Elizabeth

Safeguarding Adult Review

June 2020

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CONDOLENCES

This Safeguarding Adult Review was initiated because of the death of Elizabeth on 20.07.18. The Rotherham Safeguarding Adults Board wished to identify whether there was any learning regarding the way agencies worked together to support Elizabeth.

The Safeguarding Adults Board and the author of this review would like to express their sincere condolences to Elizabeth's family and all those who knew her and have been affected by her death.

THE AUTHOR

Sue Walters is an independent consultant with an extensive background in the NHS. She has undertaken safeguarding reviews and investigations.

1. REASONING FOR CONDUCTING THIS SAR

Following Elizabeth's death, a 'lesson learned' exercise took place in November 2018. The agencies who had been involved in supporting Elizabeth since 2013 submitted chronologies to try and gain an understanding of what, if anything, could have been done differently. At this meeting several concerns were raised regarding the care and support Elizabeth received and this resulted in a Section 42 safeguarding enquiry. The Safeguarding enquiry recommended a Safeguarding Adult Review (SAR) as it was felt that Elizabeth may have died because of self-neglect and there was reasonable cause for concern regarding how agencies responded to Elizabeth and had worked together.

The purpose of the SAR is to identify multi-agency learning for future practice. To this end, the practitioners were invited to a learning event and have fed into the shaping of themes, the learning to strengthen practice and where possible to acknowledge good practice.

2. TERMS OF REFERENCE:

A SAR should

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;

- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice with a positive impact on outcomes for adults.

Questions to be answered by the Agency Reports and considered by the Overview Report.

i. Please outline your organisations specific role and responsibility for Elizabeth prior to her discharge into Placement 3, including Nursing home 1 and Placement 2 Rehabilitation.

ii. Outline the pathway and interagency partnership working to;
    a. Fully fund Elizabeth's care at Nursing home 1
    b. The process from going from fully funded healthcare to Independent Funding Request (IFR) and please outline the criteria
    c. What the process was to continue funding via IFR
    d. Who was involved in the decision making regarding the IFR/CHC/Social Care funding
    e. What was the involvement from partners/colleagues?
    f. Please outline organisations key decision points and decision makers
    g. Please include all assessments of need and Elizabeth's involvement including Health, Rehabilitation and Social Care

iii. What consideration was made to discharge Elizabeth from Placement 3 Placement 4 and what assessment of need took place, outline any reported mental state

iv. It is suggested that Elizabeth's mood and alcohol consumption and unwillingness to engage with services was noted but no evidence of support evidenced by agencies, please provide evidence

v. Please outline any agreed support for shopping, meal preparation and medication prior to the move into Placement 4

vi. What consideration was taken to accommodate Elizabeth's physical disability with Placement 4 and what was the provision of meals and how was the risks mitigated as there is some suggestion that Elizabeth could not access or use the cooker and kitchen cupboards

vii. Was any assessment completed for Elizabeth's capacity due to mood and alcohol consumption

Organisations to be involved with the review and agency reports required:

- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Hospital Social Work Team.)
- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Rothercare)
- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Housing)
- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (CHC Team)
- Rotherham, Doncaster and South Humberside Trust (RDaSH) Mental Health and Substance Misuse services
- Rotherham NHS Foundation Trust (Ward Discharge)
- Occupational Therapy
- Rotherham Clinical Commissioning Group (CCG) CHC Team
- Domiciliary Care Provider
- Residential Home
- Placement 3
- Placement 2 Rehabilitation Unit
- Her Majesties Coroner's Office

3. TIMEFRAME FOR THE SAR

The review considers agency involvement from Elizabeth's admission into hospital in 2013 following her fall until the date of Elizabeth's death in July 2018.

4. REVIEW PRINCIPLES, HINDSIGHT AND POSITIVE REFLECTION

The primary purpose of this review is to learn lessons. SAR's are not investigations or concerned with disciplinary issues, these are for the police, the coroner and operational directors to address. Similarly, it is helpful to reflect on the statements contained in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have

occurred. It must be accepted that it is easier to recognise what should have been done at the time. There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[1]

Participants at the learning event held on October 23rd 2019 while wanting to learn raised a significant challenge about understanding hindsight bias. Hindsight, as in actions that should have been taken in the time leading up to an incident, can seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident. The approach taken in this review has been to examine how things were and perceived to be at the time, why decisions were made and actions taken at the time.

