Response to Christopher Serious Case Review by Bristol Safeguarding Adults Board

Introduction

In December 2015 a 31 year old man called Christopher died in hospital as a result of a respiratory tract infection, short bowel syndrome and previous surgery for enterocolitis which were compounded by recent weight loss, being an in-patient with poor mobility, a poor cough reflex and recent general anaesthetic. Christopher had complex health and learning disabilities throughout his life. He was admitted to hospital after becoming ill and losing significant weight as a result of refusing food and medication in his supported living provider's care.

After receiving a request for a Safeguarding Adults Review (SAR) in 2017, the Bristol Safeguarding Adults Board commissioned Professor Michael Preston-Shoot as an Independent Reviewer, to undertake a SAR into the care and support Christopher's received between moving into supported independent living and his death. The SAR was asked to consider the effectiveness of multi-agency working and decision making in respect of Christopher's complex health needs. The report concludes that Christopher experienced 'systemic organisational neglect' as a result of the cumulative impact of the 'lack of robust, effective individual and coordinated multi-agency work to manage his complex needs'.

As Independent Chair of the Bristol Safeguarding Adults Board (BSAB) I am responding on behalf of the Board to these findings. I would like to start by expressing my condolences and thanks to Christopher's family. They initiated the referral for the review to the Board, highlighting Christopher's case, and their engagement has provided the Independent Reviewer and Review Panel with a crucial perspective on Christopher's experiences. They have written their own public statement which is posted on our website alongside this Board Response.

The purpose of a Safeguarding Adults Review is to use the case under review to understand how effectively or otherwise the safeguarding system in Bristol is working with respect to multi-agency practice. Safeguarding Adults Reviews should be open and transparent and present the learning identified in an effective and accessible way. For this reason a briefing note for professionals is available accompanying the report which can be used for individual learning, team meeting briefings or individual supervision to ensure that the findings are disseminated widely.

The report clearly finds that some of the practice experienced by Christopher and the systems that were in place at the time were not the quality we would expect for the adults

in our city. The BSAB and individual Board partners have accepted the recommendations in the report and are committed to delivering change as a result of these findings. Organisations have not waited for the publication of the review to make change. In the two years since Christopher's death improvements have been made to begin to address some of the issues identified in the report. These are set out in the response below as are our plans for addressing the recommendations made.

The BSAB will work together to act upon the recommendations identified and I hope that the published report will aid individual professionals, teams and organisations across the city to reflect on their own practice and take steps to develop more effective working practice both together and as single agencies.

Louise Lawton

Independent Chair
Bristol Safeguarding Adults Board

Recommendations and Board Response

Arising from the analysis undertaken within this review, it is recommended that the Bristol Safeguarding Adults Board:

1. Reviews the application of thresholds for Section 42 (Care Act 2014) enquiries involving concerns about neglect and self-neglect, the guidance given about making referrals and the feedback given to referrers.

   The BSAB undertook a multi-agency audit of the Section 42 Threshold in May 2017. Among other actions, this audit led to Bristol City Council updating the Safeguarding Adults Referral form to aid accurate information provision to support decision making. Learning from the audit also informed the Bristol contribution to the revision of the regional Safeguarding Adults Policy. In addition, following the audit, the BSAB have developed a training package on making a good referral which will be launched this month.

In 2017 the BSAB launched a new Self-Neglect Multi-agency Policy. We will be auditing the multi-agency response to self-neglect this month to understand how effectively this policy is being used. The BSAB are committed to a process of regular multi-agency auditing throughout the next three years to ensure the Section 42 threshold is being appropriately applied.

2. Reviews the use of escalation routes when agencies are concerned about the screening of a safeguarding referral.

   The BSAB reviewed its escalation policy and relaunched it in March 2018. We have delivered training inputs to a wide range of professionals across the city as part of conferences, forums and learning events, on the importance of using this policy and developing a healthy culture of challenge within the partnership. The BSAB will continue to monitor the use of the policy and work with senior leadership from across the partnership to model appropriate challenge and escalation.

