A Safeguarding Adult Review (SAR) in Rapid Time – Gabrielle

Chair's introduction

Throughout the Coronavirus pandemic BSAB members remained alert to new risks posed by the necessary changes to health and social care service delivery. Within assurance reports it was clear that partners remained acutely aware of balancing risks of infection with maintaining support to manage health and social care needs. During the initial lockdown safeguarding leads from the local authority and community health providers highlighted how many families had, understandably, requested a suspension of carer or district nursing services and the steps taken to mitigate risks to adults with care and support needs.

In July 2020 the Board's Case Review Group were asked by our acute health provider to consider a Safeguarding Adults Review in the case of Gabrielle. The group concluded that, whilst partners had taken steps to mitigate known risks to her, a review would identify important learning for all agencies seeking to manage the ongoing complexities posed for adults with care and support needs, particularly those with clinical vulnerabilities advised to 'shield'. The BSAB board therefore agreed in October 2020 to commission a discretionary SAR. Given the ongoing risks associated with further rises in infections, the BSAB sought the assistance of SCIE to complete this as a SAR in Rapid Time.

I would like to take this opportunity to thank all the practitioners who supported this review at a time of unprecedented workforce pressures. The open and honest way in which they worked together to understand the issues and their insight into how best to achieve practice improvements proved so valuable to this report. Similarly I would like to thank SAB representative who have supported the review and development of an action plan, particularly representatives from the Barnet Carers Centre and Heather Wilson from the Clinical Commissioning Group who worked alongside Sarah Williams to collate information. It is clear there is extensive continued commitment to take forward this learning by addressing the recommendations both as a partnership and within each partner organisation.

The BSAB have accepted all the recommendations and, as with any SAR, the publication of the report is only the start of the process. The Board will now, through our planned activities, regular assurance reports and the bi-annual challenge and progress events monitor the implementation of these recommendations and resulting action plan. Progress made by the BSAB and each agency to address the recommendations will be reported in our Annual Report.

Please email BSAB@barnet.gov.uk if you require further information,

Yours Sincerely,

Fiona Bateman
Independent Chair, Barnet Safeguarding Adults Board

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Commissioned by Barnet Safeguarding Adult Board

Independent Reviewer: Sarah Williams

Short summary of case and wider historical background

In 2020, the Covid 19 pandemic placed extraordinary strain on health and care professionals, who had to balance the need for individuals with serious health conditions to receive care in the community, with the need to keep them safe from coronavirus infection. In March, the Government had not yet introduced the Coronavirus Act 2020 or associated guidance and PPE equipment was not widely available outside the NHS. During this period, professionals and care agencies reported that many clients and service users refused care and home visits due to fear of infection. Gabrielle had complex medical conditions which limited her capacity to take decisions. A treatment plan was agreed with her family, but this was not consistently followed. From late March 2020, her family had declined district nurse visits due to fears of contamination during the pandemic. Sadly, Gabrielle died a few months later.

General comment: contingency planning

In March 2020, cases of Covid-19 were sharply rising across the UK and it could be reasonably foreseen that we would be following other European countries into lockdown imminently. This was beginning to place extreme pressure on the NHS and community nursing and care. In the absence of national guidance, NHS Trusts and local authorities urgently reviewed their business continuity plans in anticipation of mass hospitalisations and deaths. Although not analysed during the course of this review, the Board should seek assurance from all partners that their business continuity plans explicitly incorporate measures to address safeguarding during periods of crisis, and that these are regularly kept under review.

Mental capacity and best interest decisions

Systems findings

It is vital that the Best Interest weighing process becomes embedded in the practice of professionals working with adults who lack capacity to take decisions. An extensive programme of training in the Mental Capacity Act 2005 has been delivered across the Safeguarding Partnership, and agency assessments require practitioners to record whether the individual has capacity, and whether a lasting power of attorney is held. It is

therefore unclear why mental capacity assessments were not routinely undertaken and recorded by professionals in this case.

Recommendations:

The Board need to undertake work with front-line staff to understand how best to improve legal literacy in respect of the issue of mental capacity and best interest decisions. This should explore whether practitioners are overwilling to accept decisions by family members to refuse assessments or services, without balancing respect for the family's views against proportionate risk reduction.