"*What hindsight does is it blinds us to the uncertainty with which we live. That is, we always exaggerate how much certainty there is. Because after the fact, everything is explained. Everything is obvious. And the presence of hindsight in a way mitigates against the careful design of decision making under conditions of uncertainty."— Daniel Kahneman*

5. OVERVIEW

The following summary is based on agency reports and additional information provided by practitioners at the learning event, and small group discussions.

February 2013 -16th September 2013

Elizabeth was a 60 year old lady who, following a serious fall at home on 20th February 2013, spent a number of years in 24 hour care. This was the start of a traumatic journey for Elizabeth, who was still relatively young in her 50's, and which included a cardiac arrest on 4th March 2013. Elizabeth's fall in 2013 left her with a spinal injury which completely changed her life.

16th September 2013 - June 2016 Hospital and Nursing home 1

[1] **Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)**

Elizabeth was discharged from hospital into Nursing Home 1 where she was fully funded by *Continuing Health Care (CHC)*. This was because at the time it was felt that Elizabeth was not at a point to engage in rehabilitation. Comments by participants and in IMR reports highlight Elizabeth's anxiety due to her injury and the separation from her mother.

'Elizabeth was often unable to participate in the rehabilitation process due to her anxiety'. (Rotherham NHS Foundation trust)

It is not clear how professionals engaged Elizabeth in this decision-making process and what other options had been available. For example, what adaptions could have been made to Elizabeth's mothers home? Elizabeth had an increased weight gain during this period (25kgs over 7 months) and was dealing with many changes such as learning to live with a supra pubic catheter, and a new environment away from her mother. There is no real evidence of health and social care input into Elizabeth's life other than routine appointments. at this point. Her GP was requested to review her medication on a couple of occasions due to her 'low mood'. In late 2015 a meeting is held to discuss her potential rehabilitation but this is not progressed for several months.

June 2016 –October 2016 Placement 2 Rehabilitation

in March 2016, a decision was made that Elizabeth was suitable for rehabilitation, and was admitted into Placement 2 Rehabilitation into a neuro-rehab bed. It was felt that she would benefit from further slow stream rehabilitation and an *Independent Funding Request (IFR)* was granted. Elizabeth made steady progress and was eventually able to sit unsupported and undertake standing transfers with the support of two people and a stand aid

'*However her anxiety over her condition and separation from her mother was a constant feature. Due to her improvement, discharge to Placement 3 was arranged to allow her to build on the progress she had made. '(IMR The Rotherham NHS Foundation Trust)*

October 2016 - 29th June 2018 Placement 3

In October 2016, Elizabeth left Placement 2 Rehabilitation to go to Placement 3 to undertake a period of transition rehabilitation to develop her skills. Elizabeth felt 'safe' during her time in Placement 3 . This was still funded by Independent Funding Request.

Elizabeth made great gains in her daily life skills, mobility and general confidence. She engaged effectively with physiotherapy, walking practise, standing practise and upper limb work. Elizabeth then suffered several setbacks, she had two foot operations - ankle arthrodesis designed to increase her ability to weight bear and walk, various infections and then her Mother passed away suddenly in

March 2018. This led to Elizabeth having an increase in depression and anxiety and saw her alcohol consumption increase. This seemed to have been 'managed 'by staff at Placement 3 on a measured alcohol monitoring programme. The difficulties experienced by Elizabeth were succinctly described by the IMR author from Rotherham NHS Foundation Trust:

'Elizabeth had to cope with many significant life-events in addition to her mothers' death, an acrimonious relationship with her nearest relative, isolation and her self-expressed feelings of uselessness and dependence compounded by having to settle the affairs of her late mother and disperse the contents of her much-loved home at a time when her personal resources were severely compromised.'

In April 2018, the Clinical Commissioning Group (CCG) ended Elizabeth's Independent Funding Request and a Decision Support Tool (DST) was organised for the 27th April 2018. Elizabeth was present and was accompanied, at her request, by a manager from Placement 3. At this meeting, Elizabeth was said to be very social and engaging in conversation. *'Interacted well' 'Likes to get to know people first' 'Manages her anxiety through coping strategies and talking to staff at Placement 3 in a group session'* This fits with previous descriptions of Elizabeth as a 'social person'.

