WORCESTERSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW
Re. Jane

Date: June 2020

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PRIVATE AND CONFIDENTIAL – FINAL

NOTE OF GRATITUDE

The experience of Jane is the subject of this Safeguarding Adults Review (SAR.) Her mother, Theresa was very helpful and thanks are extended to her. Condolences are expressed to Theresa for her loss.

Thanks are also extended to the team members of the services who also co-operated fulsomely with this Review as well as the Worcestershire Safeguarding Adults Board Business Unit who supported the work activity required.

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1.0 PART ONE – INTRODUCTON AND SUMMARY

1.1 SUMMARY NARRATIVE

1.1.1 Jane was 47 years old when she died in hospital on 27th June 2018.

1.1.2 The causes of her death were recorded as (a) hypertensive heart disease; (b) septicaemia leg ulcers; and (c) micronodular cirrhosis.

1.1.3 She had been admitted to hospital on 20th June 2018 in connection with these physical health concerns. Within the previous fifteen months, she had had five admissions to hospital related to these ongoing physical health concerns.

1.1.4 In addition, for most of her adult life, Jane had also lived with the experience of mental health needs arising from a diagnosis of schizophrenia about thirty years previous to her death when she was training to be a nurse. It is understood that from the point of view of medical treatment, by all accounts, her experience of the condition was seen to be stable with the use of long-term course of treatment and care.

1.1.5 Currently, of the total population of approximately 566,000 people resident in the county of Worcestershire, it is estimated that 3,390 [1] (0.7% of the adult population aged over 16) live with a diagnosis of schizophrenia. Jane was one of that number.

1.1.6 Jane had lived in the County all her life. She had shared a home with her mother in an urban district. It appears that Jane had tried to live independently at some time earlier in her adult life after the onset of her experience of schizophrenia. However, this was not successful and she moved to live with her mother.

1.1.7 Jane's mother, Theresa, therefore, was a family / kinship / informal carer. From Theresa's perspective, the caring responsibility was not always easy. Besides the ordinary pressures of the informal caring role, Theresa was also in paid employment.

2.0 **Reason for referral for a Safeguarding Adults Review (SAR.)** Views of Jane's experience of care in the last years of her life led to a referral being made to the Worcestershire Safeguarding Adults Board (WSAB.) The main issues which were of interest for learning were firstly, with regard to safeguarding. It did not appear clear whether local agencies had worked together effectively to safeguard Jane prior to her death. In particular, there was a view that Jane's "voice" may not have been "heard" by professionals as strongly as that of her mother, Theresa. There was also specific interest in factors relating to statutory powers and duties such as the extent to which considerations attached to the application of the requirements of the Mental Capacity Act were applied positively. The circumstances also allowed Interest in good practice issues such as "paity of esteem" to be considered in the SAR.

3.0 **Decision to undertake a SAR.** On review of information received about Jane's care through its scoping processes, the WSAB decided that the circumstances met the criteria for the use of a statutory SAR stated in the Care Act 2014 and associated Guidance. [2]

3.1 WSAB have an agreed process following consideration of a referral that a person's care should be the focus for a SAR. In response to reflecting on the experience of Jane, following initial scoping the practice community developed a chronology of contact between the WSAB partner agencies, Jane and her mother over time. Most agencies contributed to the chronology. The chronology was completed around the end of August 2018, just two months after Jane's death.

4.0 **Terms of Reference.** Through its scoping process and engagement of an Independent Reviewer [3] four main areas for consideration in this SAR were agreed for consideration in the SAR as follows:

- Embracing the principles of **Making Safeguarding Personal** (MSP,) to what extent did agencies balance their practice focus on Jane in the context of her close family and other informal carer relationships?

- Reflecting on the requirements of **statutory responsibilities**, how successful were agencies in applying the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and Section 117 of the Mental Health Act 1983 in their practice with Jane?

- How far were developing commitments to **"parity of esteem**" in respect of both mental health and physical health evident in the delivery of services and work to improve Jane's experience?

- Building on commitments **to effective / co-ordinated multi-disciplinary practice**, what are agencies' reflections on the opportunities for early identification of challenges in the care of Jane and the effectiveness of practice at the time?

4.1 The individual themes of the Terms of Reference inter-relate. Therefore, the themes are not addressed entirely separately in the report are 'woven-in' as relevant within areas of discussion and learning.

5.0 **Review period of the SAR.** The general time period for review was determined to be the last two / three years of Jane's life during which her physical health deteriorated.

6.0 **SAR: purpose, process and pathway**. The WSAB website it states that overall, *"The main purpose of WSAB is to promote wellbeing and reduce the risk of harm for people with care and support needs."* [4] The use of SARs, therefore, is one part of its wider responsibilities. With regard to SARs, the WSAB has a SAR sub-group and a Case Review Group. These Groups

oversee decisions and actions about whether or not a SAR is required and if so, of what type. The helpful influence of these important groups has led to changes in the content and presentation of this report which were appreciated by the Independent Reviewer.

6.1 For WSAB, a SAR is a review process. It seeks to determine how agencies and individuals involved with a person with care and support needs can learn from what might have been done differently which might have reduced or prevented harm or a death from taking place. [5] It is the purpose of a SAR, therefore, to promote learning and changes in practice. [6] As such, a SAR is not an investigation and does not seek to apportion blame.

6.2 In terms of the conduct of the SAR overall, a developing body of experience and knowledge is seeking to create and maintain effective standards for SAR practice. This SAR has drawn on the "Quality Markers" developed by the Social Care Institute for Excellence (SCIE.) [7] These are consistent with the six adult safeguarding principles derived from the Care Act 2014 including "proportionality" [8] i.e. a SAR should be proportional to the circumstances it reviews. That approach has been adopted in this instance.

6.3 In addition, the Care and Support Statutory Guidance states [9] that SARs should be "*trusted and safe experiences that encourage honesty, transparency and sharing of information ... (as) ... If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial."* This approach has also been adopted in this SAR and appears to have been welcomed in the experience of participants.

6.4 Based on this approach, some final points applied in the SAR included, firstly, completing the SAR within a reasonable time period so that colleagues are as close to the events under review as possible. This was achieved although agreeing the final version of the Report took longer than originally scheduled. Secondly, producing a report which is appropriately brief and relevant with recommendations for the WSAB. Thirdly, the recommendations focus on what can be implemented locally rather than national change. Fourthly, best practice aims to avoid "hindsight bias" in the conduct of the SAR and this has been an aim of this SAR. [10] Finally, the Independent Reviewer was also keen to assist the WSAB to be able to mainstream recommendations into existing / on-going plans of WSAB agencies which are relevant to the outcomes of this SAR e.g. plans for wider training on Mental Capacity with the implementation of Liberty Protection Safeguards in late 2020 in mind.

