REPORT OF
LEARNING TOGETHER
SAFEGUARDING ADULTS REVIEW
INTO THE CASE OF MRS H

PRESENTED TO THE BERKSHIRE WEST SAFEGUARDING ADULTS PARTNERSHIP BOARD

JULY 2016

HOW DOES THE SYSTEM SAFEGUARD PEOPLE WITHOUT CAPACITY WHO ARE IN RECEIPT OF PRIVATELY FUNDED / NON-COMMISSIONED SERVICES?

West of Berkshire Safeguarding Adults Board

The West of Berkshire Safeguarding Adults Board (SAB) has in place a guidance document for Multi Agency Safeguarding Adult Reviews of Serious Cases. This has been revised to reflect changes arising following the implementation of the Care Act 2014. The guidance sets out a number of steps to be taken to ensure consistency and transparency in the process and these have been applied to both the decision making for this case and to the expectations of the SAB in its response to this final report.

The final findings of the report will be presented to the SAB by the Lead Reviewers. The Board will be asked to consider and accept the findings on the basis of a commitment by the representatives of the relevant partner agencies to develop effective action plans and provide quarterly update information to the Effectiveness Subgroup, until such time as all actions have been completed. Where this is not the case the Chair of the Effectiveness Subgroup will escalate to the Board.

The Effectiveness Subgroup will review and update action plans to reflect findings of any Safeguarding Adult Reviews and report back to the Board on progress.

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Introduction

Why this case was chosen to be reviewed?

This case was selected for a Safeguarding Adult Review (SAR) in January 2015 following the submission of Notification of a Case for Consideration to the SAR Panel in January 2015 by Thames Valley Police.

The view of the panel was the circumstances of the death of Mrs H met the criteria as described within section 44 of the Care Act 2014 that an adult has died and the Safeguarding Adults Board (SAB) knows or suspects that the death resulted from abuse or neglect.

Succinct summary of the case

Mrs H was living in an annexe of her son's home. She had a private carer who visited four times daily to provide meals, housework and to take her shopping. It was understood that Mrs H's son was not actively involved in her care; he worked long hours and left the responsibility for his mother's care with her private carer who was also a family friend.

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 Reading Social Services for an assessment for day services by the consultant at the Hazelwood Memory Clinic.

In August 2012, a day service was offered and declined by Mrs H's son; there was no further recorded involvement until late in 2013 when Circuit Lane Surgery received an urgent referral for pressure sores. The surgery was involved in treating the sores and prescribing a course of pro shots. Reading Social Services Occupational Therapists supported with the provision of a chair and mattress.

There was no further recorded involvement apart from a blood test between the end of January 2014 and November 2014 at which time Mrs H was admitted to Royal Berkshire Hospital from home by the GP. Safeguarding alerts at the time said that Mrs H had been hospitalised. She was described as being severely malnourished, needing blood fluids and feeding. Mrs H passed away in hospital on 29 November 2014.

Methodology

The focus of a case review using the SCIE systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

Using a systems approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation from organisations.

Review Team

The SAR was carried out by a review team with two lead reviewers who were learning the methodology as part of the review process. They were supported by a mentor, an experienced SCIE Reviewer. Collectively, their role was to do the data collection and analysis, and author the final report. SCIE provided methodological oversight and quality assurance. Ownership of the final report lies with the SAB as commissioner of the SAR.

The review team was made up of senior representatives from different agencies. Review team members did not have any responsibility in relation to the case being reviewed; they were independent.

Name	Role	Agency
June Graves,	Head of Care Commissioning, Housing & Safeguarding	West Berkshire Council
Sarah O'Connor	Adult Safeguarding Service Manager	Wokingham Borough Council
Linda York	Detective Chief Inspector	Thames Valley Police
Jillian Morton	Detective Constable	Thames Valley Police
Kathy Kelly	Named Professional for Safeguarding	Clinical Commissioning Group
Catherine Haynes	Adult Safeguarding Named Professional	Berkshire Healthcare Foundation Trust
Simon McGurk	Interim Service Manager Safeguarding Adults	Reading Borough Council
Elizabeth Porter	Lead Nurse Adult Safeguarding	Royal Berkshire Hospital NHS Foundation Trust

Structure of the review process

Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process. The Review Team held a number of analysis meetings and the emerging narrative and learning from these were progressively presented to the Case Group in what are known as 'Follow On' meetings. Over the course of this review, the Review Team met seven times, over a full day for the first analysis meeting and thereafter over a morning or an afternoon. Three of these meetings included the case group, one for an introductory session and then for two half-day follow on meetings to present the emerging analysis. Attendance and participation at all meetings was good.

