Action Plan Closure report	
Action plan title	Mrs E and Mr F Safeguarding Adults Review (SAR) Action Plan
Plan start date	June 2022
Plan closure date	March 2024
Report author	Chair, PSAB Quality Assurance subgroup

Background and context

Mrs E - case summary

Mrs E was a frail older woman in her eighties with a diagnosis of dementia and complex physical and mental health needs. She lacked mental capacity in relation to decisions about her care and support needs. Her main carers were her son and her husband.

Several incidents occurred in 2016 and 2017 to raise concerns about her care and support needs and her poor living conditions. In May 2019, a safeguarding concern was raised about neglect and acts of omission and Mrs E was admitted to hospital, where it was noted that she was dirty and had matted hair. She was discharged with a four times a day package of care. The family requested that this be cancelled saying they had concerns about the carers and about the cost of the care. This was done following a Best Interests decision.

Mrs E did not receive visits from any service after December 2019. The onset of the pandemic meant that many face-to-face services ceased after March 2020 and Mrs E did not get her prescribed injections. Welfare checks were made by telephone, but family reported no concerns. The pandemic meant there were delays to the planned home adaptations and these were not completed before she died, a year after the need for improved washing and toilet facilities was identified.

Mrs E died at home in June 2020. When the ambulance service responded, Mrs E's husband reported that she had been unwell and in a comatose state for three days prior to calling for help from services. Mrs E was found in a poor state and covered in dried faeces. Her death was found to be partly due to an infected pressure sore.

Mr F - case summary

Mr F was an older man in his eighties who had a number of mental and physical health conditions, including dementia, depression, kidney and respiratory disease.

Mr F lived with his stepson, who was his main carer. Mr F was referred to Adult Social Care by his GP in September 2018, and following a hospital admission in November 2018 he was discharged with a package of care. He lacked insight into his needs and refused many aspects of care offered by practitioners. He reduced his care package and eventually cancelled it, putting him at significant risk of harm. Although he was considered to have mental capacity to make this decision, he was influenced by his stepson, and his mental capacity was doubted at times by professionals.

There were a number of concerns identified about the care provided by Mr F's stepson, including poor medication management, keys being removed from the key safe which caused practitioners difficulty in gaining access, and a lack of awareness of Mr F's poor health. Professionals also noted the stepson's misuse of substances.

In September 2019 Mr F was found in a poor condition by a visiting professional who called an ambulance. No action had been taken by his stepson. Mr F died in hospital 3 days later.

Summary of findings from SAR

Mrs E

- There was good practice identified in that a Mental Capacity Act assessment was carried out, with attempted engagement with Mrs E.
- Although the Best Interests decision to cancel the care package was made appropriately, there was no review or monitoring following this, despite the high risk of neglect.
- There was little evidence of multi-agency communication and information sharing.
- The care package was cancelled by the family in part due to financial concerns, which increased the risk of harm to Mrs E. Some safeguards could have been put in place to ensure the family was not misusing Mrs E's money.
- Mrs E could have been offered an advocate to help make her views known. She was entitled to advocacy under the Care Act and Mental Capacity Act.
- Mrs E had advanced dementia, a life limiting condition which requires highly skilled care at the end of life. Contact could have been made with the palliative care service.

Mr F

- There was good practice identified in the determination and persistence of frontline staff in continuing their contact with Mr F, despite Mr F's resistance to care and treatment, the lack of engagement of his carers, and practical difficulties of access to the property and resources in the home. In particular the Mental Health and Dementia nurses were able to build a good relationship with Mr F and support him emotionally.
- There was doubt about Mr F's mental capacity to make informed decisions about his care and finances. However, his mental capacity was never formally assessed which meant there was no clarity about the legal framework for interventions.
- The coercion by his stepson and how it influenced Mr F's decisions was not recognised and could potentially have been a criminal offence.
- It was suspected that Mr F's care package may have been cancelled for financial reasons. This could have been explored further and options considered to enable care to continue.
- The concerns about Mr F may have met the threshold for a safeguarding enquiry under the Care Act which may have led to different care and support outcomes for Mr F. If they did not meet the threshold, professionals could have used the Multi Agency Risk Management framework to work together to address the risks to Mr F more robustly and in a coordinated way. However they were not aware of this framework at the time.
- There could have been better information sharing between professionals, for example sharing of information with domiciliary care agencies. Police input could have been sought on the issues of coercion and substance misuse.
- Mr F could have been supported by an independent advocate to understand the options available to him and express his views without being influenced by his carer.

