Luton Safeguarding Adults Board
Working in partnership to protect adults at risk

Report of the Safeguarding Adults Review regarding Adult A

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1. Introduction

1.1 Why this case was chosen to be reviewed

The Luton Safeguarding Adults Board (SAB) decided this case should be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014. In June 2017 Adult A was found by police and ambulance staff in very poor physical health. Adult A was suffering from sepsis and had a self-crushing injury to both legs resulting in 'compartment syndrome[1]' with both legs becoming 'oedematous and necrotic'[2]. These injuries were a result of self-neglect and Adult A had not been seen by any professional for almost four years despite having a diagnosis of schizophrenia and having been treated for that condition for almost twenty years. It was therefore determined that there was 'reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult' and that the 'SAB knows or suspects that the adult has experienced serious abuse or neglect'.[3]

1.2 Pen picture of Adult A

Adult A lives, with a younger sibling, in the house where they have lived since childhood. Adult A has an older sibling who is married with two children. Adult A has been assessed for and claims disability benefits. Adult A and the younger sibling are also supported by a Trust Fund established by the parents before their death. Adult A has a significant history of poor mental health. Adult A was initially diagnosed with catatonic schizophrenia in 1985 when 22 years old. Between 1985 and 2005 Adult A was admitted to hospital on six occasions (four compulsory admissions under section 3 of the Mental Health Act 1983), on each occasion the admission was precipitated by Adult A ceasing to take medication leading to a significant deterioration in Adult A's mental health.

1.3 Timeframe

The review covers the period between 2012 (when Adult A's mother died, and responsibility for the medical care was passed to the GP by the mental health trust) and November 2017 (when Adult A was admitted to hospital after experiencing life threatening ulcers following years of self-neglect).

1.4 Terms of Reference

The purpose of a SAR is described in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring. In order to focus that learning as part of developing the terms of reference the SAB agreed some broad research questions that would be explored in the review. These were as follows:

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[1] Compartment syndrome is a painful and potentially serious condition caused by bleeding or swelling within an enclosed bundle of muscles – known as a muscle compartment. https://www.nhs.uk/conditions/compartment-syndrome/

[2] The definition of oedematous in the dictionary is characterized by an excessive accumulation of serous fluid in the intercellular spaces of tissue. Necrosis is the death of cells or tissues from severe injury or disease, especially in a localized area of the body. Causes of necrosis include inadequate blood supply (as in infarcted tissue), bacterial infection, traumatic injury, and hyperthermia. https://www.collinsdictionary.com/dictionary/english/oedema

[3] section 44 of the Care Act 2014 (1b and 3b) http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

- How well does the Luton safeguarding system identify 'vulnerable people' who need support but are resistant to help?
- How well-equipped are professionals in the Luton Safeguarding system to understand their responsibility for safeguarding vulnerable adults in such circumstances?

1.5 Methodology

1.5.1 Statutory guidance requires SARs to be conducted in line with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. In addition:

- "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; and 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." [4]

1.5.2 This review uses the SCIE Learning Together methodology and looks to identify system wide issues.
The methodology included:
(i) all agencies completing a chronology which was integrated to form a timeline for the review;
(ii) the Reviewer analysing the timeline and seeking related documentation as required;
(iii) a workshop facilitated for representatives of all key agencies, with a focus on gathering data from front line staff who were directly involved in the case;
(iv) involvement (as far as this is possible) with key family members.

1.6 Reviewing expertise and independence

1.6.1 The review has been led by Fiona Johnson, an independent social work consultant accredited to carry out SCIE reviews and with experience in writing serious case reviews; and Frances Pearson, who is also an accredited reviewer, and is Chair of the Luton SAB. Both reviewers have had no previous direct involvement with the case under review.

1.6.2 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of

[4] (DoH,14:138) section 14 of the Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

the analytic process and reliability of the findings as rooted in the evidence.

1.7 Methodological comment and limitations

1.7.1 *Perspectives of the family members* - Contact was made with Adult A inviting participation in the SAR however this opportunity was declined. Initially it was also requested that the SAR should not progress as Adult A did not think it was necessary. Following legal advice, the SAB determined that the SAR should progress as it met the statutory criteria and it was felt that there was learning that could be achieved to safeguard other vulnerable adults. There was further discussion with Adult A who indicated acceptance of the review but asked that when published it should be anonymised.

1.7.2 *Participation of professionals* - The lead reviewers and the review team have been impressed throughout by the professionalism, knowledge and experience that the case group (the professionals from all agencies involved with Adult A) have contributed to the review; and their capacity to reflect on their own work so openly and thoughtfully in the review process.

1.7.3 *The review team* – Members of the review team provided significant assistance to the lead reviewers both in identifying and accessing relevant documents and in assisting to facilitate the workshop. They were also key when developing the findings providing the wider over-view of service delivery and reflecting on the extent to which practice in this case reflected wider systemic issues.

1.7.4 The review took longer than expected for several reasons. Initially there was some delay in accessing relevant agency records as the Mental Health Trust had difficulty accessing historical records, however this issue was resolved quickly. There was, however, further significant delay because ASC was late in returning their chronology due to a sudden unexpected staffing resource issue which meant the allocated task had to be reassigned. The resource issue has now been addressed and a full chronology was returned.

1.8 Structure of the report

The Findings has two main sections:

- The Appraisal of Professional Practice which provides an overview of ‘what’ happened in this case and ‘why’. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team’s judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects of the case the explanation for ‘why’ will be further examined in the findings in section 3 and a cross reference will be provided. More specifically, this section provides an overview of professional practice in this case whilst acknowledging the difficult and complex task frontline practitioners face.

- The Findings in Detail which identifies the key messages of learning that have emerged from the review of the services provided to Adult A and elaborates on the areas within the safeguarding system which require strengthening in order to improve future outcomes for vulnerable adults.

2 The Findings

2.1 Appraisal of professional practice in this case: a synopsis.

Response by professionals to Mother's death

2.1.1 Prior to 2012, Adult A was living with the younger sibling and mother and was supported via a care plan (known as the Care Programme Approach) whereby Adult A was seen regularly by a psychiatrist, who had oversight of medication, and was supported in the community by a care co-ordinator who visited the family home, saw Adult A and provided support to Adult A's mother who had previously alerted professionals when Adult A stopped taking medication.

2.1.2 When Adult A's mother died unexpectedly in August 2012, the Care Coordinator (CC) immediately visited, and met with the older sibling who was concerned as to how the two siblings would manage without their mother's assistance. This was good practice from the CC as a mechanism for identifying and averting a possible crisis. The CC identified that Adult A was at risk of deterioration in mental health and referred to the Crisis Resolution Home Treatment Team (CRHT) for assessment because Adult A was showing signs of hallucinations and the older sibling reported that Adult A had not been taking medication. The CRHT contacted Adult A, who declined an assessment but after further discussion a joint visit with CC was arranged but then cancelled by CRHT. Eventually, three days later, the CRHT visited alone and saw Adult A, who, they felt, was mentally well, so no further action was taken, the CC was content with this assessment as she felt that Adult A had stabilised following an immediate grief reaction to the mother's death. The CC's interventions at this point were positive and effective.

2.1.3 The CC however did not consider undertaking a 'carers assessment' for the younger sibling or undertake a needs assessment regarding the support that could be offered to the two vulnerable individuals living in the community. This was a significant oversight by the CC as it is the first time that Adult A and the younger sibling were living independently in the community without the ongoing support from parents with daily living. Given that Adult A's history indicated that it was probable at some point there would be a relapse it was important that there was an assessment of the capacity of the person that Adult A was living with (who was a de-facto carer) to provide appropriate support over time. **The relevance and importance of the 'carers assessment' as a risk management tool when working with vulnerable adults are explored further in Finding 1**.