Date	Time	Purpose of Meeting	Who Attended
15/06/15	930-1330	Scoping meeting for Review Team.	Mentor, Lead Reviewers, Review Team,
15/06/15	1400-1600	Introduction to a Learning Together Review for Case Group.	Mentor, Lead Reviewers, Review Team, Case Group.
1/07/15 2/7/15	2 hour slots	Individual Conversations.	Lead Reviewers, Review Team, Case Group

7/7/15			
7/9/15	930-1330	Meeting to discuss draft working out document and Key Practice Episodes.	Mentor, Lead Reviewers and Review Team
16/11/15	1000-1600	First follow on meeting with Case Group and Review Team to share emerging analysis.	Lead Reviewers, Review Team, Case Group
13/1/16	1100-1400	First SCIE Findings Clinic - Key Practice Episodes and View in the Tunnel.	SCIE, Mentor, Lead Reviewers
29/1/16	930-1330	Meeting Review Team-look at Findings.	Lead Reviewers, Mentor, Review Team
9/02/16	1100-1600	Second SCIE Findings Clinic - confirm findings, discuss their formulation and linked questions for the Board.	SCIE, Mentor, Lead Reviewers
17/02/16	1000-1400	Debrief and share findings with Case Group.	Lead Reviewers, Case Group, Review Team
29/02/16	900-1700	Lead Reviewers – make amendments to report following feedback.	Lead Reviewers,
15/03/16	1000-1300	Share Final Report with Safeguarding Adults Review Panel and Safeguarding Adults Board.	Case Group, Lead Reviewers, Review Team, SAR Panel, Board members

Parameters and mandate

In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. This replaces terms of reference that have a specific focus of analysis before the review process has begun. Following discussion with the Review Team and Case Worker group, a 'research' question was developed as a starting point for the Review. This was:

'HOW DOES THE SYSTEM SAFEGUARD PEOPLE WITHOUT CAPACITY WHO ARE IN RECEIPT OF PRIVATELY FUNDED / NON-COMMISSIONED SERVICES?'

The Review Team set the parameters for the detailed analysis of the period between May 2012 and November 2014. The relatively long time span reflected long periods of time in the overall chronology where there was no recorded involvement of professionals.

Sources of data

The systems approach requires the review team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the 'local rationality'. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

The Review Team conducted structured conversations with staff that fulfilled the following roles, which together formed the Case Worker Group for the review. At least two members of the Review Team were involved each time:

Data from practitioners

The following staff contributed to the review by meeting with members of the review team for a 'conversation' on 1, 2 and 7 July 2015.

- Occupational Therapist
- Senior Social Worker
- District Nurse
- Senior Specialist Practitioner Adults Safeguarding
- Mental Health Nurse

Due to criminal proceedings taking place at the same time as the review, two key case workers (the GP and District Nurse) were not involved as they were listed as potential witnesses in the court case scheduled for January 2017. These proceedings also had a direct impact on the speed at which the review has been conducted and completed.

Data from Documentation

The following documentation was available for the Review Team:

- Chronologies provided by Reading Borough Council, South Central Ambulance Service, Royal Berkshire Hospital NHS Foundation Trust, Berkshire Healthcare Foundation Trust and Thames Valley Police.
- GP Surgery records.
- Reading BC records.

Data from family, friends and community

Mrs H is deceased and due to criminal proceedings taking place at the same time as the review the Review Team has been unable to speak to family members or her private carer.

The nature of the findings

Findings in the final report have been developed and expanded upon under the headings below.

- What is the issue?
- How did the issue manifest itself in the case?
- What makes it an underlying issue and not a quirk of the case?
- What do you know about how widespread or prevalent is it?
- What are the implications for the reliability of the system?
- Questions for the SAB to consider

When considering the information presented for this review a number of key lines of enquiry have been identified and reflected what this told us about the emerging pattern of activity and behaviour in this case under the following headings.

- Human Bias
- Management Systems
- Tools

Methodological comment and limitations

Mrs H is deceased and criminal proceedings limited the Review Team's ability to conduct all the conversations that would have more fully informed the review. There was a long time frame set for the case to come to court (January 2017).

At the hearing in January 2017 the son and carer were found not guilty of neglect.

Following the court case in January 2017, the lead reviewers in conjunction with the Independent Chair and the Chair of the SAR Panel agreed that the two key case workers noted above would not now be included in the review. The rationale behind this decision was that the length of time that had passed, together with their involvement in the court case would impact on the ability of the conversation style process to draw out information.

The lead reviewers would like to offer their thanks and appreciation for the time and positive attitude shown by all the practitioners who have taken part, either as part of the Review Team or the Case Worker Group.

1. The findings:

What light has this case review shed on the reliability of our systems?

Introduction

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. The particular case acts as 'a window on the system' (Vincent 2004: 13).[1]

Case Review findings therefore need to say something more about the SAB area/agencies and their usual patterns of working. They exist in the present and potentially impact in the future.

The review team have therefore selected findings to pinpoint those that most urgently need tackling for the benefit of service users and their carers, which **may not** be the issues that appear to be the most critical in the context of a particular case.

In order to help with the identification and prioritisation, the systems model that SCIE has developed includes six broad categories of underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change:

- Innate human biases (cognitive and emotional)
- Service user and carer -professional interaction
- Responses to incidents
- Longer term work
- Tools
- Management systems

Each category may have many subcategories and it is the subcategories that state succinctly what the problem is and are therefore helpful to the reader. There is, of course, overlap between categories.

This report has sought to use all the information presented across the multi agency environment for the defined time period to identify specific areas for further exploration and analysis to produce findings and questions for the SAB to consider.

As previously noted criminal proceedings are still in progress, these are not likely to complete until early in 2017. It has been proposed by SCIE, supported by the independent chair of the SAR Panel, to wait and finalise the review once the criminal proceedings have concluded. This will allow the views of 'witnesses' and family members to inform the final published report.

