Tameside Adult Safeguarding Board Partnership

Safeguarding Adult Review

RE: Barry

Executive Summary

Tameside
Adults
Safeguarding
Partnership Board

1. Introduction

Section 44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adults Review (SAR). A review is required to be undertaken if the Board considers that there is significant learning to be gained across partner agencies.

Barry was an 84 year old man who died from natural causes in hospital in 2018. Request was made to Tameside Adult Safeguarding Partnership Board (TASPB) after concerns were raised about the standard of care which Barry received in the final part of his life with the view to consider whether the criteria for a safeguarding adult review had been met. A multi-agency panel reviewed information held by agencies who cared for Barry and decision was made that it was evident that lessons could be learnt about the care received by Barry.

2. Terms of Reference of Review

The review explored the following elements of learning:

- The quality of support offered to Barry and family by agencies. This is especially with respect to reviewing assessments made by practitioners to assess Barry's involvement in decision making about his care including assessment of the level of his understanding.
- The use of advocacy services to ensure that families are able to make their wishes and feelings known to practitioners.
- Role of practitioners in ensuring that clients and families are able to participate in decision making.
- The interface of the Best Interest Assessment with this process. This is with a view to provide assurance that the patients' needs are met and a making safeguarding personal approach applied.

In this context consideration was given to:-

- Supportive decision making with people with capacity.
- Professional approach to explore power and balance.
- Roles of professionals when patients are non-compliant with care.
- The quality and frequency of carers' assessments.
- Practitioner perception of the role of family as carers and the impact on care delivery.

The review also promoted opportunities to explore examples of good practice and identify lessons to apply to current and future practice.

3. The Family and Background Information

Barry lived with his wife at their home in Tameside where they had lived for over 40 years. The couple had no children and appeared to have very few extended family. The couple were described as being close. Barry had ran his own business which was well established in the local community. The couple had a shared hobby.

Both Barry and his wife appeared to have some mobility problems and had some difficulty in using the upstairs part of their home. They received equipment to aid daily living from occupational therapy service. This included the installation of a ceiling track hoist.

Barry was diagnosed with vascular Parkinson’s symptoms in 2012. He developed cerebral vascular disease and had suffered a number of mini strokes which had caused him to have a left sided palsy and some swallowing difficulties. He also had a diagnosis of vascular dementia.

The Learning Review Panel have been unable to obtain information from Barry’s wife since his death. This has been due the wife’s own ill health. Until 2016 JH had been Barry’s main carer although he appeared to be able to have some independence in his home.

After an inpatient admission to hospital in 2017 it became evident that Barry’s care needs had increased and practitioners believed that his care could no longer be met within his own home. In addition JH had expressed that she would find it difficult to meet the needs of her husband since the deterioration of his health.

Barry sadly died in hospital in October 2018. Cause of death was recorded as hospital acquired aspiration pneumonia. Coroner’s inquest took place in January 2020 in which concerns were raised about some aspects of care which Barry received.

These concerns were that a safeguarding investigation, which had been initiated prior to Barry’s death was incorrectly recorded. In the view of the Coroner, it was considered that this investigation should have been recorded as unsubstantiated and not inconclusive. In addition the Coroner raised concerns about Barry’s refusal of medical treatment. The Coroner concluded that the lack of capacity assessment was a procedural breach and that all involved were working in the best interest of Barry. The Coroner did not link these matters to the causation of Barry’s death. It is intended that these issues will be included in the learning of this report.

4. Analysis

Guided by the terms of reference for this review, specific themes emerged following a systematic analysis of all the available information, both from agency records and from the practitioner event, as well as discussion with the review steering group. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve multi agency adult safeguarding practice in Tameside.

