The Richmond and Wandsworth Safeguarding Adults Board

SAR Executive Summary, Recommendations and composite action plan

March 2018

Executive Summary

1. Introduction

Sophie was in the care of LBW Adult Social Services mental health team, when she died aged 19 in a residential provision, Lancaster Lodge (LL), because of injuries sustained from a ligature. LL is an 11-bedded 'therapeutic residential service' for adults aged 17- 40 years old, part of Richmond Psychosocial Foundation International (RPFI). LL is located in London Borough of Richmond upon Thames (LBRUT). Sophie had been a Looked After Child in the care of the London Borough of Wandsworth (LBW) and her care was being managed through transition to adult mental health and social care services.

Sophie had a diagnosis of bipolar affective disorder, depression and atypical autism. Sophie had a history of self-harming and it was well known that she found change particularly challenging, she had difficulty in expressing her feelings, and displayed disproportionate behavioural responses to interruptions in routine or stressful situations.

2. Overview of SAR process

A SAR referral was made to the Richmond SAB by South West London and St Georges Mental Health Trust on 17/05/2016. The SAB agreed that the SAR criteria were met on 09/06/2016. The Review commence on 04 July 2016 with Independent Reviewer Nicky Walker-Hall. 5 panel meetings between 04 July and 04 December 2016 and the SAR was halted December 2016 due to an ongoing criminal investigation. The Police investigation was completed August 2017 and Social Care Institute for Excellence (SCIE) was appointed to complete the SAR August 2017. The

SAR recommenced with workshops on 27/09/2017 (Training Workshop); 10/10/2017 (SAR Workshop/Panel) and 01/11/2017 (Review Team/Senior Manager Workshop/Panel).

3. Involves agencies

The following agencies were involved in the SAR:

- Richmond and Wandsworth Councils – Adult and Children Services
- Metropolitan Police
- Care Quality Commission
- South West London and St Georges Mental Health Trust
- Richmond Psychosocial Foundation International Institute (RPFI).

4. Family Involvement

Contact has been maintained with Sophie's parent throughout the SAR process. A meeting was held with her parents on 22/02/2018 to discuss findings and report content with Reviewers and representative from Richmond and Wandsworth Adult Social Services. Sophie's parents have had input into the final report.

5. Review Process

The Learning Together – SCIE Model was used for this review. It Involves front line practitioners and managers and aims to find out what happened and why but also goes further and reflects on what the case reveals about strengths, gaps and inadequacies in the multi-agency safeguarding system. The SAR process involved one training workshop a full day workshop for practitioners and managers and a half day manager review to test the findings.

The findings and questions were presented to an extended SAR subgroup on 6 March 2018 and the recommendations framed in a multiagency meeting.

6. Review questions

The use of research questions in a Learning Together systems review is equivalent to Terms of Reference. The Richmond SAB decided that the following research questions should underpin the SAR:

1) *How effectively are transition arrangements from children's mental health services, and 'settling' in to adult services, managed to support service users and their families?*

2) *How do services and practitioners respond when service users in crisis are also undergoing periods of change?*

3) *How do placement authorities respond to concerns/changes in provision of care, and when these are also expressed by service users?*

7. Review findings and questions to the SAB

The SCIE methodology does not make recommendations but rather facilitates discussions across the SAB to generate recommendations which are relevant and meaningful he partners. The review identified 5 findings and a series of questions to the SAB to help the SAB to formulate recommendations and agree a composite action plan.

Finding 1: How effectively and flexibly do commissioners/ placement authorities maintain an active relationship with out of borough placements through the operation of formal and informal processes of oversight?

- How would the Board like the future oversight of the transitional and medium-term care in adult services of young vulnerable adults in out of borough placements to take place in order to aspire to the best outcome for the young person that takes into account their changing needs.
- How does the Board gain assurance that when commissioning and contracting care agencies are discharging their duties under the Care and Statutory Support Guidance 2017 to 'regularly assuring themselves of the safety and effectiveness of commissioned services (The Care & Statutory Support Guidance updated 2018, para 4.19 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance).

Finding 2: How well are organisations, regulators, providers and commissioners working together to protect individual residents and predict and manage personal crisis?