Adult A disengages from mental health services

2.1.4 The CC continued to visit Adult A regularly but had difficulty gaining access and Adult A failed to attend outpatient clinic appointments or attended clinic at the wrong time. The CC was not concerned as she felt Adult A's presentation (when she was permitted contact) indicated that Adult A was taking medication and there was no sign of deteriorating mental health problems. There was discussion in the clinic about following the 'Disengagement Policy' and a possible discharge of Adult A back to the community meaning that the General Practitioner (GP) would become the 'Lead Professional'.

2.1.5 At the end of March 2013 Adult A was discussed in a Multi-Disciplinary Team meeting attended by the CC, the psychiatrist and other members of the hospital-based staff who worked with Adult A; the GP was not present at the meeting. It was noted that the two siblings were coping with shopping and housework following the mother's death. It was also reported that Adult A was requesting discharge from the mental health service and had repeatedly requested this over the last six years. After some discussion it was agreed, with consensus, to discharge Adult A back to 'GP care only' in line with the 'disengagement policy'. Following this decision, a letter was sent to the GP which said that Adult A had not attended appointments at the clinic but as Adult A 'seems to be engaging well with the GP and receiving medications' it had been decided to discharge to GP-led care. This letter did not detail what was expected of the GP as lead professional nor did it provide any detail about Adult A's past care from the Mental Health Trust. There was no risk assessment included nor any indication of what could trigger further difficulties for Adult A. The GP on receipt of the letter was unclear whether Adult A was being simply discharged from the care of the psychiatrist and would continue to be supported by the CC. The GP asked the practice receptionist to contact the Mental Health Trust to clarify this, but no reply was received. **The nature of communications when patients are discharged from Mental Health Trust services to support in the community is explored further in Finding 2.**

2.1.6 The decision by the Multi-disciplinary team (MDT) to discharge Adult A to the community was flawed as it did not take enough account of the history of non-compliance with medication which meant that a relapse was likely at some point in the future. Given the likelihood of relapse it was important that the GP understood fully the likely triggers and necessary action when this happened, none of this was detailed in the discharge letter. One explanation for this decision being made by the MDT was that it was early in the implementation of the 'recovery model', this approach is based on two simple premises: firstly, it is possible to recover from a mental health condition and secondly the most effective recovery is patient-directed[5] which meant the health professionals were

[5] The recovery model is a holistic, person-centred approach to mental health care. The model has quickly gained momentum over the past decade and is becoming the standard model of mental health care. This model is based on two simple premises: 1.) It is possible to recover from a mental health condition and 2.) The most effective recovery is patient-directed. https://www.verywellmind.com/what-is-the-recovery-model-2509979

viewing the possibility of Adult A recovering from the mental illness and wished to enable greater control of the health treatment. Thus, the clinicians were probably strongly influenced by a desire to enable the empowerment of two vulnerable adults. Adult A strongly wished to be discharged from the psychiatric service and the clinicians were responding to that desire with insufficient consideration of the practicality of the GP acting as key worker to an individual who was almost certain to relapse at some point. This poor decision was compounded by the lack of an effective assessment of the younger sibling's capacity to be a carer; and a lack of resources in GP practices to support them with their work with mentally ill adults living in the community. There are now primary care mental health link workers who can assist GPs working with adults such as Adult A but at this time these resources were not in place.

2.1.7 A further limitation of this decision was that there was no consideration of Adult A's status under Section 117 of the Mental Health Act 1983. Adult A had previously been the subject of a section 3 order under the Mental Health Act 1983 and was entitled to after-care to meet needs because of the mental health condition that caused the detention, and to reduce the chance of the condition getting worse. Any decision to end or significantly change the care plan should have been endorsed by the Clinical Commissioning Group (CCG) in conjunction with ASC. If this process had been in place it is possible that there would have been challenge to the plan for the GP to be the lead worker or at least the GP would have been better informed about what this role required. **It is not clear why there was no consideration of Adult A's rights under Section 117, but it was reported at the workshop that there is a lack of clarity about the implementation of Section 117 discharge processes and this is discussed further in Finding 3.**

Adult A's mental health is managed in the community

2.1.8 During April 2013 the CC saw the younger sibling who reported that Adult A had not taken the medication and would not go to the GP for a repeat prescription. The younger sibling reported that Adult A was staying mainly in the bedroom but did not consider that this behaviour was unusual. In response to this the CC arranged with the pharmacist for the medication (Fluvoxamine, Lansoprazole and Pimozide) to be delivered weekly every four weeks via a Nomad pack. This arrangement involved the pharmacist sending a 'repeat prescription request' to the GP which triggered a prescription which then enabled the pharmacist to deliver, direct to the family home, medication for four weeks. The pharmacist requested repeat prescriptions until October 2016, meaning that Adult A did not have to request a prescription during that period although in the latter period the medication was collected from the pharmacist by the younger sibling.

2.1.9 When a GP is authorising repeat prescriptions there is an expectation that the patient should be seen for a regular review of their health needs. Adult A should have been seen by the GP every six months for a medication review and annually for a mental health medical review. Adult

A was invited to attend the surgery for these appointments repeatedly between 2013 and 2016 but never attended. Attempts were made by the practice to contact Adult A by letter and by telephone, but these were unsuccessful. In March 2016, when Adult A had missed three annual reviews, they telephoned, and a message was left, but there was no response. No other action was taken by the GP. This was clearly a failure in practice by the GP as Adult A should not have been issued prescriptions without being seen and when Adult A failed to attend appointments a home visit should have been attempted and if that was unsuccessful ASC and Police should have been contacted to check on Adult A's well-being. When this matter was reviewed with the GP Practice, they reported that this was an unusual occurrence as most patients do respond to contact and there are systems in the Practice that should trigger a review where they do not. It was explained as an oversight and the practice said that steps have been taken to ensure that it should not recur**. It is likely however, that this is a situation that could occur in other GP practices and the SAB may wish to request a report from the CCG regarding how this issue has been resolved.**

2.1.10 The pharmacist continued to issue medication via monthly Nomad packs until 15th November 2016. At that time the pharmacist contacted the surgery to request that a prescription was issued in order to continue dispensing and spoke to the receptionist who said that no more prescriptions would be issued as Adult A had not attended the surgery for a medication review. This conversation did not involve the GP who was clear that he would not have ceased to issue a prescription in these circumstances. The pharmacist therefore did not request a prescription but relayed this message to the younger sibling who collected medicines on behalf of Adult A. From this point onwards, Adult A had no prescriptions issued for medication for schizophrenia to be dispensed. It appears that the prescriptions ceased to be issued when the pharmacist stopped requesting a repeat prescription because he was told by the GP's receptionist that the prescription would not be issued because Adult A had not attended appointments. The GP was unaware that that the requests for repeat prescription had ceased. **The monitoring of repeat prescription requests and how this affects vulnerable patients is discussed further in Finding 4.**