5. Overall quality of support offered to Barry and family by agencies

The multi-agency chronology demonstrated that agencies were overall effective in working together to ensure that they met the physical needs of Barry during his period of deteriorating health. Practitioners across agencies appeared to be working to carry out Barry's wishes with respect to his health needs and there is evidence that services contacted and responded between agencies as Barry's care needs progressed. There was consistent discussion about assessment of Barry's mental capacity to make decisions even though some concerns have been identified about the level of understanding of practitioners about the pathways to follow to make assessment of mental capacity.

There is also evidence that JH was supported in her caring role prior to hospital admission in July 2017. Services worked hard to ensure that Barry's care needs were met. There is evidence that she was assessed at key points in the progression of Barry's care needs to support her in her caring role.

There are, however, some concerns that although practitioners across agencies worked hard to ensure that Barry's health needs were met, this was often in the context of what practitioners perceived those health needs rather than what Barry and JH considered them to be. This is not to say that some interventions were not necessary but there is some concern that the impact of such interventions were not clearly shared with and/or understood by the family. The impact that some accepted working practices had on the family was not always considered. There was evidence that there were some missed opportunities for practitioners to explain some of the difficulties which Barry was experiencing and so at times he became "labelled" as non- compliant with treatment and practitioners believed that he was having a decline in his mental health with delusional thoughts of being poisoned.

There is little evidence provided which highlighted that either Barry or JH understood fully the nature of Barry's condition, expectations for disease progression and the impact which this may have on the short and long term outcomes for Barry.

There was little evidence that either Barry or JH were directly spoken with or had access to key practitioners to assist them to explore their fears about Barry's health. Rather than Barry being able to lead on his care needs, with support from practitioners, it appeared that he was being referred and/or allocated to services without the family or practitioners understanding the impact which this may have on his health journey. Practitioners were choosing on his behalf.

6. Communication

The way in which communication about a medical diagnosis is delivered to a client with a chronic illness and subsequent management of the symptoms, as well as emotional support available for the family, is indicative of any subsequent success of the management of the disease for the individual and family members even when the outcome of the illness is likely to be death.

In addition the individual and the family need to be able to feel that they are able to continue to manage any symptoms and adaptation of lifestyle so that a quality of life can be maintained. This will include the acknowledgment that relationships in families are likely to change between partners, children and extended family members. As disease progresses there is a need for the individual and the family to be prepared for deterioration of physical and emotional health and to be assisted with access to information to inform any new reality of that deterioration.

The most successful outcome is likely to require that practitioners support the individual and their family to feel that they are in control of the management of the chronic illness and that they have easy access to help and support from practitioners as the need arises. Multi- agency services wrap around the individual and their family so that they can through their journey safely. The client is in control as far as possible knowing that there is support from professionals to assist in moments of need including when the family are having difficulties.

During the timeline in which this review was undertaken it was clear that there was a consistent approach to multi agency discussion of the care which was required to meet Barry's deteriorating health needs. This included discussions with respect to JH's caring capacity. JH and Barry were included within this communication. When Barry could not attend the meeting it was clear that practitioners from social care and from the dietetic service met with him to share the outcome of meetings.

There was some evidence to suggest, however, that whilst the client and his partner were included in meetings, the meetings were practitioner led with a focus on what care practitioners believed Barry required and how it would be provided, rather than having a starting point of what the client and his partner perceived their needs to be. This is not to suggest that the practitioners should not need to make the family aware of what could or could not be provided but pathways of care were being determined by the multi -agency team for the family rather than with them.

Whilst discussions took place with the family by all services it is unclear whether either Barry or JH clearly understood the impact that this would mean on their lives. For example it was not clear that the family understood what was meant when Barry's care needs were being assessed to be at the level of him requiring 24 hour nursing care. This point is emphasised further when it becomes clear that some months later Barry did not wish to remain in a nursing placement away from his home and was subsequently assessed by the Continuing Health Care Team as being suitable for returning home, even though there had been no improvement in his level of health and social care need. It is unclear whether this lack of understanding prompted both Barry and JH to be portraying differing messages to practitioners and potentially to each other.

