

# Hampshire Safeguarding Adult Board



## Safeguarding Adult Thematic Review

### A Review of Learning from SARs related to Learning disability and Physical Health Care

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### **TERMS OF REFERENCE**

## 1. INTRODUCTION

- 1.1. Hampshire Safeguarding Adult Board (HSAB) have published two Safeguarding Adult Reviews (SARs) under similar circumstances, the first in respect of Mr A in June 2013, the second in respect of Ms B in December 2015. Both SARs had similar features in that both adults had learning disabilities and died because of physical healthcare conditions. Concerns were raised that their deaths had been premature and not expected.
- 1.2. When Mr C died in June 2016, similar concerns were raised. Questions were posed by HSAB as to the effectiveness and embedding of the learning from the previous two SARs as well as national learning regarding the experiences of people with learning disabilities who require treatment for physical health conditions.
- 1.3. HSAB undertook this Thematic Review to identify progress since the previous two SARs, blocks and barriers to implementation and embedding of learning.

## 2. PROCESS AND SCOPE

- 2.1. The Terms of Reference for the Thematic Review can be found in Appendix 1.
- 2.2. The review of the death of Mr C was undertaken between February – May 2017 in order that the learning from that review could be compared to the previous ones. Progress, trends and themes emerging from all three reviews could then be addressed.
- 2.3. Once the themes were established there was a multi-agency learning event with strategic safeguarding leads held on 19<sup>th</sup> July to identify further work that was required across Hampshire. Section 7 onwards identifies the themes and results of the discussions from the learning event that identify areas for further improvement.

## 3. THE REVIEWER

- 3.1. HSAB commissioned an independent reviewer to chair and author both elements of the process. Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in Safeguarding roles in the NHS for a number of years. Karen is completely independent of HSAB and its partner agencies.

## 4. PHYSICAL HEALTH AND TREATMENT OF THOSE WITH LEARNING DISABILITY: THE RESEARCH

- 4.1. In considering this thematic review, it is important to set the context within which people with learning disabilities live. The subject of health inequalities and diagnostic overshadowing<sup>1</sup> has been the topic of much research over recent years.
- 4.2. Statistics indicate that people with a learning disability, on average, have poorer health than people without a learning disability<sup>2</sup>. These inequalities are manifested in both physical and mental health. Some of this is because people with a learning disability are statistically more likely to have secondary

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<sup>1</sup> **Diagnostic overshadowing** refers to the negative bias impacting a clinician's judgment regarding co-occurring disorders in individuals who have intellectual disabilities or other mental illness. Symptoms or behaviors that may be due to a specific mental illness are attributed to another disorder, historically Mental Retardation, without considering alternative etiology available at [https://link.springer.com/referenceworkentry/10.1007%2F978-1-4419-1698-3\\_398](https://link.springer.com/referenceworkentry/10.1007%2F978-1-4419-1698-3_398) accessed 02 June 2017

<sup>2</sup> Emerson, E., Baines, S., Allerton, L., & Welch, V. (2012) Health Inequalities and People with Learning Disabilities in the UK available at [http://cdn.basw.co.uk/upload/basw\\_14846-4.pdf](http://cdn.basw.co.uk/upload/basw_14846-4.pdf) accessed 01 June 2017

health conditions<sup>3,4</sup>.

- 4.3. These statistics do not explain the whole picture though, and research would suggest that it is as much to do with lifestyle factors as well as the way that people with a learning disability experience health and social care services. Emerson et al<sup>ibid</sup> argue that the evidence indicates that these healthcare inequalities are in direct contravention of the legislation within the Equality Act (2010), The Mental Capacity Act (2005) as well as more recently The Care Act (2014).
- 4.4. As well as these inequalities in health, research also shows that people with a learning disability are likely to die at a younger age than those without a learning disability<sup>5</sup>
- 4.5. This thematic review gives opportunities for HSAB to identify how far the messages from SARs and research inform practice within the locality.

## 5. THE THREE PEOPLE AND THEIR CIRCUMSTANCES

- 5.1. The table below identifies the key circumstances and issues found within the SARs alongside recent published review of themes and learning from Bristol University<sup>6</sup> and an analysis of SARs in London Boroughs<sup>7</sup>

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<sup>3</sup> Cooper, S. et al (2007) Mental ill-health in adults with intellectual disabilities: prevalence and associated factors in British Journal of Psychiatry, Vol 190 , 2 7 - 3 5. Available at <http://bjp.rcpsych.org/content/190/1/27.full-text.pdf+html> accessed 01 June 2017

<sup>4</sup> Haverman, M. et al (2010) Major Health Risks in Aging Persons With Intellectual Disabilities: An Overview of Recent Studies In Journal of Policy and Practice in Intellectual Disabilities Volume 7 Number 1 pp 59–69 March 2010 available at <http://onlinelibrary.wiley.com/store/10.1111/j.1741-1130.2010.00248.x/asset/j.1741-1130.2010.00248.x.pdf?v=1&t=i3e7fmbys&s=c6dc1c30bc040118010821d5c988f56287484f04> accessed 01 June 2017

<sup>5</sup> Heslop, P. et al. (2013) Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD): Final Report. Norah Fry Research Centre available at <http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf> accessed on 01 June 2017

<sup>6</sup> University of Bristol, School for Policy Studies Key findings of repository 2015/2016 available at <http://www.bristol.ac.uk/sps/leder/repository/summary-of-themes/> accessed 04/05/2017

<sup>7</sup> Braye, S. & Preston-Shoot, M. (2017) Learning from SARs: A Report for the London Safeguarding Adults Board <https://londonadass.org.uk/learning-from-sars-report/> Accessed 08 September 2017

Theme	Mr A (Aged 52 at death): SAR June 2013	Ms B (Aged 46 at death): SAR December 2015	Mr C (Aged 66 at death): SAR May 2017	Current National Learning <sup>6 &amp; 7</sup>
Diagnosis and features relevant to Learning Disability	Autism and severe end of spectrum of LD <ul style="list-style-type: none"> <li>• Inflexibility of thought</li> <li>• Easily distressed by change in routine</li> <li>• Lack of inhibition</li> <li>• Repetitive language</li> <li>• Fixed routines must be very set</li> <li>• Needs to feel secure in environment as unable to gain sense of security from other people</li> </ul>	Mild learning disability, personality disorder and epilepsy.	Mild learning disability, epilepsy and a history of psychotic depression.	
Living and Care arrangements	Supported Living featuring placement moves due to challenging behaviour and safeguarding concerns for other residents. Little consideration of transition planning.	Residential home Guardianship order <sup>8</sup> Placement move not managed well.	Supported living. Many years on one placement then multiple moves due to challenging behaviour. Transitions not well managed, significant learning in this area.	
Physical Health conditions	Complications from previous medication. Dental Pain. Empyema <sup>9</sup>	Heart Failure Obesity Depression	Epilepsy. Later attributed to Self-Neglect: <ul style="list-style-type: none"> <li>• Malnutrition</li> <li>• Acute Kidney Injury<sup>10</sup></li> <li>• Pneumonia</li> </ul>	

<sup>8</sup>The purpose of **Guardianship (under the Mental Health Act 1983)** is to enable patients to receive care in the community where it cannot be provided without the use of compulsory powers. It provides a framework, as part of the overall care and treatment plan, for working with a patient to achieve as independent a life as possible.