From a professional viewpoint, Elizabeth was engaged and in agreement. If we stand back and reflect, we might question the validity of this assumption with the benefit of hindsight. There was no independent advocate and even though Elizabeth received paperwork about recommendations, no appeal process was followed. Elizabeth did want to move on from Placement 3. We cannot be sure though that she understood the consequences of a recommendation that meant that she would move so quickly to living independently and alone for the first time in many years. The IMR report submitted by Placement 3 describes their sense of frustration that Elizabeth's presentation as someone very independent and capable masked the reality of how she would/could live without a high level of support.

'Elizabeth presented as being very capable and independent, so it is difficult at such a one-off meeting to convey the pervasive impact of her anxiety issues as the information didn't fit into the boxes/ criteria being assessed.'

Staff at Placement 3 strongly recommended that because of Elizabeth's 'low state of mind' that she should continue with 24 hour care until she had improved.

The Local Authority (LA) stated at the Learning Event that they had very little history on Elizabeth, as she was not known to social care. Elizabeth had in fact been known and assessed for previous DST's, jointly with the CHC team in the CCG. She was of course known by other services who began to flag concerns about a 'low mood', the impact of Elizabeth's mother's death, and increased alcohol intake.

The outcome of the DST was that Elizabeth had no 'Primary Health Need' (Continuing Health Care need), therefore her current placement at Placement 3 was no longer an option due to it being out of RMBC[2]'s ability to commission health placements.

The subsequent local authority assessment in May 2018 echoed the concerns expressed by Placement 3 staff, in their report and at the learning event, in terms of Elizabeth's need for high levels of support.

'*Without high level of continuity of support Elizabeth would be at significant risk to her health and negatively impact her well-being needs.' (AD Continuing Healthcare Team May 2018[3])*

The IFR panel agreed to extend funding for the placement for a further two months giving an end date of 30th June 2018. The few months prior to this decision demonstrated a complex and complicated scenario with delays. The funding was only increased to allow time to find Elizabeth a placement and not for rehabilitation.

The allocated social worker from RMBC made a number of visits to Elizabeth with professionals from other agencies to get Elizabeth's views and outcomes. Elizabeth had been offered some accommodation but was clear that she only wanted to live in a specific area known to her and expressed to social care that she did want to live independently. This was an area she knew well and had lived in with her mother.

29th June 2018 - 20th July 2018 Placement 4 Temporary accommodation

Elizabeth moved into temporary accommodation (8 Weeks Max) at Placement 4 with support from the re-ablement service. The 8 week placement was in place whilst Elizabeth placed bids on properties in the areas that she would like to live and that were either adapted or could be adapted.

[2] Rotherham Metropolitan Borough Council
[3] Rotherham Metropolitan Borough Council

The domiciliary care provider care package commenced with support. At the Learning event, Adult Social Care confirmed that although a one to one meeting had not been carried out with the Domiciliary Care Provider, a detailed support plan, with Elizabeth's health and social history and alcohol dependency, was shared with the Agency. We learnt that the domiciliary care providers did not feel that they had received a full handover and were not aware of Elizabeth's history. Elizabeth made frequent visits back to Placement 3 to say how unhappy she was with her care package. She expressed her dislike of Placement 4 and said that she didn't like change. She was worried that she couldn't cook properly, that she did not have a working television in her bedroom and that she was in bed too early. It was not brought to the Social Workers attention that Elizabeth was worried that she would not be able to manage the cooking. Elizabeth was offered support via mainstream services such as alcohol services but had declined.

Elizabeth had a full Care Act Assessment and was due for a six week review. An unplanned review was arranged a day before she had the overdose. The Domiciliary Care Provider did not make any contact with Adult Social Care or raise any concerns during the time they had care involvement with Elizabeth.

Even though Elizabeth had a Care Act Assessment and previous assessments somehow Elizabeth's holistic needs were missed. There was no evidence of a complete review of Elizabeth's emotional health and well-being. At this point, Elizabeth stated that she was: '*unable to see a future at the moment'* and that she *'felt like she wanted to be dead'.*

The Community Matron, who was very concerned about Elizabeth's deteriorating mental and physical health*,* informed the social worker that Elizabeth had agreed a 24-hour care placement. It became clear in subsequent discussions that the CCG CHC team were under the impression that Elizabeth via the Community Matron had made a previous request for 24 hour care and this had been 'turned down' by social workers. There is no evidence to suggest that this was the case but it did lead to the local authority requesting an assessment by mental health services. Elizabeth's agreement to explore 24 hour care was a new development for the social work team. It was a 'complete turnaround' of Elizabeth's previous requests.

