

Independent Chair: Elizabeth Hanlon

Hertfordshire Safeguarding Adult Board Response to Publication of SAR on Josanne

Hertfordshire Safeguarding Adult Board (HSAB) has published the report of the Safeguarding Adult Review (SAR) of the services provided to Josanne who sadly died in Hertfordshire in 2017.

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

Josanne was known to and supported by a number of agencies in Hertfordshire. The review considers how well these agencies worked together prior to, and leading up to, her final hospital admission in January 2017 when sadly she passed away. The review also considered Josanne's time in hospital and looked at multi agency working and support offered to Josanne and her family.

The review has looked at the very sad and distressing, premature and avoidable death of Josanne. Josanne's family have been very clear that their hope is that this review will help agencies and individuals to learn, improve and make a difference for people with a learning disability and their families in the future. East & North Herts NHS Trust undertook a Serious Incident investigation which led to the drafting of a detailed action plan. Actions including review of processes for referral, feeding tube pathways, recognising the deteriorating patient and training to improve understanding of MCA.

The Safeguarding Adults Review has identified eight 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 sub group of the board has reviewed the recommendations and have developed an action plan.

The recommendations and responses are as follows;

Recommendation 1 - Multi-disciplinary working, care planning and co-ordination

- Where there are multiple agencies and professionals involved in the care and support of an individual with a learning disability and complex/multiple physical health care needs, it is critical to have a clear plan and effective mechanisms for communication and understanding of the individuals support needs and actions i.e. what, when and who is in place. Continuity of care when a person with a learning disability and complex/multiple health needs is admitted to hospital should always be paramount.
- Clarity of communication and co-ordination reduces the risk of delays and gaps in care and promotes continuity and will in addition facilitate 'courage' to challenge gaps, delays and deviation from the plan by those involved in providing care.

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).*

Recommendation 2 - Hospital Passport/About me Purple folder

Recommendation 3 - Learning Disability Flag, reasonable adjustments and continuity of person centred care

- Putting each individual and their needs at the centre of their care and decision making, promoting the opportunity to hear the persons voice even when they don't use words to communicate is essential for person centred holistic care. Having an 'about me/hospital book or 'My Purple folder' is an effective mechanism to help hospital staff to understand critical needs as well as how best to communicate with a person with a learning disability.
- Implementing the LD flag. The process for 'flagging' that a person has a learning disability and may need additional support/reasonable adjustments needs to be explicit and 'everyone's' responsibility. Staff need ongoing learning disability awareness training to have confidence when supporting a person with a learning disability, promote person centred working, encourage curiosity to understand each individual's needs, appreciate and facilitate continuity of care, trigger the asking of questions to understand the severity of individual conditions along with any critical procedures/interventions, and to make 'reasonable adjustments' as required.

Board Response – *The HSAB will ensure that the current purple folder used in Hertfordshire is reviewed to ensure that the critical needs of any individual including the best way to communicate are at the heart of the document. The usage of a Learning Disabilities flag (which is already employed by some partners) will be championed by the Board and assurances will be sought from all partners on the robustness of these systems.*

Recommendation 4 - Mental Capacity Act and Deprivation of Liberty

- The Mental Capacity Act provides a legal framework to assess capacity and use 'best interest' decision making, involving those who know the person well when they are identified as lacking capacity. Deprivation of Liberty Safeguards ensures consideration of consent in all aspects of care and treatment

Board Response - *The Board will link with the Learning Disabilities Mortality Review Programme in Hertfordshire to seek assurance on the work stream around mental capacity. Recommendation eight of Government response to the Learning Disabilities Mortality Review (LeDer) states that Local services should strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.*

The HSAB will monitor and support this work and request regular assurance on the progress of the training and audit requirement.

Recommendation 5 - Patient journey and recognising a deteriorating patient

- A clear pathway for PEG procedures which describes actions by whom, when etc. along with clarity as to who assumes the co-ordinating role, facilitates MDT discussions and senior decision making when a person with a learning disability with complex/multiple needs is admitted to hospital reduces risks of delay and gaps in care.

- Robust and well understood processes for inter-disciplinary and inter-departmental working facilitates, recognition of and timely action for the deteriorating patient and mechanisms for escalation.

Board Response – *The first part of this recommendation runs in parallel with the first learning point on the report regarding the importance of having a care coordinator in place and this will therefore be monitored in the same way via the LeDer programme.*

In addition the HSAB will require partners to provide assurance on how a deteriorating patient is managed in both the acute hospital trusts and in community settings. This will include the escalation of concerns where necessary.

Recommendation 6 - Local system for repeat / frequent attendances

- Multiple attendances/admissions should have triggered a multi-disciplinary meeting/review.

Board Response – *The HSAB will develop Guidance to be provided to all organisations to identify 'frequent attendees' and how to escalated concerns*

Recommendation 7 - Safeguarding Adult Principles and Process, reporting and responding to concerns/complaints

- Awareness of the 6 Safeguarding adult principles, individual responsibilities within the care act as well as good understanding of the management of process to report and respond to concerns/complaints including escalation.

Board Response – *The HSAB will conduct a review of the current escalation guide to include points of contact within key organisations where applicable.*

An assurance report from partners on complaints procedures including what information is available to members of the public if making a complaint will be requested to be presented at Board.

Recommendation 8 - Person Centred Planning

- Promotion of safe, high quality and effective care is the business of every staff member irrespective of where they work. Training/awareness, policies and procedures are only effective if put into practice. Using Josanne's experience to 'step into the shoes' of each patient, provides a collective opportunity to 'test' the person-centred approach, think holistically about each patients' needs, facilitate and value understanding of a person with a learning disability from those who know them well; listening and hearing what is shared.

Board Response – *In response to this recommendation the HSAB will facilitate a 'Whose Shoes Event' to highlight the critical importance of a person-centred approach. The Board will also establish an agreed definition of person centred planning and what that mean's to partners in Hertfordshire.*

To gain further assurance the Board will also commission a multi-agency audit to 'person centred planning' – to include a focus group with service users

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.