3. Reviews the content and outcomes of single agency training on safeguarding referrals and procedures.

   In response to this finding we have undertaken a training survey of organisations across the city in respect of safeguarding. Nearly 100 organisations completed a submission and as a result the BSAB is developing training resources such as training frameworks to support agencies to ensure staff are trained to a sufficient level. We will use this data as part of our monitoring of referrals quality going forward.

4. Reviews the content and impact of single agency and multi-agency training on Mental Capacity Act assessments, particularly with respect to individuals in independent and supported living, care settings and end of life pathways.

   The BSAB has completed a training survey of organisations across the city. This highlighted areas requiring development of their Mental Capacity Act (MCA) training. We will be developing new multi-agency learning forums to support the development of practice in this area building on the 2016 BSAB Annual Conference which focused on MCA.

   The Independent Supported Living Provider where Christopher lived has a training programme that exceeds current CQC requirements. This includes Praeder Willi and PEG training which are specialist courses for supporting adults with complex health and nutrition needs. Following Christopher's death the provider has also introduced a specific training course on Safeguarding and the interface with MCA for all senior

support workers and developed example safeguarding forms as part of their guidance to ensure MCA is considered throughout safeguarding.

A multi- disciplinary short life working group was established in November 2016, to consider University Hospitals Bristol MCA / DoLS arrangements including representatives from the Learning Disability and Palliative Care Teams. Among other work, the group undertook a review of the Trust MCA Policy and training content, delivery of be-spoke MCA training and the establishment of the Safeguarding Link Professional Role.

Further actions relating to MCA are included in University Hospitals Bristol Safeguarding Work plan for 2018/19, specifically - 'To promote greater understanding of the MCA in relation to specific areas, including patients with LD, End of Life Care and BEH through the delivery of targeted training / the role of the Safeguarding Link Professional, locally agreed actions and audits.'

Bristol Community Health who run the Community Learning Disability Team have a workforce development plan in place to support staff to improve their skills in undertaking MCA assessments particularly in the context of working with service users with the most complex needs.

5. Undertakes a multi-agency case file audit on the standards of mental capacity assessments and best interest decision-making, particularly with respect to individuals in independent and supported living, care settings and in secondary healthcare settings.

   The BSAB will be conducting this audit as part of our 2018-19 Strategic Plan.

6. Seeks reassurance from commissioners and providers on arrangements for ensuring that staff have the necessary knowledge, experience and skills for meeting the health, housing and social care needs of learning disabled adults with complex physical health and mental health needs.

   The BSAB will be seeking assurance from the relevant commissioners on how they are effectively progressing this work. Current work by individual organisations is outlined below as submitted to the Board.

   Since 2017 Bristol City Council have introduced a Quality Assurance and Learning Framework that includes defined Practice Standards which are informed by statutory guidance and regulation based on evidence about the elements of practice that lead to a good quality services and positive outcomes for people. All staff (Team managers, social workers, social care practitioners, occupational therapists etc.) employed by Bristol City Council's Adult Social Care services are expected to meet

these and reviewed against them. Further to this, in 2017 Bristol City Council updated their adult care operating model to improve adult's access to appropriate services.

In the last year, Bristol City Council have commissioned updated training on Self-Neglect for their social care professionals and they have made reflective supervision training mandatory for the last two years. In respect of commissioned providers' expertise, Bristol City Council are reviewing their accommodation strategy as part of the Better Lives Programme to ensure there are appropriate placement options for adults with complex needs in the city.

Safeguarding and Learning Disability Training remains mandatory for all University Hospitals Bristol staff, delivered at a level appropriate to their role and responsibilities. Training compliance data is monitored robustly through the Trusts internal governance structures and externally by the BNSSG Clinical Commissioning Group.

The Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group's Transforming Care Partnership are required to have in place service specifications which support the national service model for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. To deliver the national service model the CCG has developed a workforce strategy which is ensuring it can meet the demands of community based care and support and deliver high quality care that promotes and maintains independent living as close to home as possible.

