



## **Safeguarding Adult Review**

**Lawrence Beasley**

**May 2017**

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## **1. Introduction**

### **1.1 Why this case was chosen to be reviewed?**

Barking and Dagenham Safeguarding Adults Board made the decision to commission a Safeguarding Adult Review under Section 44 of the Care Act (2014), following the death of Lawrence Beasley. This was because the circumstances of the case appeared to have a wider significance for practice, both in relation to hospital discharge and in the use of the Mental Capacity Act. The decision to use the SCIE Learning Together methodology was in order to maximise wider learning from the case than might be provided by a more traditional review methodology. This was also an opportunity for the Board to trial this systemic methodology.

### **1.2 Succinct summary of case**

Lawrence Beasley was a 63 year old man living in sheltered accommodation with both physical and mental health needs. Supported through the Care Programme Approach, Lawrence had a diagnosis of paranoid schizophrenia but refused all anti-psychotic medication. He was diabetic and received insulin injections twice daily from the District Nursing service, but chose to drink a lot of fizzy drinks and eat chocolate. During the period under review Lawrence had 3 hospital admissions due to his physical health. Before his second hospital discharge a Crisis Intervention package was put in place. However when he was discharged from hospital the third time, on 17th March 2016, he received no community services. He died at home 4 days later.

### **1.3 Family composition**

Lawrence was supported by his brother, and prior to the period under review, by his brother's daughter, Lawrence's niece.

### **1.4 Timeframe**

The time period considered by this Review was 21<sup>st</sup> July 2015 until 17<sup>th</sup> March 2016. The Review was commissioned in early June 2016 and reported to the Adult Safeguarding Board on 13<sup>th</sup> December 2016.

### **1.5 Organisational learning and improvement**

Barking and Dagenham Safeguarding Adults Board (SAB) identified that undertaking a Safeguarding Adults Review of this case held the potential to

shed light on particular areas of practice, including addressing the following Research questions posed by the Review Team;

- **How can professionals in Barking and Dagenham working with adults at risk be supported to always consider capacity?**
- **How can we ensure safe discharge for service users who have a history of being hard to engage?**

The use of research questions in a Learning Together systems review replaces traditional Terms of Reference. Posed at the start of the process, to provide a frame of reference for the review, the research questions identify the key lines of enquiry that the Safeguarding Adults Board (SAB) believe are most relevant to current practice.

## **1.6 Care Act 2014**

The Care Act 2014 requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

- *An adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,*

And

- *There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.*

The Care Act states that: *each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:*

- *Identifying the lessons to be learnt from the adult's case,*

And

- *Applying those lessons to future cases.*

The Care and Support Statutory Guidance [14:138] DoH, October 2014, sets out the following principles which should be applied by SABs and their partner organisations to all reviews:

- *There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,*
- *The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined,*

- *Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed,*
- *Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith,*
- *Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.*

## **2. Methodology**

In order to comply with these requirements Barking and Dagenham Safeguarding Adult Board has used the SCIE *Learning Together* systems model (Fish, Munro & Bairstow 2010) to carry out this Safeguarding Adult Review. The Learning Together methodology is explained in Appendix 1.

### **2.1 Reviewing expertise and independence**

This SAR has been led by two Lead Reviewers who are both independent of the case under review and of the organisations whose actions are being reviewed. Julie Pett is accredited to carry out SCIE Learning Together reviews and has led a number of SARs using this methodology. Meg Boustead has completed the Learning Together course and is applying for accreditation in the model. Neither has any had previous involvement with this case, or any previous or current relationship with the London Borough of Barking and Dagenham or partner agencies.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and the reliability of the findings as rooted in the evidence.

### **2.2 Acronyms used and terminology explained**

In order to explain the terms used in this report, Appendix 2 provides a section on terminology to support readers who are not familiar with the processes and language of adult social care and health provision.

### 2.3 Specialist advice

There have not been any specialist advisors involved in this Review as the Review team had sufficient expertise to inform the Review.

### 2.4 Methodological comment and limitations

Time constraints prevented further conversations being held with a small number of additional practitioners who were not initially identified. This included a GP and a CPN. Although it would have been helpful to have the benefit of the views of these practitioners, the Review Team do not consider that this has had a material impact on the Findings below.