The IMR report from Rotherham, Doncaster and South Humber NHS Trust (RDASH) states that a mental health assessment took place and that the changes in her accommodation had been "*the direct cause of her low mood'.* There is also a brief comment about Elizabeth's deteriorating physical health. This did not lead to a referral back to Continuing Health Care in terms of deteriorating

physical health. The local authority completed the CHC checklist but of course it could have been completed by other professionals who were in contact with Elizabeth, such as. GP. Community Matron. Mental Health, Placement 3 and enablement services

We now know that Elizabeth died from hospital acquired pneumonia, after an intentional mixed overdose, her liver function improved with the hospital support, but she deteriorated due to the pneumonia and sadly passed away.

6. THE LEARNING EVENT

Each agency produced an excellent chronology of events. Feedback by the author at the event was that there was no picture of who Elizabeth was as a person, and what her life was like before 2013. The Learning event provided us with all a greater sense of Elizabeth's life. For example, she was known to some of the nursing staff and to the Community Matron as Elizabeth had worked in hospitals as a cook over many years.

'*She was an intelligent, lively lady, with a great sense of humour and was well liked by all who met her. Elizabeth was incredibly generous and kind. She was always smartly dressed and had pride in her appearance. She was reported to have had long term anxiety and depression and had used alcohol as a coping strategy' (Learning Review November 2018)*

We heard that Elizabeth had a boyfriend at one point, but there was no mention of this in any assessments. We heard that she had previously had some issues with alcohol and later heard that she may have taken an overdose before 2013. She lived with her Mother for many years , and we heard how her death left Elizabeth bereft and traumatised. We were reminded that during the move to Placement 4 she was still grieving. In short, we remembered that Elizabeth was not the sum of her physical needs/ after her fall.

The Learning event gave staff from different agencies an opportunity to reflect on:

- What worked well
- What could be improved for other people in the future

Participants discussed the importance of understanding hindsight bias and the need to understand context during the scope of the review. Exchanges were positive and there was good critical challenge and questioning rather than a focus on blame and criticism.

Good points

Elizabeth was not 'taken off the books' by the CCG CHC team although in theory, the CCG CHC team would have no further contact once the DST was completed. The Community Matron, and Placement 3, all continued to advocate on Elizabeth's behalf.

An assessment was planned by social care on the day that Elizabeth took an overdose. The social care team had taken on board concerns expressed by other agencies and at the same time felt paralysed by legal barriers and processes.

Positive collaboration between the Housing Occupational Therapist, Social Worker and the Extra Care Housing Manager to support Elizabeth's complex needs and avoid her having to move to somewhere she did not feel she could settle.

Elizabeth expressed concerns about how she was dealing with her physical changes and expressed a wish to die on at least three occasions prior to her move to Placement 4. It appears that she was seen promptly by Psychologists and Psychiatrist. Her GP made an urgent referral to the Access Team[4] in January 2016. The referral indicated a long standing history of depression and queried the option of therapy. She was assessed, the outcome of which was relayed back to the GP in March 2016, indicating that she did not require input from mental health services. Her involvement from then to just prior to her death was sporadic in nature. Elizabeth was referred to the Access Team on 11 July 2018 following suicidal ideation and it was felt that she did not require further input from secondary services.

Following the overdose, she was reviewed by the Mental Health Liaison Team in Rotherham Hospital. They reported that the overdose was connected to a breakdown of care provision, the impact of changes to funding, which meant that Elizabeth had to move to accommodation which she felt was unsuitable. The assessment also indicated other contributory factors to her low mood, including the death of her mother. The RDaSH report suggests that 'It *may have been prudent to bolster a risk assessment with identifying clear support mechanisms for Elizabeth. '*

[4] RDaSH

Elizabeth's capacity to make decisions was considered by agencies and attempts were made to involve her in decision-making.

