

Independent Chair: Elizabeth Hanlon

Hertfordshire Safeguarding Adult Board Response to Publication of SAR on Stanley (Pseudonym)

Hertfordshire Safeguarding Adult Board (HSAB) has published the report of the Safeguarding Adult Review (SAR) of the services provided to an individual who sadly died in Hertfordshire in 2016. This individual is known for the purposes of this review as 'Stanley'.

The board would like to send their condolences to the family of Stanley and thank them for their support in carrying out the SAR.

The review has found Stanley had complex needs and identified a variety of services and practitioners who were working hard to try and meet those needs. Stanley's reluctance to seek and agree to care meant it was more challenging for those practitioners to do so. Such circumstances call for a higher level of coordination and collaboration between services, working together to try and reduce the risks to health and safety that arise from self-neglect.

Though there were some elements of good multi-agency liaison, it was identified that there was not a unified multi-agency plan in place to support Stanley. Had such a plan been in place this would have enabled all practitioners to work together more cohesively. Such an arrangement may have delivered better care for Stanley as well as making better use of stretched Health and Social Care resources by reducing multiple admissions and missed appointments. The events surrounding the days leading up to Stanley's death were a catalogue of miscommunication, misplaced assumptions and poor coordination of care. It is less likely this would have occurred had robust multi-agency working been established at an earlier point.

What is evident is that there are areas of learning for agencies to address in order to lessen the risks for other dependent adults accessing the care services that they rely upon.

The SAR has identified three recommendations that have been adopted by the HSAB and that will be used to inform practice improvements across services for adults with care and support needs throughout Hertfordshire.

The recommendations and responses are as follows;

Recommendation 1 - The HSAB partner agencies should develop an enhanced multi-agency approach for people who have the most complex needs and highest risks arising from their self-neglect. This enhanced approach may include elements such as:

- i) An identified lead professional
- ii) A multiagency care plan, coordinated and communicated across all services involved
- iii) A communication strategy between all involved relating to the person's care
- iv) Multi-agency risk assessment and risk management including crisis and contingency plan
- v) Access to specialist advice for the whole multi-agency team, for example, Psychology, legal advice, fire safety advisor
- vi) Commitment to liaise with partner agencies prior to terminating engagement

Learning from this review should inform the development of their self-neglect pathway and resource pack that is underway.

Board Response – *The HSAB is currently drafting Self-Neglect Guidance for practitioners including a resource pack. In addition guidance on Multi-disciplinary complex cases is in development which will outline the importance of calling a multi-agency meeting when a case demands it. The HSAB plan to formally launch these initiatives across the partnership later this year and will follow this through with an audit of practice once the guidance has been embedded. This will enable the HSAB to hold agencies to account and provide assurance of progress in this area.*

The HSAB will be providing a supervision guide for practitioners around complex cases, this is being developed by the Policy and Procedures sub-group of the Board. In addition, in order to provide additional assurance, partners will be asked to provide an update on self-neglect training provision across their agencies, this will be used as part of a training needs analysis to identify any gaps in provision.

Recommendation 2 Agencies contributing to this review should take account of the learning from the review and address the following areas to strengthen practice.

2.1 East of England Ambulance Service Trust:

Strengthen quality of safeguarding adult referrals through providing further guidance to their crews and Single Point of Contact. Referrals should indicate whether it is an adult social care or a safeguarding response that is required and the level of urgency.

2.2 Hertfordshire County Council – Health and Community Services and East of England Ambulance Service Trust:

Work together to deliver a solution that provides effective management of safeguarding adult referrals. This solution will need to be negotiated between both services, with recognition of the resource constraints and pressures of both services.