Furthermore, different practitioners were undertaking conversations with the family at differing times. The chronology demonstrates that there was a slightly different discussion held with the family by each one. The meetings demonstrated that professionals did not always hold the same view of the care which should be undertaken or the mental capacity of Barry to make decisions about his care. This appeared to add to the level of understanding which Barry and JH had about what needed to be done and added to the confusion.

There is some evidence from the information gathered that communication with Barry and JH could have been improved. Whilst there was clearly much effort undertaken from practitioners such as speech and language therapists, dieticians and the GP to provide information, there is little to indicate that practitioners returned to the family to check level of understanding.

An example of this was with respect to the impact of PEG feeding and medication administration. A key omission was that there does not appear to have been consistent practice of returning to speak with either Barry or JH for continual assessment of their understanding to be measured. In addition as Barry's care progressed the couple were often not given explanation as to why events may be occurring, for example feeling of nausea and diarrhoea after being fed via PEG. It would have been good practice to return to speak with both Barry and JH to ascertain what had been understood and their response to the information. This omission was often made not just with respect to the clinical care which Barry was receiving but also with his wish to return home.

Because a number of services believed that Barry had overall mental capacity to make decisions about his health care he was considered to be non-compliant with some aspects of his care. Practitioners had difficulty in identifying whether at times some behaviours were indicative of a deteriorating mental health condition, fear that he was being poisoned, or an interpretation by some practitioners that Barry did not wish to continue to live. Mental Capacity assessments were not specific to one intervention. There was also evidence to the contrary when some practitioners did spend time in gaining some insight into his fears that Barry was not non-compliant with care but was afraid and was uncomfortable when the feeds were being administered.

7. Key Worker/ Advocate for families

A challenge of meeting the needs of a person who has chronic health condition is that service provision becomes more complex as multi-agency services mean that a greater number of practitioners may need to be involved in the care of the client. To lessen any confusion for the client and family it is accepted practice to have one key point of contact for the family. The role of this practitioner is to continually assess the client and family response to the progression of the client's health condition, identify with all family members the nature of their concerns and work with them to ensure that they have understanding as to what was being said. The key practitioner would also address with other practitioners, on behalf of the client and family any conflicting information being given and identify any further service provision. There is a lack of clarity that Barry did have a key worker who was responsible for ensuring that the family obtained the support which they required. This was opportunity for GP, specialist nursing service from the neuro- rehabilitation service or social worker to have undertaken. This will be made a recommendation for agencies to implement.

Since the implementation of the Mental Capacity Act 2005, the need for generic practitioners in health and welfare services to act as an advocate for a client or family appears to have become confused with the need for advocacy to be considered only when the client is deemed to lack mental capacity to make their own decisions. Key professionals such as social work and nursing would usually accept that the practitioner from these services have a key role in undertaking the advocacy role. This is especially so when there is chronic ill health identified within the family whether or not the client is deemed to be capable of making decisions for themselves.

Care UK define the role of an advocate as the following:

"To offer independent support to those who feel they are not being heard and to ensure they are taken seriously and that their rights are respected. It is also to assist people to access and understand appropriate information and services"

Care UK (2017)

Because practitioners believed that Barry did not lack capacity to make decisions until the immediate time before his death, it was reasonable that a formal advocacy arrangement for the family, as set out under the Mental Capacity Act 2005, would not have been considered. There was an opportunity, however, to formally identify which practitioner from any agency would take on the role of key worker with the family to act as support for the family to access care more simplistically and to help them understand the impact which any interventions may be having on Barry's health.

The combined chronology does demonstrate to some extent that a number of professionals did believe that they were the key worker for the family. However, this appears to be in the context that they believed that they were the representative from their own agency rather than the single point of contact for overseeing the overall service provision to the family. The impact which this had was that the family were having a number of care plans rather than one combined approach to their care. The Learning Review Panel discussed that there is a role for the local Neighbourhood Team model to be applied here and this will be made a recommendation from this review.