Agencies become aware of safeguarding concerns

2.1.11 On 27th June 2017 Adult A was found by police and ambulance staff in very poor physical health. Adult A was suffering from sepsis and had a self-crushing injury to both legs resulting in compartment syndrome with both legs becoming oedematous and necrotic. This had resulted in an infestation of maggots and fleas in the lower limbs, the lower body having decomposed into the chair on which Adult A was sitting which was covered in excrement and urine. The home conditions were extremely poor. Adult A was admitted to hospital and was actively treated for the physical health problems which responded well to treatment. Initially it was thought the leg would be amputated but this was avoided. At this point Adult A was also assessed by psychiatric

services who prescribed medication for schizophrenia. It is noteworthy that at this point the mental health practitioners in Luton did not know how to access records from the previous mental health trust and so relied on information from Adult A and the GP. BLPT (Bedfordshire & Luton Partnership Trust) provided local mental health services until March 2010. Clinical records at this time were held both on paper records and the Continuum IT system. SEPT (South Essex Partnership Trust) took over the provision of local mental health services in April 2010. Clinical records continued to be held both on paper records with some held electronically on the Continuum IT system. In Luton clinical records were moved to the electronic Mobius system in the last year of the contract (2014-15). Paper records were scanned and archived. ELFT (East London Foundation Trust) took over the provision of local mental health services in April 2015. In 2016 all clinical records moved to the electronic RIO system. Processes for accessing old electronic and paper records were put in place and communicated to all operational managers across Bedfordshire and Luton. In Luton there was a widespread change of operational management soon after and knowledge of how to access old clinical records was lost. Teams in Luton were under the misunderstanding that they were unable to access historical clinical records as became apparent during the review process. Once this problem was identified staff were advised how to access the records and the Lead Reviewers were advised that all Luton teams now know how to access all historical clinical records. **This may be something on which the SAB wishes to receive a further report from ELFT.**

2.1.12 On 28th June 2017 the Ambulance Service and Hospital Accident & Emergency staff referred Adult A to ASC because of safeguarding concerns. The Police did not make a referral and it is not clear why this did not happen however one explanation is that their involvement was to assist the Ambulance Service (they came in response to a request for additional support) and the officers may have assumed that responsibility for the safeguarding referral lay with the Ambulance Service. When this was discussed at the workshop the consensus view was that the Police usually make safeguarding referrals appropriately.

2.1.13 On receipt of these initial safeguarding referrals the decision by the MASH was not to progress to a section 42 investigation, that is an assessment 'in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs'[6]. Instead they asked the Discharge Assessment Rehabilitation Team (DART)[7] to offer a carers assessment to the sibling 2. The DART assessor assessed and reviewed the case and decided that it was the worst case of self-neglect she had seen, and on 20th July 2017 she contacted ASC to ask them to reconsider the decision not to initiate a section 42 enquiry. Following this, it was agreed that the matter should progress to a section 42 enquiry.

[6] Adult safeguarding practice questions https://www.scie.org.uk/safeguarding/adults/practice/questions
[7] DART is a hospital-based social work team working to enable patients to return to the community

2.1.14 The rationale for the decision not to progress to a section 42 enquiry was that Adult A was in a safe place, in hospital and the major need was regarding the future discharge home. The ASC assessment teams were also pressurised with high caseloads. Safeguarding practitioners told the reviewers that they felt they consequently had to prioritise other cases where there was greater risk. This highlighted a discrepancy between what they thought and what their managers felt was the message within the organisation. This difference of perception rather than who was correct, is perhaps more telling about organisational pressures and strains. The worker making the decision, also felt that she was not aware that Adult A's condition was as serious as became apparent later. This decision nevertheless was wrong. Adult A had been living in the community with only a younger sibling for support and had a significant history of mental health difficulties and non-compliance with taking medication leading to self-neglect. This was the first significant evidence of safeguarding concerns and the first opportunity for professionals to assess Adult A's ongoing safeguarding needs. Participants at the workshop indicated that although there had been improvements in resources at the front line there was still high demand and limited resources. Furthermore, it was noted that Luton ASC has a low rate of referrals converting to section 42 enquiries. Luton's conversion rate in 2017/18 was 17% however the Luton Safeguarding Adults Board in its regular assurance discussion has agreed that the current audits (that are ongoing) and which focus on triage are a better source of data about the effectiveness of response. The board has scrutinised data around conversion rates at its two meetings so far in 2019 and is waiting for the publication of a framework on responding to section 42 enquiries that the Association of Directors of Adult Social Services (ADASS) is due to publish in August 2019. The intention is then for the Board to review its position about whether the conversion rate for Luton is indicative of the best approach to rising volume of concerns. Data shows that recorded concerns continue to rise (a 46% increase compared to Q1-Q3 of the previous year) while the conversion rate is dropping. In 17/18 only 19% of concerns led to an enquiry, for the year to date the rate is 17% and for quarter 3 2018/19 it was 13%.[8] **The issue of whether workload pressures affect thresholds for intervention under section 42 is one that the SAB will continue to consider as part of the wider discussion on approaches to high volumes of safeguarding concerns. This appraisal of practice supports the importance of continued partnership scrutiny on this issue and the wider one of how to respond to high volumes of safeguarding concerns.**

2.1.15 Following the initiation of the section 42 enquiry, the social worker and safeguarding Nurse visited Adult A on the ward on 21st July 2017. Adult A was deemed to have capacity to consent to the safeguarding enquiry but not to have full insight into personal mental health needs and the impact that not taking medication had on personal mental health. Adult A

[8] Performance report on Adult Safeguarding Q3 18/19 Luton SAB

engaged well but did not think there was a need for safeguarding. Adult A also indicated a disinclination to work with the mental health team but that GP services, including medication, would be acceptable. Adult A co-operated with the assessment and agreed to having ongoing support from social services including a home help.

2.1.16 On 14th August 2017 the social worker visited the GP surgery and reviewed their actions regarding Adult A. The social worker requested that the GP check to see if there were any other patients who had been provided repeat medication prescriptions without review and asked them to review their systems to ensure this could not recur. Following this a planning meeting was held on 4th September 2017. The actions from this meeting included: arranging a home visit prior to Adult A's discharge from hospital; investigation into the past history including why Adult A not seen by GP or mental health services for four years and what risk assessments were completed; contact to be made with Adult A's sibling; liaison with the Mental Health Trust regarding future support to be provided; consent to be obtained from Adult A to enable actions to be undertaken. Adult A and the family were not at the meeting although the younger sibling was sent an invitation letter.

2.1.17 From 12th September 2017 Adult A's mental health deteriorated because of non-compliance with medication. On 15th September 2017 the psychiatric service re-assessed and determined that Adult A should be detained under Section 2 of the Mental Health Act. At this stage Adult A was physically fit for discharge and treatment in the community but could not be discharged because of non-compliance with medication and deteriorating mental health. On 28th September 2017 Adult A was transferred to Poplars Ward, an old-age psychiatric unit, as it was not possible to find a bed in the working age psychiatric ward that could meet the physical health needs. The social worker undertaking the section 42 enquiry was not involved in the planning for Adult A's move which was organised by health professionals.

2.1.18 On 18th October 2017 the social worker received a letter from the GP advising that the practice aimed to improve procedures and communication in relation to patients not attending appointments and non-engagement. On 22nd November 2017 the safeguarding enquiry was closed with the safeguarding outcome recorded as 'substantiated (neglect and acts of omission risk reduced)'. It was also recorded that Adult A had capacity and had not agreed to the protection plan but was willing to be supported by the care co-ordinator (CC). On 24th November 2017 the Mental Health trust requested an assessment of the support to be provided to Adult A if discharged to live in the community. This request should not have been made as this assessment should have been undertaken by the allocated CC. The record of the outcome of the assessment was that Adult A needed additional support but there was no evidence at this time of contact with Adult A's younger sibling or any assessment of the sibling's needs as a carer despite this being a requirement of The Care Act 2014, from 2015 onwards.