A decision specific capacity assessment was not available to the Review Team until four months after the Review was presented to the Board, despite efforts by Review Team members to locate it. This report has been amended in the light of this additional evidence which did not affect the systemic Findings within this report to a great extent. It may, however, have influenced the development of other Findings.

### 2.5 The Review Team

The two Lead Reviewers worked closely with a Review Team consisting of a group of senior managers from agencies that had been directly involved with Lawrence. However members of the Review Team did not have any direct management responsibility in relation to the services offered to Lawrence. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice and to the development of the findings from the review. Review Team members worked collaboratively with the two Lead Reviewers in conducting conversations with Case Group Members, reading documentation and analysing the data. The Review Team was also able to provide useful evidence regarding the practice issues identified in the case.

#### The Review team consisted of:

Title	Agency
Named Nurse, Safeguarding Adults	Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT)
Group Manager, Integrated Care	London Borough of Barking and Dagenham (LBBD)

Assistant Integrated Care Director for Mental Health & Learning Disability Services	North East London NHS Foundation Trust (NELFT)
Specialist Safeguarding Adults Advisor	North East London NHS Foundation Trust (NELFT)
Business Manager	Housing Association
Detective Sergeant, Specialist Crime Review Group	Metropolitan Police
Quality Assurance & Safeguarding Adult Board Manager	London Borough of Barking and Dagenham (LBBD)

## 2.6 Participation of professionals

This Review benefited from a committed and engaged Case Group consisting of individual practitioners who had worked with Lawrence.

Case Group members were drawn from:

- London Borough of Barking and Dagenham (LBBD)
- North East London NHS Foundation Trust (NELFT)
- Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT)
- Housing Association
- Domiciliary Care Agency

## 2.7 Perspectives of family members

The brother of Lawrence was visited by one of the Lead Reviewers and the Quality Assurance & Safeguarding Adult Board Manager on 26<sup>th</sup> July 2016. He was able to give a helpful perspective on Lawrence as a person, and expressed his own frustration that he did not feel that the right level of support had been provided to his brother over the years.

# 3. The Findings

## 3.1 Structure of the Findings

Six priority Findings have emerged from this Safeguarding Adult Review. These Findings explain why professional practice was not more effective in protecting Lawrence in this case. Each Finding lays out the evidence identified by the Review Team to show why these are not one-off or case specific issues and

why they undermine the reliability with which professionals can do their jobs now and in the future.

## **3.2 Appraisal of professional practice in this case: a synopsis**

This section provides an overview, both of what happened in this case and why it happened and is the view of Review team members about the quality of the practice in this case, including where practice fell below what would be expected. The Review Team has made these judgments in the light of what was known, and was knowable, at the time. Systemic issues are explored in more detail in the Findings and are cross referenced.

### **3.2.1 Background**

This case is characterised by the failure of health or social care agencies, to carry out decision specific Mental Capacity assessment, with one exception. This is despite Lawrence's mental capacity being discussed by professionals on a number of occasions, and the decision to undertake a Mental Capacity assessment being recorded several times. The Review Team recognises that professional ambivalence about completing Mental Capacity assessments is far wider than this case, and that it is may be related to the lack of clear strategic ownership for MCA within and across the partnerships. The issue of the **lack of strategic leadership in relation to MCA is explored in Finding 4.**

### **3.2.2 First hospital admission, followed by 3 and a half months at home; July to November 2015**

This period is characterised by some practitioners working with Lawrence raising their concerns about Lawrence's living situation, particularly in relation to his unwise dietary choices and self-neglect. When one of the District Nurses considered that Lawrence's infected foot could not be managed in the community, the GP arranged with the consultant for Lawrence to be transported directly to the Vascular Ward in Hospital 2. As Lawrence was reluctant to go into hospital this was an effective way to admit Lawrence. The District Nurse also raised a Safeguarding alert in relation to Lawrence's self-neglect, which

was good practice. She also completed a Mental Capacity assessment on a NEFLT form. This was also good practice, although the Mental Capacity assessment was not decision specific as it covered general concern about self-neglect. **Application of MCA is explored in Finding 6.**

When Lawrence was discharged home from hospital at the end of July the District Nurses and Sheltered Housing staff instigated a practitioners meeting because they believed that continuing to live in his flat was putting Lawrence's health at risk. Practitioners agreed that extra care housing would be more appropriate to meet Lawrence's needs, but this does not appear to have been pursued. The District Nurses continued to visit Lawrence twice a day to administer his insulin and dress his diabetic ulcers, and continued to raise concerns about his self-care.