<sup>9</sup> Pleural empyema is empyema (an accumulation of pus) in the pleural cavity that can develop when bacteria invade the pleural space, usually in the context of a pneumonia. It is one of various kinds of pleural effusion

<sup>10</sup> The kidneys clean the blood by removing waste products. Many different conditions can lead to the kidneys not working well within hours or days. This is called acute kidney injury (known as acute renal failure in the past). Causes include: dehydration; low blood pressure; some drugs; severe infections; blockage of the waterworks (urinary tract); <https://www.nice.org.uk/guidance/cg169/ifp/chapter/Acute-kidney-injury>

Theme	Mr A (Aged 52 at death): SAR June 2013	Ms B (Aged 46 at death): SAR December 2015	Mr C (Aged 66 at death): SAR May 2017	Current National Learning <sup>6 &amp; 7</sup>
			<ul style="list-style-type: none"> <li>Sepsis</li> </ul>	
Specific issues of relevance	<p>Behaviour deterioration. Discharged from hospital following admission for chest complications – carers still concerned unwell. Absence of senior clinicians at planning meetings. Confusion over planned admission between hospital and carers. Agreed plans for anaesthetic not adhered to. Inappropriate restraint in hospital. Failure to contingency plan</p>	<p>Previous fabricated illness from internet searching of symptoms. Mis-communication of diagnosis and care required. Mental Health Act Assessment deemed not identifying need for MHA Section. Behaviour deterioration NOT considered to be due to physical health concerns</p>	<p>Physical health deterioration due to not eating and drinking. Physical causes considered and excluded.</p>	
Case Specific issues not repeated	<p>Issues and recommendations for Dental Service working in isolation. Recommendation for dental 'key worker'</p>	<p>Delegation of duties from one professional to another.</p>	<p>Malnutrition from not eating and drinking.</p>	
Annual Health Check Status	<p>Not identified but recommendation made.</p>	<p>Not considered due to mild nature of LD but should have been considered as part of s117<sup>11</sup> aftercare status</p>	<p>Not identified as an issue in scope of review.</p>	

<sup>11</sup> Section 117 of the 1983 Mental Health Act requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. After-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition. The duty to provide after-care services continues as long as the patient is in need of such services.  
[http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/01/Code\\_of\\_Practice.pdf](http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/01/Code_of_Practice.pdf)

Theme	Mr A (Aged 52 at death): SAR June 2013	Ms B (Aged 46 at death): SAR December 2015	Mr C (Aged 66 at death): SAR May 2017	Current National Learning <sup>6 &amp; 7</sup>
Mental Capacity Act (MCA) /DoLs <sup>12</sup>	Not embedded practice lack of formal multi agency best interests' meetings and decisions. No use of DoLs. Court of protection not considered regarding plan of care.	Considered in the main to have capacity but questions as to if this was regarding specific decisions. In light of that, no clear recording that explanations given to risk related to apparent self-neglect. Differing views did not lead to decision and time specific assessment of capacity and then best interests consideration.	Generally applied well with evidence of BI meetings held in community and in hospital. Learning related to: <ul style="list-style-type: none"> <li>• Effective use of Independent Mental Capacity Advocate</li> <li>• Applying MCA when considering diagnostic interventions vis-a-vis capacity to understand impact of not complying with treatment.</li> <li>• Use of Court of Protection DoLs used well for Covert medication.</li> </ul>	Improving awareness of MCA to ensure centrality to professionals' thinking. Improving awareness of when to use MCA. Further and improved training. <sup>6</sup> Missing or poorly performed capacity assessments and in some cases of explicit best interest decision making <sup>7</sup> .
Hospital passport	Not in use	Not in use	Used and found to be helpful by hospital staff	Insufficient or ineffective use of hospital passports
CHC Funding	Not applied for at appropriate time.	Not considered or required	Delays in agreeing funding created issues.	Not identified.
Use of Advocates	Not considered in treatment and care decisions.	Not considered in treatment and care decisions	Considered on several occasions but issues of understanding role and finding advocate that person can work with.	Greater use of independent advocate required <sup>6 &amp; 7</sup>
Communication/ Coordination	Lacking and felt to be important factor. Care Programme Approach (CPA) <sup>13</sup> recommended for future	Felt to be lacking. CPA not evidenced as functioning as part of S117 MHA requirements.	CPA used well in community. Issue when inpatient became apparent regarding communication and	Importance of having a care coordinator where someone has Learning disabilities and

<sup>12</sup> **The Deprivation of Liberty Safeguards** (DoLs) are an amendment to the Mental Capacity Act 2005 that apply in England and Wales. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty

<sup>13</sup> The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

<http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx>

Theme	Mr A (Aged 52 at death): SAR June 2013	Ms B (Aged 46 at death): SAR December 2015	Mr C (Aged 66 at death): SAR May 2017	Current National Learning <sup>6 &amp; 7</sup>
	complex cases with LD		coordination.	complex health needs. Regular multi agency reviews required.
Safeguarding	Not well applied but pre Care Act. Safeguarding related to risks to other residents. No evidence of Making Safeguarding Personal approach.	Alert raised regarding Self Neglect- Threshold not met safeguarding. No other safeguarding concerns raised (deemed appropriate as would not have added value).	Safeguarding issues related to concerns for another resident from Mr C's challenging behaviour.	A lack of communication of risk leading to safeguarding concerns
Use of Restraint	Not considered as a safeguarding issue. Best interests/DoLs not considered	Not required	Not used effectively or consistently to manage investigations e.g. sedation	Undue reliance on restraint in managing behaviour. <sup>6</sup>
Use of Hospital Learning Disability Liaison Services	Not available	Available but not identified specific needs	Not available as area of GP affected service.	More effective use of LD Liaison services required <sup>6</sup>
Family / carer involvement	Not used or consulted with in a meaningful way, especially regarding treatment and care decisions. Carers not listened to.	Estranged from family. Had friend as next of kin. Not consulted when care and concerns were escalating. Carers not listened to and not confident to challenge.	Family had devolved day to day decisions, but were not contacted about significant concerns/decisions. Clarity of family dynamics not understood. Paid carers not listened to/consulted.	Need for regular and improved communication with families and/or their representatives regarding placements and care needs. <sup>6</sup> Lack of involvement of carers common theme and understanding of family dynamics <sup>7</sup>
Discharge planning	Not undertaken with multi agency partners	Not undertaken with multi agency partners	Not undertaken with multi agency partners when circumstances changed	All parties to be made aware of discharge information.
Escalation when professional disagreements	Not used, Recommendation to develop policy	Not utilised appropriately when disagreement between professionals.	Not used regarding concerns that advocate not seeing role for IMCA.	Practitioners' failure to escalate and inadequate response to escalation both within and across agencies. <sup>7</sup>



## 6. PROGRESS

- 6.1. One of the important elements in reviewing the above table is the progress and improvements that have been made across the three reviews. This is important learning as it evidences that in fact the learning from the previous SARs and national learning have had some impact on the practice across Hampshire.
- 6.2. The three cases detailed above involved three very different people with three very different stories and journeys. What they all had in common was the need for effective and coordinated healthcare interventions in a timely manner. All three also had placement moves that were made as their behaviour escalated and all three were admitted to an acute hospital for diagnosis and/or treatment.
- 6.3. The progress made is included in this section, with areas where further work and improvements are required in section seven of this report.

### Use and application of Mental Capacity Act

- 6.4. The SAR for Mr C evidences some good application of the Mental Capacity Act and DoLs by most professionals involved. There was evidence of multi-agency best interest meetings whilst Mr C was an inpatient and several mental capacity assessments that were time and decision specific are evident throughout the period under review. This is in stark contrast to the previous two SARS where there was evidence that MCA and DoLs were not understood and applied effectively. There is still some issues that are outstanding that are addressed in section 7 below.

### Use and application of the hospital passport

- 6.5. The hospital passport had not previously been used effectively in the case of Mr A and Ms B but for Mr C it was used and the hospital staff found it very helpful. The Department of Health progress report in 2010<sup>14</sup> in its response to the Mencap 'Death by indifference'<sup>15</sup> report, recommended the use of a hospital passport as an important tool to aid health professionals to understand the individuality of the person that they are treating in hospital. Although the hospital passport was not initially thought to be an issue with Mr C, this thematic review has found that further development may aid improvement in other areas and therefore features within improvement areas and recommendations.