7.0 **Making Safeguarding Personal.** This SAR was undertaken at a point in which there is continued will amongst WSAB partners to strengthen the leadership of culture change in safeguarding practice sought through the MSP initiative. It speaks well of the WSAB that it wanted to build on previous reflect on this situation to test if the MSP message is being carried through at the front-line. A further developing point of consideration is that in practice, there are links between MSP and "strengths-based approaches" which are emphasised in the light of the Care Act 2014. This was consistent with WSAB

approach in wanting to recognise positive practice where it was appropriate to do so. In terms of overall approach, the *"Pathways to harm*" approach was attractive to the WSAB as an organising principle for review. Amongst its advantages, were that it appeared to the possibility for securing a proportionate review. Reflecting on this with the Independent Reviewer through the process, there was interest in how a more asset / strengths-based approach contributed to thinking which suggested some possible refinement through a "*Pathways to Hope"* approach. [11] Insights from s*ystems-type* approaches were also used through a hypothesis-testing approach at the Practitioners Learning Event on 01 May 2019. [12]

8.0 Other context. It was clarified during the SAR set-up phase that the Coroner had determined that Jane had died of natural causes. Also, it was confirmed that no disciplinary action had been taken against any employee involved in the support of Jane.

9.0 Involvement of family and friends. Often, but not always, families are the first point of relationship to an individual. In the conduct of the Review, the Independent Reviewer met Jane's mother, Theresa. Theresa was supported by a friend in the contact with the Independent Reviewer and WSAB Manager. Two meetings took place with Jane's mother to discuss their experience and views overall, firstly and then, secondly, a further meeting to discuss the draft SAR Report. Theresa was kept updated through correspondence half-way through the SAR. In this SAR, Theresa's views are recorded in the body of the Report. It was agreed with Theresa that names should be changed for herself and for her daughter Jane so that they are anonymised as subjects of this Report. The Report seeks to maintain a balance between the WSAB's commitment to transparency to support learning, on the one hand and the need to respect certain elements of experience relating to Jane, her family and staff involved, on the other.

10.0 Involvement of staff and managers is also a key feature of the review. The WSAB began the process through a helpful chronology. A Root Cause Analysis (RCA) was undertaken by the Health and Care NHS Trust which the Reviewer found helpful. For the SAR proper, a programme of individual interviews were set up with practitioners who worked directly or to some extent with Jane as well as with managers from all relevant agencies involved in Jane's care. Where required, further meetings were set up. A significant number of staff and managers - about 15 in total - contributed either through face-to-face or telephone interview, email contact or attendance at meetings - a Practitioner's Learning Event, the SAR Sub-Group and the Case Review Panel.

11.0 Style and Publication. The Independent Reviewer was provided with information as requested throughout. The positive approach of partners who participated in the SAR process was noted. The daily pressures which organisations are under is acknowledged as the context in which such positive response was offered. The names of health and care agencies are not used and neither are the names of individual staff members. Following consideration and helpful feedback by the WSAB SAR sub-group and the

Case Review Sub-Group, the final version of this report was presented to the WSAB in November 2019. The Care Act 2014 requires that SAR findings must be published in the SAB Annual Report and WSAB must act on the findings of the SAR. [13]

12.0 Limitations / parameters of the SAR. Some potential limitations or parameters around the SAR include, firstly, that the SAR's main focus were the last years of Jane's life but some longer-term observations are made e.g. with regard to Jane's wish to smoke. Secondly, because the main focus of the SAR is on learning, that creates the framework through which it is presented i.e. the SAR is not an investigation nor something which seeks to attribute blame. Thirdly, the material of the circumstances is challenging for all concerned, particularly with regard to the safeguarding episode. All parties may not agree with all aspects of the Independent Reviewer's assessment. Fourthly, the Independent Reviewer may not have met every family member, friend or worker who might have contributed. However, there was a need to keep the SAR activity within a reasonable time limit so as to maximise learning drives the depth which can be attained in such a review. Fifth, therefore, not every issue or incident experience by Jane, her mother or the staff who worked with them is a subject of reflection but a sufficiently strong range has been achieved overall.

13.0 PART TWO – REVIEW AND ANALYSIS

13.1 JANE AS A PERSON

13.1.1 The person who knew Jane best was her mother, Theresa. The overall context in which Jane and Theresa shared their lives was outlined above at para 1.1. Theresa stated that she and Jane "*loved each other."* She agreed that Jane was an intelligent person. Theresa outlined to the Reviewer some of Jane's experience from her point of view and the challenges which both Jane and herself faced. She explained that Jane's mental health had been "under control." She explained that when Jane was physically fitter, Jane was able to make her way own to various locations in the conduct of her life. For example, she attended a local mental health unit for routine treatments (injections) and participation in some programmes. As Jane's physical health began to deteriorate, getting to locations could be challenging. For example, Jane sometimes used a wheelchair and Theresa said that this could be a stressful experience for her as a Carer in trying to push Jane through the streets from home to the local Hospital. Theresa said that Jane "did not always co-operate" in response to suggested care and that janes was "disruptive" during hospital stays. Theresa's friend stated something similar.

13.1.2 The professional who knew Theresa best, perhaps, but certainly the longest was a Community Psychiatric Nurse (CPN.) This CPN had retired sometime previously and was not available for consultation in the review. The current CPN had known Jane for more or less the period covered in the SAR, however and she had also first met Jane many years ago when Jane had had admissions to a psychiatric hospital where the CPN was working at the time. Mental health services observed that Theresa "*thought the world"* of Jane and

loved her deeply. Domiciliary care staff thought that Theresa was “brilliant” with Jane. Broadly, professionals’ observations of Jane as a person noted that “*some days (*Jane *was) happy, giggly;”* whilst on others she could be “*snappy or tearful.*” The “dynamics” between Jane and her mother were noted in medical observation and Jane was thought to be *“flat as a person… not that lively… perhaps due to the effects of psychotropic drugs.”* It is perhaps arguable [14] that such an observation could perhaps be applied to many other people who take psychotropic drugs.