> *"I want to build on the support I had and want to live on my own and manage my own routines. I understand that it would be difficult but nothing comes free, I want to see that I move into an adapted accommodation that is suitable". "I don't consider going to a care home would be a better option".*

The learning event identified that capacity should not have been the main concern but how transitions were managed to help Elizabeth to adapt to yet another change.

Learning points

'Managing change – not capacity '

Participants suggested that a focus on capacity had not been helpful as the real issue was about managing the changes and transitions for Elizabeth. This should have included a clear exit strategy and transition plan once it was agreed that funding could not continue. The discharge process could have started much earlier, particularly when the placement is funded by IFR.

'If we know someone is in an IFR placement we need to work as an MDT'

Elizabeth was still grieving the loss of her Mother and had been dealing with her mothers' estate, plus was increasingly using alcohol which meant that she was not in a good position to make more life changing decisions. Social Care did try to delay discharge but this was not agreed.

Participants felt that there had been a protracted period of discussions about funding and then an abrupt end. '*No buffer' as one participant stated.* Elizabeth's high anxiety and low mood might have raised 'red flags 'about her readiness to live semi independently. Staff advocating for Elizabeth did not feel that their voice was heard by the IFR panel.

An additional fact emerged at the learning event concerning the sale of Elizabeth's mothers' property. Elizabeth had not been able to return to this property but would receive payment following the sale. Waiting for this and factoring this into planning might have been helpful.

Case Management

During discussions about funding there were multi-disciplinary meetings(MDTs) taking place. However, when we reviewed this at the learning event some practitioners felt that the right people

had not been invited to the meetings and that there was therefore a missed opportunity to share the full range of information. In addition, there was a sense of a lack of clarity about who was managing /coordinating decision making and placements. At the same time, the CCG and RMBC clearly articulated the process that was followed at each point. For example; for DST, it would be a nurse representative; for IFR this would be the referrer (in this case the Community Matron) and RMBC for the placement in Placement 4. However, we are still left with the view of some present at the event and in reports, that for some reason the process was not understood outside of the decision making groups and MDT.

Following the event, some attendees reflected and felt that the emphasis on CHC ending became a distraction, *a red herring'*, a focus on process over the person. It is perhaps possible that people lost sight of Elizabeth's age and saw her as an older person. Elizabeth had legitimate concerns about how she would manage and was clear about what support she needed and how she wanted it. In the middle of this, concerns raised by different agencies and practitioners were therefore not addressed, or escalated through the right channels. This took the focus away from the great and lasting impact of Elizabeth's mothers death and her increasing anxiety.
They raised the following questions for future learning:

- Why wasn't step down considered as an option?
- What stopped the agencies working with Elizabeth from asking for this?
- Could Elizabeth have stayed longer at Placement 3? Was there a duty of care?
- Why did we all have to hurry? What was the hurry given that Elizabeth would receive a substantial payment from her mother's property?
- Why wasn't a new MDT called to restart the DST process when there was concern about Elizabeth's possible deterioration in health?

Of course, anyone of the agencies could have raised the above and simply said that' this is not right'. Indeed, this was the resounding message from attendees at the learning event. Yet again, we must remember the challenge of hindsight bias.

Making Safeguarding Personal

Participants at the event concluded that an emphasis on funding and 'wrangling' between professionals meant that Elizabeth's needs were 'lost' on occasions. Funding on this occasion seems to have been the 'driver'.

An approach grounded in the principles of MSP[5] might have raised questions about the relevance and inappropriateness of Elizabeth spending long periods in a nursing home for example. Even though she didn't seem to want to engage in 'rehab' could another sort of accommodation be found? After all, she was still relatively young. Knowing and understanding a person's history, preferences, wishes & feelings are a fundamentally important element of assessment and safeguarding. Without this information, practitioners are in danger of working with someone who was depersonalised and patterns of risk and harm were not easily identifiable.

