

From the West of Berkshire Safeguarding Adults Board (SAB)

Thank you for taking the time to read this briefing note. It is one way by which we are supporting multi-agency professionals working with adults at risk to learn from practice. The SAB undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk.

This briefing note pulls together key messages arising from a local Safeguarding Adults Review.

We ask that you take time to reflect on these issues and consider, together with your team, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

The briefing note will also be disseminated to training providers to ensure the content informs safeguarding adults training.

How you can make a difference

Take some time to think about what these key messages mean for your practice:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

What is a Safeguarding Adults Review?

The Board commissions Safeguarding Adults Reviews (SARs), when:

An adult in the area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult; or

An adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Mrs H Case Review

The key messages in this briefing note reflect the findings to emerge from a recent case review of a lady who was living in an annexe of her son's home. She had a private carer (a friend of the family) who visited four times daily to provide meals, housework and shopping. Mrs H's son was not actively involved in the care of his mother as he worked long hours and all care was being delivered by one carer.

Over the course of a two and a half year period, Mrs H was seen periodically by a range of health and social care professionals starting in May 2012 when she was referred to the Council for an assessment for day services by the consultant at the Memory Clinic. In August 2012, a day service was offered but declined by Mrs H's son. The consultant was not made aware of this by the council and was therefore allowed to believe the arrangement for a day service was in place.

In the full knowledge that the caring arrangements rested solely with one unqualified individual caring for someone with identified complex care needs, when the day service was subsequently declined, there was no recorded professional consideration of the impact on either Mrs H or her carer. The case was closed and transferred across to the long term team without any further action taken and the decision accepted without challenge.

In terms of overall decision making about Mrs H, her mental capacity was not considered.

There was no further recorded involvement until over a year later when the GP surgery received an urgent referral for pressure sores. The surgery was involved in treating the sores and Occupational Therapists supported with the provision of a chair and mattress.

A year later Mrs H was admitted to hospital where she was described as being severely malnourished, needing blood fluids and feeding. Sadly, Mrs H passed away in hospital.

The full report can be found on the Board's website:

<http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/>

Key considerations for practice arising from the review

In terms of practice, the overarching findings of this case fall into two areas: failure to apply the Mental Capacity Act framework in practice and a lack of professional curiosity within a person centred approach across all agencies.

Finding 1

There is an overriding professional assumption that people with dementia do not have mental capacity in relation to decisions about their care and treatment, which is preventing assessments from being carried out. This results in the voice and choices of the service user not being heard or promoted.

Multiple professionals involved with Mrs H stated they had consulted with her carer, as “Mrs H had dementia”. There was no evidence that communication techniques were used with Mrs H to ascertain her wishes and views.

All professionals failed to apply the principles of the Mental Capacity Act 2005 and the Code of Practice. Professionals made an assumption that Mrs H lacked capacity due to her diagnosis of dementia and communication difficulties. By not applying the Code of Practice and the staged approach required in the second stage of the assessment of capacity (i.e. taking all practicable steps to enable Mrs H to communicate) her views were never sought to inform personalised outcomes for her.

Individuals can be treated in a discriminatory manner due to their diagnosis. Discriminatory practice leads to a lack of empowerment and the voice of the individual not being heard and not kept central to decision making.

Self-funders are particularly disadvantaged due to less involvement from frontline services which may prompt formal assessments of capacity.

FURTHER INFORMATION

<https://www.scie.org.uk/dementia/after-diagnosis/support/safeguarding.asp>

<https://www.scie.org.uk/dementia/after-diagnosis/support/files/safeguarding-people-with-dementia-qcf.pdf>

Finding 2

Responsibilities under the Mental Capacity Act (MCA) 2005 have not been sufficiently integrated, with the result that people do not fully understand it or apply it in practice as a safeguard for people who may lack capacity.

Professionals relied on the view of the carer and son due to an assumption that Mrs H lacked capacity but did not apply the required framework to establish whether or not she had capacity.

It is an expectation that practitioners and people making decisions about the care and treatment of someone who may lack capacity will have an awareness of the practical application of the legal framework. The MCA provides clear criteria to define mental incapacity, a best interest check list approach to ensure decisions are made in the person's best interests. If the law and code of practice are followed, the legislation affords protection not only for the individual but for

The Mental Capacity Act 2007 is a statutory legislative framework and its principles promote the individual's rights to supported decision making wherever possible. If the individual is assessed as lacking capacity, it provides a protective framework of best interest decision making and accountability. Failure of frontline staff, managers and systems to understand and apply the principles and accountable legislative framework results in an infringement of individual's rights, creates a lack of intended safeguards and risks to practitioners and agencies of legal challenge.

the decision maker. The protection is of no value if the capacity assessment and best interests check list are not followed.

A better understanding and application of the MCA would have ensured follow up when the day service was declined. The nature of the arrangement, with all support coming from a single carer, set alongside someone with a deteriorating condition and capacity issues, should have been flagged as a risk factor.

The Mental Capacity Act (MCA) 2005 implemented in 2007 has five key principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act or decision made for or on behalf of a person who lacks capacity, must be done or made in their best interests.
5. An act or decision must be done in a way which is the less restrictive of a person's rights and freedom of action.

FURTHER INFORMATION

<http://www.sabberkshirewest.co.uk/practitioners/mental-capacity-act-and-dols/>

SCIE [video on MCA and National Mental Capacity Forum](#) featuring Baroness Finlay.

[Mental Capacity Act Code of Practice 2005](#).

[NHS Choices](#) website.