Appraisal of professional practice in this case – a synopsis

In terms of practice the overarching findings of this case fall into two areas - failure to apply legislative MCA framework in practice and a lack of professional curiosity within a person centred approach across all agencies.

Good practice timely responses were made to issues of vulnerability such as pressure sores by the GP and the Memory Clinic for the deterioration in Mrs H dementia. Also a good practice response was made at the time the case became known to the Safeguarding service.

The need for both stimulation and respite was identified by the Memory Clinic at the review meeting in June 2012. As good practice the consultant wrote specifically to Reading Borough Council Social Services (RBCSS) and requested an assessment for day services with transport. RBCSS responded well, the assessment was completed, services where identified and offered.

In the assessment the social worker recognised the need for carers respite to be in place, she was visiting seven days a week and wanted time to do things at home and see her daughter. It was also known that Mrs H son was not actively involved in the care of his mother as he worked long hours and that all care was being delivered by one carer. The sustainability of the private arrangement was not considered as part of the overall assessment process, which is not good practice. Finding 3 identifies a default human bias towards an acceptance that privately arranged care by families is appropriate and caring. The curiosity of professionals did not extend to scrutinising the existing private arrangements as there were no specific concerns.

The Memory Clinic consultant in his request for day services made a direct request for a day service placement with transport. The client record does not show if the request was taken into account in allocating the placement, why it was needed or if a response was given to the consultant, which is poor practice. Finding 4 highlights that assumptions are made by professionals that requested actions will be carried out and in the absence of any notification of an outcome to the contrary will continue to work with a patient on this basis.

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 risk or impact on Mrs H or her carer. Both would be left with unmet needs and it was poor practice that the case was closed and transferred across to the long term team without any further action taken and the decision accepted without challenge. Finding 3 identifies a default human bias towards an acceptance that privately arranged care is good and that short term models of intervention inhibit professional curiosity to check and see if this is the case.

In terms of overall decision making about Mrs H her mental capacity was not considered. As identified in finding 2 a better understanding and application of the MCA would have ensured follow up when the 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.

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 RBCSS and therefore allowed to believe it was in place. As per finding 4, in this instance as there had been a direct request by the consultation for day services, an outcome response should have been provided.

There was a good response from the GP when Mrs H's condition deteriorated and she was referred back to the Memory Clinic for a further review. It was not good practice that the consultant did not inform RBCSS of the deterioration as previous contact had been made regarding day services. This is a reverse example of finding 4 to the previous one, as the change in condition was not known and therefore could not be factored into any response to the decision to decline day services.

It was good practice that when the Memory Clinic Nurse (MCN) prepared for Mrs H review in 2013 she read her records, contacted the family and offered a home visit (this was declined by her son). These records did not include a response to the request for day services. As per previous examples against finding 4, the lack of a response to requests for day services meant that the MCN in her preparation did not have to hand all the information about Mrs H and an opportunity was lost to pursue this as an option.

Subsequent to this time period there have been some changes the Memory Clinic now has in place agreed time frames with the CCG for acknowledgements/ responses to be given within 3 days.

Mental Capacity was not formally assessed and a Mini Mental State Examination was not completed in the review meeting. Mrs H capacity to consent to care plan was considered by the MCN to '*require the help of family and carer to help make care plan decisions*'. However, there is no evidence to suggest the process for review at the clinic prompted capacity assessments, which is not good practice. This is reflected in finding 1 as evidence of a human bias towards an assumption that people with dementia do not have capacity allowing professionals to conclude that a capacity assessment is not required.

Finding 5 highlights issues of automated workflow which has a direct impact on practice and reflected as a compounding factor in the practice issues associated with finding 4.

The MCN relied on the carer to speak for Mrs H and to provide all the information used in the review as Mrs H had dysphasia (partial or complete impairment of the ability to communicate). The MCN obtained information about Mrs H condition from the carer and not the client as her experience of dementia was patients confabulate/lie to compensate for their condition, therefore there is less reliance on their information. This may have been normal practice, however it would be expected as good practice for other established methods of communicating with people who have difficulties to be used and that these would be well established part of the review meeting. This is reflected in finding number 1 in relation to the voice of the service user.

The review process did not prompt the MCN to gather information about the skills and qualifications of a carer or to challenge her experience of working with the patient "*I don't know if she had any qualifications"* *"she is the carer thus I deemed her to be caring".* This is not good practice as there would be an expectation that professionals involved in the care and support of vulnerable people would consider the appropriateness of care arrangements in place. Finding number 3 demonstrates a bias towards an assumption that family arranged care is caring, and the impact of short term interventions that allow for a narrow view to be taken of the overall circumstances of the person they are working with.

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

Finding Number 1 (Human Bias)

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.

What is the issue?

Individuals can be treated in a discriminatory manner due to their diagnosis. It is well cited and explored within social work literature that discriminatory practice leads to a lack of empowerment and the voice of the individual not being heard or kept central to decision making. In this case 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 to communicate, Mrs H views where never sought to inform personalised outcomes for her and the safeguards of the legislation where not provided.

How did the issue manifest in this case?

This section provides an illustration from the case and is not intended to identify every instance comprehensively.