Disagreement about Lawrence's mental capacity meant that the different professionals were not able to form a shared view of the best way to support Lawrence. **Finding 6 explores the apparent professional reluctance to conduct a decision specific capacity assessment** which might have helped determine the way forward at this stage.

### **3.2.3 Stay in Hospital 1; November 2015 to January 2016**

On 20th November Lawrence was admitted to hospital again as his infected foot had become gangrenous. There was an ensuing discussion and a capacity assessment completed about his mental capacity in relation to his refusal to consent to treatment **which is explored in Finding 6.**

Eventually Lawrence did consent to the operation he needed and it took place on 25<sup>th</sup> November. It is unclear whether the initial capacity assessment, where Lawrence was deemed not to have capacity, was subsequently reviewed in the light of this change of decision by Lawrence. **Finding 5 explores the implications of the subsequent presumption of capacity.**

When Lawrence was deemed medically fit, on 9<sup>th</sup> December, the hospital planned to discharge Lawrence home to his sheltered housing flat. This prompted the District Nurses to raise a further safeguarding alert as they were concerned about him returning home before a Multi-Disciplinary Team (MDT) meeting was held. The plan then changed to seek a temporary nursing home placement for Lawrence and his discharge was therefore appropriately delayed. He remained in hospital until January 2016 but it appears that he did not meet the criteria for this service so the plan for him to be moved to a temporary nursing home placement was not pursued.

The Multi-Disciplinary Team (MDT) meeting held on 20<sup>th</sup> January in Hospital to plan Lawrence's discharge agreed that a Crisis Intervention package would be put in place. Lawrence's Care Co-ordinator from the Mental Health team was expected to complete the assessment and support plan, rather than this being

led by the Joint Assessment and Discharge Team (JAD) as would have been the case if Lawrence did not have a Care Coordinator. **Finding 2 explores the implications on commissioning of the separation of mental health services for working age adults from other integrated services.**

#### **3.2.4 Six weeks at home leading to final hospital admission and subsequent discharge home; January to March 2016**

After Lawrence was discharged home on 22<sup>nd</sup> January 2016 carers from the Domiciliary Care Agency visited Lawrence three times a day. Although Lawrence always let the carers in he did not respond to prompts to clean himself or tidy his flat, and concerns persisted about his self-care. It was good practice that his main carer was consistent throughout this period, which allowed him to build up a good relationship with Lawrence.

At the end of February the Mental Health Care Co-ordinator (MHCC) visited Lawrence with a Senior House Officer (SHO) to conduct the annual Care Programme Approach Review. However there is no record of consultation with other professionals involved in Lawrence's care which would have been expected practice for a CPA review. The MHCC also appropriately started the process of reviewing the Crisis Intervention plan, which had to be reviewed after 6 weeks. The re-assessment had not been concluded before Lawrence was admitted to Hospital 2 on 7<sup>th</sup> March with a chest infection.

The Hospital pharmacist rang the MHCC to double check information about Lawrence's anti-psychotic medication which was good practice, but unfortunately the ward were not aware of the involvement of Mental Health, or that District Nursing had administered Lawrence's insulin in the community. The MHCC also assumed that the Ward knew that Lawrence were aware of Lawrence's long term mental health needs. When the nurses administered insulin to Lawrence they '*dialled the pen*' and handed it to Lawrence to administer. This was recorded in the notes as '*self-administered*', which was usual practice at that time [Note: this practice has now been changed]. Likewise the medical staff were not aware that Lawrence's blood sugars were unstable at the point of discharge. **The pressure on hospitals to discharge patients and potential obstacles to good communication on wards is explored in Finding 3.**

When Lawrence was medically fit for discharge he declined all services and contact with his family. He was therefore discharged home on 17<sup>th</sup> March without any community based services being informed.

