Action Plan Closure report	
Action plan title	Pamela Ratsey Safeguarding Adults Review (SAR) Action Plan
Plan start date	Jan 2022
Plan closure date	Oct 2023
Report author	Chair, PSAB Quality Assurance Subgroup

Background and context

The Pamela Ratsey SAR was published in January 2022. It was the family's wish that Pamela's full name be used in the review instead of a pseudonym. Pamela was an older person who lived in Hampshire and was placed in a Portsmouth residential care home by Hampshire County Council. Concerns were raised by her family and other agencies about poor care and neglect, and a safeguarding enquiry was carried out by Portsmouth City Council. Pamela sadly died as a result of pneumonia and a pressure sore. The coroner found that neglect contributed to her death.

Summary of Findings from the SAR

An independent reviewer carried out the SAR and the key findings were:

1. There was minimal engagement with Pamela's family and services did not seek their views or listen to their concerns.
2. There was a lack of clarity and consistency in the consideration of Pamela's mental capacity.
3. There was a lack of professional curiosity and risk management.
4. Pamela’s complex care needs were neglected at the home, and internal concerns about managing these needs were not shared with the placing authority or on hospital discharge.
5. Several services did not escalate concerns about Pamela’s increasing needs.
6. Safeguarding enquiries were not personalised and did not effectively reduce the risk of neglect.
7. There were delays in reviewing Pamela's care and arranging for her to move.

The reviewer identified a number of improvements which had been made since the incident to address these findings, including the introduction of a Quality Improvement Team, new processes within the Adult Multi-Agency Safeguarding Hub (MASH), improved electronic recording practices within Community Nursing, and a new Pressure Ulcer Panel.

Recommendations from the SAR

In addition to those areas noted above where improvements had already been implemented, the following actions were developed by the Board in response to the reviewer's recommendations:

1. Review the Multi-Agency Risk Management (MARM) Framework and develop a range of risk assessment tools.
2. Review current practice regarding pressure ulcer care in residential care and from providers to ensure residents get the treatment and clinical oversight that they need.
3. Ask the Continuing Healthcare (CHC) manager to undertake a staff survey (the aim was to assess if training was needed for Adult Social Care staff on completing CHC checklists).
4. Adult MASH manager to meet with Hampshire County Council to agree a process for cross border communication regarding high risk safeguarding cases.
5. Portsmouth Hospitals NHS Foundation Trust (PHUT) to review their discharge arrangements, to ensure patients are safely discharged to a setting that can meet their care needs.
6. Set up a PSAB Safeguarding Adults Leads Network.
7. Review of the health resource available to the Adult MASH.
8. Association of Directors of Adult Social Services (ADASS) Safeguarding Peer Review to be commissioned.
9. Portsmouth City Council (PCC) to undertake an audit of practice in relation to reviews of care and support plans.
10. Quality Improvement Team to review what posters/leaflets are available in nursing /residential homes regarding reporting abuse/neglect and what may need to be developed.
11. Mental Capacity Act (MCA) self-audits to be completed by board member organisations.
12. Quality Assurance subgroup to facilitate a multi-agency audit of MCA practice.
13. Adult Social Care to facilitate a Discharge to Assess practice review with a focus on compliance with MCA.
14. Community Nursing practice is reviewed, and a plan put in place to address any areas for improvement.

Key actions taken:

1. The MARM framework has been reviewed and updated and circulated, including the development of additional tools and templates. A series of three awareness sessions have been run in partnership with the other safeguarding adults board in the area (4LSAB). A more formal launch is planned for early in 2024.

2. The Care home team supports care home providers via regular Multi-disciplinary team meetings. Community Nursing and link tissue viability nurses offer advice and treatment regarding pressure ulcers to residents in care homes.
3. CHC staff survey was undertaken, and appropriate training and support provided to relevant staff.
4. Adult MASH Manager has established links with the relevant staff within Hampshire County Council and there are regular meetings with Team and Service Managers.
5. PHUT have delivered some rapid improvement workshops and have held a workshop specifically focussed on discharge practice.
6. The PSAB have developed a newsletter which goes to all partners on a quarterly basis, and the Adult MASH run monthly safeguarding clinics and hold 'meet the MASH' sessions to support partners. The 4LSAB Safeguarding Concerns Guidance has also been developed which gives detailed guidance about when and how to raise a safeguarding concern. At the moment there is no capacity within the PSAB to set up an Adult Safeguarding Leads network. This will be reviewed in 2024 as part of the business plan.
7. The business case for health resource within the Adult MASH was considered by the Integrated Care Board. It was their view that it was not a statutory requirement to provide this, and they declined Portsmouth City Council's request for this.
8. The ADASS Peer Review was commissioned and took place in November 2022. There is an action plan in place that will be monitored through the PSAB.
9. PCC undertook a review of social work practice regarding PCC funded residents who were place outside the city. The review was completed by PCC's Principal Social Worker. The review gave assurance that residents being placed outside the city were being reviewed and there was appropriate scrutiny of their care and support arrangements.
10. The Quality Assirance subgroup has not commissioned specific audit work regarding MCA practice. The local authority has undertaken a significant piece of work looking at the quality of practice and have developed a programme of learning events to support improved practice.
11. MCA self-audits were completed by board members, and this exercise will be repeated in January 2024
12. A workshop was delivered on MCA and executive functioning.

Outcomes

1. The care home team and quality team work closely together and support the Care Homes on a range of clinical and non-clinical issues.
2. The newsletter, alongside safeguarding clinics and meet the MASH sessions mean partner agencies have access to safeguarding advice and support if they need it.
3. The local authority has developed links with the relevant colleagues in Hampshire which makes it easier to raise issues in a timely way.
4. Support to Care Homes has improved.

5. The local authority has provided MCA practice workshops and plan to re-audit practice in 2024.

The Quality Assurance subgroup are aware that some of the action planning undertaken did not consider how impact/outcomes would be measured. This is a priority area of work, and the chair will ensure that this is built into future action planning.

Next steps:

1. Review the current training offer to providers, in partnership with providers, to ensure the offer meets their needs. Dedicated resource has been secured, sitting with the Head of Quality and Performance at PCC and they will lead on this piece of work.
2. Launch the revised and updated MARM framework.
3. Identification and management of risk will be a strategic priority for the PSAB and will be written into the business plan that will run until 2025.

The Quality Assurance subgroup are recommending the closure of this action plan and the endorsement of the follow up actions. These actions will be monitored through the Quality Assurance subgroup and reported into the PSAB via the Quality Assurance subgroup quarterly report.