2.1.19 The process of completing the section 42 enquiry was muddled. One reason for this was that the social worker undertaking the enquiry became unwell and was 'signed-off' sick for a long period in October 2017. Responsibility for Adult A was transferred to another staff member who had a very large caseload and was unable to prioritise the work. As a result, the case conference which should have been held at the end of the enquiry in November did not happen until February 2018 and so there was no direct communication with the CC who was working with Adult A to enable return to the community. Within ASC, transfer of responsibilities for section 42 investigations following the triaging of initial concerns, which remained with the practitioners who had previously carried out this function, was taking place as part of an agreed organisational change to spread safeguarding expertise, and confidence in dealing with adult safeguarding, beyond the safeguarding team. Practitioners who worked with Adult A reported a sense of confusion about responsibilities, both in, and beyond, their team, during this period of change. Managers felt that changing responsibilities were understood in the service. Rather than any view being 'correct', at that point in time, safeguarding practice was taking place against a backdrop of organisational change in relation to that practice, with the attendant risks of any such change, including to performance.

2.1.20 Whilst the section 42 investigation achieved some of its goals, (the GP reviewed practice regarding issuing repeat prescriptions and Adult A was immediately safeguarded when in hospital), Adult A's longer-term safeguarding needs were not fully resolved. There was also no obvious joint working between ASC and the mental health trust. As Adult A was not 'open' to the mental health team at the point of his admission to hospital, because key worker responsibility had been transferred to the GP, the enquiry went to ASC despite the primary need being for mental health services. Also, there was no case conference to agree a joint agency plan which meant there was some evidence of duplication in that both the care co-ordinator and the social worker contacted Environmental Health Department regarding resolving the problem of rats in the house in which Adult A was living. There were some specific problems with the working environment in ASC at this time, which may not be duplicated at other times. It is also clear that within mental health services there was a lack of clarity about the care co-ordinator's responsibility to undertake needs assessments rather than referring to ASC. Nevertheless, the nature of Section 42 enquiries involves a wide range of responsibilities, combining the dual function of ensuring that a vulnerable adult is safeguarded and provided with a suitable care package of support, whilst also reviewing and evaluating the services that have been provided to the vulnerable adult. **This issue is discussed further in Finding 5 which questions whether the breadth of responsibilities involved in the Section 42 enquiries may lead to some aspects being prioritised over others**.

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

2.2.1 The SAB agreed broad research questions at the start of the process, which go beyond the facts and issues in this case, to look more widely at the Luton Safeguarding C System. The questions are set out at in paragraph 2.3.2 and directly link to the areas covered in the appraisal of practice and the findings. The major focus of the research questions was that the review would consider how well agencies across the SAB worked with adults who were vulnerable because of self-neglect as this was an area of work of concern to all partner agencies in the SAB

2.2.2 The two research questions that were agreed were: a) How well does the Luton Safeguarding Adults System identify 'vulnerable people' who need support but are resistant to help? And b) How well-equipped are professionals in the Luton Adults Safeguarding System to understand their responsibility for safeguarding vulnerable adults in such circumstances?

2.2.3 A significant part of the review was spent in trying to understand how a vulnerable adult who had been known to the mental health system for many years could have become invisible for such a long period. A key factor in understanding this was to realise the important role that Adult A's mother had played, as the carer, in alerting professionals when Adult A's mental health was deteriorating. The absence of an assessment of the younger sibling to check that the capability and willingness to play this role once the parents had died was key and highlighted a significant weakness in the Safeguarding System's capacity to identify and support such vulnerable adults. This part of the review also showed some limitations of the current arrangements for managing patients in receipt of long-term medication and the need for systems that both ensure that such patients are reviewed regularly but also identify when they stop requesting medication.

2.2.4 The review also highlighted difficulties in the systems for enabling patients with mental health difficulties to be supported appropriately after discharge from hospital or specialist mental health services. It is entirely positive that adults with long-term chronic conditions should be enabled to be discharged from specialist services but where this happens it is important that they continue to receive support to enable the effective management of their condition in such a way that prevents their re-admission to hospital. The review has shown that there is a lack of understanding of Section 117 processes and that discharge letters could be strengthened.

2.2.5 The review has also shown that the tasks involved in undertaking section 42 enquiries may be too great for one individual and that one way of strengthening the Luton Safeguarding Adults system may be to develop mechanisms for joint working in some situations.

2.2.6 Finally the review has also shown that there is good joint working at the point of crisis and that the acute hospital services were effective and identified the need for further intervention for Adult A as well as resolving the physical health issues.

2.3 Summary of findings

The review team have prioritised 5 findings for the SAB to consider. These are:

	Finding	Category
1	Assessments of carers focus on the needs of the carer but do not consider how capable they might be at being a carer; with the consequence that assessments can become tokenistic and fail to fully consider the risks to the patient.	Practice norms and culture in long terms work
2	Is the written record of the handover where there is transfer of care from specialist psychiatric services to GP community care, sufficiently detailed about mutual responsibilities, and clear about how risk is managed?	Practice norm & culture – long term work.
3	Professionals in Luton lack clarity about how to implement discharge processes under Section 117 of the mental Health Act 1983 meaning that many mental health patients are not advised of their right to support and some are not supported adequately.	Professional norms & culture around multiagency working in assessment
4	There are no systems to alert a GP when a repeat prescription is no longer requested by a patient, meaning that vulnerable patients may have to reach crisis before their needs are identified.	Patterns in human–management system operation
5	Does the requirement that a section 42 Enquiry should both safeguard the individual vulnerable adult and scrutinise the quality of the services delivered to that vulnerable adult place an unrealistic responsibility on the worker undertaking the assessment which may lead to one aspect being prioritised over the other?	Professional norms & culture around multiagency working in assessment

2.4 Findings in Detail

FINDING 1: Assessments of carers focus on the needs of the carer but do not consider how capable they might be at being a carer; with the consequence that assessments can become tokenistic and fail to fully consider the risks to the patient**.** *Practice norms and culture in long term work*

Description

The Care Act 2014 requires that any carer who appears to have a need for support should be offered an assessment by the local authority. This assessment should determine what is needed and how the carer can be helped. From April 2015 any carer who appears to have a need for support should be offered one by social services. All carers are entitled to an assessment no matter what level of need, the amount of care provided or the carer's financial means. The assessment is required regardless of whether the person cared for has had a community care assessment/needs assessment or if they have been considered not to be eligible for support. The assessment looks at how caring affects the carer's life, including health issues and whether they are able or willing to carry on caring. It will also look at other important physical, mental and emotional needs the carer may have to help them achieve things such as work, education, maintaining relationships, and social activities. Following the assessment, social services will decide if the carer is eligible for services to be provided either to the carer or to the person being cared for to reduce the impact of caring. As a minimum, social services must provide all carers – including those not considered eligible for support – with information and advice on local services to prevent their needs from developing further.[9]

How did the issue manifest in this case?

There were several times when a carer's assessment could and should have been initiated, although this was never formally undertaken. The earliest and most significant point was when Adult A's mother died, and the CC worked with Adult A and the younger sibling to enable them to continue living independently. At that point it was clear that the CC was looking to the younger sibling to pick up responsibility for some, if not all, of the tasks previously completed by the mother. Many of these the younger sibling did take on (day-to-day shopping and cleaning) however a key role that Adult A's mother had previously played was in alerting the mental health services when Adult A's mental health deteriorated and, also checking whether Adult A was taking the medication. The CC discussed the medication with the younger sibling and assumed that the younger sibling would take a similar role to the mother but did not assess the younger sibling's capacity to undertake this task. After Adult A's admission to hospital, the younger sibling disclosed a fear that Adult A would be angry if outside professionals were involved and explained that this was why no contact was made with any agency when Adult A's mental health deteriorated. It was only when Adult A was unconscious that the younger sibling felt free to ring the emergency services.