Although they had not been informed of his discharge, the sheltered housing staff, the Mental Health Care Co-ordinator and the Domiciliary Care provider all came to know that Lawrence had returned home later that day. However

despite efforts by the Domiciliary Care provider and the Mental Health Care Co-ordinator to re-instate the Crisis Intervention package, confusion about the process of re-starting the package and about who had the responsibility for doing so meant that the package was not re-started by the weekend. **This is explored in Findings 1 and 2.**

There was also a shared assumption that the District Nurses would have been aware of Lawrence’s being at home, which they were not. **The reliance on other agencies or families to inform key services is explored in Finding 1.** Lawrence responded to the morning call from the sheltered housing staff on the Saturday and Sunday but failed to respond on Monday morning and he was found dead in his flat on Monday 21st March.

The Review Team is of the view that although his death was not directly the result of a lack of care or support, carers would have provided an additional layer of observation and safety. If the District Nurses and carers had gone in over that weekend his death at that specific time could possibly have been prevented.

### **3.3 In what ways does this case provide a useful window on our systems?**

This case illustrates the widespread challenge of how the undoubted potential of the Mental Capacity Act can be realised, by drawing attention to some of the underlying, systemic reasons why Mental Capacity assessments are often not undertaken when they should be. It also reflects the challenge for practitioners of finding an appropriate balance between the requirement to promote the self determination of the service user, and the duty of care of practitioners to protect and safeguard welfare. As importantly, it also typifies the dilemma of ensuring safe hospital discharges when demand for beds puts pressure on doctors and nurses alike to discharge earlier.

### **3.4 Summary of Findings**

The review team have prioritised 6 findings for the SAB to consider. These are:

<b>No.</b>	<b>Finding</b>	<b>Category</b>
<b>1.</b>	<b>The routine process for informing community services of discharges from hospital is not working consistently, which is increasing the risk of a system post-discharge that is reliant on individual ‘heroes’ to check, communicate and follow up.</b>	<b>Management systems</b>
<b>2.</b>	<b>As it is unusual for service users of Mental Health Services for Working Age Adults to have physical community care needs, this may result in a lack of</b>	<b>Management systems</b>

	<b>clarity about the process of commissioning services. This can lead to service users not receiving timely support for physical needs.</b>	
<b>3.</b>	<b>Due to the importance of achieving the right balance between the imperative to discharge patients and the need to ensure safe discharge of vulnerable service users, any obstacles to effective communication between medical and nursing staff within the hospital need to be identified and eradicated</b>	<b>Long term communication</b>
<b>4.</b>	<b>It is not clear enough in the Barking and Dagenham area where the strategic lead for the MCA lies, across and within the partnerships. This is impacting both upon the ways in which practitioners from all health and social care agencies are supported to apply MCA, and the quality assurance of the application</b>	<b>Management systems</b>
<b>5.</b>	<b>MCA emphasis on presumption of capacity is inadvertently making it more likely that some practitioners may assume capacity rather than record their rationale for decision and this risks loss of evidence going forward</b>	<b>Human Bias</b>
<b>6.</b>	<b>The responsibility of making a best interest decision for a service user when they lack capacity weighs too heavily on some practitioners, which means they tend to avoid undertaking them</b>	<b>Management systems</b>

### **3.5 Findings in detail**

#### **Finding 1**

**The routine process for informing community services of discharges from hospital is not working consistently, which is increasing the risk of a system post-discharge that is reliant on individual ‘heroes’ to check, communicate and follow up. The routine process for informing community services of discharges from hospital is not working consistently, which is increasing the risk of a system post-discharge that is reliant on individual ‘heroes’ to check, communicate and follow up.**

#### **Introduction**

Hospital discharge planning should ensure that when patients are medically fit to return home, they are able to do so in a safe manner. This should be a planned process involving the patient, their family and any practitioners involved in the patient's care.

### **How did the issue manifest in the case?**

Lawrence was discharged from hospital 2 without any community agency or Lawrence's brother being informed. This was because Lawrence had told hospital staff that he did not want his brother to be told of his discharge and that he did not need any 'help' at home.

Some agencies did become aware that he had been discharged; through the Sheltered Housing scheme realising he was home, the Mental Health Care Co-ordinator (MHCC) and his brother coincidentally seeing him at the sheltered housing complex on the day of his discharge, and the Domiciliary Care Agency worker realising he was home the following day and subsequently taking him his dinner.