### Use of advocacy

- 6.6. There was no advocacy sought for Mr A and Ms B in the treatment decisions that were being made. In the case of Mr C, advocacy was used albeit that it was not effective due to confusion over roles as well as Mr C's refusal to work with an advocate (See Section 7).

### Use and application of Care Programme Approach (CPA) <sup>IBID</sup> for complex patients

- 6.7. For different reasons CPA was not used in the case of Mr A and Ms B. Recommendations made in both of those reviews led to changes and CPA was in use for Mr C. CPA was the focus that brought professionals together in the community for reviews. The Mr C SAR identified that it had been a good tool for communication and coordination albeit that there is further learning detailed below.

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<sup>14</sup> Department for Health (2013) Six Lives: Progress Report on Healthcare for People with Learning Disabilities

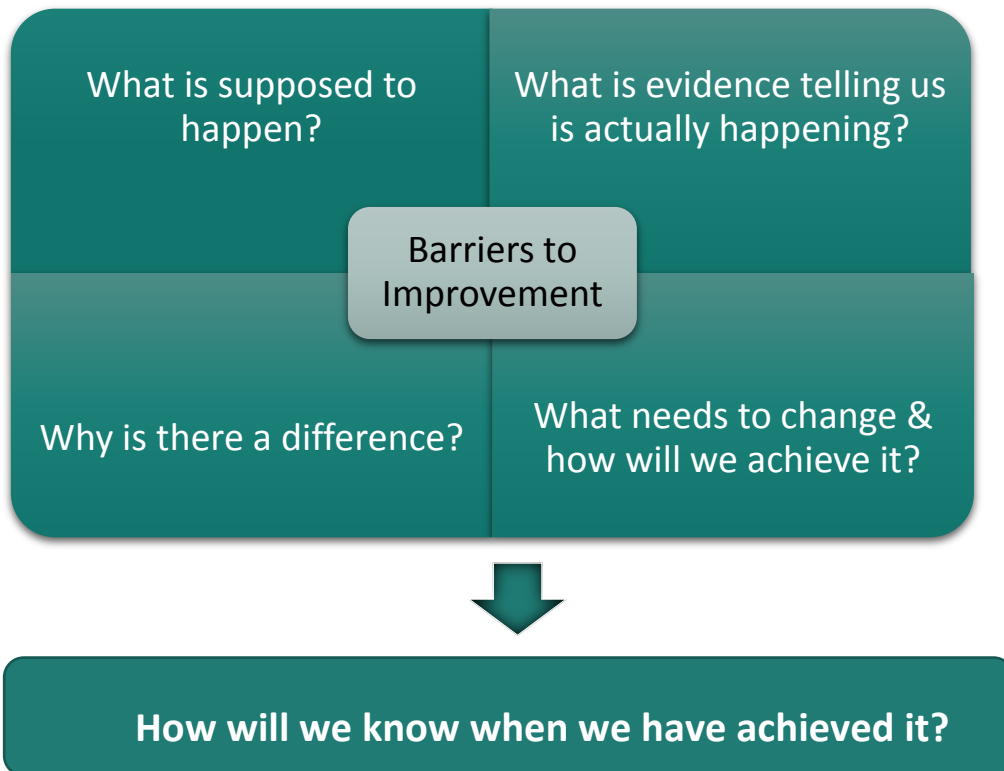
<sup>15</sup> Mencap (2007) Death by indifference

### Use of sensory friendly environments

6.8. There is evidence of some improvements within the hospital regarding the environment particularly in outpatient areas. There is further learning identified below.

## 7. AREAS FOR LEARNING AND IMPROVEMENT

7.1. In considering areas for further learning and improvement, questions and considerations were framed using the following model (based on HSAB Reflective Learning Framework) at the multi-agency learning event. Each theme for improvement posed several questions; responses from the multi-agency partners who attended the learning event (the partners) lead to improvement points and recommendations.



### Application of Mental Capacity Act (MCA)

7.2. The Mental Capacity Act is the legal framework designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. It requires that professionals apply a set of key principles in order that decisions can be made in a person's best interests.

7.3. The issues that the Mr C SAR raises identifies a need to more deeply embed use of the Mental Capacity Act. There were clear indications that diagnostic tests required robust application of the Act and best

Questions for Multi Agency Partners:

- How are we assured that the policies and processes are effective regarding in depth understanding of MCA and DoLs?
- Is there benefit of having a one preferred tool/ model across Hampshire? E.g. HCC Toolkit
- How do we ensure that if diagnostic testing/treatment is needed, MCA and DoLs is used effectively to ensure this happens if it is deemed in a person's best interests?
- What further guidance is needed for complex situations that could result in serious impairment to health and well-being?

interest decisions that were understood and communicated to all. This would have ensured that any sedation that was deemed necessary was applied using the principles within the Act. There are also issues that all three cases raise about the possibility of use of the Court of Protection when it is clear that care and treatment concerns are becoming of increasingly challenging when someone who lacks capacity is putting themselves at risk.

### Response

7.4. It was noted that there are some pockets of good practice. It was felt by the partners, however, that there are issues related to the use of the Mental Capacity Act, that it is inconsistently applied and not recorded robustly. Partners described a situation where, in some cases, the Mental Capacity Act has become seen as an unwieldy bureaucratic process that staff do not have a confidence in using and that the person gets lost in the process.

7.5. An explanation as to one possible cause for this was that much of the training related to Mental Capacity Act is E learning. This does not provide options to apply this learning using practical application in real life situations that make it real for professionals. This results in a difficulty for some to apply this learning in practice.

7.6. Where MCA roles are integral to safeguarding roles, there may be a misconception that MCA requires specialist knowledge and is linked to safeguarding alone. This has resulted in a belief amongst professionals that mental capacity assessment is only required in consideration of safeguarding concerns, rather than being integral to everyday practice. This may also be a barrier to broader understanding of MCA being at the forefront as soon as there is a concern about a specific decision.

7.7. It is also argued that an increased confidence and competency in application of the use of MCA will aid escalation and professional challenge where it is not being applied effectively (See also Section 7.48-7.52).

7.8. There is a belief amongst partners, that in order that there is a cultural shift in attitudes and beliefs regarding MCA, that each organisation needs to see ownership at a strategic level leading to support for embedding of the principles of the Act at all levels.

7.9. Other suggested barriers were cited as:

- professional workloads (without confidence to use it, professionals may avoid it when busy)
- lack of use of advocates (see below).
- urgency and competing demands of other processes/environments e.g. hospitals and placements
- multiple tools and ways of recording make multi agency working complex.

**Improvement Points:**

- E Learning needs to be used carefully with consideration being given to evidence of competency and confidence following an e learning course.
- There is a benefit of having one MCA Toolkit that is adopted by all key agencies across Hampshire.
- Application of the Mental Capacity Act needs to become viewed as integral to core practice and not viewed as a special event.
- Professionals who are competent and confident in use of Mental Capacity Act, used as 'champions' may support learning and application. MCA roles that are separate from specialist safeguarding roles portray an understanding of the generic nature of use of MCA

**Use of Advocates**

- 7.10. The learning from recommendations from Mr A and Ms B appeared to have been achieved in that advocates were used and suggested by various professionals working with Mr C. There was, however, confusion regarding roles. There are several types of advocacy available (e.g. Care Act, Mental Capacity) and more informal roles e.g. a family member acting as advocate. Staff appear confused as to what to expect when an advocate is appointed. A deeper understanding is required.

**Questions for Multi Agency Partners:**

- Does our guidance have enough details regarding the role of various advocates? Should there be one guidance covering all advocacy roles
- Does guidance include details of incompatibility? How do we overcome this? Are resources an issue?