Policies across the partnership should be reviewed to ensure that in cases where the individual lacks capacity to take decisions in respect of their care, any decision by family members to refuse a service or substantially alter a care plan will automatically result in a review of the care plan or care pathway. This should occur even where there is no indication that this is not in the individual's best interest or a family member holds a lasting power of attorney or deputyship. Partners should review their ICT systems to ensure that case files need to clearly record whether a copy of a lasting power of attorney has been seen by a professional or verified by the Office of the Public Guardian, not just that one is in place.

Communication of safeguarding concerns

Systems finding

The fact that information is passed between different professionals by way of email or formal referral results in a cautious approach to communicating low-level safeguarding concerns. When different agencies have co-located services, there can be a more natural flow of information as 'soft' intelligence is more likely to be shared verbally. Practitioners need to feel confident that information they share will be used proportionately by other agencies, so that each agency has all of the pieces of the puzzle they need to identify when safeguarding risks are escalating for an adult in need of care and support.

Recommendations:

The Board to seek assurance from partners that they have clear policies in place for multi-disciplinary cooperation in cases where individuals have complex mental and/or physical health problems, to facilitate holistic planning and risk management. These should provide for communication of safeguarding concerns and other information which fall below the threshold for a section 42 referral. These policies should incorporate multidisciplinary team meetings, including use of videoconferencing or telephone consultations, to improve communication between different agencies. Evidence should be sought that these policies are driving positive change to practice and patient outcomes.

Ideally, multiagency teams working together around a patient should have limited access to partners' ICT records and be able to upload important information to case files. This would reflect current practice in respect of mental health and MASH records.

Over-optimism and trust

Systems finding:

In the context of the pandemic, professionals overlooked the rationale of having a refused visit policy, which is to ensure that there is a proportionate response to risk, even when there is a reasonable explanation for the refusal. Assertions by family members in respect

of improved health were not considered in the context of the available evidence. An over-reliance on information from families without professional oversight from any agency greatly increases the risk of harm for adults who are wholly reliant on others for their care.

Recommendations:

Health and Social Care partners should review their refused visit policies to ensure that these include a requirement for a proportionate risk management plan to be devised and kept under review when individuals (or a family member) stop a service because they are self-isolating. Where there is any history of neglect or self-neglect, including low-level concern, this must incorporate methods to physically oversee compliance with care plans (using remote technology where safe and appropriate), and a robust escalation procedure in the event of non-compliance with the risk management plan. A multiagency meeting should be convened to ensure that all professionals involved are aware of the risks and share oversight of the risk management plan. Roll out of any changes to policy need to be effectively communicated to staff to ensure understanding.

Many cases have been closed to Health or Social Care as consequence of the individual or family members deciding to stop their service during the coronavirus crisis. These cases must be proactively reviewed by agencies as the vaccine becomes widely available, rather than relying on self-referrals to reinstate the service. This is particularly important given the reported drop in the number of referrals Barnet received in respect of self-neglect during the first lockdown, and spike in cases subsequently. Failure of agencies to take responsibility for initiating contact will leave those suffering neglect or self-neglect, who may currently be invisible to professionals, at long-term risk of harm. The Board should seek assurance that partners have audited cases closed during the pandemic and new referrals received. Partners to confirm that processes are in place to adequately assess and review risk, and that individuals received the support they require either from professionals or their own support networks.

All care plans and care pathway plans should incorporate a contingency plan in the event that the adult in need of care and support, or their carer, has to self-isolate. This provision should continue after the current COVID-19 crisis.

Additionally, the Board should produce a leaflet for carers who wish to take over responsibility for all care of a family member and terminate professional services, advising them of their legal duty of care. This should set out the potential consequences of failing to adequately meet the person's needs and provide information about who to contact and how to obtain additional support if they are struggling to provide proper care. Informal carers should be asked to sign an agreement form with the most recent care plan appended, confirming that they understand their legal duty to provide a good enough standard of care.

Supervision during periods of crisis.

Systems finding:

The overwhelming pressure on staffing levels during the pandemic reduced the efficacy of supervision processes, resulting in episodic analysis of information.

Recommendations:

The Board must seek assurance from all partners that contingency plans during periods of crisis focus on effective supervision of staff, including agency staff. Recording systems for agency staff need to be improved to enable safeguarding concerns and patterns of

non-compliance to be easily identified when consistent staffing cannot be provided. If possible, ICT systems should enable safeguarding concerns and carers not complying with medical advice to be automatically flagged for analysis by a supervisor.