8. Specialist Health Services

Health care in the UK has long recognised as good practice the need for development of specialist multi agency teams for some chronic health conditions to work with individuals and their families. The purpose of the specialist team is to ensure that the client can be cared for by professionals who hold key knowledge and skills about the nature of the health condition, know the contemporaneous clinical management of disease progression and can act as a repository to assist the family in accessing appropriate support and information to meet their needs. The specialist health service will normally consist of a range of disciplines working together to assess the needs of the client and their families with an objective to ensure that optimal quality of life is maintained throughout the progression of the disease.

There is normally an allocation of a key worker for the client and their family. Specialist services work with generic health services as well as other agencies and advise on the most appropriate services to meet the need of the client and their family. Specialist practitioners will also offer advice, support and training to generic multi agency practitioners so that the care received by the family is appropriate to need. A fundamental role of this individual practitioner is to ensure that the family have opportunity to develop a relationship with a practitioner so that emotional support is available to the family and families can be supported to gain access to the care they require in a coordinated way. The family can contact a person from the specialist service so that they can be signposted to care which may address a specific care need and they can help also the family in overcoming barriers to accessing services as necessary. It is usually a specialist nurse who undertakes this role but could be anyone with whom a family develops a rapport.

This does not appear to have occurred in the care of Barry. Practitioners such as GP service were making referral to the Neuro Rehabilitation Team in order to access specialist interventions for Barry rather than the team being involved in the early part of Barry’s diagnosis of Parkinson’s disease. A team had had a conversation with the family in June 2017 that Barry’s condition was now deteriorating. Once Barry was moved to a nursing facility, his GP changed. This meant that a new neuro rehabilitation team in the Tameside area was now responsible for his care and the old team transferred. Until July 2018, when the GP made referral back to the team, there was no involvement from the new Neuro Rehabilitation Team. The reason for this is unclear.

When a second referral was made to the new team by the GP, they felt that there was not a role for them to support Barry. This was because the GP had specifically requested that the team sign post or provide a specific intervention to Barry with respect to improvement of his communication needs. The team felt that they were unable to do this. It was for a specific task rather than an assessment of need. The referral had been made for a specific communication service to be provided.

9. Care of Family and Carers

When caring for a client with a chronic health condition respective codes of practice for practitioners from all health and welfare agencies promote the duty of care to the individual. The main caregivers, however, to our clients are usually not practitioners but family members. Practitioner support for the carer often becomes unclear especially if the needs of the family member conflict with those of the client.

JH and Barry appear to have lived a life in which they had been reliant and supportive of each other with very little extended family support. JH had been the main carer for her husband from the time that his health was deteriorating and had been assessed appropriately at key times through carer's assessments. JH had expressed that she wished to care for Barry until the time in which she was no longer able to do so. In addition JH had some deteriorating health needs of her own which may have impacted on her ability to care for Barry.

There was some indication that prior to November 2017 there were some episodes when JH was not given full support to care for Barry. For example, Barry had been discharged from hospital with a prescribed pureed diet feeding regime which JH reported to staff he was reluctant to take. JH was advised to contact dietetic services but was subsequently informed that because Barry was now discharged from the hospital that JH would need to make contact with a number of other services herself, to discuss alternative feeding regime and for re referral to be made back to the dietetic service. This is an example of how the allocation of a key practitioner/advocate to work with the family is important. It was a missed opportunity to support JH in her caring role. Barry's refusal of fluids was a key factor in his readmission to hospital after this time and there is a possibility that this admission may have been prevented if JH had been provided with practical support at this time to assist Barry with a suitable feeding regime.