Multiple professionals involved with Mrs H stated they had consulted with her carer as "Mrs H had dementia". There was no evidence in this case that communication techniques were used with Mrs H to ascertain her past, present wishes and views. The diagnosis of dementia led professionals to make an assumption that she lacked capacity for all decisions without formally assessing her capacity. The views of Mrs H are not recorded or explored by any professional involved. This is not person centered assessment or planning.

How do we know it is an underlying issue and not something unique to this case?

This section gives a flavour of input from case group and review team members about how this issue plays out in other similar cases/scenarios **and/or**: ways that the pattern is embedded in usual practice.

Professionals involved in the case explained this as standard practice to consult and rely on the views of a carer due to service design, demand and custom and practice. The views of the review and the case group highlight that this is common within frontline practice and remains a challenge to embed the principles and safeguards of the Mental Capacity Act. Local knowledge supports that self-funders are particularly disadvantage due to less process and involvement from frontline services which may prompt formal assessments of capacity. We therefore know this is a pattern that underlies more than just this case.

How prevalent is the issue?

This section deals with numbers. It provides evidence gathered about how many cases are actually or potentially affected by the pattern.

The Law Commission Review 2014 was undertaken in acknowledgement that the Mental Capacity Act 2005 and subsequent Deprivation of Liberty Safeguards 2007 legislation was never embedded into practice and systems as was initially intend by design of the Act to ensure empowering and protection principles for some of the most vulnerable members of our society. It was identified that the legislation had in general terms failed to achieve it purpose in upholding individual's human rights. NHS England as a result implemented a Mental Capacity Act assurance framework document this again reflects that concern regards implementation of Mental Capacity Act principles and an accountable safeguarding and decision making framework, local commissioning arrangements currently work to promote awareness and practical application. This therefore has both a national and local prevalence issues.

Current statistical data provided by the Alzheimer's society indicates that "diagnosis rates on average in England are just 48 per cent, which despite being a two per cent increase from 2012, means there are still around 416,000 people in England who are living with dementia but who are not diagnosed". The Health and Social Care Quality and Outcomes data for 2014-2015 for provides statistical data for the West of Berkshire indicating some 1984 individuals are in receipt of dementia services (memory clinic reviews) for that period, Joint strategic Needs Assessments (JSNA) indicates a trend of an increasing aging population with people living longer and therefore more likely to develop a dementia illness. This data indicates the likely increase of demand for dementia services within the board's area and highlights additional pressures for the area of service delivery and identifies the risk that such bias could be operating across the 1984 cases.

How widespread is this pattern?

This section deals with geographic spread. It provides evidence gathered about how wide spread the practice response is – a specific team, local area, district, county, region, national?

All members of the case group and review team considered this bias to and lack of application to be a wide spread issue. We know that this not only locally but nationally by the findings and report undertaken by the Law commission 2016.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?

This section articulates what a safe system would look like and the implications of this finding. What kind of risk does this pattern introduce to the safe and reliable functioning of our system? What would the consequences be of doing nothing be?

The impact of this bias for individuals and the safety of the system are hugely significant. This case illustrates the prevalence of this bias across multiagency systems and professional practice. Such bias may therefore be prevalent in other areas of service delivery for example individuals with a diagnosis of learning disability or mental health conditions. This finding therefore has significance for all health and social care organisations.

The Mental Capacity Act 2007 is a statutory legislative framework and its principles promote the individuals rights to supported decision making wherever possible. If the individual is assessed as lacking capacity it provides a protective framework of best interest's decision making and accountability. Therefore, promoting person centred and personalised decision making relating to a person's care and treatment. 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.

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.

Human bias is natural; we all do it so need help to guard against it. Demonstrated in a particular way in this case the assumptions made by professionals of Mrs H lacking capacity and a failure to avoid such bias by, application of the correct legislation and codes of practice, when identifying a potential lack of capacity, resulted in a failure to safeguard Mrs H and ensure her best interests where fully assessed and considered.

QUESTIONS FOR THE BOARD TO CONSIDER

- Does the SAB accept that human bias towards vulnerable people with dementia is something they need to safeguard against?
- What additional safeguards may be required?
- How will the Board take forward the learning of the identified failures to implement Mental Capacity Act 2005 values and safeguards in this case?
- What difference will the statutory accountabilities of the SAB make in ensuring an effective implementation of current and potentially new Mental Capacity Act Legislation and Codes of Practice?
- How will the SAB assure itself that practice is improving to provide appropriate safeguards for people who may lack capacity?

Finding Number 2. Management systems

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

What’s the issue?

The Mental Capacity Act 2005 implemented in 2007 has five key principles it states:

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 done, or decision made, under this act for or on behalf of a person who lacks capacity must be done or made in their best interests
5. Before this act is done or decision made it must be done in a way which is the less restrictive of person’s rights and freedom of action.

The Act 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 protection for the decision maker. The protection however will be of no value if the capacity assessment and best interests check list has not been followed.

It is an expectation that practitioners and people making decisions about the care and treatment of someone who may lack capacity to apply will have an awareness practical application of the legal framework when required. This said, it needs to be acknowledged that is often a complex area of work.

