reflection

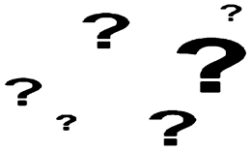


Do you know who to report to or seek advice from if you have a safeguarding concern about an adult you are working with?

Do you know how to escalate a concern?

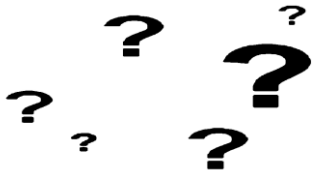
Are you familiar with the arrangements in your service for sharing information with other agencies?





Do you understand how the Mental Health Act and the Mental Capacity Act can be used to ensure that adults with mental health needs can get the treatment they need?

Do you know how and when you can refer to the Court of Protection?



Managers are encouraged to explore the learning points above in team meetings and supervision.

Further training in relation to safeguarding and the Mental Capacity Act is available at the East Sussex Learning Portal

If you require any further information about the SAR and action plan please contact: Fraser Cooper, SAB Development Manager - fraser.cooper@eastsussex.gcsx.gov.uk