From November 2017 there appeared to be differing opinions about JH's ability to meet Barry's care needs when he was discharged from hospital. JH was being taught how to administer food and fluid via a PEG but other practitioners believed that they were concerned about JH's mental capacity to retain information. Decision was made at a multi- agency meeting that Barry now met the requirement for twenty four hour nursing care to be given. JH stated that she wished to continue to care for Barry but practitioners persuaded her that Barry needed to be moved to an nursing facility and that home was no longer an option. There is some evidence that some practitioners questioned this decision prior to discharge. Over the following months the couple appear to have been expressing conflicting messages as to the possibility of Barry returning to the family home and JH's ability to meet his care needs.

In the final month before Barry's death a multi- agency meeting made a decision that they would take measures to assess the possibility of Barry returning to his home. Even though JH was present at the meeting and stated that she would no longer be able to care for Barry, the possibility of his return was still pursued. An assessment of the home identified that Barry's return to the property was no longer a possibility but JH's expression of no longer being able to carry out his care was not a factor for this decision.

There is evidence too that the couple's relationship was put under strain. It is unclear whether Barry understood that his partner would have been willing to care for him but felt that she was unable to. JH may have been able to meet her husband's care needs had the package of support on offer included how she would be supported to carry out the role.

10. The Quality and Frequency of Carers' Assessments

Section 10 of the Care Act 2014 makes requirement of local authorities to carry out a carer's assessment for any person who is caring for another adult unless the carer is a paid employee. The purpose of this part of the Care Act 2014 legislation is to ensure that carers are aware of the role that they have agreed to undertake and to ensure that they can be afforded with the relevant resources to carry out the role effectively.

There should be no implicit expectation from services that family members including partners will wish to care for a loved one and if they are prepared to undertake such a role, they need to be clear of support available to them (Age UK 2018). Once a carer's assessment has been completed a plan is put into place to ensure that the care needs of the individual can be met with the identified resources available to the carer to carry out their caring role.

The legislation appears unclear as to whether reassessment of a carer needs to occur. However, as care needs of the person changes as well as circumstances of the carer it is reasonable to assume that further assessment should be made.

Discussion with the review and information provided within the chronology, identified that there is a potential expectation from practitioners that partners of the individual with care needs would ultimately have some responsibility to provide that care unless there is good reason which would make this arrangement unpractical.

In the early part of the chronology provided to the panel it was evident that JH wished to continue caring for Barry and coordinated care for him with the assistance of a care company. There is evidence within the records of Adult Social Care that JH had received assessment by them on a regular basis since 2014 and that these had been amended accordingly as her own health needs had deteriorated as well as those of Barry. JH had expressed a wish in 2017 that she would wish to continue to care for her husband until they were no longer able to be together.

During an admission to hospital in October 2017 further multi-agency assessment was made which indicated that Barry required 24 hour nursing support and that this could only be provided away from the couple's home environment. JH agreed that she would no longer be able to meet Barry's care needs and a substantial package of care was put into place. There is evidence that Barry also agreed to the package of care. There is some evidence to suggest that JH had been persuaded by practitioners that Barry should not return home to the home environment with a 24 hour nursing package.

A latter assessment in July 2018 appears to have made no consideration of JH's expressed views about caring for her partner. This illustrated how practitioner perception of the role of family as carers may impact on care delivery of a person.

This may have served to emphasis even further to JH any potential feelings of inadequacy which she may have felt from being no longer able to care for her husband.

11. Assessment of Mental Capacity

There is marked difference in practice with respect to the assessment of mental capacity which had been undertaken by Adult Social Care and those from other agencies. Adult Social Care focused, correctly, on Barry’s overall capacity to make decision with respect to where he wished to live and the type of care which he wished to receive. There is evidence that Barry retained this capacity until very near to the time of his death.

The chronology illustrated that there was often conflict between professionals as to whether Barry had capacity to make decisions relating to a number of aspects of his health and care needs. He was not assessed on his ability to make decision on a specific issue. There are a number of occasions when practitioners were questioning Barry’s level of understanding about the care he required and continued to deliver some aspects of his care for which he was appearing to communicate that he did not wish to receive. In some multi-agency teams it was clear that there continued to be disagreement about the level of mental capacity which Barry had. This continued until two weeks prior to Barry’s death when mental health professionals made assessment and deemed Barry to not have capacity. It is likely that at this time Barry’s capacity to make decisions had deteriorated anyway as a result of his worsening health.