13.1.3 Jane’s experience of schizophrenia had come upon her whilst she was training to be a nurse. The fact that she was training to be a nurse indicates that Jane had appeared to demonstrate the required ability to begin a professional qualification programme. Her experience of a serious and enduring mental health need preventing her from working towards completion of the programme.

13.1.4 It is not clear if Jane had friends of her own. A brother who attended her funeral lived some distance away. In the last years of her life, Jane’s main source of company seemed to be that of her mother and any visitors to the home. Amongst the visitors would be a good number of paid health and care professionals.

13.1.5 Jane was also someone who smoked, sometimes as many as 25 cigarettes a day. So it should also be noted, perhaps, that smoking prevalence is comparatively high in the district in which she lived at 19.4%. [15] The district in which she lived is also noted as having average levels of physically active adults compared to England.[16] However, Jane was unable to leave her home un-aided during the last few years of her life therefore probably did not share this profile relating to physical activity.

13.1.6 Smoking may have been one contributor to Jane’s life-expectancy. At the time in which this SAR was undertaken, more people may expect to live longer than in previous times. Therefore, the age at which Jane died - 47 - may be regarded as a relatively young age to die in our current context. In Worcestershire, for instance, life expectancy for women overall is reported as 83.5 years, [17] some 35 more years of life than that enjoyed by Jane. In a *Needs and Assets Profile* of the area in which Jane lived, [18] the Worcestershire Health and Well Being Board reported that in March 2018 life expectancy for women is 7.2 years lower in the most deprived parts of the area than in the least deprived. [19] Pockets of relative deprivation are located not far from where Jane lived. [20] This reality would have been a wider factor in which Jane experienced life.

13.1.7 With specific reference to the experience of those living with mental health challenges such as Jane, the 2016 *Five Year Forward View for Mental Health* [21] reported that “*people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people*.” [22] In other words, the experience of people with “*prolonged mental illness”* appear to compound other factors with regard to life expectancy in a negative way. Smoking is noted as a factor which can have a negative impact for people with long

standing mental health problems as they are "*twice as likely to smoke"* than other people in the population. The *Five-Year Forward View for Mental Health* therefore states that "…*extra efforts should be made to reduce smoking …(in) this group*." [23] It is acknowledged that working with someone like Jane to consider reducing or stopping smoking may be a challenge for the person such as Jane and professionals. Such work encompasses issues of personal liberty and choice for the individual alongside any challenges in behaviour change should the person wish to reduce or stop smoking. It is accepted that there may be evidence of programmes to address smoking behaviour in the area. Nevertheless, Jane died at a comparatively early age. WSAB partners may bear this mind as they respond to the *Five-Year Forward View for Mental Health* and review those public health initiatives aimed specifically at people living with serious mental health issues.

13.1.8 None of these general or specific observations mean that Jane might have lived longer than she did. They are merely mentioned as context to support the WSAB in its further reflections and learning from the events connected to the care of Jane which it wished to review.

14.0 **SERVICE CONTEXT.** Jane was supported by a full range of professional health and care services, namely:

- Primary care / GP services from a Medical Centre
- one of three Clinical Commissioning Groups established in the County to commission overall healthcare provision for the population [24]
- Domiciliary Care commissioned by the Council through a delegated arrangement via the Health and Care NHS Trust to a private provider. The provider participated in a Registered Managers Network to promote quality provision through stronger occupational identity
- A Health and Care NHS Trust providing community health care services including the district nursing, occupational therapy and mental health services used by Jane.
- An Acute Hospitals Trust as the main provider of hospital services in the County used by Jane and included given specialisms such as vascular teams, Tissue Viability Nurse, etc.
- The Council which provided support at the point of hospital discharge through a "recover at home" model which included some social work consideration.

15.0 **VIEWS OF FAMILY.** Jane's mother, Theresa, stated that overall Jane "*had the best care"* and that professionals were "*marvellous."* She stated that Jane had had some contrasting experiences between Hospital Wards treating her physical health needs. She described one Ward as "*marvellous"* and another as "*dreadful."* Theresa and a friend stated that Jane didn't always co-operate during her hospital stays and that Jane could be disruptive during her stays in the Wards. Theresa said that Jane was sometimes "*tearful"* whilst an in-patient. She stated that there was a difference of opinion between herself and Jane with regard to proposed treatments for ongoing leg ulcers. Jane had agreed with the

hospital and Theresa didn't agree to the use of full compression dressings. Their difference in view intersected with the views of professionals working in the situation and is a point of reflection below cf. paras 23 ff.

15.1 The national carers group, *Carers UK*, witness to the pressures of informal caring. They reported that nationally, family or other informal carers, often have to stop their paid employment due to the demands of the caring role. [25] Theresa managed to continue working despite the pressures which she experienced of also being a family carer to Jane. In the 2011 Census, 63,685 people defined themselves as "carers" in Worcestershire – just over 10% of the local population. Jane's mother, Theresa, would be included in that group.

16.0 Embracing the principles of MSP, to what extent did agencies balance their practice focus on Jane in the context of her close family and other informal carer relationships?

16.1 The Local Government Association (LGA) state that MSP *"aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances."* [26] In reflecting on the extent to which agencies balanced their practice focus on Jane in the context of her close family and other informal carer relationships through the SAR process, the Reviewer believed that in daily practice professionals had best intent in aiming to establish choice and control with Jane. The documented chronology available to the Reviewer showed that professionals talked with Jane individually as well as with Theresa on their views including how they wanted to improve and resolve particular issues. For example, there were clear conversations by professionals with Jane about what Jane wanted with regard to a possible discharge home from hospital care. Likewise, there were discussions with Theresa about her contribution to Jane's care and support. This is all consistent with MSP.

16.2 Professionals appeared to the Independent Reviewer to recognise that sometimes Jane's response caused challenges for herself and others through what was interpreted by some as Jane's lack of cooperation. On the one hand, this was an issue between Jane and professionals. For instance, Jane did not want to use the Occupational Therapy assessment of possible use of a 'slide-sheet' to assist Jane with transfer to her bed. In addition, professionals encountered difference of views between Jane and Theresa. For example, in considering treatment for Jane's leg ulcers with the use of compression bandages, Theresa also stated that there was a difference of opinion between herself and Jane. The accounts given of this difference clearly show the dilemma for professionals attempting to support both Jane and Theresa in Jane's best interest. The issue for professionals, therefore, was arguably to what extent differing views were open to reconciliation where that was what was needed to move forward.