Despite this knowledge, the MHCC assumed that the Domiciliary Care Service would visit over the weekend; the Domiciliary Care Service assumed that Sheltered Housing would monitor him, and everyone assumed that the District Nurses (DNs) would be visiting. These were all false assumptions.

### **What makes it underlying (rather than an issue particular to the individuals involved?)**

During conversations and at the Follow-on Meeting held on 28<sup>th</sup> September 2016, the District Nurses estimated that they are only informed of hospital discharges that they should be told about in approximately 90% of cases. In some of the remaining 10% of cases they are informed by family members or other agencies.

Review team members are aware that Domiciliary Care agencies are often not informed of discharges. There is no safety net in place if the discharge process fails.

There is also a reliance on family members informing community services that service users have returned home. A Review team member gave an example of her family members needing to inform key agencies of a discharge as the hospital had not done so.

### **What is known about how prevalent the issue is?**

The Review Team is aware that in the Metropolitan Police area around 50% of SARs are in relation to unsafe discharge.

Between January and November 2016, 63 discharge alerts were raised in relation to inappropriate or failed discharges from the hospital, for Redbridge and Barking and Dagenham.

### **What is known about how widespread issue is?**

Safe discharge from hospital for people with community care needs is a national issue and a large proportion of SARS and Serious Incidents in England concern discharge from hospital.

Unplanned discharge from hospital is widespread. Research has highlighted the complexity of the interaction within hospitals as well as between hospitals and community services.

*Hospital discharge is a vulnerable stage in the patient pathway. Research highlights communication failures and the problems of co-ordination as resulting in delayed, poorly timed and unsafe discharges. The complexity of hospital discharge exemplifies the threats to patient safety found 'between' care processes and organisations. In developing this perspective, safe discharge is seen as relying upon enhanced knowledge sharing and collaboration between stakeholders, which can mitigate system complexity and promote safety...*

*The study reinforces the view of hospital discharge as a complex system involving dynamic and multidirectional patterns of knowledge sharing between multiple groups. The study shows that discharge planning and care transitions develop through a series of linked 'situations' or opportunities for knowledge sharing...* WARING Justin, et al

Local Authorities have Performance Indicators linked to hospital discharge. Secondary providers such as Hospitals 1 and 2 also have performance indicators around discharge and transfer of care. There is pressure on both to transfer patients quickly back to the community when they are medically fit.

A recent SAR undertaken by one of the lead Reviewers evidenced how frequent changes were made to Domiciliary Care daily caseloads by phone and missed calls occurred quite frequently, but usually to no adverse effect. Practitioners thus became complacent to potential risks to service users who missed care. It was also established that the reverse also happened quite often, with community staff making unnecessary visits because discharge from hospital had been delayed for sound reasons (such as the patient was not well enough) but community staff were not informed. Resources were therefore wasted through unnecessary initial appointments following discharge.

Clarkson P. et al 'Integrating assessments of older people; examining evidence and impact from a randomised, control trial; Age and Aging' says that '*differences in professional culture...undermine integrated systems.*' This includes differences in types and use of documents.

In relation to the lack of a clinical portal, incompatible IT systems are reported as undermining joint initiatives in a number of research papers in SCIE Research

Briefing 41: *“Factors that promote and hinder joint and integrated working between health and social care”.*

Missed calls increase risk and create anxiety for service users and their families. Conversely unnecessary calls are a waste of resources. There is also widespread public perception about the risks of inappropriate discharge from hospital. In 2012 ITV reported that *“8000 patients a week, some elderly and vulnerable, are being sent home from hospital in the middle of the night to relieve pressure on beds”*

### **What are the implications for the reliability of the multi-agency safeguarding adult system?**

Confusion around discharge is not normally a problem because practitioners manage it case by case. Because of lack of verification there is reliance on service users or their families reporting any missed calls. This issue is compounded by the plethora of different electronic and paper recording systems used by different organisations, and the absence of any “clinical portal” to facilitate sharing key information.

If discharge planning does not incorporate risk assessment in relation to the outcome of the discharge for the individual there is a continued risk of compromised discharge and consequent sub-optimal care.

Pressure to avoid delayed discharge works against the time required for a more person centred service.