[9] https://www.carersuk.org/about-us/13-help-advice/practical-support/4578-new-rights-for-carers-from-april-2015

How do we know it is an underlying issue and not something unique to this case?
Within the section of the Pan-Bedfordshire Safeguarding Adults procedures entitled 'Procedures for Investigating Concerns' (34 pages)[10] there are three mentions of carers assessments – on each occasion it states '*Carry out a carer's assessment and provide support and information to carers to improve the care they are able to offer*' – there is no suggestion that this assessment should also assess the level of support that the carer is able to provide and how this should influence the overall safeguarding risk assessment.

Research into 134 SARs by Michael Preston-Shoot identified in seven reviews that there needed to be better assessment and involvement of family carers with 22% of reviews highlighting improved understanding of family dynamics. Overall, he concluded that carer's assessments needed to be thorough because carers could not be assumed to always play a positive role.

'Equally, however, there may be complex co-dependent dynamics between caregivers and those they are caring for perhaps involving abuse and neglect (120, 125, 126, 133). Carer's assessments should be offered and be thorough, exploring mixed messages about giving care and support, willingness and ability to cope, and any evidence of difficulties and neglect (103,106, 109, 125, 134)'. [11]

How common and widespread is this pattern?
Census data released December 2012 reveals that the number of carers increased from 5.2 million to 5.8 million in England and Wales between 2001 and 2011. Carers in the Region, A Profile of East England[1], published in November 2009 by the University of Leeds, aimed to provide better information about carers at a regional level. The profile indicated over half a million carers in the region and:

• Over 4,500 people aged 85+ undertaking a caring role
• Over 96,000 people caring for 50+ hours a week
• Over 51,000 carers who considered themselves to be in poor health
• Over 270,000 people trying to combine work and a caring role
• 72% of carers worse off financially as a result of caring

The 2011 Census identified 18,256 carers in Luton, of whom 4,886 are providing 50+ hours of unpaid care each week.[12]

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
If carers are a key part of the support systems for vulnerable adults and professionals are assessing their support needs but not considering their

[10]The Pan-Bedfordshire Multi Agency Adult Safeguarding Policy, Practice and Procedures http://lutonsab.org.uk/wp-content/uploads/2018/04/BBC-CBC-LBC-SA-Policy-and-Procedures-2017-2018.docx-2.pdf these procedures are currently under review

[11] Michael Preston-Shoot, (2018) "Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change", The Journal of Adult Protection, Vol. 20 Issue: 2, pp.78-92, https://doi.org/10.1108/JAP-01-2018-0001 Permanent link to this document: https://doi.org/10.1108/JAP-01-2018-0001

[12] LUTON CARERS STRATEGY CARING FOR CARERS Luton Borough Council & NHS Luton Clinical Commissioning Group

capacity and capability to provide the caring function, they are omitting a key part of the risk assessment of the safeguarding needs of the vulnerable adult.

FINDING 1: Assessments of carers focus on the needs of the carer but do not consider how capable they might be at being a carer; with the consequence that assessments can become tokenistic and fail to fully consider the risks to the patient**.**

Carers are key partners for professionals to work with when risk assessing the safeguarding needs of vulnerable adults. This review has identified that the way in which carers assessments are undertaken may mean that there is insufficient consideration of the ability of the carers to provide adequate support. This therefore undermines the strength of the safeguarding plans that are put in place.

QUESTIONS FOR THE BOARD TO CONSIDER

- Does the Board think that the newly revised Pan-Bedfordshire Safeguarding Adults procedures entitled 'Procedures for Investigating Concerns' includes sufficient reference to carers?
- How confident are partner agencies that their staff are able to identify and assess carers?
- Does the Board think that staff are provided with appropriate training, support and tools to enable assessments of carers to be sufficiently robust regarding safeguarding vulnerable adults?
- How does the Board think that current arrangements for supporting carers could be strengthened in order to reduce risks to vulnerable adults?

FINDING 2: Is the written record of the handover where there is transfer of care from specialist psychiatric services to GP community care, sufficiently detailed about mutual responsibilities, and clear about how risk is managed? *Practice norms and culture in long term work.*

Description

When there is consideration of transferring care from specialist mental health services to the GP there is an expectation that there will be written communication between the two agencies to facilitate the transfer in key worker responsibilities.

At the time of the review the following was policy: '*Service users can only be discharged from Care Programme Approach (CPA) following a CPA review. All relevant parties such as the service user, carers, significant others, GPs and any others involved will be sent a discharge notification letter by the care coordinator of confirmation that the discharge has taken place. The GP will receive a letter stating that if they have any further concerns or relapse, the service user can be re referred through the Clinical Assessment or ASPA Service*'.[13]

Soon after policy was revised to say: - '*The support of CPA should not be withdrawn without:*

- *An appropriate handover (to lead professional or GP)*
- *Exchange of information with all concerned including carers*
- *Plans for review, support, and follow up as appropriate*
- *A clear statement about the action to take and who to contact in the event of relapse or change'*[14]

Current policy includes the following: '*Where a service user is discharged the referrer will be notified of this in writing and will have the opportunity to review the situation and discuss treatment options with that service user and ensure the importance of attending appointments is well understood'*.[15]

How did the issue manifest in this case?

In this case following discussion in a multi-disciplinary team meeting it was agreed (with consensus) to discharge Adult A back to 'GP care only' in line with the disengagement policy in place at that time. A letter was sent to the GP which said Adult A 'seems to be engaging well with the GP and receiving medications.' The letter sent to the GP was very brief and reported that there was a good relationship between Adult A and the surgery when in fact Adult A was struggling to attend the surgery to request repeat prescriptions. This letter did not provide a full history, a risk assessment or a management plan. It did say if there were further concerns to refer Adult A back to the service but did not specify how this was to be achieved. The GP was unclear whether the letter meant that the care co-ordinator input would cease or was just referring to ending the psychiatrist input. There was also no reference to Adult A's status in terms of Section 117 support and no reference to entitlement to ongoing aftercare.

[13] SEPT CPA AND NON-CPA POLICY CLP30 version 2

[14] SEPT Care Programme Approach (CPA), non-CPA and Care Management, Disengagement and Non-Concordance Policy POLICY/PROCEDURE NUMBER: CLP30 version 3

[15] ELFT CLINICAL GUIDELINES FOR COMMUNITY MENTAL HEALTH SERVICE USERS DISENGAGING OR NON-CONCORDANT WITH CURRENT PRESCRIBED TREATMENT PLANS
(Bedford and Luton)

How do we know it is an underlying issue and not something unique to this case?
The Review Team considered that the letter sent to the GP was probably typical for communications at the time. Since then pro-forma letters have been devised for clinicians, one for the initial assessment with a Psychiatrist and the other for follow-up appointments with a Psychiatrist. There is no pro-forma for discharge letters and clinicians write an individualised report on discharge. The review team thought it was probable that many discharge letters may well remain similar to those identified in this case. The national CQUIN audit identifies the number of patients in an audit sample for whom the provider has provided to the GP an up-to-date copy of the patient's care plan or a discharge summary which sets out appropriate details of all of the following:

- NHS number.
- All primary and secondary mental and physical health diagnosis, including ICD codes.
- Medications prescribed and monitoring requirements.
- Physical health condition and ongoing monitoring and treatment needs.
- Recovery focussed healthy lifestyle plans.

Performance in Luton in 2018 was 25% which supports a need for improvement.