16.3 Broader reflections on the relationship between the cared-for and the carer within family or other close relationships points to some possible learning for WSAB. The Reviewer recognises that this is a complex theme for which there is much evidence from both perspectives. [27] Some of the evidence appears to

give consideration to the consequences of the pressures of caring. Other evidence aims to describe relationship "dynamics" between the cared-for and the carer as a way to support improvement. The MSP Toolkit 2015 [28] outlines a number of approaches designed to help practitioners in the real-life situations they encounter. For example, the toolkit outlines a variety of "structured conversations" approaches such as Family Group Conferences [29] or Consensus Statements. [30] It suggests these as practical approaches which an MDT forming early around a person such as Jane in a situation which they agree as complex, could be used e.g. in a situation where a person needs support with decision-making or dialogue with informal carers is required. [31] Attachment Theory [32] is also highlighted as an informing perspective to adult-focussed experience [33] through a typology of the influence of "predictability, safety and responsiveness" from early attachment figures which may help practitioner reflections and actions in a situation such as Jane's. Whilst aiming to avoid hindsight bias in reflecting on the accounts given by professionals, it is possible that response to the dilemmas faced by professionals in this instance may have been strengthened if some such approach had been used to bring professionals and her mother together with Jane at an early point.

16.4 In this context, it is interesting to note that the multi-disciplinary Professionals Meeting of 14 June 2018 was welcomed by all the professionals concerned. The meeting seemed to bring them together to share information face-to-face in a solution-focussed way. This meeting was perhaps one which shared some features of the approaches envisioned in the MSP Toolkit of review of methods. Clearly, the Professionals Meeting did not involve Jane or Theresa at that stage. That was not its purpose in this instance. All things being equal, however, it could have formed the basis for further interaction with Jane and Theresa using group process as a means to keep Jane at the centre of their concern.

16.5 Professionals also wanted to ensure that they were supporting Theresa as the family / informal carer as well as Jane. The carer has a right to an assessment, and it was quite far into the SAR process before any of the team mentioned this explicitly. In their actions, however, professionals were clearly mindful of the contribution of Theresa as a carer. It also became clear that there are resources in the locality to support carers such as the "Carers Clinic" in the mental health service which seemed to the Reviewer to be a positive service consistent with the aims of MSP to have a range of responses available to support improvement. Attempts were made to link Theresa to this resource. This was good practice.

16.6 The main aim of the Professionals Meeting was to share information. This included information about safeguarding concerns. One way in which there was interaction between Theresa and the safeguarding process was through a note which she had been asked to give to Ambulance staff on their arrival to convey Jane to hospital. Theresa saw reference to safeguarding in the note and realised that she was seen by practitioners as an object of concern. Theresa appeared surprised and shocked on seeing the notes and it's not clear if a conversation had occurred with her at this point about the concern expressed by professionals. Therefore, sequencing of information flows in the

episode did not seem to develop in a way which colleagues may have wished to create a more positive place from which to agree a shared way forward with Theresa in the interests of Jane's care. This had the unfortunate consequence of creating conflict where it might have been avoided had a better alternative approach been possible.

16.7 It is acknowledged by the Reviewer that issues connected to safeguarding can arouse strong emotions and Theresa objected to the statements made. Various references in the SAR chronology refer to disagreements between Jane and Theresa and quoted words and actions which had been used. Some actions by Theresa, such as apparently withholding access to cigarettes, were aimed at ensuring compliance on the part of Jane to a given point of view and were a concern to professionals. It appears that some words were recorded as having been used in interactions between Jane and Theresa which caused concern to professional staff. Alongside this, however, overall mental health services seemed to recognise that Theresa "*thought the world"* of Jane and loved her deeply. Theresa said the same thing herself. It would seem, therefore, that there may have been an opportunity to create a space in which conversations could be had with family members about the words which it was stated were exchanged in the kind of environment envisaged by FGC as outlined above.

17.0 Reflecting on the requirements of statutory responsibilities, how successful were agencies in applying the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and Section 117 of the Mental Health Act 1983 in their practice with Jane?

17.1 Through the time period of the SAR and most especially during her hospital admissions, professionals did reflect on any need to use the Mental Capacity Act 2005. Jane's capacity to understand her situation and the choices before her were raised by the team and considered. This is clearly good practice. There were differing views about Jane's capacity, however. These would have been influenced by the time and occasion at which professionals met Jane, being aware that assessment of capacity is decision and time specific. For instance, when she was at home, at one point in his assessment, her GP thought that Jane did not have capacity. In the Hospital setting, professionals believed that Jane's capacity fluctuated. At a Safeguarding Event organised by the LGA,[34] the Independent Reviewer noted the opinion of Professor Michael Preston-Shoot that it is a learning point from a number of SARs, that with regard to assessments under the Mental Capacity Act, often the "executive capacity" [35] is insufficiently considered. This is a helpful learning point for this SAR, too, and it is recommended that updating training on Mental Capacity incorporate emphasis on this theme.

17.2 From all that the Independent Reviewer has read in the chronology and other documents relevant to the SAR as well as the interviews and group meetings, the dilemma for professionals, for Theresa and most importantly for Jane herself at the time is plain to see. It appears that professionals recognised that Jane's lack of cooperation with treatment plans or options on occasion was not evidence in itself of incapacity – lack of cooperation is not the same as

incapacity. Likewise, although to some extent perhaps understandable, it seems that it was recognised by professionals that an assessment of capacity could not necessarily be used as a means to secure cooperation with a treatment plan, either.

17.3 Mental Capacity assessments can be challenging matters of judgement and it is right that they are so. It seems that it was so in the professional's assessment of Jane. This can be seen as commendable. On occasion, professionals using the same evidence may come to different, defensible conclusions. It seems that it would have been defensible had professionals come to a different view in this instance. But the fact that they didn't in respect of their assessment of Jane's capacity, does not mean they were wrong in their judgements.

17.4 In reflecting on the statutory issues involved to support Jane, a related concern was the weight of influence which was given in the practice scenario to Jane's voice as compared to her mother's. Use of the MCA may have been seen as a possible way to underpin the application of preferred treatment options by professionals which were at odds with Theresa's views. This may have been justifiable and there is no doubt of the concern amongst the colleagues for Jane in the options they pursued. Alongside this concern, professionals were balancing their need to support Theresa as a family carer. They could not care for Jane properly without Theresa's contribution. Caring for Jane had consequences for Theresa as an informal carer and she stated what those were e.g. in the amount of laundry which she had to do alongside other tasks.