#### **FINDING 1**

##### **ISSUE FOR CONSIDERATION BY THE BOARD**

**The routine process for informing community services of discharges from hospital is not working consistently, which is increasing the risk of a system post-discharge that is reliant on individual ‘heroes’ to check, communicate and follow up**

##### **MANAGEMENT SYSTEMS**

#### **SUMMARY**

When the discharge process does not work as well as it should, there is no “safety net” in place to ensure that services are re-instated. Instead the system is reliant on family members or other agencies informing key agencies of the discharge because they are not told automatically. This means that there is a continued risk that hospital

discharge processes will mean that some service users who require services in the community will not receive them.

#### **Questions for the Board and Organisations to consider**

- Is the Board aware of the proportion of discharges that are recorded as “inappropriate discharges”?
- Is the Board aware of the proportion of discharges where community agencies which should have been informed of the discharge are not alerted?
- Is the Board satisfied that in B&D there is a strong enough link between discharge planning and holistic risk assessment?
- How will the Board assure itself that discharge processes are working effectively?

#### **Finding 2**

**As it is unusual for service users of Mental Health Services for Working Age Adults to have physical community care needs, this may result in a lack of clarity about the process of commissioning services. This can lead to service users not receiving timely support for physical needs.**

#### **Introduction**

Nationally there is often a separation between the way services are assessed and commissioned for working age adults with mental health needs or learning disabilities (low numbers) and older people (high volume). These separate commissioning routes can create confusion when a service user has needs that cross over.

In Barking and Dagenham re-ablement support is referred to as Crisis Intervention.

#### **How did the issue manifest in the case?**

Prior to discharge from Hospital 1 in January 2016, Lawrence was assessed as needing crisis support (re-ablement) after his long stay on the ward. He was therefore provided with a Crisis Intervention package when he returned home. Lawrence had a Mental Health Care Co-ordinator (MHCC) and so the Joint Assessment and Discharge team (JAD) would not normally have become involved in his assessment. However the MHCC was unfamiliar with completing the support plan, and as the template on the RIO system differs from that used by the Adult Social Care (ASC) Brokerage Team it meant that the support plan had to be transcribed from RIO by the JAD Team to the usual template before it could be implemented. There was some confusion about who was responsible for commissioning the care package. However Lawrence remained in hospital,

despite being medically fit, while this was being negotiated, so his safety was not compromised.

Lawrence's community care support was via a Crisis Intervention package. This therefore automatically ended when Lawrence was admitted to Hospital 2 in March 2016; he therefore required a full re-assessment before his care package could be re-commenced.

Lawrence was discharged from Hospital 2 initially without the MHCC's knowledge, although they became aware that same day. The MHCC and the Domiciliary Care Agency both misunderstood the difference between restarting a long term care package and re-commissioning a Crisis Intervention package, including being unclear about the role of Brokerage.

As when Lawrence was due to leave Hospital 1, practitioners were confused about who was responsible for commissioning community services. As Lawrence had a MHCC, the MHCC was responsible, but the Domiciliary Care Agency contacted the Intake Team in ASC as they would re-start packages if there was no mental health involvement.

### **What makes it underlying (rather than an issue particular to the individuals involved?)**

A Crisis intervention package will be put in place for a time-limited period, usually up to 6 weeks, to support return home or meet short term physical needs. This will not be subject to a financial assessment. If the service user requires support beyond the 6 week period of the Crisis Intervention package, they will require a financial assessment and will then be supported through a longer term care package, often via a personal budget. In Barking and Dagenham the Joint Assessment and Discharge (JAD) team will generally commence new or re-start care packages before discharge from hospital unless Mental Health or Learning Disability services are involved. Likewise the Adult Social Care (ASC) Intake team can commence or re-start care packages for service users in the community unless Mental Health or Learning Disability services are involved.

In common with many other areas, Barking and Dagenham Domiciliary Care services are commissioned by through a Brokerage team, who deal directly with the domiciliary care providers and arrange contracts, payment arrangements etc. Brokerage are dependent upon ASC or JAD completing the assessment and support plan.

At the Follow On Meeting on 28<sup>th</sup> September, the Case Group continued to be confused about:

- The differences between a Crisis Intervention Package and Long Term Needs
- The difference between Intake Team and Brokerage
- Who was responsible for undertaking assessments

Due to the infrequent nature of younger service users requiring community care packages, it appears that some mental health practitioners working with Working Age Adults are not familiar with the distinction between Crisis Intervention and longer term care packages, and therefore are unclear about the process for re-commissioning a Crisis Intervention service that has ceased.