**Response**

- 7.11. There does appear to be a confusion about the use of advocates with a large amount of inconsistency across the partner agencies. The confusion seems to be not only about the role of advocates but also how and when to access the services of an advocate. This is thought to be particularly the case related to care and treatment decisions. In the case of Mr C, one of the advocates appointed by the hospital did not understand the scope of their own role.
- 7.12. The confusion that exists is believed to be fundamentally related to issues with how the legislation is understood and interpreted. There is also an issue due to the diverse mode of service delivery required from commissioners of advocacy services. There is evidence that advocacy services are being used as an issue based, episodic intervention. More effective advocacy would be provision of a seamless service that provides advocacy on a range of issues by an advocate who has taken time to build a relationship with a person and can understand and truly advocate for them.

**Improvement Points:**

- Professionals and staff working with adults who may lack capacity need to have the role and use of advocates 'demystified'
- Commissioners need to provide clarity to organisations regarding the advocacy services that are being commissioned.
- Advocacy services need to be clear about their roles and raise their profile within the services that are required to use them.

**Use of CPA for complex patients**

- 7.13. Whilst it was good that CPA was used effectively in the community and evidenced learning from previous SARS, things changed when Mr C was admitted to hospital. National learning suggests that communication and coordination is crucial to ensure better outcomes for People with Learning Disability in hospital. The ethos of CPA, with a care coordinator and a multi-agency review process of plans needs consideration for inpatient stays, as this would have benefits and improve outcomes.

**Questions for Multi Agency Partners:**

- What models of communication and coordination work well across community and inpatient areas?
- Could CPA be used in the hospital setting where it is already in use in the community?

**Response**

- 7.14. CPA is about the patient journey with the person at the forefront. It can incorporate MCA, advocacy, risk management etc. It is therefore a very effective tool for multi-agency working. In the case of Mr C, CPA stopped when he went into hospital.
- 7.15. It was identified that very few hospital staff understand CPA; the nature of the process and the meetings do not easily fit into hospital processes. Staff within hospitals have difficulty being released for external meetings and therefore there needs to be a different way of coordinating multi agency care processes.
- 7.16. There also appears to be a 'hand off' between community and hospital; following admission hospital is seen as being the lead care delivery. It was also argued by partners that when a patient is admitted to hospital, the hand off that takes place provides a relief of the pressure to the community care coordinator. The community care coordinator is no longer required to be the active key worker for that temporary period.
- 7.17. Whilst CPA may not be able to be continued as it stands within the hospital setting, it is argued that there should be a single point of contact within the hospital, who acts as a liaison between the community CPA care coordinator and the hospital. This role may well be appropriate for the Learning Disability Liaison Nursing Service (see below). Where staff within an acute hospital do not have time to attend meetings within the community settings, there needs to be innovative ways of making attendance easier e.g. virtual attendance using communication technology as well as consideration

given to meetings taking place on hospital premises.

- 7.18. In this way, CPA can continue to be current and overseen by the community care coordinator, with a single point of contact within the hospital, despite the fact that those making decisions regarding current treatment and care may be hospital staff. Keeping the CPA current and shared with hospital staff would ensure that all are aware of treatment plans and decisions both within the hospital and planning for discharge.
- 7.19. Although it was felt that the hospital passport was used well in the case of Mr C, there were discussions by the partners at the learning event that indicated that the passport should be used even more widely. Where the person is subject to CPA, this should be included within the passport to alert the hospital team.
- 7.20. During the course of this review, there were also discussions regarding difficulties in coordination and communication where patients with complex needs are not subject to CPA. It was identified that there is a process that exists, as a result of previous SARs (Risk Management Framework) that should be used on those cases. The Risk Management Framework is designed to guide staff in managing high levels of risk, in circumstances that sit outside of the Statutory Safeguarding Adults Framework but for which a multi-agency approach is still required to manage the risks.
- 7.21. It was felt that the knowledge and use of this process requires embedding within agencies. It is also the case that the Risk Management framework could be applied to those cases where patients are subject to CPA but that there are ongoing concerns requiring a robust response.

#### **Improvement Points:**

- There is a benefit of ensuring that CPA continues whilst a person is in hospital and provides a vehicle for multi-agency working.
- Communication and coordination using existing processes is of benefit to the person and ensures all information is known and shared.
- Where a person is subject to CPA, the hospital passport should contain this information.

#### **Managing transitions**

- 7.22. For the purposes of this review, transition refers to any movement from one care setting to another whether that be for assessment, longer term residential care or into hospital for investigation, diagnosis and/or treatment.
- 7.23. This area is one that requires more work. All three cases identify transitions of placement that were poorly managed, usually because of a sudden escalating needs or concerns for other residents. Use of safeguarding processes where there are concerns for others require a Making Safeguarding Personal approach and plans that are person centred. Use of contingency planning and placement trials have been recommendations locally and nationally but do not appear to have embedded in practice in Hampshire.

#### **Questions for Multi Agency Partners:**

- How far have we come to achieving the recommendation in Mr A SAR regarding transition planning?
- What are the barriers?
- What is the solution?

## Response

- 7.24. It was recognised by the partners that there will always be a need for placement moves, admissions to hospital and changes of workers and carers. These transitions can cause difficulties for people at all levels of need on the continuum of learning disability and are therefore always a risk. There was recognition by partners of how important it is to attempt to address the issues and ensure that all transitions are managed as safely and carefully as possible.
- 7.25. It is apparent that professionals need to be proactively planning for transitions as part of ongoing planning and review of care. Transition planning needs to have some broad agreements as to what will be in the person's best interests but also acknowledge that each transition will be different based on the type of move/change. Transition plans need to recognise agreed contingency arrangements as an integral part of the plan. Where CPA is in use, transition planning needs to be incorporated into the CPA process for people with a learning disability.
- 7.26. There was also an identification that planning for placement moves often relies on the key worker who is based in the organisation from the identified funding source. This was argued as a considerable barrier to effective transition planning. Whilst the funding organisation needs to be part of the planning process, any permanent key worker who coordinates the entire care for a person should also coordinate transition from one placement to another. In that way, planning can ensure that there is consistency, continuity and is person centred rather than being organisationally led.
- 7.27. Further discussions led to considerations of a framework for managing transitions as part of a wider transition policy for people with learning disability. It was acknowledged that discussions about planning for transitions can in themselves raise anxieties for the person, therefore care needs to be taken about this. Carers and family should all be a part of the transition planning; existence of such plans should be referenced in the hospital passport.

### Improvement Points

- Key workers should coordinate placement transition plans as opposed to being led by funding organisation.
- Transition planning needs to be integral in risk management plans and be proactively undertaken.
- Transitions need to be planned, with provision for contingency arrangements for unplanned and unexpected events.
- Transition plans need to be person centred and based on best interest considerations and as far as possible, trialled.
- Family and Carers need to be included in planning and preparation wherever appropriate.
- Transition plans to Acute Hospital to be sensitively included in Hospital Passports

## Hospital discharge

7.28. There is a continuing theme nationally and locally regarding the quality of information transferred

**Questions for Multi Agency Partners:**

- Why is there an issue?
- How do we ensure that involvement of all in hospital discharge planning and processes?
- If the hospital takes the lead, how are we assured that there is a robust system and where does the governance lie?

when a person is discharged from an acute hospital. A discharge plan, prepared from a multi-agency perspective that is understood and communicated to all appropriate professionals would be a robust way forward.

**Response**

7.29. In the three cases considered, discharge planning was problematic for different reasons. At the learning event, the partners identified discharge planning is started from admission and should involve all stakeholders. It is recognised that delayed and poor discharges are costly not only from a resource perspective but also from an emotional well-being perspective for the patient and their family.