There were a significant number of occasions when best interest meetings had been called with some effective decision making being carried out. However, prior to the best interest meeting there was no evidence presented to the panel that Barry’s mental capacity had been assessed effectively to suggest that best interest meeting was necessary. The best interest meeting was not specific to one aspect of Barry’s care and so in effect became a multi-agency meeting, with a more generic focus about care planning for Barry’s overall deteriorating care needs rather than his best interests for a specific element of care.

The practitioner event identified that health practitioners working in acute health services will often ask for referral of clients to mental health services for the purpose of mental capacity assessment. This practice identified further that practitioners have potentially not understood that the practitioner who is undertaking a specific intervention is the person who is responsible for making the assessment. There was evidence too that because mental capacity had been assessed by other agencies for other aspects of Barry’s care, it was believed that this assessment was transferable to other decisions which needed to be made.

The Integrated Foundation Trust informed the review panel that a number of changes had been made in training in order to address the implementation of the requirements of the Mental Capacity Act 2005 within safeguarding training in the organisation. A multi-agency recommendation will be made in this review to ensure that all agencies working with people with chronic health problems are aware of procedures to be followed with respect to assessment of mental capacity as well as ensuring that there are procedures to ensure that audit of practice occurs.

12. Administration of Covert Medication

The Mental Capacity Act 2005 identifies that procedures to administer covert medication to a client require that a full assessment of mental capacity should be undertaken prior to the administration. There was evidence that hospital nursing staff had administered covert medication without this assessment having been undertaken. This was in contrast to the nursing home setting where practitioners contacted the GP for permission to administer. This was denied by the GP as the GP service believed that Barry did have mental capacity to make decision.

The Integrated Care Foundation Trust have identified that there was a lack of clarification and since this time have revised their covert medication policy and have taken steps to highlight and make aware to staff within clinical areas of the trust of the requirements. Recommendation will be made in the review to ensure that other services such as nursing homes, GP practices have also ensured that they are administering covert medication to clients lawfully.

13. Referral to Mental Health Services

Barry was referred to mental health services for a number of reasons. These related to the assessment of his mental capacity with respect to his ability to make decisions about all aspects of his management but also because some of the communications which practitioners had were leading them to believe that Barry was developing a deterioration in his mental health state.

In addition, because Barry also had a diagnosis of vascular dementia, practitioners who were involved with the practitioner event believed that multi agency services consider it to be necessary for assessment of the client by a mental health practitioner. This practice, whilst recognised that this is routine in the UK, was considered to be inconsistent with pathways for dementia management internationally, the UK being one of the only countries where the impact of vascular dementia on a person’s ongoing mental capacity is assessed by psychiatry services. The belief from practitioners from the panel and at the practice event was that this assessment should be made through referral to neuro rehabilitation medicine as the condition is essentially one which is a brain injury. This observation requires some further consideration as currently legislation in the UK (Mental Capacity Act 2005) requires the involvement of mental health services to make assessment formal assessments – for example in making application for deprivation of liberty safeguards. Further discussion at the Learning Review panel was that this learning requires to be shared with national strategic and policy makers for health services so that changes can be considered nationally.

14. Conclusion

Barry appeared to have been a very independent person. He had been diagnosed some time before the timeline of this review with symptoms of vascular Parkinson's disease. He had chronic difficulty with swallowing which was believed to be the result of a number of strokes and a developing vascular dementia. Barry had developed communication difficulties along with swallowing difficulties which had caused some frustration for him in being able to discuss symptoms of his illness and the way in which some symptoms of interventions were having on his overall daily living.

Information gained for the safeguarding adult review indicates that Barry had mental capacity to make decisions until the last few weeks of his life.