This is made more complex by the incompatibility of MH Assessment templates with Brokerages electronic system. All CPA documentation is completed on RiO; however, for all social care packages, Mental Health practitioners need to complete AIS Paperwork to ensure compatibility. As MH practitioners working with working age adults do this very infrequently, they do not build up familiarity or expertise in this area.

There is currently a plan to change the organisation of mental health services within NELFT, from a distinction between Working Age Adults and Older People, to general mental health and an all age Frailty team which will differentiate on the basis of need rather than age. This should help eradicate this aspect of this issue, as all MH practitioners in the Frailty team will become familiar with the process for commissioning Crisis Intervention packages, and the difference between a Crisis Intervention Package and a longer term Care package.

### **What is known about how prevalent the issue is?**

During 2015-16 the JAD started 464 packages of Crisis Intervention and made 26 placements into nursing or residential care.

During the same period there were 219 people open to the Older Adults Mental Health team with packages. The Working Age Adult Mental Health service has 104 people living in Supportive Accommodation and a small number supported through direct support or a personalisation budget. The low numbers means that practitioners in the service do not have the opportunity to develop experience and skills in commissioning either Crisis Intervention packages or longer term care packages.

Review Team members explained that at the Resource Allocation Moderation Panel (RAMP) only 1 or 2 requests for care packages are presented each year from services for Working Age Adults. This demonstrates that each mental health practitioner may only use this process once every few years.

### **What is known about how widespread the issue is?**

It is common for services for people with mental health conditions or learning disabilities (small numbers) to be separated organisationally from services for older people (high volume). This can lead to tension between services when a younger adult develops different community care needs.

The NICE Guidelines on "*Transition between inpatient hospital settings and community or care home settings for adults with social care needs*" published in December 2015 covers all ages but differentiates between "*older people*" and

others, stating that a “*Comprehensive assessment of older people with complex needs*” should be commenced at the point of admission to hospital.

The NICE guidelines state that the term “*older people...generally refers to people aged 65 years and over. But it could refer to people who are younger, depending on their general health, needs and circumstances*”. This implies some flexibility around the cut-off point, in line with the person-centred approach but also adds to confusion around who is responsible for assessment.

This is further compounded by the variety of recording systems in operation. Incompatible IT systems are reported as undermining joint initiatives in a number of research papers in SCIE Research Briefing 41: “*Factors that promote and hinder joint and integrated working between health and social care*”.

### **What are the implications for the reliability of the multi-agency safeguarding adult system?**

Any gap between services increases the risk of “silos” and of people “falling between the cracks”. This separation of service provision, while rational organisationally, may increase the risk of practitioners becoming immured in their own specialism and therefore not sufficiently familiar with how neighbouring services are organised.

## **FINDING 2**

### **ISSUE FOR CONSIDERATION BY THE BOARD**

**As it is unusual for service users of Mental Health Services for Working Age Adults to have physical community care needs, this may result in a lack of clarity about the process of commissioning services. This can lead to service users not receiving timely support for physical needs.**

### **MANAGEMENT SYSTEMS**

### **SUMMARY**

The separation between wider Integrated Services and Integrated Services for people with Mental Health needs creates the risk of confusion about how care packages are commissioned, and who is responsible for commissioning them.

### **Questions for the Board and Organisations to consider**

- Is the Board aware of how widespread this issue is?
- Is the separation between wider Integrated Services and Integrated Services for people with Mental Health needs causing any obstacles in provision of services to younger adults with physical care needs?
- What can be done to improve the familiarisation of mental health practitioners working with Working Age Adults with processes for commissioning Crisis Intervention packages and care packages until the new all age frailty team comes into operation?

### **Finding 3**

**Due to the importance of achieving the right balance between the imperative to discharge patients and the need to ensure safe discharge of vulnerable service users, any obstacles to effective communication between medical and nursing staff within the hospital need to be identified and eradicated.**

#### **Introduction**

When a patient is close to discharge, it is important that there is a holistic assessment of their needs to ensure that not only they are medically fit but that it is safe to discharge. Discharge dates from secondary care often have to change due to the service user's needs and supporting information may change frequently. At certain times of the year, for example at holiday times, there may be additional pressure around discharge due to staffing levels or due to increased numbers of patients needing admission.