[Case Study: a practical analysis of a mental capacity assessment](#) is a practice analysis reflecting on issues of mental capacity, choice, best interests and deprivation of liberty

Finding 3

Professionals make assumptions that because families have made private care arrangements those arrangements will be appropriately caring. Short term models of intervention enable this by inhibiting professional curiosity.

No action was taken to assess the sustainability of the existing care arrangements, despite professional knowledge that the private carer was delivering care seven days per week. There was no exploration about the skills and qualifications of the carer or challenge of her experience of working with the patient and her understanding of dementia.

The workforce was organised to do quick pieces of work to avoid longer term dependencies on services, to manage demand with longer term working only coming into place once all other short term options had been exhausted. At the time Mrs H's son declined the day service, this model of working meant there was no long term view taken of the impact or testing of the sustainability of the existing care arrangements.

The default position is an acceptance that privately arranged care is appropriately caring, an assumption that has been disproven many times through the application of the safeguarding framework across the country.

Where professionals are involved with a family they assume the family / carer dynamic presented is a true reflection. Most of the time this is the case. Professionals have a default human bias towards an acceptance that privately arranged care by families is appropriate and caring; they do not question this unless there are specific concerns, and do not show the same level of curiosity about these arrangements as they would for a local authority commissioned care service. The nature and appropriateness of the private arrangements go unchallenged, even where additional needs have been identified.

This leaves service users in private arrangements at greater risk than those with a local authority commissioned service.

Finding 4

Lack of, or late, responses to professionals on outcomes of requested actions results in a mismatch of information and incomplete understanding of the levels of risk in decision-making.

There is a well-recognised issue associated with multi-agency/multiple 'hand offs' of case work and the potential for poor outcomes for individuals and professionals alike.

In this case, there was clear evidence that the timing and method of transferring information across agencies led to a vulnerable person, unable to articulate for themselves their wants and wishes, being denied the opportunity to move into a more comprehensive package of care and the protection that would have provided by being more visible in the system.

It would have been expected that feedback would have been given to the consultant and GP that the day service placement had been declined. The consultant was not made aware by the council and therefore was allowed to believe it was in place. In this instance, as there had been a direct request by the consultation for day services, an outcome response should have been provided.

For professionals, both in health and social care, decision making took place on the assumption that actions previously requested had been taken, resulting in a compromised position all round.

Mrs H was significantly disadvantaged over time by the unchallenged decision to decline the day service placement and the lack of follow up at a professional level. This resulted in this lady remaining out of sight at home with unsustainable care arrangements in place.

We have to rely on the professional's ability to give and receive appropriate information about the people they are working with and to make sure that this is done in the most timely and efficient manner. Numerous serious case reviews have highlighted the issue of poor communication and information sharing as the root cause of a vulnerable person coming to harm.

The Information Sharing Protocol covers all of the agencies that form the West of Berkshire Safeguarding Adults Board in the three local authority areas of Reading, West Berkshire and Wokingham. It provides a framework for making decisions about sharing information in order to help protect vulnerable adults who may be at risk of abuse or neglect. The Protocol offers guidance to front-line staff in assessing possible risk to adults, and in balancing the risk against the rights to confidentiality and privacy.

<http://www.sabberkshirewest.co.uk/media/1084/wob-sab-information-sharing-protocol.pdf>

See also the Government's Seven Golden Rules for Information Sharing
<http://www.sabberkshirewest.co.uk/media/1139/information-sharing-posters.pdf>

Finding 5

Has the workflow process been automated too much at the expense of professional discussion: resulting in assumptions being wrongly made about appropriate and timely service provision?

A need was identified for both social stimulation for Mrs H and carer respite by the Memory Clinic consultant and confirmed in Mrs H's Community Care Assessment. Provision was identified to meet the required need. The service was declined by her son and there was no consultation with the direct carer to review the risk and impact for either carer or individual. The contact is recorded but the system does not prompt workers to take any further action when a service for an assessed need is declined.

There does not appear to be any process requiring management oversight of cases where a service is declined to consider the overall risk for the individual. The systems are therefore reliant on the skill of the person receiving information to initiate and undertake a review of risk.

The allocation of a Social Worker was identified and recorded in the system. However, this never occurred. The system workflow process failed to "flag up" that the case was never allocated and was therefore never referred to the long term team which would have provided a framework of monitoring and review for Mrs H.

This case demonstrates how an individual case can be open to different parts of the Adult Social Care system for example, sitting on a review waiting list whilst receiving three subsequent short term service interventions which then did not prompt a reprioritisation of the need for full review. Information was recorded within the system but was not reviewed in totality which would have identified an increasing risk to Mrs H. This is likely to be happening in other areas as the same IT systems and service design are used.

The automated sign off and case management of allocation of work within the short term ASC services at that time potentially resulted in a missed opportunity to identify bespoke needs and promote professional reflection on cases. Previously to the implementation of this IT system, workflow allocations would be made verbally by service managers which would prompt discussion about the case and required actions from a multi-disciplinary perspective.

In other case reviews for adults, findings have identified a similar concern for bureaucratic processes losing sight of the individual. In addition, professional judgement and accountability is reduced.

A lack of formal systems to review and risk assess declined services for self-funding customers fail to identify when a safeguarding concern may be present and ensure that it is the customer's own preference to decline services.

Systems that enable cases to be closed with the assumption that individuals will contact services if further need is required, place the individual at unassessed risk, with no clear processes to review individuals with deteriorating conditions.

<http://www.sabberkshirewest.co.uk/>

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