7.30. There has been much work to address issues and the discharge planning process that is in place is felt to be robust. Discussions at the learning event identified why the process is not working in some cases.

7.31. Reasons cited were multi-faceted and included:

- Professionals do not always understand the roles of other professionals that are involved leading to communication and coordination issues.
- There are many resource pressures and demand on beds that can mean extra pressure to discharge; planning and coordination for complex patients takes time.
- Other processes may hold up discharge e.g. funding for placements
- Professionals sometimes lose focus of the patient at the centre.

7.32. Suggested ways to improve the process are linked to a more joined up approach across the health and social care economy and may well be improved under NHS Sustainability and Transformation Plans<sup>16</sup>, which include improved discharges for complex patients.

7.33. This element links to previous sections in so much that if there is CPA in place and a robust hospital passport, then these systems can support multi agency planning for discharge. This would also encourage a review of discharge plans should circumstances change, as well as ensuring that there is accountability for each part of the process.

7.34. It was also noted that there are many good discharges and that there is much to learn from when things go well, therefore sharing of patient stories would be helpful.

7.35. Given that the process that is in place should provide an appropriate framework, there needs to be increased quality assurance and audit to evidence what elements need to be addressed further.

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<sup>16</sup> Hampshire and Isle of Wight Sustainability and Transformation Plan Summary.

<https://www.westhampshireccg.nhs.uk/download.cfm?doc=docm93jjjm4n592.pdf&ver=812>



7.36. Where staff have concerns in relation to discharges, these link to the later section on escalation processes.

**Improvement Points:**

- The current discharge planning process has all the key required elements, however needs to include provision for review where clinical condition changes following any assessment by a future provider of care.
- Use of CPA and hospital passports can aid the discharge planning process.
- Sharing of patient stories where discharges have gone well can provide learning.
- Hospitals can provide evidence of quality of discharge processes by using audit
- Early escalation can alert professionals of issues in order that they can be addressed.

**Learning Disability Liaison Nursing Service**

7.37. Although not in place at the time of the Mr A SAR, and in use for the Ms B SAR, Mr C did not benefit as he had a GP in an area not covered by the service at the time. National learning and research<sup>17</sup> indicates that this service is of significant benefit to people with learning disabilities who become patients of an acute hospital either as an outpatient or inpatient.

7.38. The research referenced above identified that to be effective, Learning Disability Liaison Nurses must have the following;

- a high level of learning disability expertise and credibility with hospital staff
- authority to make decisions that change patient pathways
- high visibility and availability within the hospital
- strong support from senior Trust managers

**Questions for Multi Agency Partners:**

- Is there confidence that the current system is effective?
- How do we know?

**Response**

7.39. At the learning event, it was discussed that there is no national benchmark for the service provision and that therefore services differ in how they are funded, who employs them and the kudos within the hospital that they are given.

7.40. The importance of this service cannot be underestimated and therefore it requires strengthening. These roles are often single roles within a hospital so networking between those within the region was discussed to support professionals in these roles.

7.41. It was argued that there needs to be a mapping exercise to understand what is available followed by support to standardise the service as much as possible.

7.42. This review has shown that the Liaison Nursing Service can have a significant role in some of the issues of concern that have been presented. Partners felt that the role may well benefit by being enhanced by Learning Disability Champions, who would be link roles on each ward/department to support the

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<sup>17</sup> Tuffrey-Wijne I, et al. (2013) **Identifying the factors affecting the implementation of strategies to promote a safer environment for patients with learning disabilities in NHS hospitals:** a mixed-methods study. Health Serv Deliv Res 1(13).

liaison role.

- 7.43. In one NHS Trust in the West Midlands, there is a flagging system linked to GP register systems that sends a text message to the liaison nurse when a patient with a learning disability is admitted, thereby ensuring a speedy response. There is also a benefit in involving the Learning Disability Liaison Nurse in the planning of an admission where it is known in advance that a patient with a learning disability needs to go into hospital.
- 7.44. It can be seen, therefore, that although there have been improvements in ensuring that there is access to a Learning Disability Liaison Nursing Service, there is still more to that could improve the service. An effective service would be one that reflects best practice from the referenced research, is understood across all organisations and that is used to its full potential.

#### **Improvements:**

- Research suggests that a hospital liaison nursing service is important in the support and coordination when people with a learning disability need to go to hospital.
- The service will function better with support from LD champions in patient areas e.g. Wards and outpatient areas.
- With no national benchmarking, there are benefits from having standardised service delivery model to aid understanding and coordination across all organisations that need to refer into and use the service.

#### **Involvement of families in care and treatment decisions**

- 7.45. There was learning and recommendations across all three SARs as well as nationally regarding the involvement of family in care and treatment decisions. It is an area that has shown no real improvement and indeed considerable concerns in the Mr C SAR and requires significant improvement.

#### **Questions for Multi Agency Partners:**

- Why is the system not working?
- How do we ensure that no decision is made that is not communicated to family as appropriate (e.g. considering issues of consent and capacity)?

#### **Response**

- 7.46. Partners at the learning event identified that the person should remain at the centre of all care and treatment decisions. Use of the Mental Capacity Act legal framework for best interest decisions where someone is deemed to lack capacity supports this. By following that framework, the issue of family involvement should become clear. Where there are concerns that a person may not want family informed or included, it is useful to use an advocate to ensure that the decision to exclude family is fully reasoned and understood. Robust documentation is important to identify rationale for including or excluding family from treatment decisions and recording next of kin. This is also recognised as an issue within the analysis of SARs <sup>7</sup> *ibid*, where understanding of family dynamics is sometimes missing from practice.
- 7.47. The reasons that were cited as to why there are issues are linked to other areas identified within this review i.e. Mental Capacity Act, Use of Advocates and hospital passport. Staff are not confident in

applying frameworks for the above and therefore, appropriate inclusion or exclusion of families in care and treatment decisions is not applied or recorded robustly.

- 7.48. Increased confidence in the application of the Mental Capacity Act would therefore ensure that best interest decisions involved use of an advocate where possible and the advocate would contact family. (In the Mr C SAR, Mr C's brother only found out about Mr C being in hospital following contact from the advocate). Use of the hospital passport to clearly document next of kin with any rationale for not contacting family etc. would aid understanding and would accompany the person, explaining the reason from a person-centred perspective.
- 7.49. It was acknowledged that there are many examples of good practice and that, as previously stated, it is important to use these in training and supervision.

**Improvement Points:**

- Addressing the issues and learning regarding use of Mental Capacity Act and Use of Advocates will drive improvement in involvement of families in care and treatment decisions.
- Acknowledging that there are sometimes complex family dynamics, it is important to use a person-centred approach and document rationale for excluding family members for such decisions.
- Use of the hospital passport can support the person to communicate who the person wants to be told about their admission to hospital etc.

**Professionals challenge and escalation processes**

- 7.50. Both previous SARS have recommended escalation policies and processes to be developed in named organisations or agencies. This has also been a theme in national learning<sup>7Ibid</sup> and has been a significant feature in Children's Serious Case Reviews. Escalation of concerns continue to be an issue in that staff are not aware, or do not have the confidence to escalate their concerns. Further thought and consideration is required to overcome this issue.

**Questions for Multi Agency Partners:**

- How many escalation policies are there?
- Do we need to think about a multi-agency policy?
- What circumstance would a policy need to cover (e.g. concerns about health and well-being, safeguarding)?