Recommendations from SAR/audit

Mrs E

Recommendation 1 It is recommended that PSAB use the opportunity afforded by the launch of the new Mental Capacity Act/ Liberty Protection Safeguards in April 2022 to increase awareness and confidence in implementing the requirements of the law.

Recommendation 2 It is recommended that there is a review of the use of Community Deprivation of Liberty Orders to ensure that they are put in place appropriately to safeguard individuals without capacity, with need care needs, who are living at home.

Recommendation 3 It is recommended that regular reviews are put in place for individuals without capacity, with care needs, living at home to ensure their ongoing safety.

Recommendation 4 It is recommended that clear guidance is in place regarding the management of high-risk situations where the Multi-Agency Risk Management Framework does not apply.

Recommendation 5 It is recommended that PSAB request partners to draw up simple guidance on financial abuse and misuse of funds together with information about the solutions available in different circumstances and how to action them.

Recommendation 6 It is recommended that PSAB request that the Local Authority ensures that practitioners are informed about the advocacy services provided under the Care Act 2014 and the Mental Capacity Act 2005 and that they know how to refer appropriately.

Recommendation 7 It is recommended that the PSAB request that partners put in place improved guidance around Risk identification and Management in cases where an individual lacks capacity and a high level of risk exists. It is also recommended that a keyworker is allocated to maintain continuity and provide a focus for communication.

Recommendation 8 It is recommended that PSAB ensure that the role of palliative care at home and how to access it is understood by practitioners.

Recommendation 9 It is recommended that PSAB pass these concerns to the Department of Work and Pensions for their consideration.

Recommendation 10 It is recommended that PSAB seeks assurance that a clear public message goes out to assure people that services remain available in cases of serious need during the pandemic.

Mr F

Recommendation 11 It is recommended that PSAB use the opportunity afforded by the launch of the new Mental Capacity Act/ Liberty Protection Safeguards in April 2022 to increase awareness and confidence in implementing the requirements of the law. It is also recommended that sources of expertise are readily available to practitioners involved in complex cases where individuals are at serious risk of harm.

Recommendation 12 It is recommended that PSAB expand training and awareness of the MARM to all partners so they can use it appropriately**.**

Recommendation 13 It is recommended that PSAB request partners to draw up simple guidance on financial abuse and misuse of funds together with information about the solutions available in different circumstances and how to action them**.**

Recommendation 14 It is recommended that PSAB ensure that practitioners can identify coercion and control or other potentially illegal activity which impacts on an individual at risk of harm and understands how to access expertise.

Recommendation 15 It is recommended that PSAB request that the Local Authority ensures that practitioners are informed about the advocacy services provided under

the Care Act 2014 and the Mental Capacity Act 2005 and that they know how to refer appropriately.

Recommendation 16 It is recommended that the PSAB request that Adult Social Care review the client information given to a Care Agency when they are commissioning to ensure all essential information is passed on.

Key activity planned

1. Liberty Protection Safeguards (LPS) Implementation Lead to be appointed who will have a focus on developing training/raising awareness. Local Implementation network to be developed to support raising awareness across all relevant agencies/partners in Portsmouth.
2. Case review of adults without capacity to consent to their care and support arrangements who are living in the community.
3. Adult Social Care will ensure that practitioners undertaking reviews are aware of the requirements linked to deprivations of liberty in community settings.
4. Risk Panels to be set up.
5. Multi-Agency Risk Management (MARM) framework to be reviewed. Further training to be commissioned. MARM champions to be developed.
6. PSAB will draw up a practice guide to financial abuse, to be shared across all partners.
7. Awareness raising of advocacy services through newsletters, team meetings and staff briefings.
8. Existing safeguarding training to be updated to ensure coercion and control is incorporated.
9. Review of information to providers to be undertaken, to ensure that have what they need to deliver the care commissioned.
10. Communication out to all relevant services about the role of palliative care.
11. Discussion with Department of Work and Pensions (DWP) about the concerns raised in the report about Carers Allowance being potentially inappropriately claimed.
12. Partners to review information on service availability to ensure it is relevant and up to date.
13. Recommendation from PSAB: All staff know how and when to escalate unresolved differences of opinion between agencies, to safeguard and promote the welfare of adults with care and support needs.
14. Escalation Policy will be promoted by all services, who will ensure their staff have access to it and know how and when to use it.