17.5 A further statutory aspect of Jane's care was that she eligible for care under Section 117 of the Mental Health Act 1983. [36] Relevant WSAB partners have a solid policy document updated and renewed in 2018. Care services in the community by Jane over the past couple of years of her life included a large contribution focussed on her physical care needs. The private domiciliary care agency responded to a commission from the County Council and appeared to enjoy positive relationships with both Jane and Theresa. This is to be commended. The County Council also provided services to assist a safe and speedy discharge from hospital for Jane when she was admitted for physical reasons. There were a couple of instances which Jane experienced of domiciliary care provision where sequencing did not work as smoothly as everyone would want. Knowing that challenges in sequencing care experience is not one which is just restricted to Worcestershire, partners will continue to explore ways in which they can secure more successful sequencing of services to support seamless experience. Jane was admitted to Hospital five times in the last 18 months or so of her life. The number of occasions of admission did not appear to be a cause of concern to the practice community. The Reviewer understands that there are agreed approaches locally where people's attendance at hospital is regarded as "frequent." Jane's attendances were not judged to be of that level and therefore no other extra specific actions were made in response.

17.6 Under the Health and Care Trust Section 117 policy, the link to admission to hospital for the care of a person's mental health is well-made. At the end of this SAR, it was not clear to the Independent Reviewer that the nature of review of Jane's care was able to focus on the implications of Section 117. At the Practitioner's Learning Event meeting, it was noted that the expectations of a single worker within an integrated arrangement might be too great. This is especially so around certain knowledge domains where specialist training is required. For example, elements of the statutory basis of mental health are generally associated with the role of the Approved Mental Health Professional (AMHP.) This role is mainly held by Social Workers (SW) and no SW worked directly with Jane on a long-term basis. The Section 117 Policy assumes a differentiation between the Section 117 and Care Act based provision. [37]

17.7 The route into reviewing the basis on which the care was offered was not entirely clear in this respect. Partners may wish to encourage further awareness-raising in this area. Jane's physical health needs did not appear to be those for which Section 117 services might have been offered as a result of compulsory admission to psychiatric hospital.

17.8 In addition, it has been noted that no one appeared to make a link between the free provision of services under Section 117 with regard to the possible use of a befriending service. It is the experience of many people that as they become unable to leave their home due to the effects of disability or some factors associated with ageing, then they may become more isolated with all its acknowledged effects. [38] The professional team attending to Jane had noted the possible effects of loneliness on Jane. In response, they had attempted to make arrangements to secure a befriending service. This was good practice. But the referral did not come to fruition, however, due to concerns by Jane about the cost. Consideration did not appear to have been given about whether or not Jane might have been entitled to a free service under the Mental Health Act 1983 Section 117 arrangements. Jane may well have accepted the provision had there been no charge and this may have created an opportunity for improvement in her experience which was missed.

17.9 WSAB has also raised consideration of the apparent absence of the Care Programme Approach (CPA) being used as part of Jane's wider support. Given her status as someone who had experienced compulsory admissions to hospital under the Mental Health Act 1983, it was not clear why the CPA had not been applied in this instance. It may be helpful for colleagues to clarify in due course if there is any other consideration why the CPA was not sued within the system to help support Jane.

17.10 At the time in which this SAR was undertaken, preparations were underway for the introduction of changes brought about by The Mental Capacity (Amendment) Act 2019. WSAB partners will be ensuring that staff are trained in this as needed. This opportunity would seem timely to link to the learning from this SAR, therefore. Issues connected to ensuring that focus is given to

the person who is the subject of care in all circumstances and the role of the "executive capacity" in the assessment.

18.0 How far were developing commitments to "parity of esteem" in respect of both mental health and physical health evident in the delivery of services and work to improve Jane's experience?

18.1 WSAB colleagues have wished to assure themselves about the "parity of esteem" issue in the context of national and good practice commitments. The context for this concern is the 15-20 years mortality gap in the county of Worcestershire for people with mental health needs referred to in the Report elsewhere. Specific contributory factors such as smoking behaviours were mentioned as an area of challenge.

18.2 Nationally, therefore, it seems that the focus on better physical health for people with mental health needs relates to both better experience of physical health care as well as the effects of medication taken to address mental health needs. The Government's 2011 *No Health Without Mental Health - A cross-government mental health outcomes strategy for people of all ages* [39] has aimed to *" 'mainstream' mental health within England, to establish and develop parity of esteem between mental and physical health."*

18.3 With regard to improving approaches to mental health care which impacted on Jane, whilst evidentially successful in their aim of treating mental health symptoms, psychotropic drugs are known to be less positive for the physical health of people taking them. [40] The Royal College of Psychiatrist's 2012 National Schizophrenia Audit argued for better management of physical health issues experienced by people living with schizophrenia. Amongst other recommendations focussed on better experience for people with schizophrenia, the Audit argued that "*Mental health services and primary care services need to work together to agree who will monitor and treat physical health problems among people with schizophrenia."* [41]

18.4 For Jane, the effect of psychotropic medication was noted by members of the team. This was evidence of good practice. For instance, there had been some consideration about whether or not the medication regime for Jane's mental health might need to be changed because of the known possible effect of the drugs on the coronary system. The fact of Jane's death meant that these steps were not carried forward. The medications were prescribed with the best intention to support Jane to live with the effects of her serious mental health challenges. The medical research community continues to work to make medication increasingly better targeted with negative side-effects being reduced or eradicated.

18.5 With regard to improving the physical health of people with mental health needs, WSAB partners noted a specific consideration of the clinical / case review aspects of long-term care for individuals such as Jane. Partners are mindful of the positive intention associated with the activity called clinical or

case “Review.” They want to re-assure themselves that such Review is meaningful and not in any sense routine or a “tick-box exercise” in dialogue with a person such as Jane about their care circumstances. SAR discussions reflected on the challenge for the practice community about how they might “grade” or “stratify” the cohort of people to whom such clinical / case review might be applied. Reflecting on this cohort as being one with a range of complex needs, the idea of a “health wheel” was developed in discussion as a way of grading the level of need experienced by an individual such as Jane. The “health-wheel” might include a number of relevant factors such as mental health, physical health and safeguarding and would require some form of scoring mechanism. A given score using that developed tool might indicate that escalation in more fully developed team working through an appropriate clinical / case review process might be required. This should be considered alongside the requirements of S117 After-care planning and the Care Programme Approach. The outcome would add to the framework to support increasing parity of esteem through more effective MDT working.