In the memory clinic appointments did not allow or promote further assessment of capacity concerns and consideration of further assessment and safeguarding frameworks were required i.e. Best Interest Assessments relating to ongoing care and treatment arrangements.
Thirty minute review appointments resulted in a potential failure to achieve person centred review, therefore for those who may lack capacity their voice and views are not heard. Adult Social Care staff similarly where not clear of their duty and need to assess capacity in line with the principles of the Act.

How did the issue manifest in this case?

This section provides an illustration from the case and is not intended to identify every instance comprehensively.

During the Memory Clinic review and at other points of contact with various professionals Mental Capacity was not formally assessed and the Mini Mental State Examination was not completed, despite information which would indicate a possible lack of capacity.

Establishing capacity did not feature as part of the review process in determining whether best interest decisions were being made for Mrs H in terms of her current and future care and support, despite the fact that the Community Pychiatric Nurse (CPN) relied on the carer D to speak for Mrs H as Mrs H had dysphasia (partial or complete impairment of the ability to communicate) and “she wasn’t able to form words” and that Mrs H capacity to consent to care plan was considered by the CPN to ‘require the help of family and carer to help make care plan decisions’.

The CPN relied on the carer to speak for Mrs H as Mrs H had dysphasia (partial or complete impairment of the ability to communicate) and “she wasn’t able to form words”. Likewise other 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 this.

How do we know it is an underlying issue and not something unique to this case?

This section gives a flavour of input from case group and review team members about how this issue plays out in other similar cases/scenarios **and/or**: ways that the pattern is embedded in usual practice.

The systems and governance of practice did not identify or resolve the issue over a substantial period of time and with information recorded that indicated a need to consider Mrs H's capacity. Therefore this is an indicator that the issues may be more prevalent than just this case. Two other local authorities and health partners confirmed that prompts and IT systems were in their infancy in identifying mandatory fields for Mental Capacity Act application, and thus oversight of practice in this area was limited.

How prevalent is the issue?

This section deals with numbers. It provides evidence gathered about how many cases are actually or potentially affected by the pattern.

National and local drivers continue to reduce staffing levels, and time and capacity of staff by aim of utilising efficient and effective IT systems at the time of this case new IT system and ways of working where being implemented. This case demonstrates the impact on best practice and the level of detail being recorded and focus of practitioners learning new IT systems and "different" ways of working. Serious case reviews and learning from previous children's services reviews have identified themes relating to constant IT systems change and the impact on directed.

Nationally we know that the law commission has undertaken a review of Mental Capacity Act to address issues of lack of application in practice and a failure to implement the safeguards offered and intended by this legislation. To ensure practice is not discriminatory to a particular client group and to maximize choice and control for the individuals in decisions being made in person's best interests. The work of the Chief Social Worker for adults and Principal Social Worker networks highlights these concerns at both a national and local level placing these issues on a National agenda.

How widespread is this pattern?

This section deals with geographic spread. It provides evidence gathered about how wide spread the practice response is – a specific team, local area, district, county, region, national?

The Law Commission report in 2014 states "its implementation has not met the expectations that it rightly raised. The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. Capacity assessments are not often carried out; when they are, the quality is often poor. Supported decision-making, and the adjustments required to enable it, are not well embedded. A fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment. Professionals need to be aware of their responsibilities under the Act, just as families need to be aware of their rights under it".

Why does it matter? What are the implications for the reliability of the multi-agency adults safeguarding systems?

This section articulates what a safe system would look like and the implications of this finding. What kind of risk does this pattern introduce to the safe and reliable functioning of our system? What would the consequences be of doing nothing be?

The implications are that staff are not clear on their duty of care to individuals who may lack capacity, and insufficient prompts are provided to support them to apply appropriate safeguarding framework for decision making. This results in the values and principles of the MCA not being upheld and people's rights ignored

Staff in Health and Social care agencies require clear guidance, supervision and support regards individual professional and organisational accountability requirements and to understand their duties under the Mental Capacity Act 2005 for individuals who may have Mental Incapacity. This is particularly relevant for self funding individuals in being clear as to who is the decision maker for the individuals lacking capacity and for what decisions ensuring decisions that are being made are the in persons best interests and are done so under the appropriate legal frameworks and safeguards.

Where someone is speaking and acting on another person's behalf due to capacity issues, it should be done within the framework of the MCA/Best Interests and in the context of adult safeguarding. Professionals do not appear to be considering capacity assessments for someone with dementia and it is not known how embedded MCA was at the time in the work of the memory clinic staff.

Finding Number 2

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

The Mental Capacity Act 2005 and the Code of Practice are primary legislation. It makes clear the statutory duty of agencies to formally assess capacity if there is a concern that a person may lack the mental capacity to make decisions regarding their care and treatment arrangements and ensure decisions are made in their best interests in accordance with the Act. A failure to discharge this duty when working with vulnerable adults can leave the adult at risk and fails to consider the best interests of the individual, but also does not provide the legal protection afforded to the "decision maker" by the Act. This has widespread implications for the individual the worker and the organisations.

QUESTIONS FOR THE BOARD TO CONSIDER

- **Are the board aware of how prevalent the issues of failure across multi professional agencies within its area are in the discharge of its statutory duties under the Mental Capacity Act?**
- **How can the Board be assured that appropriate methods are developed to measure improvement within organisations of the application, were required, of Mental Capacity Act and Code of Practice?**
- **How can the board promote the safeguards provided by this legislation for individuals who may lack capacity?**

Finding Number. 3 Human Bias

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.