How common and widespread is this pattern?
Potentially this would apply to all mental health patients discharged in Luton from adult Community Mental Health Teams (CMHTs). Between 1.4.18 to 31.3.19 there were approximately 1,210 discharges from the 4 Luton adult CMHTs. Of these approximately 160 had been under CPA at some point in time during their care and treatment with the adult CMHTs.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
When a patient is transferred from specialist psychiatric services to GP care it is important that all parties are clear about what the transfer involves, who is responsible for future monitoring of the patient's well-being and how any deterioration in the patient's condition should be managed in the future. Without such clarity there is a danger that vulnerable patients will fail to be safeguarded effectively.

FINDING 2: Is the written record of the handover where there is transfer of care from specialist psychiatric services to GP community care, sufficiently detailed about mutual responsibilities, and clear about how risk is managed?

There is a concern that the written record of the transfer of care from specialist psychiatric services to GP care is insufficiently detailed and does not provide clarity about relative responsibilities and actions to be taken if the patient's mental health deteriorates.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the Board know about the quality of current transfer records between specialist services and GP care?
- What does the Board know about how well current pro-forma letters have improved communications between GPs and specialist services?
- How does the Board think that practice can be improved in this area?

FINDING 3: Professionals in Luton lack clarity about how to implement discharge processes under Section 117 of the Mental Health Act 1983 meaning that many mental health patients are not advised of their right to support and some are not supported adequately. *Professional norms & culture around multiagency working in assessment*

Description

Some patients who have been kept in hospital under the Mental Health Act 1983 can get free help and support after they leave hospital. The law that gives this right is section 117 of the Mental Health Act, and it is often referred to as 'section 117 aftercare'. A patient can get free aftercare under section 117 if they have been detained:

- for treatment under section 3
- under a hospital order under section 37
- following transfer from prison under section 47 or 48
- under a hospital direction under section 45A[16]

Section 117 of the Mental Health Act 1983 states that it shall be the duty of the clinical commissioning group and local social services authority (in cooperation with relevant voluntary agencies) to arrange for the provision of (or in the case of the local social services authority, provide) after-care services for any person to whom section 117 applies, until such time as both of those organisations are satisfied that the patient concerned is no longer in need of any such services.

After-care is defined as services which are intended to: meet a need that arises from or relates to a patient's mental health problem, and reduce the risk of the mental condition getting worse, meaning the patient must go back to hospital

If responsibility for a patient is to be transferred practitioners should ensure that appropriate transfer arrangements are made, including in accordance with the Mental Health Act Section 117 Policy Care Programme Approach Policy and that the receiving organisation is aware of the duty under section 117 towards that patient. The needs assessment should clearly specify which part of the package relates to the provision of section 117 after-care to enable this to occur.

Planning of Section 117 After-care - The planning of after-care needs to start when the patient is admitted to hospital and should be planned within the framework of the Care Programme Approach in accordance with policy. The section 117 after-care plan should normally be formulated at a multi-disciplinary meeting; this meeting will also identify the care co-ordinator. The care plan should clearly identify the interventions that are related to after-care under section 117 and those that are not, and the patient should be given a copy. It should be regularly reviewed in accordance with the Care Programme Approach.[17]

How did the issue manifest in this case?

At no point was Adult A ever advised about support under Section 117 despite Adult A being eligible for such support having been the subject of Section 3 admissions to

[16] https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#one

[17] MENTAL HEALTH ACT SECTION 117 POLICY ELFT (East London Foundation Trust) January 2018 https://www.elft.nhs.uk/uploads/files/1/Section%20117%20Policy.pdf

hospital on many occasions. There is also no evidence in the records, of any professional considering whether Adult A should be assessed and supported under Section 117.

How do we know it is an underlying issue and not something unique to this case?
When the question of whether Adult A should have been supported and assessed under Section 117 was discussed at the SAR workshop there was confusion amongst the professionals attending (both front line professionals and members of the review team) as to how Section 117 was managed in Luton. There were assertions that the process was joint between CCG and ASC and that there should be a meeting to agree the mutual responsibilities. It was agreed however that there was a lack of clarity and that Section 117 was not often applied despite there being many mental health patients who were eligible for assistance under Section 117.

How common and widespread is this pattern?
Potentially this would apply to all mental health patients in Luton who had: -

- received treatment under section 3
- been under a hospital order under section 37
- been transferred from prison under section 47 or 48
- been under a hospital direction under section 45A[18]

Currently ELFT are aware of 603 Luton patients who meet these criteria.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
If there is confusion amongst professionals about how and when patients should receive Section 117 support these vulnerable adults may not be provided with all the help they are entitled to when discharged from hospital meaning that their mental health may deteriorate resulting in re-admission to hospital.

FINDING 3: Professionals in Luton lack clarity about how to implement discharge processes under Section 117 of the mental Health Act 1983 meaning that many mental health patients are not advised of their right to support and some are not supported adequately.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the Board know about how discharge processes under Section 117 should be working and are working?
- Does the Board think that current guidance on Section 117 discharge systems is adequate?
- How does the Board think partners can achieve that better practice regarding Section 117 discharges?

[18] https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#one

FINDING 4: There are no systems to alert a GP when a repeat prescription is no longer requested by a patient, meaning that vulnerable patients may have to reach crisis before their needs are identified. *Patterns in human–management system operation*

Description

Two thirds of prescriptions generated in primary care are for patients needing repeat supplies of regular medicines and as such, account for a significant workload for general practices. Many of the patients receiving these prescriptions have relatively stable conditions. The community pharmacy repeat dispensing service provided the option to GPs to allow pharmacists to assist GPs in providing repeat medication to patients with stable conditions requiring the same drugs over long periods of time.[19]

'Repeat prescribing' is described as a 'a partnership between the patient and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each issue.' [20] In this case it allowed the prescriber, the GP to authorise a prescription for over three years without any direct contact with the patient. This however was not in accordance with GP guidance which required that there should be a regular medical review to check that the 'patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated'. [21]

It should be noted however that the arrangements in place in 2013 that allowed the pharmacist to trigger the request for the repeat prescription was discontinued in 2015 when an audit conducted by the CCG identified that there had been over-prescribing. From 2015 it was expected that the patient should always be involved in the request for a repeat prescription, although, as in this case, there was some delay in the policy being implemented.

How did the issue manifest in this case?

In this case the GP issued medication (Fluvoxamine, Lansoprazole and Pimozide) for Adult A via a repeat prescription which was triggered by the pharmacist who delivered the medication to Adult A's house. By March 2016, Adult A had missed three annual reviews and six medical reviews and ignored both telephone messages and letters sent asking for attendance at the surgery. The pharmacist continued to issue medication via monthly Nomad packs until 15 November 2016. At this time the pharmacist contacted the surgery to request a prescription be issued in order to continue dispensing. However, the pharmacist was told by the receptionist that the surgery would not issue a further prescription as Adult A had not attended the surgery for a medication review, as a result, the pharmacist did not request a repeat prescription. The GP was unaware that the pharmacist had ceased to request the prescription and that Adult A was not receiving medication as there are no systems in place to identify when a repeat prescription request is not received. From this point onwards, Adult A was not prescribed medication for schizophrenia.

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[19] DECEMBER 2013 GUIDANCE FOR THE IMPLEMENTATION OF REPEAT DISPENSING: **NHS Employers, Pharmaceutical Services Negotiating Committee, General Practitioners Committee.**

[20] Repeat Prescription Services Final Report on the changes to repeat prescribing management in Luton supported by the Medicines Optimisation Team Luton CCG Report Author Tess Dawoud, Assistant Head of Medicines Optimisation, September 2016 NHS Luton CCG

[21] APPENDIX B Repeat Prescribing Best Practice Guide Medicines Optimisation Team July 2015 NHS Luton CCG

How do we know it is an underlying issue and not something unique to this case?
The systems in place in this GP practice are standard and whilst all GPs should have processes in place that alert them to patients receiving repeat medication without regular medical review there are no requirements for a system to be in place to provide an alert when a patient who is receiving a regular repeat prescription fails to request that prescription.