- If there is a value in individual risk analyses for every vulnerable adult how might such analyses be conducted and most effectively shared?
- How can the Board be reassured that health and social care providers apply crisis intervention theory and reflect on crisis experiences learning for future situations putting in place a management plan that covers relapse and crisis management for vulnerable adults that is co-created with them and others of their choosing?
- What measures would the Board like to see in place that attempts to respond at the earliest possible stage in cases of provider failure?
- Where day to day risk management is delegated to residential or nursing providers how can statutory agencies be reassured that prevention of crisis and risk are key goas of longer term therapeutic interventions?

FINDING 3: There is no safeguard in the commissioning/contracting system to prevent unilateral service decisions being made by a provider, meaning that compliance with any contract is over-reliant on trust and good practice

- How can Health and Social Care commissioners gain intelligence about the organisational circumstances of local providers, in order to better gain advance notice or warning as they enter periods of organisational or service change?
- How can the Board be assured that contracting arrangements contain robust safeguards that prevents providers from unilaterally changing the mode of service delivery?
- How can the Board be assured that the procedures for managing safeguarding at an organisational level taken into account the additional risk presented to residents from provider failure and actions of the multi-agency safeguarding system?
- How does the Board want to assure themselves that host authority responsibilities are sufficiently understood and shared in cases of provider failure?

Finding 4: To what extent can Richmond & Wandsworth provide a personalised care planning process that reflects the precariousness and complexity of what good looks like for adults with mental illness?

- How will the Board be assured that there are comprehensive processes in place to support residents when they are in times of crisis and when they are well in order to provide an all-round ‘good’ experience of care?
- How can the Board and member organisations best support and work with young people to reflect the nuances around family members’ involvement in their care and life?

FINDING 5: How effectively do Richmond and Wandsworth practice person-centred care for adults in a placement, both in relation to efforts made to understand individual needs and how those needs are then recorded?

- How can the Board support Local Authorities to complete transition assessments that are as robust for young people transiting from institutional care to institutional care, as they are for children living independently?
- How can Health and Social Care Authorities support person-centred care planning for vulnerable individuals in residential or nursing care?
- How can the Board support a standardisation of assessment process that supports personalisation and a recovery approach to care planning for individuals receiving residential home care and encourages learning and sharing across agencies?
- How can the Board explore the barriers to the use of advocates with young people transitioning to adult's services, what they are and how they might be overcome?

8. Recommendations and Composite Action Plan

Finding	Recommendation	Actions	Lead agency and person	Completion date
1. How effectively and flexibly do commissioners/ placement authorities maintain an active relationship with placements (out of borough and more widely) through the operation of formal and informal processes of oversight?	A protocol on the roles and responsibilities of agencies in placements and Out of Borough placements to be agreed	Develop a clear protocol for use by staff Ensure all social care staff and other stakeholders are aware of the protocol and how to use it	• Head of Commissioning (Richmond & Kingston CCG); • Mental Health and Learning Disability Commissioner (Wandsworth and Merton CCG); • Head of Commissioning, Public Health, Well-being and Service Development, (Richmond and Wandsworth Councils)	July 2018 August 2018
	Review contracting arrangements in relation to provider's responsibility to notify commissioners of changes in the services and define how relationship with the placement authority will be conducted	Raise awareness amongst providers of the importance of partnership working with agencies who procure services Review and update contracting arrangement for all spot placements.	• Head of Commissioning (Richmond & Kingston CCG); • Mental Health and Learning Disability Commissioner (Wandsworth and Merton CCG); • Head of Commissioning, Public Health, Well-being and Service Development (Richmond and Wandsworth Councils)	July 2018 December 2018

Finding	Recommendation	Actions	Lead agency and person	Completion date
2. How well are organisations, regulators, providers and commissioners working together to protect individual residents and predict and manage personal crisis?	Define leadership and roles of all partners in managing risk for people who are in mental health crisis and how these are reduced and monitored	Develop an agreed risk management protocol for use by all agencies All agencies able to demonstrate that staff are aware of and using the agreed risk management protocol	• Head of Safeguarding and Professional Standards (Richmond and Wandsworth Councils) • SAB Subgroup (Measuring Effectiveness)	December 2018 Feb 2019
3. There is no safeguard in the commissioning / contracting system to prevent unilateral service decisions being made by a provider, meaning that compliance with any contract is over-reliant on trust and good practice	Influence the culture of providers in relation to personalised care	CQC to do well lead inspections in relation to providers Training /awareness session on managing risks and working with partners	• Inspection Manager – CQC • Head of Commissioning Adult Social Care and Provider Management (Richmond and Wandsworth Councils)	March 2019 Feb 2019
	Define escalation of management of risk in relation to safeguarding at provider concern level and define of how co-ordination is managed	Review procedures to ensure definition of escalation procedures in place	• Head of Safeguarding and Professional Standards (Richmond and Wandsworth Councils)	December 2018
	Refresh multiagency agreement on effective working together at individual case level	Review practice and procedures in relation to interagency co-operation in adult safeguarding	• Head of Safeguarding and Professional Standards (Richmond and Wandsworth Councils)	December 2018