What is the issue?

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 view that families and carers are caring, they will 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 with private arrangements at greater risk than those with a local authority commissioned service.

Services have a developed into models of short term interventions, driven by an ever growing need to meet demand within diminishing resources. This has had an inhibiting effect on professional curiosity, preventing compounding risk factors in case work to be identified and acted on, professionals do all they can to maintain the status quo to meet timeframes and complete the work.

How did the issue manifest in this case?

This section provides an illustration from the case and is not intended to identify every instance comprehensively.

Private care arrangements were in place for Mrs H at the time her GP referred her to the Memory Clinic. The Memory Clinic consultant subsequently made a referral to RBCSS as she felt she needed social stimulation and her carer may need some respite. The social worker who completed the assessment in the short term team was aware of the need for carer respite. She was told the privately arranged carer was visiting seven days per week and wanted time to do things at home and see her daughter. She also knew that Mrs H son was not actively involved in her care as he worked long hours and all care was delivered by the carer. 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 in the 2013 Memory Clinic review by the nurse about the skills and qualifications of the carer or challenge of her experience of working with the patient and her understanding of dementia “I don’t know if she had any qualifications” “she is the carer thus I deemed her to be caring”. There was no follow up on the referral by the clinic consultant for day services and this was not discussed at the review meeting.

The workforce in Reading 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 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 decision not to take up the day service went unchallenged, despite there being an identified need for both stimulation and respite. The nature of the arrangement with all support coming from a single carer, set alongside someone with a deteriorating condition and capacity issues, was not flagged or responded to as a risk factor within the appropriate frameworks.

How do we know it is an underlying issue and not something unique to this case?

This section gives a flavour of input from case group and review team members about how this issue plays out in other similar cases/scenarios **and/or**: ways that the pattern is embedded in usual practice.

The Review Team considered there was nothing to suggest another process that would have prompted different actions when privately arranged care is in place, existed, but was not used. Professionals appeared to have been passive in this regard and accepted the situation as it is presented without challenge. The Review Team was convinced through conversations, and by further discussion with the Case Worker Group, that this was a common scenario in cases where private arrangements were in place.

No process was identified that required management approval or oversight of cases where a service was not provided to consider and quantify the consequential risk for the individual. It was not considered by the Case Worker Group that it would be unusual to transfer a case across to another team at the end of an intervention, even where there was an unmet need. Workflow within the ICT system did not prompt the recording of decision making at this juncture and therefore it must be concluded that this would not be unique to this case.

Both the Review Team and Case Worker Group were clear that short term models of intervention were common place across all agencies at the time and that this is still the case both locally and nationally. They felt that as professionals working in this way it creates challenges for them to maintain the boundaries of their roles and were not surprised it led to gaps in provision.

How prevalent is the issue?

This section deals with numbers. It provides evidence gathered about how many cases are actually or potentially affected by the pattern.

There is nothing to suggest that the response of professionals in Reading to a situation where, to all intents and purposes satisfactory privately arranged care is in place, is any different to any other local authority area. It was considered this could be reflective of limited experience in Reading of working with families who have made private arrangements. With this in mind the lead reviewers examined data about levels of commissioned versus privately arranged care in West of Berkshire (Reading, Wokingham and West Berkshire), which was gathered to inform the implementation of the Care Act. This demonstrated that in 2013 there were significantly less privately funded care home placements in Reading than in the two neighbouring local authority areas. However there were 10% more privately funded domiciliary care arrangements in Reading, therefore the theory that this may have accounted for the response was not proven.

How widespread is this pattern?

This section deals with geographic spread. It provides evidence gathered about how wide spread the practice response is – a specific team, local area, district, county, region, national?

Based on the information gathered as part of the review and their own working experience the Case Worker group and the Review Team considered both issues of trust in family arranged care and the use of short term models, to be normal practice and widespread across the sector. The lead reviewers were unable to identify any formal data or anecdotal evidence to the contrary.

Why does it matter? What are the implications for the reliability of the multi – agency adults safeguarding systems?

This section articulates what a safe system would look like and the implications of this finding. What kind of risk does this pattern introduce to the safe and reliable functioning of our system? What would the consequences be of doing nothing be?

The role of professionals to keep people safe either as direct action where there are concerns, or quite simply by ensuring the provision of a service to meet an assessed need, must assume all the appropriate challenges are made. If this cannot be relied upon then fundamentally there cannot be any confidence in the multi agency environment that appropriate checks and balances are in place.

The absence of a professional response to a case where services do not proceed could be considered to reflect a sense of distance in terms of overall responsibility for those who are directly in the care of LA commissioned services, and those who are not. This situation was, and has the potential to continue to be, compounded by models of short term working and an absence in these models of an overarching understanding of individual case work in decision making.

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.

Finding Number: 3 Human Bias

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.