How common and widespread is this pattern?
Prescribing is the most common patient-level intervention in the NHS, and covers all sectors of care: primary, hospital, public and community health. It is the second highest area of spending in the NHS, after staffing costs. In the community in England, 1,084 million prescription items were dispensed overall in 2015, a 1.8 per cent increase (19 million items) on the previous year and a 50.4 per cent increase (363 million items) since 2005.[22] Over 3 million prescriptions items per annum are prescribed by GPs for Luton patients. The great majority of these items are repeats and not one off acute. Antipsychotics are prescribed primarily in patients with serious mental health illness schizophrenia and bipolar disorder. Approximately 1% of the adult population has a diagnosis of serious mental health.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
Most people in receipt of repeat prescriptions are very capable of managing the process of requesting repeat prescriptions without reminder. However, if the repeat prescription system is to be used with patients who are vulnerable and may be ambivalent about taking their medication, there is a need for a process that can alert the GP when the repeat prescription request is not received. Without this system in place a vulnerable adult with mental health difficulties may be in significant crisis before professionals are aware that they have not been receiving their medication.

FINDING 4: There are no systems to alert a GP when a repeat prescription is no longer requested by a patient, meaning that vulnerable patients may have to reach crisis before their needs are identified.

The absence of triggers for the GP that repeat prescription requests have not been received means that vulnerable adults could cease to be provided with medication because the prescriptions have not been requested.

QUESTIONS FOR THE BOARD TO CONSIDER

- What does the board know about GP practices in this area?
- Is it possible to develop alert systems in GP practices that can identify when a patient does not request repeat medication when on a long-term prescription?
- What does the Board know about how well GPs are implementing the recommendations in APPENDIX B Repeat Prescribing Best Practice Guide Medicines Optimisation Team July 2015 NHS Luton CCG and whether this effectively addresses the problem?

[22]Repeat Prescription Services Final Report on the changes to repeat prescribing management in Luton supported by the Medicines Optimisation Team Luton CCG Report Author Tess Dawoud, Assistant Head of Medicines Optimisation, September 2016 NHS Luton CCG

FINDING 5: Does the requirement that a Section 42 Enquiry should both safeguard the individual vulnerable adult and scrutinise the quality of the services delivered to that vulnerable adult place an unrealistic responsibility on the worker undertaking the assessment which may lead to one aspect being prioritised over the other?
Professional norms & culture around multiagency working in assessment

Description
Section 42 of The Care Act 2014 states that local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult. The Pan-Bedfordshire guidance for professionals says that the scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the circumstances of the case. The initial and most important support is the creation of a robust safeguarding plan to address immediate risks and longer-term support for the vulnerable adult. Where possible, as appropriate to the case and with the person's agreement the adult must be supported to:

- Live free from continuing abuse.
- Build their confidence, self-esteem and acknowledgement of their right not to be abused.
- Enable access to people outside the abusive situation, for example: social or educational activities.
- Access services where they can talk about the abuse they are experiencing, e.g. counselling services, victim support, domestic abuse outreach services or other support group.
- Gain more information about their options, e.g. advocate or legal advice
- Make a plan about what they would do if they changed their mind or if they wanted help in an emergency.

The procedures also identify the need for a risk assessment that:

- Must evidence consideration of strength-based approach. This means taking into account the supportive/protective factors that mitigate the risk.
- Risk to and safety of other people with care and support needs or children
- Whether any employee or volunteer should be suspended pending enquiry.
- Where staff are suspended the impact of that suspension on the service, people accessing the service, employer and employee and the steps needed to preserve continuity of service.
- Whether remedial actions are required against a provider to protect other people with care and support needs or children. [23]

Currently the expectation is that at least in the early stages a single worker will attempt to undertake these joint roles, but it is expected to be a multi-agency response and typically, as a planning meeting, tasks may be allocated out to relevant parties. If multiple safeguarding concerns in a location or organisation are identified 'The

[23] *The Multi Agency Adult Safeguarding Policy, Practice and Procedures – LSAB.* *https://www.google.com/search?client=firefox-bd&g=luton+The+Multi+Agency+Adult+Safeguarding+Policy%2C+Practice+and+Procedures+Abuse+is+Everybody%E2%80%99s+Business+%E2%80%93+Safeguarding+is+our+Responsibilit*

Serious Concerns Procedure' could be initiated which would involve identifying additional resources for the investigation.

How did the issue manifest in this case?
In this case the social worker initiated a Section 42 enquiry and immediately visited Adult A and gained consent to pursue the enquiry. The Social worker took immediate and proactive action regarding the investigation of the GP practice which identified that she clearly understood her role in taking *'remedial actions are required against a provider to protect other people with care and support needs'*.[24]

The social worker was less pro-active about planning for Adult A's future partly because Adult A was in hospital and she considered that the major need would be at time of discharge. This became complex when Adult A's mental health deteriorated, requiring transfer to a mental health facility and was re-allocated a care-co-ordinator. ELFT was not at the initial Section 42 planning meeting as at that time there was no allocated worker from mental health services. The case conference planned for November to end the Section 42 enquiry did not happen because the social worker was off sick, and Adult A was re-allocated to another worker who had a high case load and was not able to prioritise this work. Members of the case group also reported that there were structural changes that affected practice. As a result, there was overlap of actions so both the social worker and care co-ordinator involved environmental health regarding pest control at the property. There was no liaison between ASC and ELFT about Adult A's later discharge from psychiatric hospital and there was no assessment of Adult A's younger sibling in the role as Adult A's carer.

How do we know it is an underlying issue and not something unique to this case?
Both Review team and case Group members agreed that Section 42 enquiries have two functions:
a) To identify failings in professional practice and address any shortfalls; whilst also
b) ensuring that the service-user's future protection is assured.

It was acknowledged that these two functions can prove challenging for workers particularly if there are significant professional practice issues. Members of the Case Group and Review Team also considered that it was difficult for ASC staff to review other professional's work particularly when they were from a different professional discipline, as in this case. Usually the service-user's needs would be prioritised but that an additional factor influencing practice in this case was that Adult A's mental health deteriorated requiring his admission to a mental health facility. It is considered that the care co-ordinators responsibility for leading section 42 enquiries is not well understood and this may have been an influential factor.

The section 42 enquiry in relation to Adult A was open from 21/07/17 to 22/11/17. The time taken was outside the safeguarding timeframes to which Luton Adult Social Care (ASC) should work. At this time Luton ASC's Safeguarding structure was that all Local Authority led Section 42 enquiries were completed by a stand-alone Adult Safeguarding Team. The timeliness of enquiries formed one of the areas reviewed

[24] *The Multi Agency Adult Safeguarding Policy, Practice and Procedures – LSAB. ibid*

as part of a wide-ranging Adult Safeguarding and DoLS consultation undertaken in 2017. Following the consultation, the structure now in place was implemented between December 2017 and early 2018. There remains a Safeguarding & DoLS team (part of which is based at the MASH within Luton Police Station) which undertakes the screening of all Adult Safeguarding alerts, however any subsequent Local Authority led Section 42 enquiries are now allocated for completion by one of the four community social care teams or the learning disability team. Timeliness of enquiries is identified as a key area for improvement. There are ongoing actions to address delays and/or potential causes of delays and this is subject to continuous monitoring and review.