18.6 Overall, in reflecting on the issues of “parity of esteem” between physical and mental health in Jane’s experience, it’s clear that she received wide-ranging support from health and care services both about her physical health as well as her mental health cf. para 14.0.

18.7 A positive contribution towards “parity of esteem” was noted in the SAR in that on several occasions through the SAR process, it was noted that colleagues had gone “beyond the call of duty” in the MDT in their commitment to Jane. This might be seen as suggesting some extra value in Jane’s experience. Theresa also spoke very positively about the contribution of many professionals. For example, it is striking that community-based District Nurses attended to Jane at the hospital location during an admission to promote a better experience of care for Jane.

18.8 With Jane for instance, in the last couple of years of her life, all those agencies mentioned at para.14.0 were ones which she met directly or which had commissioning responsibility for her care. To some extent, rather than escalation based on apparently increasing need with regard to her physical health, it was a safeguarding process which brought colleagues together in respect of Jane. This was probably why the “Professionals Meeting” of 14th June 2018 was regarded as so helpful by all concerned. During the SAR, the team has reflected on whether or not an earlier form of multi-disciplinary meeting - aside from the safeguarding episode - might contribute to wider preventative approaches in situations where a person’s needs are complex.

18.9 There was also evidence that the team tried to be as holistic as possible in their approach to Jane. The evidenced ways in which the team attempted to work with Jane to find solutions for some perception of isolation experienced by her is one example. Secondly, the social model of practice for supporting people requiring leg ulcer treatment which could also support action to

address loneliness was noted in the SAR. It may be that broadening out a similar social model of leg ulcer treatment would offer benefits such as:

- For the person as user / patient - Offering increased social interaction to anyone isolated as a result of the experience of leg ulcers which limit their ability to mobilise in the community.
- For staff - improved consistency and better-quality service through provision in a “centre of excellence” type environment.

There is already a model being applied elsewhere in the County which may provide helpful evidence for local reflection. [42]

19.0 **Building on commitments to effective / co-ordinated multi-disciplinary practice, what are agencies’ reflections on the opportunities for early identification of challenges in the care of Jane and the effectiveness of practice at the time?**

19.1 As mentioned above at para. 4.1, themes identified in the Terms of Reference inter-relate to one another. As such, they have not generally been considered in isolation from one another. So for instance, consideration of the way in which the agencies worked together to support Jane can begin with regard to the involvement of the GP Practice in the co-ordination of care and multi-disciplinary practice in the community setting for Jane.

19.2 As a result of quality concerns, the nearby Medical Centre from where Jane’s GPs practised was closed in March 2018, three months before Jane died. This followed action taken by the Care Quality Commission (CQC) [43] to cancel the registration of the practice under Section 30 of the Health and Social Care Act 2008. [44] The use of this Section of the Act is one of the most severe enforcement powers available to the CQC. The CCG worked closely with the Practice and the CQC in response to the situation. This included appointment of specialist GPs who worked to remedy the practice standards and ensure safe closure. This looked like excellent practice. The closure of the GP Practice is a matter of public record. The CQC website states the actions it took. The decision was also reported in the local press. Jane’s mother, Theresa, was aware of the reason for the closure. The local press reports also included a response from the lead GP of the practice. [45]

19.3 Theresa described some challenges in communication with the GP Practice over time e.g. problems in getting bandages. So did District Nurses. These challenges impacted to some extent on the care of Jane during the review period. For example, Theresa reported that she tried to get supplies from the surgery for the treatment of Jane’s leg ulcers. But she stated that the surgery did not respond to her. This experience is taken by the Reviewer to have been part of the wider picture of quality concerns which impacted on the effectiveness of the MDT and resulted in the CQC decision and action. This obviously had some effect on Jane’s care along with others registered with the practice.

19.4 In the context of relationship of health and care professionals with the GP practice in the community setting, the argument which suggests that a power dynamic exists between GPs and other care professions in the multi-disciplinary team is also noteworthy for this SAR. [46] Anecdotally, some team members may feel overlooked or see themselves as "less important" within the wider care team. Domiciliary care staff who worked with Jane mentioned this. This dynamic may make it hard for individual team members or the wider community to draw attention to what they might regard as professional failings of colleagues, particularly of GP's, who may be regarded as more powerful. It should be noted, therefore, that the actions of District Nurses in drawing attention to unresponsiveness at the Surgery e.g. concerning issues connected to analysis of blood samples, are to be commended in this context in terms of the persistence which they showed in working for Jane's best interests with the Practice.

19.5 Equally, the actions of peer GPs, the CCG and the CQC in responding to the safety issues identified within the practice show a system which worked in the way it addressed perceived / evidenced unacceptable standards. The issues affected many patients, not just Jane. The concerns with the Practice were thoroughly investigated and acted upon in a separate process. On this basis, the Independent Reviewer believed it appropriate to not seek further detail for the purpose of maintain proportionality in this SAR.

19.6 As noted, however, the relationships with the GP Surgery were only one set of relationships in the matrix of support for Jane. Another key relationship was between the mental health services and the nursing services which supported Jane. From both perspectives, professionals welcomed the opportunity afforded in the Professionals Meeting of 14 June 2018 as outlined earlier. This perhaps reflected the fact that although colleagues knew about one another's contribution in supporting Jane, there did not appear to be a routine mechanism which encouraged professionals in the system to come together as a team on a routine basis for the person they supported together such as Jane. Such a coming together does not necessarily imply a physical meeting although that is not ruled out, necessarily. Other methods such as virtual meetings could be equally valid.

19.7 In addition, there has been reflection on whether or not a clear understanding of a lead "care co-ordinator" role might support colleagues working in separate areas such as mental and physical health to come together more effectively. With regard to Jane's experience, mental health and physical health colleagues were based in the same NHS Trust and might be regarded as equal contributors. The development of Primary Care Networks (PCNs) arguably allows a context in which partners might reflect further on the best way to improve local co-ordination for people using health and care services such as Jane.

19.8 With regard to mental health services where the Council and the NHS work collaboratively using a Section 75 mechanism at the moment, there was reflection that some roles which appear to be accountable to two organisations for the delivery of statutory responsibilities may be somewhat over-burdened. For example, there was no Mental Health Social Worker working directly with Jane. It may be that such a role-holder might be more likely to reflect on statutory responsibilities for partners, ensuring a better experience for the person. In any event, it's important to note that one contributor noted that *"nobody did anything wrong"* in the care episode experienced by Jane ad the Independent Reviewer agrees with that.

