Waltham Forest
Safeguarding Adults Board

Safeguarding Adults Review

On Mark

Final
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Contents

1. Introduction

1.1 Why this case was chosen to be reviewed

This case was chosen to be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014. This case highlighted the complex issues in relation to risk management, commissioning practice and large scale safeguarding processes that can emerge when an adult with learning disabilities is placed in a hospital setting which is unable to manage his needs and behaviours safely, and other service users are placed at risk of harm. The adults living at the hospital came from other placing authorities across the country. The case also illustrated the challenges that host agencies, the local Clinical Commissioning Group (CCG) and adult social care department, neither of which commissioned placements in the hospital, face in the process of co-ordinating large scale safeguarding and quality processes required when a hospital setting is failing, and the commissioning dilemmas generated by the limits of the Marketplace.

The Waltham Forest Safeguarding Adult Board (SAB) decided to use the Social Care Institute for Excellence (SCIE) *Learning Together* systems methodology to undertake this review in order to gain the broader systems learning from the case (Fish, Munro & Bairstow, 2010). Due to the nature of the case a number of different authorities were involved, and the SAR process benefitted from the active involvement and support of partner agencies in two other SABs, Greenwich and Merton.

1.2 Succinct summary of case

Mark (not his real name) is a British white man who grew up in a close family. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at eight years of age. Mark's forensic history includes a caution for common assault in 2004 and a fine for criminal damage in 2006 at age 20. He was admitted to an inpatient psychiatric unit the following year and detained under Section 3 of the Mental Health Act (MHA) 1983 after threatening his mother with a knife. Over the following ten years Mark was detained in a number of hospitals including a low secure unit. His primary diagnosis through this period was of a mild learning disability, with a secondary diagnosis of personality disorder and ADHD.

In 2014 it was determined by his clinical team that he was ready to 'step down' to a locked rehabilitation hospital setting to increase his level of independence. In September 2015 he was transferred to Fields Hospital (not the actual name of the hospital) (while still detained under section 37 of the MHA). However within the first week he sexually assaulted a female patient, and over the following months it became clear that the hospital was unable to manage his needs and behaviours safely. During this period concerns raised by the Care Quality Commission (CQC) and commissioners ultimately led to the closure of the hospital, which was unable to demonstrate sustained improvement.

Different opinions emerged about what kind of setting Mark required and whether he needed a higher level of security again. During this period while the attempts were made by commissioners to find an alternative placement for Mark he was responsible for two further sexual assaults of fellow patients at the hospital and numerous physical attacks towards staff. Mark was re-assessed towards the end of his placement at Fields and it was confirmed that he did not have a mild learning disability. His primary diagnosis was then confirmed as a personality disorder. Mark was transferred to an alternative locked rehabilitation hospital shortly before the closure of Fields. Mark has maintained a close relationship with his mother and brother since his childhood. Mark currently remains in a hospital setting. He is now thirty years old and is single.

1.3 Review timeframe

It was decided that the critical time period to review was from September 2015, at the time when Mark was transferred from a low secure hospital to Fields Hospital, until December 2016 when he was transferred to an alternative hospital setting.

1.4 Organisational learning and improvement

Statutory guidance to support the Care Act 2014 states that:

> *'The Safeguarding Adults Board (SAB) should be primarily concerned with weighing up what type of review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way*

organisations are working together to prevent and reduce abuse and neglect of adults. Safeguarding Adults Reviews (SARs) may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases' (Department of Health (DoH)[1], INSERT YEAR, Chapter 14: p 135).

The use of research questions in a *Learning Together* systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems findings.

Waltham Forest SAB identified that the review of this case held the potential to shed light on particular areas of practice including addressing the following research questions:

- What does this case tell us about the process of placement compatibility and the availability of appropriate placements?
- What does this case tell us about the complexity of commissioning pathways where both host and placing authorities are involved?
- What does this case tell us about safeguarding pathways where both host and placing authorities are involved?
- What are the issues that need to be taken into account when managing issues of quality standards in a placement and safeguarding process at the same time?

1.5 Methodology

Statutory guidance requires SARs to be conducted in line with six identified in the Care Act 2014 and the principles below (DoH,Chapter 14: p 138):

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

It also gives SABs discretion to choose a review methodology that suits a particular circumstance:

[1] Statutory Guidance to support the Care Act 2014, Chapter 14

'The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected' (DoH, Chapter 14: p 141).

The SAB asked that the review process should be based around a one-day *Learning Together* workshop, which was used to engage with the frontline practitioners and line managers and generate the qualitative data needed to inform the review process. The *Learning Together* review process provides a close analysis of the practice within the specific case and then moves beyond that to draw out the broader systems learning that has been highlighted by the case, producing generic findings. Further detail of the review methodology and process is contained in the appendices of this report.

1.6 Reviewing expertise and independence

The SAR has been led by two people who are both accredited by SCIE and experienced in the use of the SCIE *Learning Together* model. Alison Ridley is an independent safeguarding consultant and has no previous involvement with this case, or any previous or current relationship with Waltham Forest SAB or partner agencies. Suzanne Elwick is the Head of Strategic Partnerships for the London Borough of Waltham Forest. The lead reviewers have received supervision from SCIE as is standard for *Learning Together* accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.7 Methodological comment and limitations

<u>Participation of professionals</u>

All key practitioners and managers involved with the case were able to participate in the *Learning Together* workshop and the lead reviewers were also able to talk separately with the social worker who had been the Care Programme Approach Care Co-ordinator for Mark during the latter part of the period under review.

Key senior agency managers from across a number of authorities (including Greenwich and Merton) formed the Review Team a full breakdown of membership is in Appendix 3.2

<u>Perspectives of the family members</u>

Mark was in hospital at the time of the review and several attempts were made to visit him by a member of the review team, unfortunately the meetings were cancelled on several occasions and it was not possible to complete within the timeframe of the review. Mark's mother was approached to invite her to be involved in the review process but she chose not to engage in the review.

1.8 Structure of the report

- The Appraisal of Professional Practice section provides an overview of what happened in this case in terms of the professional practice that took place. It clarifies the view of the Review Team about how timely and effective the help that was given to Mark was, including where practice was above and below expected standards.

- A short transition section highlights the ways in which features of this particular case are common to work that professionals conduct with other adults and therefore provides useful wider organisational learning to underpin improvement.

- The Findings section forms the main body of the report, and explores and tests out the key areas of generic learning that have emerged from the case. These are the systems issues that are not only specific to this one case but have a broader application.

Statutory guidance requires that SAR reports 'provide a sound analysis of what happened in the case, and why, and what needs to happen in order to prevent a reoccurrence, if possible' (DoH, Chapter 14: p 149).

2. The Findings

2.1 Appraisal of professional practice in this case: a synopsis

Introduction to the Appraisal of Practice

The appraisal sets out the view of the Review Team about how timely and effective the interventions with the service user were in this case, including where practice fell below or above expected standards and why. This synopsis of practice is a link from the specific case to the wider findings about the local safeguarding system.