The local service model requires that staff members working with a learning disability and/or autism will have:

- Knowledge, skills and experience of effective working with people with learning disabilities and/or autism
- Knowledge, skills and capability to work with the forensic population of people with a learning disability and/or autism
- Knowledge and skills to conduct assessment of risk (including risk to others and to self) and in the management of risk
- The ability to recognise and manage emerging risks and to provide interventions to reduce risks to self and others
- In-depth knowledge of the relevant legal frameworks relevant to working with people with a learning disability/autism, including the Mental Health Act and Mental Capacity Act

- Knowledge and understanding of the criminal justice system and related agencies, including the police, liaison and diversion, court, prison, MAPPA and the probation service
- Knowledge of the management of common psychiatric comorbidities associated with this group such as personality disorder, substance misuse and significant mental health issues
- Knowledge of the management of past/childhood trauma and ability to provide specific therapeutic interventions to address this

7. Seeks reassurance from commissioners and providers on how family members and advocates are involved at and beyond an individual's transition between services and/or settings.

   In partnership with commissioners, providers, family members and advocates the BSAB will be developing new guidance for working with family members and advocates. We will also be producing leaflets for families explaining safeguarding processes and supporting them to have the information they need to refer their concerns to the Safeguarding Adults Team.

   BNSSG Clinical Commissioning Group are responding to families and people with learning disabilities saying that they want more choice and a stronger say in their own care and to be closer to their family. Through the Transforming Care Partnership they are working with partners across the health, local authority and voluntary sectors to strengthen the collective voice of individuals with learning disabilities and their families, to ensure greater personalisation, increased choice about care, and greater influence over individual care pathways, as well as wider strategic service design and service delivery. This includes commitment to promoting and encouraging the use of Personal Budgets and Personal Health Budgets, particularly combining the two to deliver Integrated Personalised Commissioning which is being piloted with Bristol City Council.

   Key elements of the Integrated Personalised Commissioning Pilot are that:

   - People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances.
   - Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management as measured by tools such as 'patient activation'

- Better integration and quality of care, including better user and family experience of care.

8. Seeks reassurance from commissioning and provider organisations on supervision practice, with a particular focus on frequency and the degree to which oversight of cases is challenging as well as supportive.

   Requirements for appropriate and regular staff supervision is built into contractual and service specification arrangements by commissioners.

   The BSAB has launched a Joint Supervision Guidance in partnership with the Bristol Safeguarding Children Board. We will be reviewing evidence of the effective implementation of this guidance as part of our bi-annual organisational assessment this year.

9. Engages with commissioners on maximising the strengths and addressing the challenges regarding commissioning arrangements for placements for people with complex physical health needs and learning disability.

   The BSAB has raised these issues with key commissioners on the Board as a result of receiving this SAR. NHS England has set out a programme of work with other national partners to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This is intended to drive system-wide change and enable more people to live in the community, with the right support, and closer to home. The BSAB will work closely with commissioning partners to understand the impact of this work over time and support the commissioning bodies within the partnership as a whole to identify barriers and solutions to placements by reviewing this issue within the BSAB partnership meetings.

   Since Christopher's death, the discharge arrangement for patients admitted to University Hospitals Bristol with complex physical health needs and learning disability are now managed by the complex hospital discharge team as part of the integrated discharge hub (a multi-agency team). A short life group has also been established to review and optimise the Trusts wider discharge procedures, which is being led by the Trust Deputy Chief Operating Officer.

10. Reviews practice regarding the provision of advocacy for adults with complex physical health needs and learning disability.

The BSAB will strengthen its data collection on the use of advocates for adults with complex physical health needs and learning disability through monitoring of use of advocates in safeguarding enquiries and delivery by advocacy providers, to enable the Board to monitor the uptake of advocacy locally. The BSAB will request evidence from agencies who work with adults with complex physical health needs and learning disability of the effectiveness of their work in this area and plans to improve it.

University Hospitals Bristol have in place specialist Learning Disability and Mental Health Nurses who communicate with the wider community discharge services to ensure effective information sharing. Any concerns or incidents arising from this multi- agency working will be reviewed through the Safeguarding Adults Operational Groups to ensure the ongoing improvement of services for adults with a Learning Disability or Mental Health needs.

11. Seeks reassurance from statutory health and social care agencies regarding key working to ensure coordination in and review of complex cases involving physical and mental health needs and learning disability.

The BSAB will support statutory partners to undertake a review of the lead professional role within complex cases involving physical and mental health needs including learning disability. This review will consider whether current structures are sufficiently effective in identifying complex cases and undertaking a coordination role.

In the meantime, Bristol Community Health who manage the Community Learning Disability Team have reviewed their safeguarding policy to ensure that where there are concerns that interventions to support a person under Best Interests decision making are not being effective, a coordinated safeguarding adults referral is made by all the professionals involved to ensure effective analysis of risk.

BNSSG Clinical Commissioning Group has implemented a dynamic register (as described in the national service model) which supports and informs the commissioning of support services and at an individual level identifies those who may go on to or are starting to display behaviour that challenges. The aim is to improve service design and enable early identification and intervention.

Individuals with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition are supported by multi-disciplinary teams which are co-located through partnership arrangements between

Local Authorities, CCGs, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) and Community Health provider organisations.

Across the area Community Health Services for adults with a learning disability are provided by specialist Community Learning Disability Teams (CLDTs). MH learning disability nurses have been embedded in CLDTs directly, an approach which has been recognised as good practice by the National Development Team for Inclusion. CLDTs assess everyone on their caseload around needs which may escalate and present as behaviour that challenge. Each individual plan has mitigations and de-escalation plans. Individuals scoring red on the plan are discussed at the monthly case discussion forums. All individuals who meet eligibility criteria have allocated care coordinators and a health professional from the Community Leaning Disabilities Team and individual's Care Programme Approach (CPA) reviews are up to date and attended by the care co-ordinators or health professionals. All of these cases are regularly reviewed and bought back to case discussion forums which are made up of a team of multi-disciplinary professionals from both Health and Social Care.

12. Promotes guidance on an adults at risk pathway and on the convening of multi-professional and multi-agency conferences on complex cases involving learning disabled adults with physical and mental health needs, including the availability of specialist learning disability practitioners and legal practitioner advice that ensures that all options are considered, including referral to the Court of Protection.

The BSAB has developed a new quick reference guide to the adults at risk pathways in the city that is available on the BSAB website. The BSAB will disseminate practice review briefings as a result of this SAR to services working with adults with learning disabled adults with physical and mental health needs. The practice review will reinforce the key learning points identified in this recommendation and will be followed up by learning conversations with professionals across different sectors. The BSAB will seek assurance from partners on the use of legal advice following the dissemination of learning from this SAR.

A "Blue Light" and "Care and Treatment Review" (CTR) approach has been developed as part of NHS England's commitment to improving the care of people with learning disabilities and with the aim of reducing admissions and unnecessarily lengthy stays in hospitals. The Blue Light and CTR process has been fully embedded across BNSSG. The aim of the 'Blue Light' Protocol is to provide the commissioner with a set of prompts and questions to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds. It is also intended to help identify barriers to supporting the individual to remain in the

community and to make clear and constructive recommendations as to how these could be overcome by working together & using resources creatively.

13. Commissions a review of other cases involving transition to supported living, using the learning from this case.

    The BSAB will require that an internal audit of transitions to supported living is undertaken by Board members who are placing authorities using an audit tool developed by the BSAB in line with the findings of this review to understand whether changes have been successfully implemented to improve this process for adults and families.

14. Develops and promotes practice guidance on best practice regarding transition into and subsequent support of disabled people in supported living, using the learning from this case.

    This recommendation will be undertaken by the BSAB partnership as part of the new 2018 strategic plan. The BSAB will work with partners to ensure that the views of adults with lived experience of these transitions is central to the policy we create.