It is prudent to reflect on the concerns surrounding Elizabeth's mental health and 'low mood' and the acknowledged impact on her sense of future and hope. MDTs centred around funding and yet there was perhaps a missed opportunity to gather practitioners around the table to map out what was happening to Elizabeth. We should reflect on what happened after Elizabeth's fall and how she was given a placement in a nursing home. We know that depression is a known feature following spinal injuries and that this is often overlooked. We can see a trajectory from a working woman, who enjoys being with people, to a woman who is dependent on others, with a sense of hopelessness that escalates following her mum's death. The benefit of hindsight of course. Yet, some people saw this happening to Elizabeth and tried to advocate on her behalf. There was challenge which was courageous and this could be further developed to include an understanding of local escalation processes

Safeguarding is not only concerned, therefore, with the 'is it safe?' question. It also must be concerned with the 4 other CQC questions namely: Is provision caring, is it effective, is it responsive and Is it well-led? Such a broad focus will support making safeguarding personal [6]

Mental capacity and potential unwise decisions

The Care Act Statutory Guidance (2018 updated) reinforces this position[7]:

'This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.'

[5] Making Safeguarding Personal

[6] https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguarding%20Personal_03%20WEB.pdf

[7] **https://www.gov.uk/government/publications/care-act-statutory-guidance**

One of the original drivers for this review was that there may have been self-neglect in the way that Elizabeth lived her life. This was not considered until after her death, and Elizabeth was not assessed as an adult at risk of harm during the timeframe of this review. Self- neglect does not seem to have been clearly in evidence. Alcohol use featured in some reports but at the learning event experts suggested that this was not a true alcohol dependency but a reaction to recent events. As the author, this explanation is unclear as it does seem to have an impact on Elizabeth's ability to cope and manage daily living. In any event, much of the evidence for self neglect may have been masked and may only have come to light during the move to Placement 4

Elizabeth certainly did not want support to address her alcohol use and it may have affected her mood. She was described as very forceful and angry when agencies discussed support from mainstream services. However, Elizabeth seemed very clear about the reasons for feeling low and spoke about this following her overdose in July 2018. There are some references to deterioration in physical health but there does not appear to be extensive evidence to support self-neglect.

The RDaSH report states that Elizabeth's capacity had not been assessed *'formally due to mood and alcohol consumption*[8]*.* Following the overdose Elizabeth is contacted by the Hospital Liaison Team and is assessed capacitous' *in relation to making decisions in relation to her care and treatment'.*

Multidisciplinary team meetings - Does every voice count?

Participants at the learning event suggested that agencies should consider carefully who is invited to ensure that there is good enough information sharing. It was agreed that there had been some oversight on occasions. In the learning event and in subsequent discussions it was clear that the process surrounding IFR was not understood by everyone. Learning from other SARs suggests that sometimes there is a potential 'hierarchy 'of professional voices which is unconscious and part of the way in which the wider system is working. This then prevents others who are not part of that 'hierarchy' such as care providers from potentially having their voice heard. Information about escalation processes would be useful both for the SAB but also across organisations.

An audit[9] of themes from SARs highlights the importance of MDTs as a source of reflection and shared decision-making with one agency/practitioner having a lead coordinator role. The lack of

[8] The assessment of capacity due to mood and alcohol consumption is a specific request for exploration within the Terms of Reference supplied by the Rotherham Safeguarding Adults Board.

case manager/coordinator was raised at the learning event and in Elizabeth's case this person/role would have been critical in making early referrals at points of change, and in coordinating the 'team around Elizabeth' in terms of discharge planning. It is a point of learning that the Community Matron may have been enabled to take on this role. Again, this is with the benefit of hindsight and it is only following discussions that this seemed a probable solution.

There were clearly points of good practice. For example, In July 2018 the Community Matron flagged concerns about low mood. The GP increased her antidepressant dosage. On a subsequent Joint visit with the social worker, the Community Matron agreed to source a support worker from neurological conditions to work with Elizabeth as she did not wish to have support from mainstream mental health services. On the day before the overdose when Elizabeth expressed suicidal ideation the Team Manager arranged a mental health assessment and was arranging for an urgent review. Prior to this, following previous mental health assessments, it is not clear, if Elizabeth was signposted to organisations for support.

Better use of the MDT process was flagged for future learning when people do not '*neatly fit into boxes'* Good practice in other areas such as the use of '*High Cost Funding Panels'* in other areas was cited as an example. The message for the future was that where there are differences of opinion, and a person may need a more flexible approach, then an MDT should be convened. Participants were not aware of similar approaches in Rotherham.