A key turning point in the deterioration of Barry's health was in November 2017 when his care needs increased significantly and he was assessed as requiring twenty four hour nursing care in a nursing home. This seemed to change Barry's perspective of his care. The main change appeared to be highlighted by the intervention of the insertion of the PEG. This impacted on his life because he was no longer able to take fluid and diet orally, he appeared to be in chronic discomfort, his wife was no longer his main carer and he was assessed as being required to live away from his home environment.

Barry was having discomfort after the insertion of the PEG. These were side effects which are consistently commonly expressed by patients who have this intervention. There was little clarity, however, that this was explained to Barry or JH and/or reviewed Barry believing that staff were trying to poison him and his apparent non-compliance with the procedure.

This also led to a perceived lowering of his mood and potential that he was developing mental ill health symptoms. Some of these symptoms were considered to be as part of his deteriorating health due to Vascular Parkinson's Disease.

There is evidence that practitioners from all agencies worked very hard in trying to ensure that Barry had all services available to him to support him and JH to meet his deteriorating health needs. The care offered to the family, however, was often related to either one particular element of his care requirement which then often had impact on another aspect of his care.

Although teams had regular meetings together there did not appear to be an overarching care plan to which all services worked. There was no allocation of a key worker/service in which the family could develop a rapport. In addition there appeared to be no system in place so that once assessments were undertaken by any agency they were then reflected upon at a later date.

A key example of this was that in November 2017 the most suitable placement for Barry was agreed to be twenty four hour nursing care away from the family home. Although there had been further deterioration of Barry's health needs nine months later, further assessment was made which made Barry returning to his home was a possibility. By this time JH had her own deteriorating health need and although she expressed that she was no longer able to care for her partner the assessment was pursued. This latter assessment appears to have made no reference to previous assessment or an earlier carer's assessment.

Whilst the majority of services believed Barry to have mental capacity to make decisions, this was not always documented. There was no explicit information from any agency which stated that Barry's mental capacity to make decisions about specific elements of his care had been assessed. This identified that practitioners are still unclear about the purpose of the mental capacity assessment and the pathway to follow. It was also clear that some practitioners do not understand which practitioner should undertake the assessment.

The review has also identified the need for very robust multi agency support of family members who are the main carers for the client. Prior to Barry's admission to hospital in July 2017 JH was the main carer for Barry and she identified that she was prepared to undertake this role for as long as possible. It appears that on the whole she had support to carry this out and it was evident at the practitioner review that the allocated social worker had developed a good rapport with the family and assisted them to manage all elements of care within the family home. There were occasions when JH had found caring for Barry to be difficult. An example which demonstrated this was with respect to feeding. It was disappointing to see that she was not supported to be re referred back to dietetic services even though she had prompted this action herself. This delay in her being able to access help may have resulted in Barry becoming dehydrated and having to be readmitted to hospital on the following week. Access to help from the dietetic service may not have necessarily stopped admission but this episode was an example of practitioners not supporting a carer.

15. Learning and Reflections on Practice.

Adult social care confirmed that multi agency meetings for clients who have chronic health conditions are regularly undertaken. However, the meetings do not include all practitioners across agencies who may be having input into the overall care of the client and his/her family. This means that agencies are often working to more than one plan of care. This potentially means that the family are facing some conflict in the management of care. The family needs to be involved in the meetings and take a lead role in devising an overall multi agency care plan. The Panel was informed that since this safeguarding adult review, invitations have been extended for all practitioners involved in the care of a client to attend the multi-agency meeting.

There was no formal allocation of a key worker or one person who could act as an advocate for the family although all agencies may have believed that they were the key person working with Barry. As a result the family and other professionals were often confused or not aware of decisions being made.

Although resource issues did not have a focus of the review, it became evident that whist some gaps to care provision had been identified there was also some duplication of services which were offered to Barry. The development of a multi-agency approach to his care, with one overriding care plan may have meant that he was able to access the right service in the right place and in a timely manner to meet Barry's needs.