19.9 However, some ideas for possible development have been prompted as a result of the experience. For example, WSAB partners noted a specific consideration of the clinical / case review aspects of long-term care for individuals such as Jane. Professionals were mindful of the positive intention associated with the activity called clinical or case "Review." They wanted to re-assure themselves that such Review is meaningful and not in any sense routine or a "tick-box exercise" in dialogue with a person such as Jane about their care circumstances.

19.10 SAR discussions reflected on the challenge for the practice community about how professionals might "grade" or "stratify" the cohort of people to whom such clinical / case review might be applied. Reflecting on this cohort as being one with a range of complex needs, the idea of a "health wheel" was developed in discussion as a way of grading the level of need experienced by an individual such as Jane. The "health-wheel" might include a number of relevant factors such as mental health, physical health and safeguarding and would require some form of scoring mechanism. A given score using that developed tool might indicate that escalation in more fully developed team working through an appropriate clinical / case review process might be required. This should be considered alongside the requirements of S117 After-care planning and use of the Care Programme Approach. The outcome would add to the framework to support increasing parity of esteem through more effective MDT working.

19.11 In adopting this or a similar approach, partners might also be able to respond further on the extent to which an updated rational and practical approach to "escalation" might be developed when it appears that the MDT may need to come together as matter of routine practice. Jane's mother, Theresa and her friend stated that to them, there appeared to be a lot of different agencies involved which made consistent communication difficult. The way in which the team came together as an MDT on 14 June 2018 was consistent with the kind of preventative approach envisaged by MSP. This would have been consistent with the way in which preventative steps can mean that safeguarding concerns do not arise and explicit safeguarding processes are avoided.

20.0 GOOD PRACTICE EXAMPLES

20.0 Good practice examples are noted throughout this SAR report. In addition, a number of examples were noted at the Practitioner's Learning Event of 01 May 2019 including:

- Supportive teams e.g. "*They went above and beyond…"* "*outstanding care…"* knowledgeable / compassionate practitioners / committed / working to high professional standards
- The WSAB practice community acted in response to concerns: e.g. intervention at Woodrow Medical Centre; DN's alerting GP to Jane's situation; Professionals Meeting re. safeguarding 14/06/18
- Evidence of consideration of Parity of esteem e.g. Primary care healthy checks for people with mental health needs; working with the contribution of informal / kinship carer; consideration of available statutory tools – MCA, Section 117, Carers Assessment
- Supportive systems including the "recover at home" approach on discharge from hospital; sound structures for information sharing e.g. CPNs can see DN Notes in "*Care Notes;"* DNs attended to Jane in the hospital; DN service design model changed with neighbourhood focus; "Carers Clinic" in MHT; very good Root Cause Analysis undertaken at HCT.

21.0 RECOMMENDATIONS

21.1 Recommendations are suggested at two levels, strategic and operational.

21.2 **Strategic**

21.2.1 MSP and Carers – consider how

(a) more explicit use of various models to support preventative approaches with informal carers e.g. FGC / Consensus Statement / attachment theory approaches, might support preventative approaches to safeguarding; and

(b) approaches to clinical / case "Review" might be developed further through "grading" / "stratifying" cohort of people to whom such clinical / case review might be applied, considering the requirements of S117 After-care planning and the Care Programme Approach

21.2.2 Consider whether or not there might be innovative ways in which people's experience of loneliness might be mitigated which are free or lower costs. This could include consideration of extending the social model of leg ulcer treatment to help address social isolation and widen experience for staff as well as considering if a "Carer Mentor" idea might be developed to extend support to family / informal carers.

21.3 **Operational**

21.3.1 Take the opportunity provided by the current review of policies to build on current practice with regard to statutory responsibilities in clarifying for practitioners about the way in which care provision is made under Mental Health 1983 Sec. 117 and the Care Act 2014

21.3.2 Using an appropriate format (a) mental health services and primary care services agree and confirm who will monitor and treat physical health problems among people with schizophrenia; and (b) mental health services to review public health initiatives to support people with serious mental health issues to stop smoking.

22.0 END NOTES

[1] Thanks to the Public Health team who provided this information to the Safeguarding Unit. The practice community may want to confirm the exact number of people living with schizophrenia in the area in due course to assist needs assessment and planning.

[2] These state that SARs are commissioned when

- *there is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult, and*
- *The adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); or*
- *The adult is still alive, and WSAB knows or suspects that the adult has experienced serious abuse or neglect.*

Source: http://www.worcestershire.gov.uk/info/20363/safeguarding_adults/159/safeguarding_adults_reviews *accessed 03/05/19*

[3] To lead the review on this occasion, the services of a Reviewer who was not employed by local agencies, was procured. The Independent Reviewer has over 30 years experience in social care. This embraces specialist direct practice with adults including in mental health services; senior leadership experience in social care, as well as other specific safeguarding experience such as Chair of a Local Safeguarding Adults Board.

[4] Source: http://www.worcestershire.gov.uk/wsab *accessed 03/05/19*

[5] Source: http://www.worcestershire.gov.uk/info/20363/safeguarding_adults/159/safeguarding_adults_reviews *accessed 03/05/19*

[6] Source: http://www.worcestershire.gov.uk/info/20363/safeguarding_adults/159/safeguarding_adults_reviews *accessed 03/05/19*

[7] Source: https://www.scie.org.uk/children/safeguarding/case-reviews/quality-markers/ accessed *03/05/19*

[8] Source: https://www.scie.org.uk/safeguarding/adults/practice/sharing-information#sixprinciples *accessed 03/05/19*

[9] *Care and Support Statutory Guidance* para 14.169 updated 26 October 2018 at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance *accessed 26/10/19*

[10] For example, Fischhoff, B. (1975). Hindsight ≠ foresight: The effect of outcome knowledge on judgment under uncertainty. Journal of Experimental Psychology: Human Perception and Performance 1(2): 288-299. Vincent, C. (2006). "Patient safety". London, Elsevier. Woods, D., S. W. A. Dekker, R. Cook, L. Johannesen and N. Sarter (2010). "Behind human error. Second edition." Farnham, Surrey, Ashgate all cited by SCIE at https://www.scie.org.uk/safeguarding/adults/reviews/care-act#learning