2.3 Hertfordshire County Council, Health and Community Services, Adult Social Care:

Review their procedures for determining whether a financial waiver is warranted for a person who has funds to pay for their care so that:

- Criteria is clear and equitable
- Decision making takes account of multi-agency information and risk assessment (where applicable)
- Social Care practitioners are aware of the criteria and application process

Board Response – *There has already been considerable progress on this recommendation. The East of England Ambulance NHS Trust is strengthening the quality of its referrals by differentiating between social care and safeguarding referrals, call takers in the service are being trained to implement this change. Hertfordshire County Council and East of England Ambulance NHS Trust are exploring new escalation processes in the emergency situation. This will ensure that responses are timely. The East of England Ambulance NHS Trust will continue to proactively promote local services available in the area that may support the community when the incident is not an emergency.*

As finance was an issue for Stanley, the HSAB recognised the importance of considering a financial waiver. Hertfordshire County Council Adult Social Care already have a policy in place regarding the waiving of funds, however they are reviewing their procedures to ensure that the policy is clear and will make sure that all practitioners are aware of how to apply for a waiver.

Recommendation 3 -The HSAB, as part of its governance role, should seek assurance from agencies that their own recommendations, and their improvement plans referenced within this review, are being progressed and leading to improved responses to people in Hertfordshire, specifically:

3.1 Hertfordshire County Council, Health and Community Services, Adult Social Care:

Reviewed and improved management oversight and system resilience within their Integrated Hospital Discharge Team i.e. in the management of referrals and ensuring robust systems are in place for managing practitioners' workloads in their absence.

3.2 Hertfordshire County Council, Health and Community Services, HCS Commissioning:

- Has addressed the needs of people who may present challenges due to self-neglect within their market development strategy, for example, through commissioning specialist domiciliary care provision.
- Has used learning from this review in their strategic plans for contingency arrangements when a provider fails. This may include their planned development of a trading arm.
- Has shared learning from this review with providers, specifically reiterating the providers responsibility for continuity of care and establishing robust checks before suspending services to the person.

3.3 Hertfordshire Independent Living Service

- Review and assure that the existing and new procedures regarding 'no reply' and 're-starting suspended clients' are being robustly applied.
- That their revised referral form (providing a description of the role of named contacts) has been issued to all relevant parties, uploaded to HILS and HCC's website, and that the named contacts are being used appropriately in practice.

3.4 Hertfordshire Partnership Foundation Trust

- Assure the Delivery of Care and Care Programme Approach is applied consistently in conjunction with the Local Authority where people have complex needs and that the coordination of care takes account of holistic care needs and coordinates all agencies involved.

Board Response – *Hertfordshire County Council Adult Social Care Service will provide the HSAB with an assurance report on the management oversight and resilience within the Integrated Hospital Discharge team. This will cover case management transfers and the managing workloads of absent staff. The HSAB will hold Adult Social Care to account and will require updates on progress with a final assurance by the end of the year.*

The commissioning arm of Hertfordshire County Council who are responsible for contracts will ensure that findings from the Serious Adults Reviews are shared with providers, in order to improve practice. Commissioners from Hertfordshire County Council will present their strategy which incorporates the challenge of services users who self-neglect to the HSAB in order to provide assurance against this recommendation.

Hertfordshire Independent Living Service has reviewed current procedures to ensure staff are compliant with 'no replies' and 're-starting suspended clients'. They will also revise their referral form, updating all websites. The HSAB have requested that Hertfordshire Independent Living Service provide an assurance report on these recommendations and present them at a full Board meeting.

Hertfordshire Partnership Foundation Trust is undertaking an audit of the application of the Care Programme Approach. The findings from this audit be taken forward and any recommendations will

form part of the HSAB's agenda. Hertfordshire Partnership Foundation Trust will ensure that any changes in policy will include other agencies, particularly Adult Social Care.

All recommendations outlined in the final report have been adopted by the Hertfordshire Safeguarding Adult Board and an action plan is in place to track these actions to completion. Recommendations and actions will be reviewed regularly both by the Safeguarding Adult Review Sub-Group of the Board and the Full Board in order to ensure timely progress and challenge any delays. An audit will be commissioned by the HSAB six months following the review to identify the actions taken by individual partner agencies to identify learnings in practices and what impact these learnings have had within their organisation.