How common and widespread is this pattern?
Potentially this could apply to all safeguarding concerns and section 42 enquiries completed in Luton. 3,089 safeguarding concerns were raised in Q1-Q3 2018/19. This figure exceeds the total number of concerns raised in 2017/18 (3011) by 46%. The number of section 42 enquiries completed in the year to date (456) has also surpassed the total number completed in 2017/18 (315). Currently it is not possible to estimate how many section 42 enquiries have the dual function of both responding to concerns regarding professional practice and protecting the vulnerable person as this data is not currently collated. It is noteworthy however that there has been a significant rise in the rate of alleged 'Organisational Abuse' in 2018/19, 35 cases were reported in 2017/18, this has increased to 151 (18.1%. increase) in 2018/19.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?
The Section 42 Enquiry is a key process in safeguarding system. If that process is flawed, in that it places too great an expectation on the individual worker, then this is a major weakness in the overall adults safeguarding system.

FINDING 5: Does the requirement that a section 42 Enquiry should both safeguard the individual vulnerable adult and scrutinise the quality of the services delivered to that vulnerable adult place an unrealistic responsibility on the worker undertaking the assessment which may lead to one aspect being prioritised over the other?
The scope and extent of the assessment that is required in a Section 42 enquiry is too broad with too many components for one individual worker to manage. This leads to some aspects of the safeguarding investigation being prioritised over others and undermines the overall Section 42 enquiry. **QUESTIONS FOR THE BOARD TO CONSIDER** • What does the board know about practice in this area? • Is it possible to gather data on complex section 42 assessments that require the dual function of both responding to concerns regarding professional practice and protecting the vulnerable person? • What does the Board know about whether this issue is discussed in supervision, and whether this effectively addresses the problem? • How confident is the Board about the quality of assessment and management oversight where assessments are complex?

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high-risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009).

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

   a. Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

   b. Provide adequate explanations – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it

   c. Move from individual instance to the general significance – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.

   d. Produce findings and questions for the Board to consider. Pre-set recommendations may be suitable for problems for which the solutions are known but are less helpful for puzzles that present more difficult conundrums.

   e. Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

5 **Typology of underlying patterns**

To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively? They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

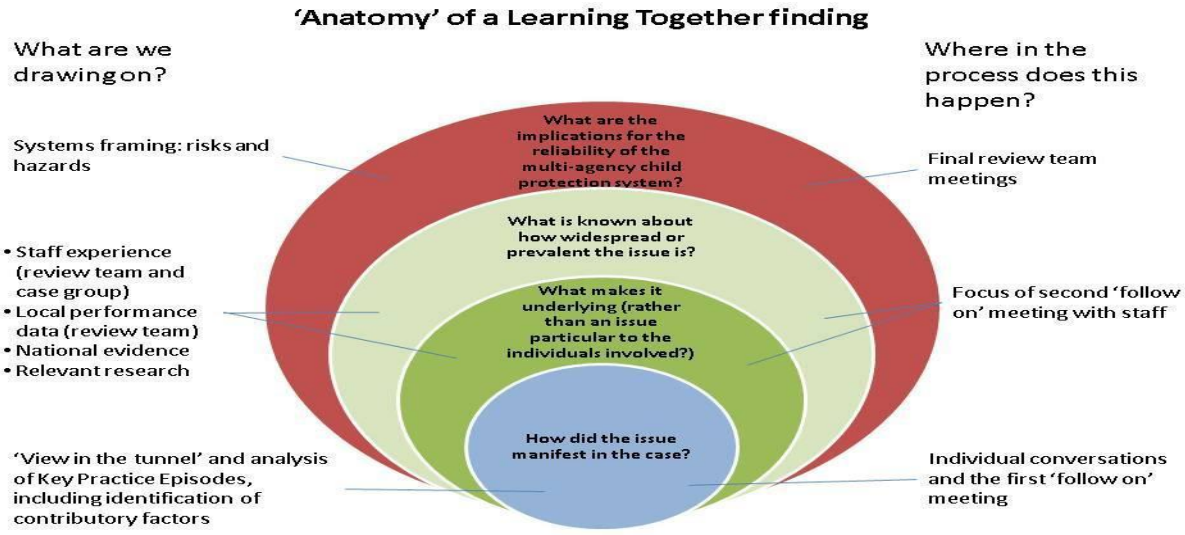
6 Anatomy of a finding

For each finding, the report is structured to present a clear account of: -

- How the issue manifests itself in the particular case?
- In what way it is an underlying issue – not a quirk of the particular individuals

involved this time and in the particular constellation of the case?

- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. Illustrated below.



7 Review Team and Case Group

7.1 The review team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent lead reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The review team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

	Review Team Members
Dr Aysha Humayun	Locum Associate Specialist to Dr Faiza Hassan Locum Consultant Psychiatrist, ELFT
Caroline Lewis	Chief Executive, MIND/BLMK
Danielle Davies	Principal Adults Social Worker, LBC
Gerald Zeidman	Chief Officer - Bedfordshire Pharmacy Committee
Jennie Russell	Deputy Director of Nursing and Quality, Luton CCG
Julie Hall	Head of Adult Safeguarding and Designated Nurse, Luton CCG
Lee Gray	Bedfordshire Police Missing and Child Sexual Exploitation Team
Paul Lindars	Associate Director Primary Care Development, Luton CCG
Lucy Nicholson	Chief Executive, Healthwatch
Michelle Welsh	Bedfordshire Police Child Abuse and Vulnerable Adult Abuse Team
Mo Aziz	Bedfordshire Police Adult Safeguarding Lead
Dinh Padicala	Named Professional for Adult Safeguarding, ELFT
Vijay Patel	LSCB/LSAB Business Unit Manager
Paul Rix	Deputy Director - Bedfordshire & Luton, ELFT
Vicky Sowah	Principal Solicitor – Social Services, LBC

Tess Dawoud	Asst Head of Medicines Optimisation, Luton CCG
Toni-Marie Doherty	Adult Safeguarding Manager, LDUH

7.2 The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.
In this case review,

7.3 **Structure of the review process**

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.
The review team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings. The sequence of events in this review is shown below:

Date	**Event**
18/10/2018	Introductory meeting for the Review Team and Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.
30/1/2019	Workshop with Review team and Case Group • identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case • appraising the practice in these KPEs • considering what was affecting the work/workers at the time (the 'view from the tunnel')
6/3/2019	Meeting with the Review Team who were provided with a draft report which set out the emerging underlying patterns and findings and where the Review Team were asked to consider whether these are specific to this individual case or pertain more widely and form a pattern.
16/5/2019	A follow-up meeting with the Review team to agree the final report.
22/7/2019	SAR/Practice Learning Review Group – to consider the draft final report
11/9/2019	SAB meeting – to consider the draft final report
TBC	Publication of the report

7.4 **Scope and terms of reference**

Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

Appendix 2 - Glossary

ASC	Adult Social Care
BLPT	Bedfordshire & Luton Partnership Trust
CC	Care Coordinator
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
CRHT	Crisis Resolution Home Treatment Team
DART	Discharge Assessment Rehabilitation Team
ELFT	East London Foundation Trust
GP	General Practitioner
LBC	Luton Borough Council
LDUH	Luton & Dunston University Hospital
MDT	Multi-disciplinary team
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SEPT	South Essex Partnership Trust

Appendix 3 - Bibliography

APPENDIX B Repeat Prescribing Best Practice Guide Medicines Optimisation Team July 2015 NHS Luton CCG

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