Key actions taken:

1. An LPS Implementation lead was appointed. LPS implementation was postponed by the current Government. A local LPS implementation network was set up but disbanded because of the current government's decision to delay the implementation of LPS. The person appointed to the implementation role was retained and their focus placed on improving Mental Capacity Act

(MCA) compliance across adult social care. They have undertaken an audit of the MCA assessment practice within adult social care and delivered MCA training workshops along with Portsmouth City Council's Principal Social Worker. The audit will be repeated going forward on an annual basis. A practice tool to support the identification of Community Deprivations of Liberty (DoLS) has been produced and awareness has been raised across adult social care regarding when a deprivation of liberty within a community setting may be occurring.

2. A sample of adults living in the community who were judged to not to have the capacity to consent to their care and support arrangements were case reviewed by the Principal Social Worker. There were no concerns raised regarding the application of the MCA within these case reviews. A report was presented to the PSAB Quality Assurance subgroup sharing the findings.

3. Adult Social Care have developed a community DoLS toolkit which has raised practitioner awareness.
4. The need for risk panels was reviewed within adult social care. It was felt that the introduction of practice panels, case file audits and an increase in senior management capacity mean that there was no longer a need to introduce separate risk panels. This decision will be kept under review.
5. The MARM Framework has been reviewed and updated and relaunched. However, findings from recent SARs indicates that the framework is not consistently used. A workshop is planned for February 2024 to hear from practitioners about the challenges of using the framework to manage risk. Some training was provided in 2022 and 2023, and further training is planned for later in 2024. In addition to the workshop, an audit of MARM practice will be undertaken. The output from the workshop and audit will inform the follow up actions to be taken. These will be monitored by the PSAB Quality Assurance Subgroup and reported into the PSAB quarterly.
6. A guide to financial abuse has been produced and is available on the PSAB website.
7. Advocacy services have been promoted and the safeguarding team within adult social care monitor the use of advocacy in relation to section 42 enquiries. The need for advocacy is also covered within the adult social care case file audit tool.
8. Coercion and control is now covered in Portsmouth City Council training which can be accessed by partner agencies. Portsmouth Hospitals NHS Trust and Solent NHS Trust have also updated their training. In addition, training was commissioned by the PSAB.
9. The system for providing information to providers has improved to ensure that they have the information they need to enable them to the deliver the care commissioned, via the introduction of a brokerage system.
10. Communication was issued to ensure that all providers understood what palliative care services were available.
11. A meeting was held with DWP to discuss the concerns raised in this SAR regarding the claiming of carers allowance. Adult social care staff were reminded of the need to be aware of potential fraud.

12. This SAR was completed during lockdown and there was some concern raised by the independent author that access to services was not clearly advertised. There is no evidence that this remains an issue.
13. The 4LSAB Escalation policy has been updated and reissued to all PSAB members and is available on the PSAB website.

Outcomes

As a result of the work undertaken following these two SARs MCA practice has improved within adult social care. MCA champions have been identified and an annual audit process has been agreed. There is more work to be done and further workshops are planned. The need to consider a referral for advocacy is now clearly recorded as part of the triage decision. The need to consider advocacy is also tested annually as part of the PSAB Quality of Referral and Decision Making Audit.

The MARM Framework has been reviewed and updated. Awareness of the framework has increased but there is more work to be done to increase its use in some services. The workshop planned in for February (2024) will assist in future planning.

Adult Social Care have introduced a brokerage model to support the commissioning of domiciliary care services for people with care and support needs. This has included improving the amount and type of information given to providers to help them determine if they can meet the person's assessed needs.

Next steps

1. The annual audit of MCA practice within adult social care will continue and will inform the commissioning of future training.
2. The use of advocacy will remain under review, via the annual audit.
3. The MARM workshop will inform next steps in the implementation of the framework.