

Independent Chair: Elizabeth Hanlon

Hertfordshire Safeguarding Adult Board Response to Publication of SAR on James L

Hertfordshire Safeguarding Adult Board (HSAB) has published the report of the Safeguarding Adult Review (SAR) of the services provided to James L who sadly died in Hertfordshire in 2016. The board would like to send their condolences to the family of James and thank them for their support in carrying out the SAR.

James was known to and supported by a number of agencies in Hertfordshire. The multi-agency review considers how well these agencies worked together prior to, and leading up to, his death in 2016. The review also considered James's time in a care home and looked at multi agency working and support offered to James and his family.

James was a gentleman of 68yrs, much loved by his sister and brother and wider family, friends and staff, some of whom had known James for over 20 years. James is described as having a moderate learning disability. James lived with his parents for much of his life but then lived independently following their death. James had a number of complex long-term physical health conditions.

The Safeguarding Adults Review has identified seven 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. A subgroup of the board has reviewed the recommendations and have developed an action plan.

The recommendations and responses are as follows;

Recommendation 1 - Joint working across health and social care to review and revise as necessary, the process for care co-ordination and communication for any adult at risk with two or more long term conditions (related to either physical or mental health) and support and intervention from more than one agency. The process should ensure that:

- All involved are clear about their own and others' roles and responsibilities
- There are clear and explicit communication mechanisms
- All involved are clear of what circumstances should trigger calling a Multi-Disciplinary Team (MDT) and their accountability for this
- There are clear and explicit escalation processes including to and with whom
- Expectations and actions relating to Admission and Discharge to in-patient and residential facilities are clearly defined and
- There are clear and explicit processes for End-of-Life decisions and planning – also linked to 4 below

Board Response – *The Board will link with the Learning Disabilities Mortality Review Programme in Hertfordshire to seek assurance that work on continuity of care is progressed. The establishment of a named care coordinator for all people with learning disabilities with two or more long term conditions*

(related to either physical or mental health) was recommended in the Government response to the Learning Disabilities Mortality Review (LeDer). This recommendation links in with an earlier SAR which was published by the SAB earlier this year.

Recommendation 2 - Information sharing agreements to be reviewed across health and social care and clarification sought that both electronic systems and ways of working are in place to share relevant information for an adult at risk (It should be noted that considerable work has taken place in this area since this case was explored and therefore this recommendation reinforces the continued joint working to review and update through the various workstreams on information sharing:

- Existing information sharing policy/policies should be reviewed to ensure that there is sufficient detail to instruct and empower all frontline staff of circumstances to and method for information sharing for an adult who may be deemed to be at risk
- The review should include 'permissions' within electronic systems and protocols to enable information sharing between different electronic systems and
- Clarity of understanding of 'flags' on systems for additional needs/reasonable adjustments

Board Response – *The Board notes that there has been considerable work undertaken in regard to information sharing since James's death. A review of the Board's information sharing protocol has been undertaken and published. Work continues with regard to sharing via electronic systems and the Board will require agencies to provide regular updates on this work to ensure progression. Work has also been conducted on the use of 'flags' on systems and practitioner understanding of these – a further assurance report will be requested for submission.*

Recommendation 3 - Review of Easy Read information available relating to complex health conditions across health and social care:

- Learning disability staff in both health and social care, including Health Facilitators, to work with representatives from hospital and community staff including GPs to review easy read information available relating to specific health conditions, consider raising awareness of and giving access to the 'Easy health' website which has a large number of easy read leaflets about common health conditions and investigations;
- Review the use of and information within the 'My Purple Folder'. This review should include work with people with a learning disability and families to understand and embed what works well and/or needs to change within the 'My Purple Folder' and
- Review and monitor actions to promote the use of the 'My Purple Folder'

Board Response – *The HSAB has ensured that the current purple folder used in Hertfordshire is being reviewed to ensure that the critical needs of any individual including the best way to communicate are at the heart of the document. This recommendation is also reflected in a previous SAR, Josanne, which was published by the board earlier this year.*

The public engagement sub-group of the Board will request an overview of easy read information from all agencies relating to specific health conditions and will consider access to the 'Easy health' website.

Recommendation 4 - Awareness raising looking at Frailty and rehabilitation-, complex health conditions and co-morbidity:

- Representatives from hospital and community (senior clinical, nursing, community nursing, GPs, General Practice nurses and social workers) to lead a learning session for health and social care colleagues focused on complex health care, co-morbidity and frailty. What these are and the impact on the person at the centre and
- To consider development of information for patients with a learning disability and families which describes co-morbidity, frailty and the impact for the patient to empower the patient and family with choice and control in planning for quality of life
- Health Liaison Team to lead training sessions to improve professional knowledge

Board Response – *The Board will promote the identified training session to be run by the Health Liaison Team to improve professional knowledge looking at Frailty and rehabilitation, complex health conditions and comorbidity*

Recommendation 5 - Formal assessment and review processes: Adult Social Care should take the lead on working in partnership with other relevant stakeholders to:

- Review processes and procedures to ensure that assessments under the Care Act 2014 are person-centred and completed using Independent Advocates where appropriate and that these are reviewed at least annually
- Provide assurance that all assessments are holistic and involve health and other partner agencies and those who know the person well
- Review and seek assurance of implementation of clear escalation processes should agencies be concerned that multiagency working is not happening/being appropriately implemented
- Review the process for person centred planning (PCP), development of a PCP which is followed by the MDT and
- Provide assurance that all care packages are reviewed at least annually and always following a change in need

Board Response – The Board accepts the recommendation and Adult Social Care will lead a review of the relevant processes and procedures outlined in the above. An assurance report will be provided to the HSAB to ensure progress is on track.

Recommendation 6 - Mental Capacity Act 2005, its principles and 2-stage test; there needs to be further joint working to increase understanding and subsequent compliance with MCA and the supporting Code of Practice:

- Seek assurance that MCA and its Code of Practice (CoP) are effectively implemented and that staff feel confident to be able to inform families/significant others of their rights under the MCA i.e. Power of Attorney or deputyships etc, or signpost to agencies who can do this.
- Review how the current MCA training and current systems facilitate the involvement of others who know the person well
- Adult Social Care should review current processes to monitor adherence to and implementation of the Care Act, MCA and CoP and

- Training on MCA and CoP should be reviewed to include case scenarios such as James' where the need for professional curiosity is highlighted

Board Response – *The Board accepts the recommendation and will conduct an overview survey with agencies to identify any areas that require additional support around staff confidence in applying the MCA. Adult Safeguarding Training will be reviewed to ensure case scenarios and used to highlight the importance of professional curiosity.*

Recommendation 7 - Supervision and reflection:

- Seek assurance that mechanisms for supervision and reflection are embedded across health and social care
- Review the extent to which the supervision process facilitates/triggers escalation and review and
- Review arrangements for supervision to facilitate the opportunity for health and social care staff to review actions and consider implications of individual needs on system working and communication

Board Response – *The HSAB will conduct an online audit that covers supervision and reflection across agencies. An assurance report will be provided to the Board with associated recommendations.*

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.