The Care Act 2014 has set out clearly the roles and responsibilities across all agencies to keep the most vulnerable in our in our communities safe. There is an assumption ‘professional curiosity’ will be applied about care arrangements and it would generally be expected by professionals and lay people alike, that arrangements for a vulnerable person with little or no capacity would be scrutinised. There are obvious consequences from this not happening, most significantly for those lacking capacity and in receipt of care delivered in this way

This case has shown that during the period under review no professional took it upon themselves to assess how realistic or effective the private care arrangements for Mrs H were. Was it simply that as these arrangements had been helpfully sorted by a third party, overworked SW teams and in the absence of any indication of concern or risk did the ‘minimum’ required?

The increased reliance on short term working practices, in both health and social care, has created an environment where professionals take a short term view on the circumstances of the people they are working with. Decision making is compromised by these models, which appear to lack the systemic ability to ensure all relevant information is available and acted upon.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is the Board aware there is a default position of acceptance that privately arranged care is appropriately caring? What level of assurance does the Board have/need that appropriate checks and balances are in place?

- Does the Board have a view on the use of short term interventions and the realism of working within these models in person centred way? Is the Board kept up to date in changes to working practices in the partner agencies to assess the impact on safeguarding?
- What is the Boards view on the accountability of professionals to be 'curious' about case work that does not present specific risk factors? What options are open to the Board to hold agencies to account where this is not the case?

Finding 4 Tools

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

What is the issue?

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 review 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 it would have provided by being more visible in the system. 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.

How did the issue manifest in this case?

This section provides an illustration from the case and is not intended to identify every instance comprehensively.

In May 2012 the Memory Clinic consultant wrote to Mrs H GP by way of follow up on an assessment at the clinic in March. The consultant copied in RBCSS and made a request for a community care assessment of Mrs H for day services.

Following a further review in June the consultant again wrote to the GP copied to RBCSS, acknowledging there had been a recent assessment for day services and requested a day centre with transport.

Mrs H was referred back to the Memory Clinic in August as her condition had deteriorated and the consultant wrote once again to the GP on 3 September regarding an appointment on 31 August, referring to the assessment for a day centre with transport but that the outcome of this was still awaited – she did not copy in RBCSS. What was not known by the consultant as she wrote, was that Mrs H son had contacted RBCSS the previous day on 30 August to say his mother would not be taking up the day service placement that had been offered.

Neither the consultant, nor the GP were made aware by RBCSS that the day service had been declined.

The consultants request from previous Memory Clinic appointments for day services to allow respite for the carer was not discussed with the carer at the review meeting or referenced in the letter sent to Mrs H son afterwards.

The consultation did not write to inform RBCSS of the further referral by the GP due to Mrs H deterioration, despite there having been previous contact made regarding day services. The GP did not inform RBCSS either. RBCSS was not aware of the change in condition which occurred in the same time frame as the placement was declined by Mrs H son.

No one professional or agency confirmed either way that services requested had been set up or not and that there had been a change in Mrs H condition.

How do we know it is an underlying issue and not something unique to this case?

This section gives a flavour of input from case group and review team members about how this issue plays out in other similar cases/scenarios **and/or**: ways that the pattern is embedded in usual practice.

The Case Worker group confirmed that the process of writing letters is the established method of professionals across health and ASC to communicate with each other on ‘routine’ case work. It is accepted it is totally reliant on the effectiveness of the postal service and the individual agencies administrative arrangements, to ensure information reaches the identified professionals. More recently some agencies have put processes in place to ensure feedback/responses are provided to confirm if requested action has been taken or not, but this is patchy. Assumptions are made that actions requested have been taken and professional decision making is done on this basis.

How prevalent is the issue?

This section deals with numbers. It provides evidence gathered about how many cases are actually or potentially affected by the pattern.

The process of writing letters is the established method of professionals across health and ASC to communicate with each other on ‘routine’ case work. We know this is common practice across the sector and therefore must conclude that if time allowed for further analysis by the Review Team, other examples such as this case would be relatively easily found.

How widespread is this pattern?

This section deals with geographic spread. It provides evidence gathered about how wide spread the practice response is – a specific team, local area, district, county, region, national?

The Case Worker group and Review Team considered the use of letter correspondence to be normal practice for professional in routine work across the sector. We were unable to identify any formal data or anecdotal evidence to disprove this.

Why does it matter? What are the implications for the reliability of the multi-agency adult safeguarding system?

This section articulates what a safe system would look like and the implications of this finding. What kind of risk does this pattern introduce to the safe and reliable functioning of our system? What would the consequences be of doing nothing be?

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.

The use of letter writing is heavily reliant on a number of things to be in place, out of the control of the letter writer, to have confidence that information will make its way to the intended recipient.

Professionals are taking risks on behalf of those who are most vulnerable and not able to articulate for themselves their history or presenting issues, by not ensuring appropriate and timely responses are made to inform the decision making process.

As systems and processes do not prompt the provision of outcome responses between professionals where information has been provided or requests made, it has to be concluded that at this very basic level the system is not safe.

Finding 4 Tools

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

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. It is common practice for professionals to write letters to patients copying in relevant agencies with recommendations for actions. It is also common practice to assume that once a letter is written/sent it will be received, appropriately processed and resulting actions taken. The fact that this case has presented a picture of a system where it was not common practice for professionals to either provide or seek feedback is concerning.