There was confusion as to the role of specialist health services i.e. the neuro rehabilitation services and mental health services. It was unclear whether these services were providing direct clinical care to Barry or otherwise.

Whilst overall communication with the family was good there were few occasions when practitioners consistently returned to the family to check level of understanding or their views on the ongoing management of Barry’s care.

Carer’s assessments were carried out promptly and appropriately at key points which usually involved a change in Barry’s care needs. These are not usually shared with other agencies so there was a lack of understanding of JH’s views and abilities to carry out care for her partner from other agencies. The Panel learnt of the potential impact on the care planning of Barry as other agencies who were involved in decision making about the management of Barry’s care were unable to include such information into the overall management plan of his care.

Although there was consideration given to the implementation of the Mental Capacity Act into the care of Barry, there was confusion about the pathways to follow. This requires further training to clarify the roles of all professionals in the assessment of mental capacity to make decisions and best interest meetings.

It also became evident that there was a lack of clarity about the use of covert medication with clients. Although information was received from the Tameside and Glossop Integrated Care NHS Foundation Trust that there had been a review of these processes within the Acute Trust there is a need that this clarity is also assured within care home settings and other agencies.

Since 2019 some services have been brought together as part of primary care networks. GPs are being asked to put in place advanced care plans for all our patients in care homes in conjunction with care home staff. The Primary Care Network is required to employ care co-ordinators for patients. Although this model is in the early stages of development there is a potential opportunity for this role to undertake the lead practitioner role for clients who have complex health needs.

The Learning Review Panel discussed the need for a model of care based on “Team round the Adult” to be implemented within Tameside. The Panel believed that all elements of learning which had been identified within this review could potentially be addressed in the use of such a model. This may be considered as an alternative to current models in place or a hybrid model be developed.

A significant key learning point of this review was raised at the Practitioner Event. Mental health services discussed the differences in international practice in the management of vascular dementia. The management of pathways for this condition within the UK guidelines is given to the mental health services to lead. Legislation such as the Mental Capacity Act 2005, specifically in the application of Deprivation of Liberty Safeguards requires a mental health consultation to be undertaken as part of this process. However, research from Europe and America demonstrates that lead health services for such a condition is usually undertaken by neuro rehabilitation teams in these countries. The rationale for this is that vascular dementia is usually defined as an injury to brain tissue rather than a mental health condition.

This learning was significant because the assessment of mental capacity of an individual in the UK is often believed to be a mental health role. As was seen in this review, referral is made from a diversity of health services, to mental health to assess mental capacity. This often means, as demonstrated in the review, that the assessment is not made by the practitioner who is actually carrying out the intervention. It also means that the person's mental capacity is assessed generally rather than being specific to the intervention.

The learning for this point was considered to be relevant for consideration by national policy and strategic managers of health and social care. It has not been included in local recommendations.

16. Recommendations

There is a need for a multi-agency approach such as "team around the adult" to be implemented in Tameside. The role of the teams would be to ensure:

- Multi-disciplinary meetings within agencies to ensure that practitioners from all services involved in the care of the client and their family are invited.
- Multi-agency care planning for clients with deteriorating health conditions to which all agencies have sight. The plan must be monitored regularly with all practitioners and the family. A copy of the plan should be included in the "red bag system" in use in Tameside.
- A system is in place for services to allocate a named professional to work with families to ensure that the multi-agency care plan is implemented consistently and families have one point of contact for support. There should be capacity for the client and family to identify a named professional.
- Assessment of carers should be carried out and included within a multi-agency care plan with clear indication that information obtained during the assessment informs and is included within the multi-agency plan.
- Further training needs to occur across services in Tameside for the implementation of the Mental Capacity Act 2005
- Procedures for the administration of covert medication needs to be implemented across care settings in Tameside.

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