Finding	Recommendation	Actions	Lead agency and person	Completion date
		Undertake multiagency training on effective working together based on agreed procedures	• SAB Subgroup • Developing Best Practice Subgroup	March 2019
4. To what extent can Richmond & Wandsworth provide a personalised care planning process that reflects the precariousness and complexity of what good looks like for adults with mental illness?	Ensure there is a system for residents and family representatives to raise concerns to Health Watch/ council /CCG and providers as part of placement agreements	All agencies to ensure there is clear information on how to raise concerns and this includes in all care homes. A named contact to be identified for service users and families to contact should they have concerns about the care in an out of authority placement. The role of the Care Coordinator to be defined and agreed.	• Director of Quality & Governance (Wandsworth & Merton CCG); • Director of Quality and Safeguarding Lead (Kingston and Richmond CCG)	February 2019 December 2018
5. How effectively do Richmond and Wandsworth practice person-centred care for adults in a placement, both in relation to efforts made to understand individual needs and how those needs are then recorded?	Develop systems to ensure effective care co-ordination in relation to the recovery process	Agree the pathway and define roles of all agencies in managing mental health recovery Undertake multiagency training of staff in relation to working with recovery	• Executive Director of Nursing and Quality South West London & St George's Mental Health Trust • SAB – Developing Best Practice Subgroup	February 2019 March 2019

Finding	Recommendation	Actions	Lead agency and person	Completion date
	Mental health and social care partners to assure the SAB that they have robust transition arrangement in relation to transfer of people with safeguarding concerns or complex care needs from children to adult's services.	Clarification of the transition pathway for young people with mental health concerns involving all stakeholders including Council, mental health services, CCG All agencies able to demonstrate that staff are aware of and using the agreed transition pathway.	• SAB Task and Finish Group led by Head of Safeguarding and Professional Services Richmond and Wandsworth Councils. • SAB – Measuring Effectiveness Subgroup	December 2018 February 2019
The Safeguarding Adults Board considered the findings and recommendations of this and other, similar case examples and concluded that further action is needed to safeguard young people with complex mental health needs/or multiple diagnosis during the time that they are transitioning from children to adult services to ensure their well-being and safety.				
6. Are young people with complex mental health needs/or dual/multiple diagnosis effectively supported to transition to adult services whilst ensuring the young person's well-being and safety?	Identify the young people most at risk of harm and abuse in order to provide an effective level of support with the aim of seamless transition to adult services that ensures the young person's safety and welfare.	Establish a risk register of young people with mental health diagnosis who are likely to require additional support during transition and ensure that support is provided. Work with local Children & Adult services providers on the possibility of providing more seamless services or services that are aimed at young people 16-25 and go beyond the age of 18.	• Executive Director of Nursing and Quality South West London & St George's Mental Health Trust • Children's Mental Health Commissioning Leads in 'Achieving for Children' and Wandsworth Children's Services • Head of Commissioning (Richmond & Kingston CCG) • Mental Health and Learning Disability Commissioner	December 2018 March 2019

Finding	Recommendation	Actions	Lead agency and person	Completion date
			(Wandsworth and Merton CCG); • Head of Commissioning, Public Health, Well-being and Service Development, (Richmond and Wandsworth Councils).	
The Safeguarding Adults Board considered that agencies needed to evaluate their understanding of their own role and seek assurance that practitioners are sufficiently informed about the safeguarding processes, including learning from this SAR.				
7. Ensure that practitioners and professionals are sufficiently informed about safeguarding processes and that learnings from this SAR is shared widely.	Ascertain and gain assurance that professionals across the safeguarding partnership know how to raise safeguarding adults concern Share learning from the SAR widely.	That a survey (Survey Monkey or other) is undertaken (like Section 11 Surveys by SCB). Hold a learning event as soon as possible to share the learning from the SAR with managers and front-line practitioners.	• SAB – Monitoring Effectiveness Subgroup • SAB Coordinator	March 2019 October 2018