Assessment of health care needs and use of DST

One of the complexities in funding for Elizabeth's care seemed to be about the definition of rehabilitation and at what point she was no longer considered to be eligible for a 'rehab placement'. The decision to close funding and transfer to social care for funding clearly was a trigger for deterioration in Elizabeth's mood and anxiety. The boundary between responsibilities of the NHS and local authorities and social care are complex and in Elizabeth's case this did not make decision-making easy, even with the use of the Decision Support Tool[10].

[9] Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice Michael Preston-Shoot The Journal of Adult Protection 1 August 2019

[10] The DST is a national tool which has been developed to support practitioners in the application of the *National Framework* for *NHS Continuing Healthcare and NHS-Funded Nursing Care* 2018 (the National Framework).

'The concept of a primary health need is central to deciding whether the entirety of someone's care needs should be met by the NHS or the local authority. Put simply, an individual has a primary health need if, having taken into account all their health and social care needs, it can be said that the main aspects or majority of the care they require is focused on addressing or preventing health needs (National framework for NHS continuing healthcare and NHS funded nursing care, practice guidance, paragraph 3.5).'

If an individual has a primary health need they are eligible for NHS continuing healthcare and therefore the NHS is responsible for meeting all that person's assessed health and social care needs, including accommodation if this is part of the overall need. It could be argued that some of Elizabeth's needs fell outside the remit of the Local Authority, and as stated in a previous section, perhaps the DST checklist could have been restarted and a new MDT requested. In addition, was the complexity of funding surrounding Elizabeth's needs an opportunity for a jointly funded package in the short term? The DST could potentially have identified a jointly funded package as an option. A local authority social worker requested this as an option (outside of the DST process). This was declined by the CCG and an extension of IFR funding was provided. Agencies and practitioners involved in working with Elizabeth agreed that (with hindsight) a step-down process would have been useful, allowing for more preparation time.

In later discussion, some agencies wondered if there had been a possibility of deferred payments linked to the sale of Elizabeth's mothers home? An Occupational Therapist (OT) had visited the property to look at the feasibility of Elizabeth moving back. It required considerable adaptation and Elizabeth did not wish to have the work undertaken, preferring to keep it as it was when her mother was alive. The estate was in probate at that time which may in fact have prohibited the release of payments. Yet, with hindsight, we may conclude that there was no rush to move Elizabeth from Placement 3 as at some point there was going to be enough money for housing and adaptations. In addition, there was some reasonable doubt that Elizabeth was not ready to move to Placement 4. The Community Matron felt that Elizabeth demonstrated potential for rehabilitation.

7. RECOMMENDATIONS

Much of the learning in this review concerns how agencies and individuals work together and build relationships of trust through a common language. Key messages from Practitioners include:

- Able to build engagement /relationships and listen: ability to reframe and influence

- Preference for outcomes over process
- Not being bound up with role and with a willingness to take risks.

This involves respect for roles and a desire to understand the legal constraints that impact their decision making. Participants at the learning event embraced the need for collective decision making and critical challenge. The ability to ask incisive questions of one another and not to accept at face value is key to good assessments. Some of the challenges link to wider system processes such as the need to have functioning integrated care systems that are truly seamless. Cultures and processes in the separate health and social care organisations inevitably influence decision making and relationships. The willingness of participants in this review to challenge the way they work together is an opportunity to effect real change. In addition, participants, in follow up discussions, wanted to explore the feasibility of having a separate 'panel '(such as Sheffield's High Cost Panel) for people with 'unique'[11] and complex needs that do not easily fit into other funding streams. Subsequent discussions revealed that Rotherham already has a group in place sitting with the Health and Wellbeing Board. More work needs to be done to ensure that staff are aware of such groups and embed the processes across the system. It is a concern that key staff within commissioning were not aware of the group.

1) **Explore and agree how the Health and Care system uses multi-agency discussions for people who do not neatly 'fit' into safeguarding**

This review has highlighted the need to ensure that funding should be a consideration but must not drive decisions. It appears that Practitioners/agencies were not aware of all possible routes for support in navigating Elizabeth's complex needs, including the existence of a group like the 'High cost Panels'.

The Health and Wellbeing Board has a key role to play in promoting and helping to embed processes for people with 'unique' needs, such as Elizabeth, across the workforce. This will ensure that staff are aware of their role, including the processes for people with vulnerabilities in line with Making Safeguarding Personal, and have clear expectations of outcomes. There should be clear guidance for referrers with details of escalation and appeal processes.

[11] Many participants in this review referred to Elizabeth's situation as unique.

Furthermore, MDT assessments should include as per national guidance[12] health and social care professionals who know the individual and not just rely on reports. Decisions about CHC should be reached collectively to ensure multidisciplinary assessment of eligibility is agreed. This was a concern raised by participants in the learning event. There was a sense that Elizabeth's needs were not always fully understood. There should be local guidance to inform referrers of the opportunity to restart processes such as DST if circumstances change.

The role of MDTs is a common theme in safeguarding reviews and in the wider integrated care agenda. There should be Investment in the development and joint training of multidisciplinary teams (MDTs) to transform their skills, cultures and ways of working. This is wider than the SAB but is vital if systems are to be transformed to achieve person centre care.

The teams who worked with Elizabeth could work together to build on this approach as an example.

2) Independent Advocacy

The SAB should review the use of Independent advocacy as outlined in the Care Act (2014)[13] This review should include the number of available and trained Advocates.

The Care Act places a duty on councils to provide independent advocacy when someone has 'substantial' difficulty being involved in the process of care and does not have an appropriate individual to support them. RMBC should undertake its own review to understand how and when independent advocates are commissioned and trained.

3) **Appreciative inquiry /Learning Reviews**

Rotherham Safeguarding Adults Board should build on the use of appreciative inquiry to build a culture of learning across agencies. This would help agencies to come together in complex circumstances such as Elizabeth's and reflect on progress.

4) Debriefs

[12] https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

[13] https://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/duties/independent-advocacy-care-act.asp

Rotherham Safeguarding Partnership should consider how it will provide support and debriefs for Practitioners from organisations, including non-statutory organisations following learning reviews. Self-care is vital and many practitioners and the SAB should explore supervision and counselling opportunities following SARs. The SAB business manager could be an initial point of contact for practitioners until processes are in place. The SAB may wish to consider linking to other mental health support services for staff such as RMBC.

Possible reflective questions for professionals

To what extent do I critically reflect on cases?

How do I avoid fixed thinking?

To what extent do I understand the effects of alcohol abuse, the risks of relapse and the impact on the person?

Have I identified all sources of support for the adult?

Is information being shared appropriately?

Do I understand how to assess the individual's capacity for change?

Have I the confidence to respectfully challenge other professionals if I believe that a person's needs are not

5) Signposting

RDaSH should consider how to make staff aware of the need for signposting to charities/voluntary sector when individuals are not considered to require mental health services support but still have significant risk factors.

6) Review and understand escalation process

This is a recommendation for the SAB and for each organisation. Participants in the review were not all aware of escalation processes and those who were had not considered their use.

7) Making Safeguarding Personal

There had been no safeguarding enquiry for Elizabeth, therefore no involvement in Elizabeth's care from safeguarding specialists in health and social care. Most practitioners involved in working with Elizabeth had not considered her to be 'at risk' or to have any safeguarding needs or concerns. It would be useful for the SAB to consider how it will raise awareness of the principles of MSP in line with person centred approaches.

8. SUMMARY

We will of course never know if Elizabeth would have taken an overdose if circumstances had been different. What we can say is that her lifestyle change following her fall and the death of her Mother had an untold impact on the way in which she saw her future. We can wonder at the impact of being in a nursing home, initially, had on her long-term ability to cope and deal with her life. We have learnt that sometimes the process surrounding funding decisions and constraints in systems means that we can take our eyes off the person and each other. Elizabeth's sad death has identified both

strengths and weaknesses across systems. There is learning for agencies in understanding multidisciplinary working; developing a shared language and managing escalation. Most importantly, there is a desire to be more person centred.

It did not mean that people did not care about Elizabeth. There was a sense of compassion and kindness in the way that agencies spoke about Elizabeth and how they had wanted to help her. This was obvious at the learning event in the way that staff spoke about Elizabeth and the way in which they acknowledged each other's challenges as agencies, making a commitment to improve working together and sharing information.

'We Person-Centred Approach people are as human as anyone else after all, and, as does everyone, must daily face the difference between our aspirations and stated values, and our actual choices and behaviours, and the resulting outcomes. However, we keep giving ourselves a chance to change, again and again, thus more closely approximating our hopes for how we can be together'
— Gay Barfield, Politicizing the Person-Centred Approach: An Agenda for Social Change