**Response**

- 7.51. This area brought much discussion and debate. It was felt that there are many escalation types and there is no clarity as to what requires escalation and how to record it. Some escalations are required internally within organisations and it is argued therefore that organisations required internal processes that cover this.
- 7.52. Escalation that is external to an organisation is more difficult and complex. In acknowledgment of the many types of escalation, it is in risk of harm to an adult with care and support needs that this review needs to address. Staff at all levels need to be aware of the need to escalate professional concerns and how to do this. Failure to escalate appropriately can leave staff feeling disempowered and the

person with care and support needs at risk of harm. Current Multi Agency Safeguarding Policy<sup>18</sup> highlights the need for internal escalation of concerns but does not cover raising concerns about another organisation or agency.

7.53. A culture of professional challenge is important in protection and prevention of harm. This comes from a background of understanding that within a multi-agency arena, professionals and organisations have differing roles and responsibilities. Clarity of roles and challenge where there are concerns is healthy in a professional workforce and should be positive and not evoke defensiveness. These principles can be included within single and multi-agency safeguarding training.

7.54. It is therefore the contention within this review that, to protect people with care and support needs, that there needs to be clarity across all agencies about how to escalate concerns that a person is at risk of harm and another agency has either not recognised that risk or is contributing to the risk. To achieve that there needs to be agreement on how to escalate and how the concern and escalation needs to be recorded. This provides evidence of robust professional challenge.

#### **Improvement points:**

- Professional challenge seen positively indicates good professional practice and effective multi-agency working. Being professionally challenged is not a reflection on professional capabilities.
- Staff across all agencies benefit from a single process followed by all.
- Documentation of escalation provides evidence of robust professional challenge.

#### **Involving paid carers in planning**

7.55. All three reviews and national learning have elements of where paid carers, who may know a person very well, were either not fully involved in planning or ongoing advice and support when a person is admitted to hospital or has moved placement. There have also been issues where carers were not listened to when they had concerns. There is more work to be undertaken regarding the role of paid carers in ongoing support of people they know well.

#### **Questions for Multi Agency Partners:**

- What would encourage carers to be consulted and to be valued by all professionals involved in the care of a person during transition or being cared for in a n alternative setting?
- What issues does it present for carers to be involved in hospital care?

#### **Response**

7.56. It was recognised by the partners at the learning event that the Mental Capacity Act is very clear that, when making best interests decisions when someone lacks capacity, people well known to the

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<sup>18</sup> Hampshire and IOW 4LSAB Multi-Agency Safeguarding Adults Policy and Guidance (2016) 2<sup>nd</sup> Ed  
[http://www.hampshiresab.org.uk/professionals-area/hampshire\\_4lsab\\_multiagency\\_safeguarding\\_adults\\_policy\\_guidance/](http://www.hampshiresab.org.uk/professionals-area/hampshire_4lsab_multiagency_safeguarding_adults_policy_guidance/)  
accessed 26 July 2017

individual should be consulted.

- 7.57. This section therefore again links with understanding of the Mental Capacity Act and the hospital passport. It is also argued, that where carers are not consulted, then escalation processes should be used to highlight the concern.
- 7.58. It was felt that the reason that carers are not consulted more often was in some part related to the 'hand off' to another organisation when a person is admitted to hospital. Other suggested reasons were articulated e.g. a minimum skill set for carers resulting in a perceived power imbalance between carers and qualified professionals as well as the attitude of some professionals to carers.
- 7.59. To address these perceived inequalities, it was felt that there is benefit in ensuring that carers have access to career progression and that by stimulating the market in this way would encourage a changing perception of how carers see themselves. It was also discussed that there is a need for a campaign to promote the work of carers and a suggestion of a 'back to the floor' exercise where qualified professionals could spend a day with a carer to understand their role more fully.

**Improvement points:**

- The Mental Capacity Act makes provision for the inclusion of carers in best interest decisions.
- Paid carers usually have an in-depth knowledge of the person they care for and therefore their information is important and valid.
- Paid carers would benefit from having their profile raised amongst qualified professionals specifically about the benefits that can be added to a person's care and treatment.
- Professionals should actively seek information from paid carers to support care.

**Provision of sensory friendly environments**

- 7.60. Whilst there have been some improvements, two of the three people reviewed struggled with environments and particularly those presented in a large busy hospital ward environment. It will be important to review if there is any further work that is required to improve things further for people with learning disabilities who are admitted.

**Questions for Multi Agency Partners:**

- What progress has been made regarding improvement of sensory environments?
- Is there more that can be done to enable improved experiences when a person is admitted to hospital?

**Response**

- 7.61. The issues that are presented when a person with a learning disability is admitted to hospital are complex. It is known that for many people, the physical environment is one that can present multiple challenges. Hospitals are large busy and bustling environments with many people working and being cared for within them. Such environments can invoke significant behaviours that identify that a person is very anxious and often frightened.
- 7.62. The development of the hospital passport was a way to try and avert some of these difficulties by ensuring that there is documentation as to what may increase a persons' anxiety and behaviours and

identify strategies to manage and calm a person.

- 7.63. At the learning event, it was identified that there is still more to do in this area. Care plans should be anticipatory and preparations for managing environments on admissions can be made on an individual basis. There were positive case examples discussed where this has been evidenced.
- 7.64. There have been considerable advances in making hospital areas dementia friendly and it was felt that the same principles could be applied to make areas more learning disability friendly.
- 7.65. It was also felt that there was a role for the Learning Disability Liaison Nursing Service who could be actively involved in ensuring that an individual’s needs can be met by liaising with various community and hospital departments to ensure all that can be done is done to limit adverse experiences from environmental factors.

**Improvement points:**

- The hospital passport needs to clearly state issues that person has with environments.
- The Liaison Nursing Service may provide a useful resource for liaising with hospital departments and community teams in planning and making reasonable adjustments in preparation for, and during any hospital stay.
- The progress that has been made in creating dementia friendly hospital departments should be applied to consideration of learning disability friendly patient areas.

**Further questions and considerations**

7.66. The following generic questions were also considered to deliver improvements:

Question	Improvement points
How do we ensure that learning from SARs reaches everyone in each organisation?	<ul style="list-style-type: none"> <li>• Key messages from SARs should be built into multi agency safeguarding and associated training (e.g. MCA Training) training.</li> <li>• Key messages should be disseminated in a ‘punchy’ easy to access format; use of videos may be useful</li> <li>• Learning from SARs should be included in supervision.</li> <li>• All Hampshire region Safeguarding Boards should agree Key Messages from SARs that will be shared across the region.</li> <li>• The four LSABs across Hampshire and Isle of Wight will hold a joint annual learning event.</li> </ul>
How do we know that learning from SARs is effective?	<ul style="list-style-type: none"> <li>• SAR Action Plans should provide evidence of where changes have been made that lead to a change or improvement in practice.</li> <li>• Use of service user/patient stories to evidence improvement.</li> <li>• Use of case file audit to evidence that change and learning is embedded in practice.</li> </ul>
What does our multi agency case file audit process tell us?	<ul style="list-style-type: none"> <li>• Most case audits only tell us what we can measure.</li> <li>• The most important elements are those that we cannot measure such as culture, attitude and aptitude and these issues need to be captured.</li> </ul>

	<ul style="list-style-type: none"> <li>• There needs to be assurance within the system that errors are managed and professional issues are dealt with</li> </ul>
What role does supervision play and how effective is it within agencies across Hampshire?	<ul style="list-style-type: none"> <li>• Supervision can mean different things to different people.</li> <li>• Reflecting on learning &amp; coaching discussions.</li> <li>• Supervision often not consistent.</li> <li>• Learning needs to be seen to be adding value.</li> </ul>

## 8. CONCLUSIONS

- 8.1. This Thematic Review has identified that three Safeguarding Adult Reviews undertaken by Hampshire Safeguarding Adult Board have had some similar themes that warranted further exploration as to whether there were any identified blocks and barriers to improvement.
- 8.2. The review identified that there has been considerable improvement since the first of the three SARs and therefore there should be recognition of this.
- 8.3. There is, however, still more that can be done to improve the experiences of those people with a learning disability who require admission to an acute hospital for diagnosis, care and/or treatment.
- 8.4. People with learning disability often have a range of family, carers and health and social care professionals involved in their care. This makes coordination of that care when there is a change, especially complex for people for whom change can be particularly difficult.
- 8.5. It is of note that there are also areas where improvements are required that are not necessarily related directly to care in an acute hospital. Many of the issues identified in all three reviews were associated with an increase of challenging behaviours brought on by issues related to transition planning. In at least one case, that then had an impact on physical health and so the links are important considerations.
- 8.6. There was no one agency where the thematic review has identified requires significant improvement. Moreover, it is a contention that many of the elements where improvement is required are related to the interface where two or more organisations are required to work together across a variety of situations and to offer appropriate challenge as necessary to improve outcomes for people with a learning disability.
- 8.7. Many of the elements that this review has focused on can be brought under four main areas for improvement. In effect, as the table below identifies, if these are managed well and improvements occurred within these areas, then the result would be improvement to the other identified areas. That is not to suggest that there is not also benefits of making direct improvements to all identified areas.

Improvement Required	Impact Areas
Understanding of Mental Capacity Act	Transitions of placement, carers and to acute hospital care Involvement of paid carers Use of Advocates Involvement of family in treatment decisions Effective hospital discharge
Hospital passport	Transitions to acute care Provision of sensory friendly environments Effective discharge planning

	Continuance of CPA Family and paid carer involvement
Learning Disability Liaison Nursing Service	Transitions to Acute Care Provision of sensory friendly environments Continuance of CPA Communication and coordination
Continuance of CPA/similar process.	Communication and coordination Effective discharge planning Family and paid carer involvement Risk management of transitions

- 8.8. In consideration of the generic questions posed of the multi-agency learning event It is important to recognise that the issues that this review and the three SARs raise are highly complex situations that involve many professionals and therefore the likelihood for errors is high. It is therefore important to ensure that professionals have the systems and processes in place to support their practice and that supervision and management support offer the opportunities for critical reflection and challenge.
- 8.9. In view of the concerns raised that some issues that were identified within the first two SARS also appeared to feature in the third SAR, it will be important for the Safeguarding Adult Board to review how it seeks assurance that the messages and learning from SARS is shared and embedded within organisations across Hampshire and related Boards regionally.
- 8.10. In order that this Thematic Review is not undertaken in a silo, it is important that it is recognised by the work being undertaken regionally<sup>19</sup> and nationally<sup>20</sup> to transform the care of people with leaning disabilities. These plans relate to the wider strategic planning and commissioning of care for those people. It will also need to feed into the NHS Sustainability and Transformation plans locally and regionally.
- 8.11. Finally, it will be important to ensure that the recommendations from this review lead to the required improvements and it is therefore necessary to make use of audit and appreciative enquiry to evidence what is working in practice and areas that need ongoing work.

## 9. RECOMMENDATIONS

- 9.1. This thematic Review makes the following recommendations for HSAB; Recommendations are made under several main themes and require **HSAB to seek assurance from appropriate agencies that the following are addressed:**

### 1. Understanding and application of the Mental Capacity Act

- a. A review of training approaches related to Mental Capacity Act. HSAB should consider commissioning a MCA Competency Framework for use across all agencies that includes:
- A blended approach to training methods
  - A training pathway for different levels of staff

<sup>19</sup> Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership Plan <http://www.isleofwightccg.nhs.uk/our-priorities/commissioning-strategy/our-commissionin-departments/Transforming%20Care%20Plan%20SHIP.pdf>

<sup>20</sup> Transforming Care for People with Learning Disabilities – Next Steps (2015) <https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf>



- Use of supervision to support and assess competency and confidence of staff in application of MCA
- b. Agencies agree and adopt the HCC MCA toolkit as one tool for use across Hampshire agencies. Guidance on use of the toolkit should include
  - caution against any organisational adaptations to the toolkit
  - guidance and signposting as to who may be involved and know the person best (e.g. paid carers and family)
  - use of Court of Protection
- c. Introduction of MCA Champions within agencies, who are those professionals that are competent and confident in the use of the MCA and would provide support to those who require it.
- d. In order that requirements under Mental Capacity Act can be complied with, all agencies must evidence to HSAB that they have mechanisms in place to record next of kin/family and significant others, as well as rationale to include or exclude those persons from best interest decisions.
- e. Agencies ensure staff have access to information regarding advocacy services and understand eligibility and entitlement of individuals to those services and the types of advocacy available.
- f. Commissioners of advocacy services ensure that there is a seamless advocacy service for service users that promotes an integrated approach (i.e. an advocate can offer different types of advocacy). Commissioners should also ensure that services cross borders where necessary to maintain continuity for a service user.
- g. That HSAB and HCC websites have links to advocacy service websites.

## 2. Communication and coordination

- a. Health partners across community and hospital services agree a joint protocol for continuance of CPA when a person with a Learning Disability is admitted to hospital. The protocol should cover:
  - enablement ideas for hospital staff to be involved in CPA meetings
  - admission planning
  - review of CPA risk assessment and plans that includes discharge planning
  - diagnosis and treatment planning
- b. Agencies must endorse and embed the existing Risk Management Framework to improve coordination and communication where patients who are admitted to hospital are not subject to CPA.
- c. Appropriate partners should collaborate to provide best practice guidance for transitions/placement moves that sets out responsibilities of commissioners and providers as well as key agencies. This should include:

- requirement for key worker to coordinate placement transitions alongside funding organisation
- ensuring that transition planning is included in risk management plans and that contingency arrangements are included
- ensuring that family and carers are included and aware of plans

### 3. Liaison Nursing Service

- HSAB should ask commissioners and providers to carry out a mapping exercise to understand current provision and make adaptations that will support the learning from this thematic review and research. The service should be able to provide:
  - support for admission
  - point of contact between hospital and community
  - support for discharge planning
  - input to CPA
  - support for adaptations to environments etc. for individuals

The service should be supported by LD champions within each ward/department.

### 4. Escalation and challenge

HSAB should develop/commission the development of a multi-agency escalation process for individual cases and consider inclusion of a template for recording escalation in order that evidence is available from across agencies and within audit.

### 5. Hospital passport

The hospital passport should be further developed to allow for clear indications of:

- who the person would like consulted on care and treatment decisions (and who should not be involved)
- consideration that need to be given to environments
- Involvement of paid carers
- who needs to be involved in 'my' discharge
- existence of CPA and who care coordinator is
- advocacy arrangements already in place with contact details

### 6. Discharge Planning

Acute Hospitals should embed and endorse their existing discharge planning process and provide evidence to HSAB of its effectiveness. A review of processes must include a requirement to advise planned care providers of any change in clinical condition that occurs between any initial assessment by a provider and actual discharge date.

### 7. Recording Next of Kin/family and significant others

In order that requirements under Mental Capacity Act can be complied with, all agencies must evidence to HDSAB that they have mechanisms in place to record the above as well as rationale to include or exclude those persons from best interest decisions.

## 8. Generic areas

- a. HSAB should seek assurance that progress on these issues is being made by conducting a Multi Agency case file audit of similar cases. Audit should also cover evidence of:
  - escalation and challenge
  - management oversight and supervision
- b. HSAB should use appreciative enquiry at board meetings for agencies to present cases that evidence good practice regarding issues that this review highlights.
- c. HSAB should produce a briefing to all partners regarding all the learning from this review and seek assurance as to how this has been disseminated in partner agencies. Use of an electronic survey may provide evidence. Mechanisms for dissemination to all providers of care should be considered.

## Appendix One

### Hampshire Safeguarding Adults Board Safeguarding Adult Review in relation to Mr C Terms of reference

#### Background

Mr C was 66 years old had a learning disability and complex needs and behaviours. He was being supported in residential care funded by Hampshire County Council. He was admitted to an acute hospital on 20/04/16 due to a deterioration in his physical presentation following a period of time when he was not eating and drinking. Mr C was assessed as lacking capacity regarding care and treatment decisions. Mr C remained in hospital for approx. 8 weeks until his discharge on 13<sup>th</sup> June 2016.

Mr C had complex needs and behaviours. The deterioration in his physical health and refusal to eat or drink was perceived throughout by all the agencies involved as behavioural in nature. There is no record of an annual health check.

During Mr C's period in hospital, the community learning disability service provided advice to the acute hospital regarding the management of his apparent non-compliance with investigations. Despite a long admission, investigations were not undertaken into the cause of Mr C ceasing to eat and drink. Serious physical deterioration was categorised as behavioural by the hospital staff who appeared to reject investigation paths because of the level of adjustment that would need to be made for Mr C's learning disability and needs. The hospital also appears to have requested alternative psychiatric opinions despite it being clear the community learning disability service and a consultant psychiatrist were involved. Mr C was discharged from hospital without a clear diagnosis or management plan. No discharge planning meeting coordinated with the community learning disability service.

Mr C Adult was discharged from hospital to a nursing home on 13<sup>th</sup> June 2016 where he arrived in a severe physical state (which was not expected by the home). When the nursing home contacted the hospital for advice and support they were informed Mr C was 'end of life'. Apparently, there was no end of life plan upon discharge or discussion with the community learning disability service or family to inform them of this fact. Mr C died at the nursing home on 17/06/16. The death was referred to the coroner who ruled the cause of death as: 1a Sepsis due to B Pneumonia and urinary tract infection Part 2 Severe malnutrition. An coroner's inquest is to held on 16<sup>th</sup> March 2017.

In addition to internal reviews by partner agencies, this case was subject to a s42 enquiry (now complete) led by Portsmouth City Council as the host authority. The s42 enquiry commenced prior to Mr C's death as a result of an alert from his care home provider. The safeguarding process was unable to conclude definitively that abuse or neglect was a casual factor in the death.

The case was referred to the Hampshire Safeguarding Adults Board (HSAB) for consideration for a SAR. The HSAB Learning and Review Subgroup (LRS) met on 30<sup>th</sup> November 2016 and it was decided that statutory criteria for conducting a safeguarding adult review were met and so a statutory review will be held using a bespoke methodology.

#### Methodology

As this is the third case since 2012 of very similar circumstances involving the death of an adult with a learning disability which raised concerns about the way deteriorating physical health needs of people with complex needs and behaviours are managed, it is likely that root causes and learning in the Mr C case will be very similar to that already highlighted in the two previous cases. Therefore, rather than repeat the same review process highlighting very similar issues and learning, the LRS has recommended that a 'systems review' is undertaken in response to this case and also Mr A (2012) and Ms B (2015).

However, in order not to lose sight of the key issues and learning in the case of Mr C this SAR will encompass a review of the information and internal investigations to ensure that any identified issues and learning are factored into this review process.

The SAR will be carried out in two stages:

- a) A review of the circumstances of the Mr C case to draw out specific learning relating to his support, care and treatment. This will include compilation of a chronology and completion of a case audit against specific questions by the individual agencies involved. As part of the SAR process, there will be a multi-agency reflective workshop to bring together the practitioners and operational managers involved in the care and support of Mr C prior to his death. This workshop will focus on the individual's journey through the system in order to reflect on and share learning and also to identify opportunities for improved working within and between agencies in the future. A 'lessons learnt' report will be produced around the key learning identified which will be shared with organisations.
- b) A thematic review and analysis of common issues and root causes across each of the three cases followed by a full day multi-agency event, to explore with partner agencies the blockages and barriers that have hindered implementation of the learning and recommendations from the previous cases. Partner organisations will then have an opportunity to agree actions to address blockages and barriers identified.

Compared to traditional SAR methodology, the approach outlined should be less time intensive but better focused on learning and why responses to date have not led to the improvements and outcomes sought in the previous SARs.

A multi-agency SAR Panel has been established to oversee the SAR. This will be chaired by an independent reviewer who will produce a report outlining key findings and multi-agency recommendations to address any blockages and barriers identified.

### Timeline for the review

The timeline for this systems review will be 2012 – 2016 in order to ensure that key circumstances from the Mr A, Ms B and current case can be considered and the cases compared.

### Agencies participating in the SAR

<b>Organisation</b>
Area 1 County Council
Area 2 City Council
Health Care Foundation Trust
Acute Hospitals Trust
Nursing Home
Private Mental Health Hospital
GP Practice
CCG 1
CCG 2
NHS England

### Composition of the SAR Panel

Independent reviewer  
Strategic Partnerships Manager, Area 1 CC

Safeguarding Nurse, CCG 1  
Head of Vulnerable Adults, CCG 2  
Safeguarding Consultant, Area 1 CC  
Advocacy Services  
Health Care Foundation Trust  
Acute Hospitals Trust  
NHS England, Area Team  
Service Manager, Area 2 CC

**Programme and timetable for the review**

<b>Activity</b>	<b>Who</b>	<b>Date</b>
Scoping meeting to draft terms of reference	HSAB Manager and SAR Panel	11 <sup>th</sup> Jan 2017
Collation of information gained from the s42 enquiry process relating to Mr C	Safeguarding Consultant, HCC (MG)	February 2017
Source independent review chair and specialist advisor	HSAB Manager	February 2017
<u>First meeting of the SAR panel</u>	Full SAR Panel	8 <sup>th</sup> March 2017
Formal notification to involved agencies	HSAB Manager	8 <sup>th</sup> March 2017
Meeting and discussion with family	Independent reviewer	March 2017
Partner agencies to be requested to complete and chronology and case audit of their contact with Mr C (one year up to DOD)	HSAB Manager	10 <sup>th</sup> March 2017
Involved agencies submit their chronology and case review regarding Mr C	Involved agencies	13 <sup>th</sup> April 2017
Review of all documents and information and produce a composite report	Independent reviewer	April 2017
Multi-agency reflective workshop	Independent reviewer and SAR Panel	26 <sup>th</sup> April 2017 (12.30pm – 4.00pm)
Mr C SAR report – key learning and recommendations	Independent reviewer	22 <sup>nd</sup> May 2017
<b>Activity</b>	<b>Who</b>	<b>Date</b>
Version 1 of thematic review circulated	Independent reviewer	30 <sup>th</sup> June
<u>V1 comments from SAR panel</u>	Full SAR Panel	7 <sup>th</sup> July
Version 2 of thematic review circulated	Independent reviewer	13 <sup>th</sup> July 2017
Version 2 thematic review circulated to multi-agency event attendees	HSAB manager	

Multi-agency event (full day) chaired by Independent reviewer	SAR Panel, agency leads	19 <sup>th</sup> July 2017
Version 1 of Review Report circulated to SAR panel	Independent reviewer	W/B 21 <sup>st</sup> Aug 2017
<u>2nd SAR panel meeting</u>	Full SAR Panel	W/B 11 <sup>th</sup> Sept 2017
Version 2 of Review Report circulated to SAR panel and LRS	Independent reviewer	W/B 20 <sup>th</sup> Sept 2017
Final comments on version 2 of the Review Report	SAR Panel (email)	W/B 27 <sup>th</sup> Sept 2017
Version 3 of the Review Report completed	Independent reviewer	9 <sup>th</sup> Oct 2017
3rd SAR Panel		1 <sup>st</sup> November 2017
Final version of the Review Report to HSAB	Independent reviewer	12 <sup>th</sup> Dec 2017
Case file audit to evidence changes in practice and in outcomes for service users.	HSAB Quality Assurance Subgroup via a TFG	June 2018