The time delays between a service user being seen and a letter being received would mean missed information in managing the case work and the care arrangements for people who lack capacity and cannot speak for themselves. 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.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is the Board assured that current communication channels between professionals do not disadvantage or create risk for vulnerable people? If it is not what would it need to do this?
- When agencies implement new models of practice how is the Board assured that communication channels are maintained and/or improved?
- Are there viable means whereby the Board could direct professionals to adopt other means of communicating on routine case work that would allow for a more timely responsive decision making environment?
- What options are available to the Board when agencies fall short of their responsibilities to communicate and share information effectively?

Finding Number: 5 Tools

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?

What’s the issue?

A heavy reliance on IT systems and process to identify and prompt required actions in any individual case, can reduce the accountability of the practitioner. The reliance on such automated processes can lead to different parts of the same organisation operating in “silos” and therefore reduces promotion of holistic assessment and intervention.

How did the issue manifest in this case?

This section provides an illustration from the case and is not intended to identify every instance comprehensively.

The psychiatrist requested assessment of need for day services, to promote the wellbeing of Mrs H and provide carer’s respite. The need was assessed and provision identified to meet the required need. The service was declined by the Son with no consultation from services with the direct carer to review the risk and impact for carer and individual. Case was closed.

A need was identified for both social stimulation and carer respite by the Memory Clinic consultant and confirmed in Mrs H Community Care Assessment. A message was received by finance officer from her son to say he did not believe his mother would be able to go to the day Centre and this is passed to case co-ordinator. The contact is recorded but the system does not prompt workers to take any further action in the event a service for an assessed need is declined.

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 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..

How do we know it is an underlying issue and not something unique to this case?

This section gives a flavour of input from case group and review team members about how this issue plays out in other similar cases/scenarios **and/or**: ways that the pattern is embedded in usual practice.

The case group stated that the automated sign off and case management of allocation of work within the short term ASC services locally 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 workflow process allocations would make verbally by the management of the service and therefore would prompt discussion about the case and required actions from a multi-disciplinary perspective.

The IT system does not trigger review or monitoring of risk in such circumstances for self-funding individuals. The system is reliant on contact being reinitiated by individuals of others without a clear process to review individuals with deteriorating conditions. 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.

How prevalent is the issue?

This section deals with numbers. It provides evidence gathered about how many cases are actually or potentially affected by the pattern.

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

In local serious 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.

How widespread is this pattern?

This section deals with geographic spread. It provides evidence gathered about how wide spread the practice response is – a specific team, local area, district, county, region, national?

All Adult Social Care services have similar service short term service design and IT operation models implemented in line with the personalisation agenda. It is therefore highly likely that issues are prevalent not only locally but nationally.

Why does it matter? What are the implications for the reliability of the multi-agency adults safeguarding systems?

This section articulates what a safe system would look like and the implications of this finding. What kind of risk does this pattern introduce to the safe and reliable functioning of our system? What would the consequences be of doing nothing be?

The system for meeting people’s assessed needs and to promote health and wellbeing, either as a direct action where there are concerns or simply by the provision of a service to meet an assessed need will assume that all appropriate actions are taken to inform professional decision making. However if it cannot be relied upon or operates in isolation, to respond appropriately in these circumstances then fundamentally there cannot be any confidence in a multi agency environment that appropriate checks and balances are in place for very vulnerable individuals.

A lack of formal systems to review and risk assess declined services for self-funding customers fails to identify when a safeguarding concern may be present and ensure that it is the customers own preference to decline services. The systems enables cases to be closed with the assumption carers/individuals will contact services if further need is required, placing the individual at unassessed risk.

Finding 5 (Tools)

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?

IT recording systems used in Health and Social Care organisations are reliant on the skill and knowledge of the individual receiving information and inputting into the system to ensure required actions have been completed and dynamic risk assessment. Over reliance on an automated process which does not have the governance and professional oversight built into its design can result in identifiable risks being record with no review or triangulation of information to inform required outcomes.

QUESTIONS FOR THE BOARD TO CONSIDER

- How can the Board be assured that IT systems and process support professional practice?
- Are the board assured that the tools designed to support and govern safe and efficient practice are fit for purpose?
- Does operational policy reflect the interface requirements between recording systems and workflow processes and the accountability of practitioners?

2. Sign-off Sheet

Sign off of the report by Review Team

Name	Role	Agency	Date
June Graves,	Head of Care Commissioning, Housing & Safeguarding	West Berkshire Council	12 July 2016
Sarah O'Connor	Adult Safeguarding Service Manager	Wokingham Borough Council	12 July 2016
Linda York	Detective Chief Inspector	Thames Valley Police	12 July 2016
Jillian Morton	Detective Constable	Thames Valley Police	12 July 2016
Kathy Kelly	Named Professional for Safeguarding	Clinical Commissioning Group	12 July 2016
Catherine Haynes	Adult Safeguarding Named Professional	Berkshire Healthcare Foundation Trust	12 July 2016
Simon McGurk	Interim Service Manager Safeguarding Adults	Reading Borough Council	12 July 2016
Elizabeth Porter	Lead Nurse Adult Safeguarding	Royal Berkshire Hospital NHS Foundation Trust	12 July 2016

(Optional) Comments and responses by senior managers SAB members

Name:
Role:
Agency:
Comment:
Date:
Signature:

Name:
Role:
Agency:
Comment:
Date:
Signature: