Thematic Review into Neglect

Isle of Wight Safeguarding Adults Board

July 2023

Introduction

A thematic review of four individuals was commissioned by the Isle of Wight Safeguarding Adults Board in 2022. All four adults had care and support needs.

There was concern about multiagency working in three of the four cases, and concern about abuse or neglect in all four cases. Two of the individuals died in 2020. The other two survived and were moved to safety into care homes where they remain.

A Safeguarding Adults Board (SAB) has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death or harm was the result of abuse or neglect. Abuse and neglect includes self-neglect. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

Two of the cases, Ms O and Ms K, met the statutory criteria for a mandatory SAR. The other two cases were discretionary, but the Board felt that there was learning to be gained. The full review has not been published due to the inability to maintain anonymity for the individuals that are still alive – the SAB has a duty to protect the rights of those individuals and their families.

The reviewer worked with several SAB partner agencies, and family where possible with consent. Not all families engaged with the SAR process, hence the Board decision to produce an executive summary of learning.

Findings and recommendations

The key findings of the report highlighted a lack of Making Safeguarding Personal (MSP).

- Services prioritised, listening to family and carers rather than the individual.
- Services should have used Safeguarding processes more effectively to protect them from neglect.
- Services were reactive, addressing immediate presenting needs and lacked consideration for what it meant to be confined to your house and/or bed from the perspective of the individual.
- Communication between ASC and the Community Nursing Services could have been improved.

The recommendations in the final report should be read in the context of the amount of change in last two years and where the Partnership feels that current arrangements supersede the practice at the time of these cases, it is recommended that the cases in this Review are used to "stress test"

new policies and arrangements – to ask the question "could this happen now?". In this way this Review of these individuals can be a tool to progress check change and improvement in services across the Partnership.

The review author identified several recommendations, and the Safeguarding Adults Review Sub-Group held a workshop following completion of the report in May 2022 to analyse the key learning. Whilst some common themes were identified as in other SARs such as lack of service user voice, lack of understanding of when to raise a Safeguarding concern and information sharing, a number of new previously unidentified pieces of learning came to the fore, which are mentioned in detail below. The workshop therefore served as a gap analysis, allowing the SAB and its partner agencies to focus on the areas of new learning.

There have been several key changes following the workshop in response to the findings and recommendations within the review:

- The reviewer had noted that when referring a case for a SAR, this does not always trigger an internal agency response to evaluate their own practice. By amending both the SAR Referral form and the SAR Referral Response Form to ensure there is senior management oversight and governance when a referral is made, this allows an opportunity to identify and embed internal learning at an earlier stage.
- 4 LSAB have produced a Hoarding and Self-Neglect policy to support practitioners in practice.
- Community nursing underwent rapid change during covid and is currently under-going further transformation. Subsequent to this review, Community Nursing have been positively inspected by CQC, practice has also been reviewed via a current on-going SAR and change in practice has been sustained.
- The GP contract requires the identification of all patients aged 65 and over who may be living with moderate or severe frailty; SystmOne which is used by all GP practices has an automatically generated electronic Frailty Index score (eFI).
- The Primary Care Network (PCN) is also looking at developing Frailty Care Co-ordinators, as positive work has been identified when using these additional roles in Care Homes.
- ASC agreed that a system-wide approach was needed to better support people on the Isle of Wight living with dementia. Partners from the IWC, IW Trust and IW IBC approached the voluntary and community sector and asked them to lead on the development of a system-wide IW dementia strategy. It was recognised that these are often the organisations that are working most closely with people with dementia (diagnosed and un-diagnosed) and their families and would therefore be best placed to lead on meaningful public engagement to help us understand what people need. Age UK Isle of Wight, Alzheimer Café IOW, Carers IW and Healthwatch Isle of Wight have led this piece of work assisted by many other local organisations including Mountbatten Hospice, Independent Arts and the Alzheimer Society. The aim of this project is to improve the experience for people from pre-diagnosis through to end of life, and to ensure that the voice and experience of local people is central to the development of this strategy. Memory Service provision at the IW NHS Trust including waiting times have been part of the consultation for this strategy. This strategy is

underpinned by a robust delivery plan which monitors progress on all areas. The Hampshire & IW IBC, IW NHS Trust and IW Council lead the development of an action plan which also highlight the activity and changes that are already taking place. This action plan is delivered in partnership with the local organizations who supported the development of the strategy and other relevant partners. The Health and Wellbeing Board and Integrated Care Partnership will monitor delivery this action plan.

- A review of the current Direct Payment Team has been completed, it explored a number of key areas within the team and the wider delivery of Direct Payments. As a result we are creating more effective processes within the DP Team. Isle of Wight Council ASC has a Personal Assistant Policy in place to ensure family members are supported in line with current legislation.

There are also a number of recommendations that will need to be taken forward by the Board and its member agencies:

- **Given the population age profile in the Isle of Wight, the Safeguarding Adults Board should develop guidance specific on working with individuals who are confined to their house and/or bed noting risk factors to be considered by agencies (including ASC, Community Nursing Services and Primary Care). This should include working with the Fire and Rescue Service to sponsor a campaign about the use of lifeline/call alarm pendants and key-safes for people in this situation and what Practitioners should do if access cannot be obtained.** This work is part of a wider discussion including Carers UK and the 4LSAB Fire Safety Development Group.
- **Procedures and standards on the information that is to be shared should be introduced that assist safe discharge from hospital to care homes. This should cover situations where there are two GPs involved – where the patient may be registered with a temporary GP on discharge to a temporary placement while retaining their home-based GP, pending return home.** – Safe discharge from hospital to care homes has been identified as a recent theme in S42 enquiries to the IOW NHS Trust, a working group has been set up to review and identify any improvements to practice, with an additional network group planned between the IOW trust and care homes, to further improve care provision and communication.
- **The Partnership should develop a policy about the use of camcorders and cameras by clients and their families that record both the client and the practitioner.** This recommendation has been taken to the 4LSAB Policy sub-group to take forward, ensuring continuity across Southampton, Hampshire, Isle of Wight and Portsmouth.

Conclusion

Some of the themes have been identified as common across the region, therefore focussed 4LSAB work will be prioritised and escalated up to DHSC.

A gap in the formal completion of Mental Capacity Assessments (MCA) was also identified within this and other recent review's, therefore a key priority for the SAB going forward will be to continue to embed MCA into all areas of practice.