Ms N Safeguarding Adults Learning Review - Professionals' Briefing

Ms N

The Isle of Wight Safeguarding Adults Board recently completed a learning review into the case on Ms N.

Ms N, 56, was found dead in March 2018. She was well known to many of the Isle of Wight NHS Trust Services for mental and physical health and her alcohol issues*. She was also well known to Adult Social Care and Domestic Violence Services. She was a frequent caller to the police and ambulance, who attended in response to reports of domestic abuse, Ms N's alcohol use and her mental health issues. This case has many similarities with a Learning Review published by the SAB in December 2017, and so much of the analysis of the case centred on some of the recurring themes – Mrs P Learning Review.

This briefing highlights some of the key learning themes for practitioners, and can be used to support personal development, in supervision, in group learning sessions, and to inform internal training, policies and procedures.

**The alcohol and substance misuse provider at the time of this case has since been decommissioned, and a new provider is now in place*

Learning

Are services effective in working singly or together to meet the needs of those people with dual or complex presentations?

The case highlighted a lack of targeted and collegiate commissioning for the specific Isle of Wight community, leading to a gap in services for those who have dual diagnoses. This was compounded by poor legal literacy and low levels of knowledge around the multi-agency safeguarding processes. Common areas of difficulty related to the distinction between decisional and executive mental capacity, the Multi Agency Risk Management (MARM) process, and effective and ongoing multi agency risk assessment and management. Professionals supported the Integrated Localities Model to support greater cohesion between agencies, teams and professionals.

How robust is the Section 42 Care Act assessment process, specifically the multi-agency information gathering to inform the decision against the three key tests?

There was an understandable pressure on staff and systems to meet the demand of Section 42 Care Act, but outcomes are only as good as the information provided. The process itself is reasonably robust but can be frustrated by delays in responses from other agencies. These add to the concerns of delays at the front door and the lack of feedback from Adult Social Care regarding Section 42 concerns raised.

There were also concerns raised over whether the 'three key tests' were being applied effectively. Six safeguarding concerns were raised about Ms N yet only one of those progressed to a Section 42 enquiry. There was an overwhelming consensus by professionals that agencies should apply Section 42 much earlier, before the adult fell into crisis, so that even if an enquiry is not commenced, a fuller multi agency picture can emerge and a greater collegiate approach applied.

How do agencies work together to support vulnerable people with complex need especially those who do not meet eligibility criteria?

Some professionals took the view that this was a particular area of vulnerability. A lack of shared systems and shortfalls in professionals' propensity to challenge, be curious and communicate, all can add to fractured support systems for this cohort. The review heard of examples where agencies look for reasons *not* to accept a referral because the client was difficult to work with. Others said there was a tendency for some who found clients challenging to pass them on.

Alcohol dependency can sometimes be seen as an excluding factor for mental health services. These two presentations often go hand in hand, and both can be a consequence of previous and current trauma and Adverse Childhood Experiences (ACEs). A dual diagnosis service should meet the current service gap, be trauma-informed and equipped to understand and support those with ACEs.

What are the barriers to communication and information sharing, especially where referrals are made, assessments are requested and activity commissioned?

Professionals understood the importance of information sharing and shared frustrations when their requests were not met or provided the whole picture regarding a service user. There was no lack of will but a lack of knowledge of systems, duties, powers and the agency landscape. For example, when asking for a GP encounter report, specificity in what was needed and why, and an understanding of the constraints health professionals work under, would more likely result in the request being met.

Similarly, agencies should ensure that professionals are aware of what they *can* share, the broad content of Information Sharing Agreements, who to contact in other agencies and how to seek any necessary authority.

Structural and systems issues can get in the way of effective information sharing. Multiple IT systems with differing access levels or methods can restrict the extent of information available. Lack of service integration can fracture relationships and breed a system where professionals are less likely to appreciate each others' roles and therefore not think laterally of what might be relevant to the request.

Do practitioners hear and respond to the wishes and feelings of clients, carers and family members especially where their presentation may fluctuate and there may be co-dependence?

The wishes and feelings of clients **and** carers are crucial and both groups require assessments based upon these, especially where relationships are complex and conflicting. Mr N was not formally assessed as a carer and therefore often felt external to the process, highlighted by not being invited to the discharge planning meeting following Ms N's inpatient admission. Agencies and professionals should agree who is best placed to engage with the client and carer, depending on who has the best relationship and decide on the optimum approach. This should be underpinned by a mutually supportive and respectful multi-disciplinary response.

There was no evidence of any consideration of inherent jurisdiction and the use of the Court of Protection. Some of Ms N's choices were unwise and these were accepted based on her decisional capacity. It does not follow that agencies are in these circumstances. If professionals remain concerned it is within their gift to seek legal advice with a view to applying to the Court of Protection to intervene. That might not have been appropriate here but there was no evidence that it was considered as an option.

Recommendations These recommendations will be taken forward by the IOWSAB in an action plan. The action plan will be monitored by the Safeguarding Adult Review Sub-group.

Recommendation 1 – Health & Social Care should assess the benefits of co-locating at service manager level to develop service level relationships, enhance and expedite decision-making and responses to enable a greater focus on outcomes and service-user benefits.

Recommendation 2 – The Isle of Wight SAB should commission a skills and knowledge gap analysis within and across agencies to scope any deficits regarding the multi-agency safeguarding and risk managements systems, mental capacity, legal options, information sharing arrangements, thresholds and the roles and responsibilities of partner agencies.

Recommendation 3 – Public Health will work with their partners to understand and articulate the needs of people with co-occurring substance misuse and mental health. This will be included in future Joint Strategic Needs Assessments. Public Health will work with their partners across Health and Social Care to ensure services meet the needs of this cohort, for example through a joint-working protocol for people with co-occurring conditions.

Recommendation 4 – The Isle of Wight Council should assure itself that Integrated Localities is working so as to provide effective multi-agency hubs enabling joined up systems, processes, information sharing and case management. This should link in to and feed other established multi agency risk and case management arrangements such as MARAC, MARM and Section 42 systems. Each should hold the other accountable for meeting needs and reducing risk.

Recommendation 5 – The Isle of Wight SAB should undertake a multi-agency audit of Section 42 safeguarding referrals to establish whether the three key tests are being applied effectively and appropriate and defensible decisions are made as to whether safeguarding enquiries are to be undertaken.

Questions for you and your service

How familiar are you with the arrangements to support multi-agency service provision?

How does your agency enable you to work in a multi-disciplinary setting?

Do you understand Section 42 Care Act 2015 and how to raise a safeguarding concern? Do you understand your duties to provide information to a safeguarding enquiry?

Do you and your agency ensure you take joint responsibility with others when managing or providing services to people with complex needs?

How well do you understand the relationship between alcohol, mental health, trauma and adverse childhood experiences? How does your practice reflect your knowledge?

How familiar are you with your agency's and the wider health and social care system's duties and permissions to share information?

Do you know who to request information from in each agency you work with, how to frame your request and any authorities you may need?

How well do you hear the wishes and feelings of clients and carers? How can you do so better? Do you know your options if clients and carers make unwise decisions?