[11] A reflective account of our experience is being submitted to *The Journal of Adult Protection* for consideration on an anecdotal contribution.
[12] Adapted from: *At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews* (January 2012) http://www.scie.org.uk/children/learningtogether/resources.asp
[13] Care Act Guidance *op. cit.* para 14.156
[14] Cf. *Does long term use of psychiatric drugs cause more harm than good?* *BMJ* 2015; 350 doi: https://doi.org/10.1136/bmj.h2435 (Published 12 May 2015) *accessed 27/10/19;* and
[15] *Ibid* p. 62
[16] *Ibid* p. 81
[17] Source: https://www.worcesternews.co.uk/news/15409398.people-in-worcestershire-living-longer-than-ever-public-health-england-report-reveals/ *accessed 04/05/19*
[18] Worcestershire Health and Well Being Board *Joint Strategic Needs Assessment - Redditch Needs and Assets* Profile March 2018 Source: file:///C:/Users/BC/Documents/ZZ%20AA%20JOBS/A%20COMMISSIONS/004%20TAX%20YEAR%202019%2020/06%20WORCS%20CC%20SAR/2019%2003%2029%20BACKGROUND%20DOCS/Redditch_District_Needs_and_Assets_profile_2018.pdf *accessed 04/05/19*
[19] *Ibid* p. 40
[20] *Ibid* p. 43
[21] *The Five Year Forward View for Mental Health - A report from the independent Mental Health Taskforce to the NHS in England* (2016) Source: https://www.england.nhs.uk/wpcontent/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf *accessed 04/05/19*
[22] *Ibid* p. 6
[23] *ibid* p.14
[24] Cf. http://www.redditchandbromsgroveccg.nhs.uk/ *accessed 06/05/19*
[25] *Carers quitting jobs from pressure* by Sean Coughlan 05 February 2019 Source: https://www.bbc.co.uk/news/education-47116657 *accessed 04/05/19*
[26] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal *accessed 27/10/19*
[27] For example , the Open University's Carer Research and Knowledge Exchange Network (CAREN) http://wels.open.ac.uk/research-project/caren/ and include: (a) *Attachment, mentalisation and expressed emotion in carers of people with long-term mental health difficulties at* http://wels.open.ac.uk/research-project/caren/node/4207 (b) *Parents Caring For Adult Children With Serious Mental Illness* (2017) at http://wels.open.ac.uk/research-project/caren/node/4168 *(c) Physical health and mental illness: listening to the voice of carers* (2017) at http://wels.open.ac.uk/research-project/caren/node/4140 and (d) *Supporting carers: Guidance and case studies* (LGA 2018) at http://wels.open.ac.uk/research-project/caren/node/3777 *accessed 28/04/19*
[28] *Making Safeguarding Personal Toolkit Fourth Edition* January 2015 https://www.adass.org.uk/media/5142/making-safeguarding-personal_a-toolkit-for-responses_4th-edition-2015.pdf *accessed 15/09/19*
[29] FGC method at: https://www.frg.org.uk/involving-families/family-group-conferences/fgc-network *accessed 15/05/19*
[30] See *House of Commons Health Committee Suicide prevention: interim report* and *Fourth Report of Session 2016–17 Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 13 December 2016* at: *https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/suicide-prevention-report-published-16-17/ accessed 15/05/19*
[31] *op. cit.* 24 p.11
[32] *Ibid* p.17
[33] Cf. Cowger, C.D. & Snively, C.A.2001. *Assessing client strengths: individual, family and community empowerment.* (In Saleebey, D. 2001. red. *The strengths perspective in social work practice* 3rd ed. Boston: Allyn & Bacon. pp. 106 - 122)
[34] LGA Event – *Adult safeguarding and homelessness* – 25th September 2019 at The Studio, 7 Canon Street, Birmingham
[35] *"...the ability to carry out decisions and intentions, especially in relation to one's own welfare*." In *Vulnerability, Mental Capacity and Self Neglect"* Northern, Eastern and Western Devon CCG accessed 27/10/19

[36]cf. Section 117 Aftercare by MIND at https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#.XOEu-MhKg2w *accessed 19/05/19*
[37] cf Section 117 Policy para. 9.3.2
[38] Oakley, Laura *Disabled people are a diverse group – but loneliness is a common experience* Laura Oakley Jul 11, 2017 at http://blogs.redcross.org.uk/health/2017/07/disabled-people-loneliness-common/ *accessed 06/05/19*
[39] Source: *No Health Without Mental Health - A cross-government mental health outcomes strategy for people of all ages* 2011 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england *accessed 06/05/19*
[40] Cf. Correll CU, Detraux J, De Lepeleire J, De Hert M. (2015) *Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder* World Psychiatry. 2015 Jun;14(2):119-36 in Baker, John 9 Oct 2015 *What impact are psychotropic drugs having on our physical health?* At: https://www.nationalelfservice.net/other-health-conditions/comorbidity/impact-psychotropic-drugs-physical-health/ *accessed 06/05/19*
[41] Royal College of Psychiatrists *National Audit of Schizophrenia* at https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis/national-audit-schizophrenia *accessed 06/05/19*
[42] This is the "Leg Club" model which it is understood in used in Worcester City cf. https://www.legclub.org/about-us/leg-club-foundation *accessed 11/05/19*
[43] Source: *CQC Inspection Report* 11 June 2018 https://www.cqc.org.uk/location/1-544614840/reports *accessed 06/05/19*
[44] Source: https://www.legislation.gov.uk/ukpga/2008/14/section/30 *accessed 06/05/19*
[45] Sources: *Woodrow Medical Centre, stripped of registration due to patient safety concerns* in Redditch and Alcester Advertiser 27 November 2018 available at: http://www.redditchadvertiser.co.uk/news/regional/17258816.woodrow-medical-centre-stripped-of-registration-due-to-patient-safety-concerns/ and *My fear is for the patients - Woodrow doctor hits out over centre closure* in The Redditch Standard 17 October 2018 available at https://redditchstandard.co.uk/news/my-fear-is-for-the-patients-woodrow-doctor-hits-out-over-centre-closure/
[46] For example: Cf. (a) https://www.researchgate.net/publication/330148452_Power_Struggles_in_MDT_Meetings_Using_Different_Orders_of_Interaction_to_Understand_the_Interplay_of_Hierarchy_Knowledge_and_Accountability_A_Discursive_Exploration_of_Team_Meeting_Practices *accessed 06/065/19* and (b) Ambrose-Miller, Wayne & Ashcroft, Rachelle 2016 Feb 29 *Challenges Faced by Social Workers as Members of Interprofessional Collaborative Health Care Teams* at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4888092/ *accessed 06/05/19*