Context

Since 2014 the Transforming Care Agenda has provided a momentum to achieve improved outcomes for adults with learning disabilities and complex needs who have been living in hospital units. However the work to achieve better outcomes has proved to be challenging in a number of ways. This case illustrates the difficulties faced by commissioners trying to find personalised placements in a Market place with a limited range of options, and the additional complexities and pressures raised when significant safeguarding and quality concerns are raised in a hospital setting.

Appraisal of practice

2.1.1 By the end of 2014 Mark had been detained under the MHA1983 in hospital settings for almost ten years. The view of his clinical team was that his care and support needs suggested that he was ready to have more independence and to 'step down' from a low secure forensic hospital. In Waltham Forest the Community Learning Disability Team (CLDT) is fully integrated, with staff employed by the North East London Foundation NHS Trust (NELFT) and the Waltham Forest Local Authority (LA). The team were tasked with the responsibility for managing Mark's move, and a Social Worker (SW1) was allocated as his CPA Care Co-ordinator. She liaised with the local Individual Service Agreement (ISA) Panel (managed by NELFT) which had been given placement commissioning responsibilities by Waltham Forest CCG.

2.1.2 Fields Hospital, a local locked rehabilitation hospital close to Mark's family home was selected by SW1 in collaboration with the treating team and NHS England (NHS E). Usually two placements would be considered to provide some choice comparison, however, in this case the Review Team felt that the commissioning decision to progress with only one placement option was reasonable because it was near to Mark's family and both he and his family were keen for him to move to the setting.

2.1.3 The ISA Panel contacted the CQC to gain a picture of any quality issues and the Waltham Forest ISA Lead and SW1 visited the hospital, and felt that it was appropriate. However, one oversight by the ISA Panel was that consideration and agreement of the provider was made without reference to the local host CCG (Greenwich). Although it is understood that normal practice would not include liaison with the host CCG authority, the Review Team reflected that given the lengthy and detailed knowledge the host CCG had of the service provider, it would have been advantageous for the ISA Panel to have liaised with them as this would have elicited information regarding Greenwich's position in terms of using the placement.

2.1.4 In September 2015, the same week that Mark transferred to Fields hospital, the CQC undertook the first of a series of routine inspection visits of the hospital. Four days after his arrival Mark gained access to a female patient (CS) through a door that should have been securely locked. The two patients were found kissing and engaging in sexual touching. Mark said that CS had given consent, although CS denied this. The hospital team attempted to undertake a capacity assessment but CS was reluctant to engage. Their view was that on balance she probably lacked the capacity to make decisions about undertaking sexual relations. The incident was therefore regarded by commissioners and safeguarding partners as having been a sexual assault by Mark, but the lack of a clear capacity assessment subsequently contributed to the police decision not to pursue criminal charges. The police position was reasonable, being based on the level of evidence required by the Crown Prosecution Service to progress the matter.

2.1.5 As the host LA where the assault had occurred, Greenwich LA co-ordinated the safeguarding enquiry over the following five week period. They experienced early difficulties in identifying the right professionals to invite to meetings, as the service provider did not have up to date contact details for all relevant commissioners. Additionally attendance at safeguarding meetings by placing commissioners was variable (some of whom were geographically distant) which was not good practice, but is a common difficulty when adults are placed at some distance from their originating place of residence. The fact that commissioners were based at considerable distance from the hospital made the task of co-ordinating the enquiry more challenging for the host authority. LA practitioners in the CLDT were conscious of their statutory role to co-ordinate the safeguarding enquiry, but felt increasingly unsupported by placing commissioners and at the SAR workshop they described how they felt they had been "left to do it all".

2.1.6 There was a further serious incident of physical assault to property by Mark several weeks later when he smashed a window at the hospital with a fire

extinguisher. The hospital chose not to press charges. The dilemma of whether or not to pursue criminal charges reflects a wider debate about how people with learning disabilities who commit offences while they are in hospitals are responded to in relation to the criminal justice system[2]. In this case there were incidents where it was felt by the multi-agency group that Mark had the capacity to understand his decisions, but despite this, criminal proceedings were not pursued, which may have been counter-productive.

2.1.7 The CQC inspection visits during this period confirmed significant concerns about staffing numbers, care plans and gaps in clinical staff. In response to this the CQC advised Sequence Care (the unit provider) and all placing commissioners that an urgent embargo on new admissions was to be put in place. However, CQC did not invite the provider Sequence Care to respond to their proposed action, which is a required step in their process, and so when Sequence Care subsequently responded in a positive way by agreeing to a voluntary embargo on new admissions and put a robust improvement plan together, CQC decided not to pursue further action at that stage.

2.1.8 Mark's Care Co-ordinator (SW1) was already very concerned that the placement was not able to manage Mark's behaviours safely and in consultation with the Waltham Forest ISA Lead, she made a referral for Mark to have a gatekeeping assessment undertaken by clinicians at the local NELFT forensic unit to see if he should return to a low secure hospital setting. This was a prompt response by Mark's Care Co-ordinator, however the outcome of the assessment confirmed the clinical view that Mark's needs did not require a return to a low secure setting. Mark had a primary diagnosis of mild learning disability (LD) and a secondary diagnosis of personality disorder and ADHD. The gateway assessment recommended that his primary diagnosis of LD should be reviewed. At this point SW1 had not yet made the NELFT safeguarding team or the Waltham Forest CCG aware of the safeguarding enquiry or the significant placement concerns that had begun to emerge.

2.1.9 Several weeks later in November 2015 Mark was found having inappropriate sexual contact through a restricted window with a fellow patient RP (whose placement was commissioned by Merton CCG), a young woman with complex needs. The hospital team's view was that Mark had the capacity to understand the consequences of his actions in this circumstance, and although it was initially unclear to them whether RP had the mental capacity to consent to sexual contact, the clinical view subsequently emerged that RP lacked capacity to

[2] See the Bradley Report (2009) and the Bradley Report Five Years On (2014), The Centre for Mental Health.

consent, raising the need to approach the incident as a sexual assault. Greenwich LA again co-ordinated a safeguarding enquiry. Communication between Greenwich LA and the Merton LA allocated social worker (SW) worked well. The Merton SW had a clear grasp of the safeguarding and quality concerns relating to RP and highlighted these to Greenwich.

2.1.10 However by this time the social workers in the CLDT were beginning to feel overwhelmed by the volume of safeguarding enquires generated by the hospital unit which they were co-ordinating, this being just one of them. They were not given additional support by their central safeguarding team because local practice in Greenwich LA at that time was for the learning disability team to undertake all safeguarding enquires. In comparison with other LA teams who would be given a greater degree of hands-on support. That model of working has now been addressed in Greenwich.

2.1.11 At the end of November 2015 the CLDT and Mark's Care Co-ordinator continued to hold their view that Mark's placement at Fields Hospital was failing and he should be stepped back up to low secure hospital setting. A second referral was made for a gateway re-assessment but the outcome was again that his needs did not indicate he should return to low secure hospital setting. The Review Team felt that it was good practice that the CLDT had continued to pursue re-assessment given the more severe pattern of Mark's behaviour that was becoming apparent, however when the outcome again confirmed the clinical view that Mark did not need to return to a higher level of secure setting, the placing authority (Waltham Forest CCG working with NELFT) began to feel increasingly concerned and frustrated. While the gateway assessments indicated he did not fit criteria to return to low secure, it was also increasingly clear that his behaviours were not being safely managed in this locked rehabilitation hospital. There was an increasing level of anxiety for the commissioners and the hospital provider as they struggled to try to keep Mark and the other patients safe. The dilemmas and pressures experienced by commissioners looking for placements in a Market place with limited choices are explored in more detail in **Finding 1.**

2.1.12 Greenwich LA progressed the wider improvement work relating to the quality concerns raised by the CQC and the safeguarding enquiries, and sent letters out to all placing authorities updating them on progress. Greenwich LA were still co-ordinating a large number of separate safeguarding enquiries and the volume of work continued to cause considerable pressure. The feeling at the time was described by practitioners from all the agencies involved at the SAR workshop as "chaotic". This was felt to have been generated in part by the complexity of the situation with a large number of commissioning partners involved. An additional

challenge for the Local Authority was their statutory responsibility to co-ordinate a significant number of safeguarding enquiries at the same time in a health setting where all placements were commissioned and funded by CCGs or by NHS E.

2.1.13 There is no corresponding statutory requirement for host CCGs to co-ordinate enquiries into hospital settings where there are significant concerns about the quality of services, beyond the responsibility they have for the safety and wellbeing of any specific individuals they have placed there. Given the inevitable interface between safeguarding and poor quality commissioning issues, it is essential that there is clarity about roles across health and social care agencies to make it more likely that joint working is effective. The gap is clear guidance in this area of practice and the dilemmas generated by the interface of responsibilities is explored in more detail in **Finding 2.**

2.1.14 In December 2015 a further strategic meeting was held by Greenwich CCG and LA safeguarding leads and the operational CLDT to monitor progress in relation to the safeguarding activity and the wider quality improvement work, and to agree further actions and clarify roles and responsibilities. The Review Team felt that this was a positive and proactive meeting which helped to move processes forward. The co-location and established culture of close working between these two agencies enhanced communication.

2.1.15 By early January 2016, the improvement action plan that had been put in place by the provider in response to the safeguarding and quality concerns was beginning to demonstrate positive changes. The senior managers of the provider organisation had put in place a new management team at the hospital including new senior clinicians. This change had a significant impact including improvements to staff quality and the dismissal of hospital staff that were not up to the necessary standards. The new managers also improved the physical hospital environment and were open to working positively with the host authorities and commissioners.

2.1.16 A Care and Treatment Review (CTR) meeting was held on 15th January2016to review Mark's care plan. Questions about whether Mark's primary diagnosis of LD should be reviewed were raised again. The CTR recommended that Mark should move to a similar community hospital setting and allow increased opportunities for independence using a Community Treatment Order to provide a legal framework, and with skilled staff and a high level of 1:1 support. In response to this in the following months SW1 made referrals to two other locked

rehabilitation hospitals, but both were declined on the grounds that they felt they were not able to respond to the particular risks that Mark's behaviours posed.

2.1.17 Although Mark's diagnosis was being questioned, there was a delay by Waltham Forest CCG and the CLDT in the arranging a formal re-assessment, which was a significant omission. During this period their focus had instead been on seeking an alternative placement for Mark and on responding to the high volume of work generated by the safeguarding and quality concerns at the unit. The Multi-Disciplinary Team (MDT) and senior clinicians at Fields hospital similarly failed to prioritise the review. However, the delay in clarifying Mark's primary diagnosis may have played into the ongoing difficulties in trying to find a suitable placement. At this point SW1 who had been undertaking weekly visits to Mark left her role and handed his case over to different Care Co-ordinator (SW2). The new Care Co-ordinator continued the pattern of weekly visits which showed a high level of commitment to Mark and provided a level of continuity.

2.1.18 In the middle of April 2016 CQC published their report, five months after their initial inspections and the concerns first being raised. The hospital was placed in special measures. On 23 April 2016 Mark committed a further sexual assault against CS. No aggression was involved. CS was understood by the hospital MDT to lack capacity in relation to sexual relations, so a further safeguarding enquiry was initiated.

2.1.19 Several days after the assault upon CS, Greenwich LA and Greenwich CCG called a Provider Concerns meeting to share information across the various stakeholders and give Sequence Care the opportunity to update about progress on the improvement plan. Waltham Forest CLDT and Waltham Forest CCG representatives attended. The provider was open about the extent of improvement work still required, which was constructive, however, the frustrations felt by some attendees at the continuing quality issues at the hospital were clear. Additionally some commissioners were only just now realising the extent of the issues following the publication of the CQC inspection report and special measures having been implemented.

2.1.20 In May 2016 Mark's Mental Health Review Tribunal confirmed that he should remain detained under section 37 (MHA) and recommended that there was a need for a specialist Personality Disorder service for him. Mark's behaviours were escalating. Further work was undertaken to find a new placement for him

and he was assessed by an alternative locked rehabilitation hospital but was declined on the grounds that they felt unable to safely manage his behaviours.

2.1.21 On 1st July 2016 a second Provider Concerns meeting was chaired by Greenwich LA to provide feedback on three unannounced joint visits they had undertaken with Greenwich CCG to monitor the improvement work. Greenwich LA was continuing to invest staff time in the co-ordination of safeguarding enquiries relating to other patients in addition to supporting the wider quality improvement work with health commissioning colleagues. The two processes ran in parallel. Greenwich LA remained concerned that there was still variable engagement from some of the other placing authorities and highlighted to commissioners the need for them to "step up and take responsibility". However feedback from all the other involved authorities suggested that there was a continued lack of a clear plan for how to do this in a co-ordinated way and an on-going sense of confusion regarding roles and responsibilities. The confusion was due in part to the lack of clarity in roles and responsibilities coupled with the pressures and frustrations generated by the huge volume of additional work that was being managed by the host CCG and the host LA.

2.1.22 In August 2016 at the request of SW2 the local NELFT forensic unit undertook a further gatekeeping assessment to determine what level of security Mark required, and the clinical response confirmed their earlier view that he did not require step-up back to a low secure hospital setting. Instead they recommended finding a community hospital unit which specialised in learning disability or personality disorder. Feedback from front line practitioners at the SAR workshop indicated that there had been a considerable amount of frustration that Mark's needs no longer seemed suited to low secure settings, but at the same time he was also being turned down by other locked rehabilitation settings. There was a sense of disquiet at what were perceived to be the repeated 'negative' outcomes of the gateway assessments.

2.1.23 Mark's next CTR was due to have been held in July 2016, but was delayed until the end of September 2016 by the CCG to allow the NHS E commissioned life planning work by the "I'm Out of Here" team to be undertaken with Mark, which was used to inform the ongoing planning. The CCG had experienced considerable pressure from NHS E to ensure that they made all efforts to pursue the aims of the Transforming Care Agenda, particularly in relation to pursuing the least restrictive alternative principle.

2.1.24 By this time it was also known that Fields Hospital would be closing. Cambian Churchill (another locked rehabilitation provider) were approached to provide a

placement for Mark, and in November 2016 they confirmed that they would accept Mark.

2.1.25 At the same time (on the 8th November 2016) Mark was assessed by NELFT clinicians in relation to his diagnosis. The need for this re-assessment had originally been flagged up 12 months earlier. The Review Team explored the reasons for this delay and it appears that the review of his diagnosis was not felt to be as pressing as the need to find an alternative placement which would be suited to responding to his presenting needs and risks. The Review Team found that Mark's primary diagnosis of LD during that period did not impact negatively on the search for a placement that would be able to manage his behaviours safely. The NELFT assessment confirmed that Mark did not have a learning disability but did have cognitive deficits, and confirmed his primary diagnosis as personality disorder. On 14th November 2016 a further CTR meeting was held (with NHS E present). Mark was removed from the register of adults with learning disabilities and complex needs who meet the Transforming Care Agenda criteria as his new diagnosis was confirmed. At this point the involvement of NHS E stopped because their remit does not extend to CCG funded patients unless they are a part of the Transforming Care cohort. Mark was no longer reportable to NHS E. Mark was transferred to the Cambian Churchill locked rehabilitation hospital the following day.

2.2 In what ways does this case provide a useful window on our systems?

This case has highlighted two issues which have wider implications for the work of effectively supporting and protecting adults with Learning Disabilities who are living in hospital settings. The first being focussed on the particular challenges faced by teams across the health and social care system who have commissioning responsibilities. The second finding highlights some of the particular difficulties of co-ordinating a safeguarding enquiry in relation to a health setting.

2.3 Summary of Findings

The review team have prioritised two findings for the SAB to consider. These are:

	Finding	**Category**
1.	The absence of 'requisite variety' in the local commissioning Marketplace combined with the pressure to move people towards greater independence works against the positive ethos	Management systems

	of the Transforming Care Agenda	
2.	Finding two is in relation to there being no coherent process for coordinating the management of social care led safeguarding enquiries and health led provider quality concerns in health settings when one triggers the other or they occur simultaneously. The absence of guidance results in different practice norms which affects the quality of the response to incidents.	Communication and collaboration in response to incidents

2.4. Finding 1 - The absence of 'requisite variety' in the local commissioning Marketplace combined with the pressure to move people towards greater independence works against the positive ethos of the Transforming Care Agenda

(Category – management system issues)

Introduction

The national 'Transforming Care Agenda' (TCA) was implemented in response to the recognition that there was a cohort of adults with learning disabilities and complex needs who had been stranded for many years in inappropriate hospital settings far away from their homes and families. The Government set clear targets for improvements, both in relation to how many adults' lives should be changed and in relation to the timescales for achieving the improvement in the 'Transforming Care: A national response to Winterbourne View Hospital: Department of Health Review Final Report' (2012).

The programme of change required the closure of inappropriate hospital settings and a complete overhaul of health and social care commissioning practice, and there was enormous political pressure to achieve improved outcomes for this cohort of adults in a very short timeframe. The scale of change required to achieve the national targets in the desired timeframe was enormous and could not realistically be achieved. The Department of Health (DoH) and NHS England each created a £7m capital fund to support people inappropriately placed in inpatient settings to move into community-based settings, however in most areas there were very limited local supported living settings which could be readily utilised to move the agenda forward effectively.

The concept of 'Requisite Variety'[3] was highlighted by Eileen Munro in her systems analysis of the Child Protection System in England in 2010. The concept identifies that a system (i.e. in this case the NHS commissioning system) should have a variety of responses available which is at least as great as the variety of circumstances it seeks to

[3] Munro, E "The Munro Review of Child Protection – Part One: A Systems Analysis", Appendix 2 (p.50)

respond to. If that variety is available the system will be flexible enough to cope effectively with the full range of circumstances it will encounter.

How did the issue manifested in this case?

In this case Mark had been detained in a low secure hospital in Norfolk, a considerable distance from his home and family who lived in London. In terms of moving him towards greater independence in line with the TCA, it had been agreed by his clinical team that the complexity of his needs required the level of security and expert support provided in a 'locked rehabilitation hospital' setting. His commissioning CCG (Waltham Forest) were keen to see him moved closer to home but there was only one potentially suitable hospital in the right geographical area.

The local Community Learning Disability Team (CLDT) had relatively limited experience of sourcing and assessing locked rehabilitation hospital settings, and similarly the forensic commissioning responsibilities had only very recently been passed to the CCG from NHS E (following national changes in April 2015). There was enormous pressure to achieve results within the timeframes that had been signed off by national politicians. NHS E required regular reporting to be undertaken by the CCGs on how adults in the TCA cohort were progressing. In this case the combination of system demands and limited commissioning options appear to have been key factors in Mark being placed in a setting that was closer to home but not able to support him safely.

What makes it an underlying issue?

Practitioners at the SAR workshop were positive about the revolutionary aims of the TCA to achieve change for service users and their families and agreed that the timeframes were necessarily ambitious ones, however there was an agreed view that the local Marketplace (in terms of locked rehabilitation hospitals and additionally finding or creating opportunities for step down to supported living in the community) does not currently have the kind of choice to enable creative commissioning outcomes. Local health practitioners and commissioners have highlighted cases of adults with learning disabilities they are currently working with who have become stuck within the system because of the scarcity of local providers (both locked rehabilitation hospitals and supported community living) who are suitable and willing to accept them.

Local health commissioners in Waltham Forest highlighted the difficulty of finding good quality local providers who are willing to shoulder the additional risk of accepting adults who have particularly complex needs and challenging behaviours. The combination of learning disability and personality disorder diagnosis is not one that many current providers feel suitably experienced or skilled to accept. This difficulty can often still result in adults with learning disabilities having to be placed far away from their home area.

How prevalent is this issue?

This combination of system pressures appears to have had an impact on how effective the aims of the TCA has been so far in Waltham Forest, where health commissioners highlighted a linked concern of a lack of available local housing which could be used to offer a supported living environment even when the specialised providers are available.

This is also a known to be a national challenge for commissioners. The DoH confirmed in 2015 that the aims of the TCA had not been achieved nationally as fast as they had hoped. By September 2014, a lower number of patients than expected had been identified as ready to be discharged. Adults with learning disabilities continued to be admitted and/or readmitted to hospital. There were still 2,600 people (within the TCA cohort of adults with learning disabilities and complex needs) in inpatient settings, which was almost unchanged from the 2,601 people in inpatient settings on 30 June 2014[4].

More recent data from the NHS E 'Transforming Care website' confirmed that by March 2017 there were still 2,490 patients in the TCA cohort in hospital. However during the March 2017 reporting period there were 125 admissions and 185 discharges/ transfers from hospital, showing an encouraging improvement in the admission/discharge ratio with more patients being discharged than admitted to specialist hospitals. However, the data also confirmed that there are continuing difficulties in moving that cohort of adults through to greater independence within community settings, 62% of adults who were in hospital at the end of March 2017 had already been living in a hospital setting for at least 2 years.

How widespread is the issue?

The challenges of finding community based commissioning solutions for this cohort of adults are experienced both locally within Waltham Forest and are echoed nationally. Members of the Review Team that represented local health commissioners described the particular challenges they face in relation to being able to source the necessary quality of support needed to make community placements (e.g. in local supported housing) work well.

In 2015 a Head of Commissioning from Cheshire commented in relation to the TCA that is "a transformational programme: it's about changing a whole system and established way of working and embedding a completely new approach. That is taking time. There are challenges – finding ways to move money around the system, establishing the right skills base to support people with very complex needs in the community and unpicking a commissioning landscape that is currently very fragmented. We also want to work in a way that brings families and individuals with us, where we can build trust and ensure the right outcomes for individuals ….. we need to be careful that we don't run to meet the target and completely miss the point."[5]

[4] 'Winterbourne View: Transforming Care Two Years On' (DoH, 2015)
[5] P.15 DoH report on TGA (2015)

The national strategic response to these concerns came in October 2015 with the publication of "Building the Right Support" plan[6], which supported the need for joined up responses across health and social care to commission personalised services locally supported by multi-disciplinary health and care teams. The approach aims to support the development of choice by shifting money into community services in order to reduce the use of in-patient services.

Regional data from NHS E confirmed that since November 2016 admissions and discharges within the London area had declined. While this is positive in relation to admissions, the rate of discharges also declined, which suggests that there are still continuing regional difficulties in finding the right community based services for this cohort of adults[7].

The most recent national data from NHS E, confirms that of the 185 patients within the TCA cohort who left hospital in March 2017, only 69 % were discharged back into the community, the remaining 29% of adults were transferred to other hospital settings[8].

Significance for the system

For the past ten years, health and social care agencies have been undergoing a revolution, working to redesign their systems to move from being service-led (where the needs of the service and the process dominate) to becoming person-centred (where the needs and wishes of the individual are used to drive the process). Personalisation is about 'making sure there is an integrated, community-based approach ….. this involves building community capacity and local strategic commissioning so that people have a good choice of support regardless of age or disability…. all systems, processes, staff and services need to put people at the centre' (SCIE, 2012[9]).

However there are continuing barriers that militate against local commissioners achieving personalised outcomes for as many adults with learning disabilities who have complex needs as they would wish to. Local health commissioners in Waltham Forest have commissioned Positive Behaviour Support training for providers and family members as an innovative way of helping to develop the Marketplace, however, this will not achieve overnight change. Dialogue about joint health and social care commissioning, which could unlock more creative solutions has started but is not yet developed and the options, both in terms of specialist providers and housing settings, in the local Market place remain limited.

[6] A joint health and social care publication from the Local Government Association (LGA), Association of Directors of Adult Safeguarding Services (ADASS) and NHS E
[7] NHS Digital website (March 2017 Assuring Transformation stats)
[8] NHS Digital website – Assuring Transformation monthly statistics (March 2017)
[9] SCIE, *Personalisation: a rough guide* (2012) p.2

FINDING 1

The absence of 'requisite variety' in the commissioning Marketplace combined with the pressure to move people towards greater independence works against the positive ethos of the Transforming Care Agenda (management systems)

The national agenda to move this specific cohort of adults with learning disabilities and complex needs back into community settings remains a significant pressure. Local commissioners need to be adequately supported to generate creative ways forward. 'Requisite variety' within the Marketplace is needed to effectively support the ambition of being able to commission personalised outcomes for adults with learning disabilities who have complex needs, and support the national strategic plans to significantly reduce the number of adults with learning disabilities living in hospital settings.

In order to be able to find ways of bringing those adults back to their home areas and offer them safe, good quality supported living opportunities, the local Marketplace needs breadth and choice, and joint commissioning initiatives need to be explored as a part of that drive. The aim of achieving successful personalised outcomes currently remains difficult to achieve. A 'one size fits all approach cannot exhibit the flexibility required to supply the help that is needed' (Munro, 2010)[10]. The current Marketplace in Waltham Forest is not yet able to offer sufficient options, either in relation to high quality care and support providers or in relation to the necessary housing.

1. Does the Board need further information about the nature and extent of the current challenges within the local commissioning Marketplace impacting on outcomes for adults with learning disabilities and complex needs?

2. How would the Board wish to be assured that the multi-agency work (including joint commissioning) of the Transforming Care Programme is progressing effectively in Waltham Forest?

3. Does the Board think they have a role in providing strategic support to local health and social care commissioners in the work of achieving the necessary Marketplace to deliver choice for adults with learning disabilities and their families?

[10] Munro, E (2010) *The Munro Review of Child Protection Part One: A Systems Analysis* (2010) Appendix 2 (p.50)

2.5 FINDING 2: Finding two is in relation to there being no coherent process for coordinating the management of social care led safeguarding enquiries and health led provider quality concerns in health settings when one triggers the other or they occur simultaneously. The absence of guidance results in different practice norms which affects the quality of the response to incidents.

(Communication and collaboration in response to incidents)

Introduction

The authority in which a person is placed is described as the host authority to distinguish this from the placing authority which is the authority that has the responsibility to coordinate and commission the placement for the person. Under Pan London Adult Safeguarding Procedures the host authority needs to respond to any safeguarding concerns raised by people living in their borough. When there are concerns about the quality of care a provider is delivering, safeguarding concerns often feature significantly. All individual safeguarding concerns need to be processed separately but thematic information should be gathered and feed into the quality of care processes. Despite this situation occurring frequently there is no clear guidance about how the two processes, often led by different agencies, (namely the Local Authority for safeguarding and quality of health care by the CCG) should be managed.

How it manifested in this case?

A safeguarding concern was raised four days after Mark's arrival at Fields and in the same week the CQC on a routine inspection raised significant concerns about staffing numbers, care plans and gaps in clinical staff with the provider Sequence Care. The provider responded positively by agreeing to a voluntary embargo on new admissions and put a robust improvement plan together. There was a delayed by the CQC for various reasons and the report was not published for almost seven months in mid-April 2016.

The host LA Greenwich under Pan London Adult Safeguarding Procedures undertook the safeguarding enquiry and also undertook the subsequent enquires related to Mark and other clients in Fields. The Greenwich CCG supported Sequence Care on their improvement and liaised with the CQC. These processes involved many different professionals from many different boroughs because of host and placing boroughs and health and LA services being involved. The people involved in the two processes were not all the same for each organisation. This created a complex and at times, according to the case group and review team, a chaotic situation. In practice the two processes felt quite separate to those working at the time, in part due to the different governance

arrangements in place with the LA leading on the safeguarding, the CCG taking responsibility around the quality concerns and the CQC involvement in relation to the inspection and improvement process.

What makes it an underlying issue?

There is a widely held assumption that the CCG have a statutory responsible to take the lead when a health setting in their area requires improvement due to quality concerns, even if, as in this case the CCG is not the commissioner of that particular service.
However there is no statutory guidance to support this view within the guidance for CCGs. https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf.

This led to confusion and to some extent a delay in someone taking the lead and providing a coordinated and strategic response to this case. Case group and review team described similar situations where there was a lack of clear process and a confusion of governance in relation to quality concerns, safeguarding and inspection processes. The Review Team advised that in practice different CCGs may respond in different ways in line with local practice and depending on who invited them or requested them to support the provider with their improvement plan. The policy and guidance in this area has not kept pace with the complexity for commissioners and providers. For a significant group of people NHSE was the sole commissioner. Now through the Transforming Care Agenda people are transferred from NHSE responsibility to the local CCG. The CCG then usually passes this responsibility on to a community health provider who is then responsible for securing a suitable "setting". This creates a complexity immediately in terms of who is the actual commissioner and what their different roles and responsibilities are. The latest guidance from ADASS in regard to Out-of-Area Safeguarding Adults Arrangements, June 2016, describes the roles for the placing authority, the host authority and the service provider. It does not provide guidance for the host CCG which, in the new developing landscape of transforming care, is a significant gap.

The Pan London Safeguarding Procedures advised that the host authority needs to investigate the safeguarding concern and the placing authority involved in commission a service:

> *'Will contribute to the enquiry as required, and maintain overall responsibility for the person they have placed, including needs assessment and care and support planning*' (ADASS Safeguarding Adults Policy Network, Guidance 2016)

The case group and review team described not only different approaches from different placing authorities in this case but also in other cases. In practice LAs interpret this guidance differently and some LAs do not really contribute to the enquiry as they believe the host authority has all the responsibility which causes further complexity and issues around sharing information.

The Care and support statutory guidance February 2017 14.72 advises that:

'There should be a clear understanding between partners at a local level when other agencies such as the local authority, CQC or CCG need to be notified or involved and what role they have. ADASS, CQC, LGA, NPCC (formerly ACPO) and NHS England have jointly produced a high level guide on these roles and responsibilities. The focus should be on promoting the wellbeing of those adults at risk.'

This high level guide, that in effect advises local areas they need to make their own arrangements, which again does not provide the right level of advice and guidance that agencies require to enable a common and shared understanding of roles and responsibilities in this complex situations.

What is known about how widespread or prevalence the issue is?

The review team advised that in their own boroughs that in almost all quality of care processes safeguarding is also an concern as the issues are so interconnected.

The review team commented that as more people with significant complex needs are moving out of secure settings in line with the TCA to more community based settings and with the absence of 'requisite variety' in the commissioning Marketplace as described in Finding 1 there will be more people in situations similar to Mark, raising safeguarding concerns for the host authority.

We have already learnt a considerable amount from Serious Case Reviews for children regarding the need to have clear roles and responsibilities when undertaking safeguarding work. It is important that the transferable learning from the child protection system that has been in operation for considerably longer is taken on board and utilised by the adult safeguarding system to prevent similar lessons needing to be learnt.

What are the implications for the reliability of the multi-agency adult protection system?

As highlighted in Finding 1 the impact of the Transforming Care Agenda on the commissioning and provider landscape has been significant and this directly relates to the issues explored.

Adult safeguarding practice is still to some extent in development. Although adult protection process and practice were already in place it was only recently with the Care Act 2014 that adult safeguarding was placed on a statutory footing and the roles and responsibilities for Local Authorities, the police and the NHS were defined in statue.

It is realistic to assume that practice in this area, particularly (but not only) in the first years of the statutory framework will need to develop and evolve and respond to a changing environment and it appears that the guidance has not kept pace with this changing environment.

The implication of a lack of clear process and guidance in relation to situations where safeguarding concerns are in process together with provider concerns is the potential for substantial duplication of effort by agencies which leads to a drain on resources. In addition, there are concerns that if some placing authorities are choosing to interpret the Pan London guidance in a way that means they are not to be involved in any aspect of safeguarding enquires this has implications for the personalisation of individuals who may get lost in the wider issues of the provider. This is despite guidance from ADASS to the contrary. It is possible that this guidance is not well known or understood.

The present lack of clear processes exasperates the likelihood that there will not be clear unified leadership which makes it more likely that people will look for someone to blame rather than work positively in partnership to find a solution to the issue in hand.

Local NHS commissioning arrangements are about to undergo significant change again in the near future with the development of Sustainability and Transformation Plans, which provides an opportunity to influence change.

Finding 2

Finding two is in relation to there being no coherent process for coordinating the management of social care led safeguarding enquiries and health led provider quality concerns in health settings when one triggers the other or they occur simultaneously. The absence of guidance results in different practice norms which affects the quality of the response to incidents.

The complex nature of managing safeguarding concerns/enquires and quality concern processes places significant demands on the system. Together with the lack of clear guidance to promote joined up processes and highlight the need for clear leadership results often in professionals working in chaotic situations which in turns affects the quality of care and support provided to service users.

Questions for the board to consider

1. Does the Board recognise this description?

2. How does the Board expect Waltham Forest agencies to respond when safeguarding enquires are in process for Waltham Forest residents in host authorities?

3. What is the Board's expectation of how process should be managed if Waltham Forest is the host authority?

4. What influence can the Board provide locally, pan London and nationally regarding the lack of guidance in this area?

3. Appendices

3.1 How the *Learning Together* review process was undertaken in this SAR

The *Learning Together* methodology can be used flexibly to provide bespoke proportionate reviews to gather and analyse the data and then develop the appraisal of practice and the findings. How the key components of the methodology were undertaken in this SAR:

- Generating the 'View from the Tunnel' – from the data provided by front line staff to reduce 'hindsight bias' and generate a more complete understanding of what happened and why. In this SAR that phase of the process was undertaken by frontline staff who were directly involved in the management of the case (including practitioners and commissioners) and their immediate line managers at the one day *Learning Together* workshop.

- Analysing the data using 'Key Practice Episodes' to 'chunk' up the timeline, to appraise the practice of the professionals and to understand what the contributory factors were. In this SAR that phase of the process was undertaken by frontline staff, their managers and members of the Review Team at the one day *Learning Together* workshop. The analysis and appraisal work was then developed further by the Lead Reviewers and written up in the Appraisal of Practice, with input from the Review Team.

- The 'Window on the System' – the generic findings which provide a window on the local safeguarding system, is generated through the analysis of learning from the specific case, in order to tease out which pieces of learning have a broader application. This phase of the review was undertaken by the Lead Reviewers and the Review Team. It was started during the one day workshop and then developed further in a separate meeting of the Lead Reviewers with the Review Team.

Waltham Forest SAR Process – Key Meetings		
Date	**Key Activity**	**To achieve**
23.02.17	SAR training session for SAB members and	Familiarity with the SCIE

	local front line staff	Learning Together model
02.03.17	Learning Together SAR Workshop for frontline practitioners and managers	Gather and analyse case data
16.03.17	SCIE independent supervision session for Lead Reviewers	To quality assure and support development of appraisal of practice and emerging findings
21.03.17	Meeting of Lead Reviewers and Review Team	Verify developing analysis of practice and input to emerging generic findings
9.06.17	One Panel meeting	SAR subgroup to quality assure the SAR report
29.06.17	Lead Reviewers facilitate SAB Findings Workshop	To share findings with SAB and facilitate development of SAB action plan

3.2 Members of the Review Team

Member of the Review Team	**Role**	**Agency**
Alison Ridley	Lead Reviewer	Independent
Suzanne Elwick	Lead Reviewer	London Borough of Waltham Forest
Andrew Coombe	Designated Nurse for Adult Safeguarding	Greenwich CCG
Peter Davis	Head of Safeguarding Adults	Royal Borough of Greenwich
Nick Sherlock	Head of Adult Safeguarding and Quality Assurance	London Borough of Croydon
Lauretta Adjei	Operations Manager	Sequence Care Group
Nick Bertram	ISA Placement and Joint Occupational Therapy Lead	NELFT
Paul Larrisey	Programme Director – Accountable Care	Waltham Forest CCG
Samantha Spillane	Specialist Safeguarding Adults Advisor	NELFT
Lorraine Thomson	Adult Case Manager, Specialised Commissioning	NHS England
Claire Solley	Interim Head of Safeguarding Adults and Deprivation of Liberty Safeguards (DoLS)	London Borough of Waltham Forest
Gemma Blunt	Safeguarding Adults and DoLS Manager	London Borough of Merton
Lindy Shufflebotham	Head of Contracting and Commissioning	Waltham Forest CCG

3.3 Summary chronology of key events

The period under review is September 2015 – December 2016.

DATE	KEY EVENT
11.09.2015	Discharge planning undertaken prior to Mark's planned 'step down' transfer from Burston House (low secure hospital) to Fields Court locked rehabilitation hospital. Mark had two transition visits to Fields. Eight hours of 1:1 support agreed each day to include accessing community and therapeutic input.
29.09.15	Comprehensive inspection of Fields Court by CQC found serious concerns; these include lack of sufficient suitably qualified staff, poor risk assessment and risk management processes, inadequate monitoring of the physical health of patients and inadequate monitoring of the physical health of patients and inadequate training of staff in relation to safeguarding and DoLS.
30.09.15	Mark moved in to Fields Court (locked rehabilitation hospital) transferred under section 37 of the MHA 1983 from Burston House Hospital (low secure). Mark was funded eight care hours per day. Care plan, Treatment plan, Positive Behaviour Support Plan and Risk assessments were in place on move.
03.10.15	Mark engaged in sexually inappropriate behaviour with a female patient (CS). He forced magnetic latch of the garden door from Fields Court and gained access into the female courtyard. He fondled and kissed the breasts of the female patient who was sitting in the courtyard at the time. Mark reported the female patient gave consent. Subsequent capacity assessment indicated that CS lacked capacity in relation to consenting to sexual relationships. CS and her next of kin did not wish for police intervention
04.10.15	Greenwich CLDT lead safeguarding response - informed CQC. Full investigation into the incident to take place. Safeguarding strategy and case conference were held. CS's placing authority is Croydon.
06.10.15	Mark began pushing boundaries, became verbally aggressive towards staff, shouting insults at the staff. Mark began to hit the office glass windows with a broom stick and kicking doors. He was verbally de-escalated back to his flat in Ivy Mews. Criminal Damage – Mark smashed window with fire extinguisher. Care home would not support prosecution.
14.10.15	Placement visit by Waltham Forest social worker to see Mark at Fields Court. NELFT arrange that the visits will take place weekly.
19.10.15	CQC Management Review Meeting to discuss inspection findings.

	Decisions made: a) To inform provider of intent to serve a section 31 Health and Social Care Act 2008 urgent imposition of condition to not admit any new patients to the location until non-compliance resolved. To include requirement for a registered manager (urgent condition not imposed as provider agreed voluntarily not to take in new admissions. b) To inform, without delay, commissioners of all patients in the service of CQCs concerns and that we intend to take urgent action. To copy in NHS England.
23.10.15	Mark's Care Co-ordinator sends email to John Howard Centre requesting urgent forensic gatekeeping assessment.
26.10.15	Mark is currently on a 1:1 basis with male staff only, this includes his escorted leave therefore risk has been removed.
28.10.15	Mark threw his medication on to the roof of the building - he reported he did this because was unable to call his mum on the phone. He accessed the office area, took a set of keys from the staff and threw them on to the roof.
04.11.15	Email received from CQC to inform that they had acted prematurely and were withdrawing the required actions detailed in their letter.
04.11.15	Police decide to close criminal investigation with no charges.
06.11.15	Safeguarding meeting chaired by Greenwich LA in relation to Mark incident accessing female section of Fields, Police investigation closed. Risk reviewed and assessed as minimal, broken door is now repaired and Sequence assure Social Worker that Mark can be kept separate from female patients. Risk assessments and care plans to be updated in relation to sexualised behaviours for both service users. Safeguarding enquiry closed by Greenwich London Borough.
09.11.15	NHS E emails Waltham Forest CCG to request again a CTR for patient
10.11.15	Forensic report received from Consultant Psychiatrist, John Howard Centre – confirming outcome of gatekeeping assessment – that Mark's needs do not require step back up to low secure setting.
12.11.15	Mark was verbally aggressive using racial slurs towards a member of staff. Mark was informed that this is not appropriate behaviour and this is a crime. The Police came and spoke with Mark but took no further action.
17.11.15	Sequence care staff discover Mark (unsupervised) fondling female resident's (RP) breasts through a restricted window whilst he is in the garden. He was on 8 hours 1:1 support for the day which had finished at 18:00 and was then on general observation. Police called and safeguarding alert sent to Greenwich LA. Safeguarding enquiry co-ordinated by Greenwich LA CLDT.
25.11.15	The Police came to interview Mark again under caution, social worker and solicitor were present. The Police said they will not take this to the CPS.
27.11.15	Hospital Manager's Hearing – outcome is that section is upheld.

30.11.15	NHS E confirm to Waltham Forest CCG their understanding that the plan is for Mark to transfer to another community rehabilitation setting as current placement is failing. A referral to the specialist sexual offences unit at the Taren fort Centre in Dartford has been suggested by psychology. Mark continues to have section 17 leave with minimal challenging behaviour when he is in the community which indicates that he does have impulse control. The social worker is visiting the service once weekly to support Mark and staff. Social worker is of the view that patient is happy in the current placement. Patient referred to Alpha Hospitals Woking but turned down for placement.
03.12.15	Care Co-ordinator and ISA Panel Waltham Forest representative requests another gatekeeping assessment from East London Foundation Trust (ELFT) LD forensic/secure services (John Howard Centre) following all the incidents. ELFT view is that patient needs to be transferred back to a low secure setting and that his step down constitutes a failed discharge. Two other providers Cygnet and Priory Group have completed a screening assessment for locked rehab and based on the information sent neither is able to meet his needs in a unit in or near London due to his complex needs and disruptive behaviour.
03.12.15	Mark attends court for historical charge of aggravated assault - this offence was committed against staff at his previous placement. Mark given 6 month conditional discharge and fined £100.
15.12.15	Assessment completed by John Howard Centre, they declined return to low secure as Mark not assessed as meeting threshold.
12.01.15	Following a community visit (section 17 leave) with his 121 worker Mark returned to Fields unaccompanied after being out in the community – Safeguarding alert raised by Sequence Care to Greenwich LA.
13.01.15	Incident during section 17 leave to be investigated for the safeguarding enquiry (re possible neglect of Mark by Fields staff) co-ordinated by Greenwich LA, case conference held under section 42 of the Care Act. Mark subsequently retracted the allegation that he had been left by staff member.
15.01.15	CTR completed at Fields - four main recommendations 1) “not ready for discharge to remain in a hospital setting. Needs dedicated therapeutic intervention in relation to sexual health and sexual behaviour 2) All Safeguarding to be resolved by Greenwich LA 3) SW to start to plan discharge plan 4) SW to discuss with Mother Mark rights in relation to legal position with Tribunal. Need full risk assessments - to patient; to others; offending behaviour, sexual behaviour; risk of reoffending
26.01.16	Referral Made to Bracton Clinic-one or two days a week for people with a personality disorder and sex offenders service both group work and one to

	one. Patient who is making progress, accessing the community and beginning to understand consequences to actions.
12.02.16	Case conference by Greenwich LA to resolve any outstanding actions relating to the three safeguarding alerts. Mark present.
01.03.16	William Morris centre declines “does not work with out of area clients”
02.03.16	Referral to NELFT Personality Unit who decline due to “ service is not commissioned to work with Antisocial personality disorder
04.03.16	CQC management review meeting to review the concerns • Provider not meeting the requirements within set timescales following on from the previous CQC inspection • Decision of meeting to write to provider in relation to the key concerns of the action plan and to seek target dates
09.03.16	NHS E confirms that in 2012 the patient’s hospital care was commissioned by Mental Health services.
14.03.16	Mark purposely opening his back door setting the alarm off, he became abusive to staff and the nurse in charge when they went to ask him to stop setting the alarm off.
30.03.16	Anonymous allegations about abuse/bad practice at Fields received by CQC. Referral made by CQC to Greenwich LA with concerns.
14.04.16	Mark assaulted Sequence Care staff member (spat in his face) police called awaiting outcome, police caution given to Mark and psychologist followed up with Mark, SW informed.
15.04.16	CQC Inspection report published (based on inspection undertaken late 2015) – some delay in publication of report. Service placed on special measures by CQC.
23.04.16	Sexual assault by Mark against CS (one of previous victims who had been assessed as lacking capacity in relation to sexual relations). Mark was in his room - Mark had finished his 1:1 support and was on general observations in his flat. Female left unsupervised in the lounge area and then she went to Mark’s room. Mark not aggressive – female was reluctant to leave Mark’s room. Both stated that no penetrative sex took place. Police called, and attended unit to interview Mark who stated they were only listening to music. Police unable to interview CS who was asleep.
24.04.16	The Police came back to the unit about 1pm to speak with CS who confirmed that Mark had touched her breast and put his finger in her private parts and she drew a picture of where he touched. Sent Reg 18 to notification to CQC, informed Greenwich safeguarding via email, two staff suspended.
25.04.16	CS capacity assessment confirms lack of capacity in relation to sexual relations, protection plan in place.
12.05.16	Greenwich Safeguarding convened a strategy meeting. Case conference to

	be held after the Police have concluded their investigations.
06.05.16	ental Health tribunal - outcome R remains on section 37, he has the need for a personality disorder service which could be a mainstream service during the day. Maudsley unit to be contacted and referred. Mark to have psychology input once weekly. Fields to recruit permanent Psychologist on site. The Get Me Out of here team commissioned by NHSE will be visiting Mark at Fields and CPA Care Co-ordinator to be in attendance. Although Mark remains on section, it is the view of Care Co-ordinator that a bespoke service with Personality Disorder specialist input is required.
11.05.16	Safeguarding strategy meeting includes actions for Consultant psychiatrist to review CS Mental Health diagnosis and complete a forensic risk assessment referral to Respond for Mark. Care Co-ordinator to contact NHS England for advice about services that Mark could be referred to.
19.05.16	NHS E liaise with Waltham Forest CCG in relation to reporting stats on the Transforming Care cohort to NHS England and whether the recommendations of the CTR have been met. -
23.05.16	Outcome of Cygnet hospital assessment is that they are unable to offer a placement in the service due to level of risk he presented. They do not have the relational or procedural security to manage his risky behaviours. He also currently demonstrates high risk sexually inappropriate behaviour that would meet our exclusion criteria and there is no realistic prospect of progressing him to safe unescorted leave.
23.05.16	Mark referral to Bromley Road locked rehab.
01.06.16	Referral completed for Forensic assessment. Mark has been assessed by locked rehab units (both LD and MH) and all of them deem him too high a risk to accept.
03.06.16	Mark was found by staff trying to forcefully use his key to open the door to access the communal area where the females are.
06.06.16	First- tier MH Tribunal decision - Section 37 upheld. The service shall not be discharged from liability to be detained.
10.06.16	Mark damaged his front door by kicking it several times which resulted in it falling to the floor. The Police were called, They assessed the damage but took it no further, incident form was completed.
15.06.16	Forensic Gatekeeping Assessment – recommended that a cognitive assessment is undertaken, and that male Personality Disorder locked rehab services would be best suited to consider Mark. Not suitable for admission to low secure LD service at this stage.
28.06.16	ISA Panel rep made referral for assessment - sent to Cambian Churchill Rehab
29.06.16	Email contact from NELFT safeguarding team requesting update on safeguarding and April's incident. Email to returned with information

	requested.
04.07.16	'Get me out of here' Transforming care team meet with Mark to undertake life planning session. Mark was agitated at boundaries being upheld, he damaged his back door by kicking the door with is foot several times until the door handle broke off.
16.06.16	Comprehensive Risk Assessment requested by Consultant Psychiatrist and funded by Sequence Care to provide a specialist opinion on Mark's behaviours, understanding and motivations, and potential risk Mark poses to both himself and to others. To provide recommendations relating to level of risk (likelihood of offending), devising a comprehensive risk management plan, levels of supervision needed and suggestions for further treatment, social activities and residential support.
19.08.16	Life planning meeting with 'Get Me Out of Here'. Mark was supported to express his view about where he wants to live in future.
22.08.16	Mark assaulted a member of staff, after pushing the staff into a wall and hurting his arm during the incident and made a fist to hit when another staff intervened. The staff called the Police - Mark was charged with common assault by the Police. (In November Mark pleaded guilty and was subsequently sentenced to 12 months conditional discharge and ordered to pay £50 contribution toward costs and victim surcharge of £20.)
16.10.16	Mark broke the back door trying to disable the alarm, and as he became increasingly agitated he slammed and broke his front door damaging the door, this matter reported to the Police but he was not charged.
26.10.16	Mark began pushing boundaries. This resulted in Mark kicking another patient's door, leading to that service user being agitated which led to destroying his possessions in his lounge. Police attended the unit and spoke with Mark about his behaviour but took no further action.
02.11.16	Mark ripped up some paperwork as he was agitated. He then requested for a broom to sweep it. He used the broom to damage the windows in the office. Whilst damaging the windows and after Mark engaged in verbal abuse, threating staff with physical violence. The incident was reported to the Police, who arrested Mark. (Mark subsequently attended Bromley Magistrates court 30.11.16 and was charged with criminal damage to property).
03.11.16	Hospital Manager's Hearing - Section 37 upheld.
11.11.16	Mark wanted to go out after 8pm to buy a drink. He became aggressive and started to use his legs to kick through the activity shed door. Mark was arrested and taken to the Plumstead Police station and kept in custody overnight.
14.11.16	CTR held - NHSE was involved. Aim to review the CTR decisions of 29/09/2016 as Mark's behaviours had escalated and a notice had been

	serviced for Mark to move on from Fields. It was deemed that a community placement was no longer a suitable option as identified at the 29/09/16 CTR. Fields Hospital due to close on 9/12/2016. Provider - Cambian was invited to this review as they had assessed Mark and felt they could provide a suitable placement for Mark. Cambian accepted Mark.
15.11.16	Mark moved to Cambian.

3.4 References

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