In the context of a very busy ward with frequent admissions and discharges it is vital that there is good and full communication between medical and nursing staff, to ensure safe discharge of vulnerable patients.

#### **How did the issue manifest in the case?**

When Lawrence was admitted to the Ward in Hospital 2 in March 2016, his Patient notes were split between the medical notes held at the Nurses' station and the Nurses' recent observations kept at the patient's bedside.

- As the Nursing staff on the ward did not read the medical history in Lawrence's case notes they were unaware of Lawrence's mental health condition and did not know that he had domiciliary services in the community.
- When reviewing Lawrence's medical notes at the on 17th March 2016, the Clinician saw that his toe had healed and so Lawrence appeared medically fit for discharge. However the Doctor did not read the Nurses' observations, so was not aware of Lawrence's unstable blood sugars when recommending discharge. When the Registrar spoke to the consultant he was therefore unaware that Lawrence's blood sugars were unstable.
- Lawrence was then discharged before the Consultant's Ward Round when both sets of notes would have been reviewed together.
- In this context the separation of medical and nursing notes constituted an additional obstacle to making sure that all relevant information is communicated.

### **What makes it underlying (rather than an issue particular to the individuals involved?)**

District Nurses routinely send Discharge Alerts when they are concerned that discharge is not as it should be. Many of these are in relation to failed communication about the patient's needs.

It is common practice to keep Nurses' Observations next to the patient's bed and medical notes locked at the Nurses' station, although this does vary from ward to ward. When Consultant makes their ward round, these observations and nurse opinions are taken into consideration even if a patient appears medically fit for discharge. However due to pressure on beds, patients are often transferred to the discharge lounge prior to the Consultant's round.

There have been some attempts to improve multi-agency and disciplinary communication. The JAD team was set up to "*promote good and consistent discharges*" for people with community care needs. The practice of multi-disciplinary Board rounds has also improved communication.

### **What is known about how prevalent the issue is?**

The Review Team are aware that in the Metropolitan Police area 50% of SARs are in relation to unsafe discharge.

Between January and November 2016 63 discharge alerts were raised in relation to inappropriate or failed discharges from hospital.

### **What is known about how widespread the issue is?**

Pressure on hospitals to discharge patients is a National issue.

Waring's study of Hospital Discharge (WARING Justin, et al, 2014) referenced in Finding 1, concludes that "*variations in knowledge sharing can hinder or promote safe discharge*".

Liz Deutsch, 2016, refers to the confusion between discharge planning and risk assessment; "*Patient discharge assessment and risk assessment started to emerge as two different things: assessment of risk was about 'patient safety' and assessment for discharge is about 'planning discharge'. They are referred to synonymously*"

One of the key aims of the Better Care Fund is to tackle the problem of delayed discharge from hospital. It therefore urges hospital trusts and partners to start planning discharge from the point of admission. This is reliant on good communication systems within the hospital as well as between the hospital and the community.

**What are the implications for the reliability of the multi-agency safeguarding adult system?**

Given the underlying pressure on hospitals to discharge patients, it is important that planning for discharge is as robust as possible in order to reduce the risk of failed discharges. It is acknowledged that the system is complex and multi-dimensional and involved interaction between arrange of professionals from different disciplines.

Given the balance that needs to be achieved between the imperative to discharge patients, and the importance of safe discharge, any obstacles to achieving safe discharge are worthy of consideration.

### **FINDING 3**

#### **ISSUE FOR CONSIDERATION BY THE BOARD**

**Due to the importance of achieving the right balance between the imperative to discharge patients and the need to ensure safe discharge of vulnerable service users, any obstacles to effective communication between medical and nursing staff within the hospital need to be identified and eradicated.**

#### **LONG TERM COMMUNICATION**

#### **SUMMARY**

In an environment where the need to ensure safe hospital discharge is continuously under pressure from the imperative to free up beds, it is worth identifying and tackling any additional obstacle to good communication between medical and nursing staff.

#### **Questions for the Board and Organisations to consider**

- Is the Board aware of other obstacles to effective communication between hospital staff on wards?
- Is there anything more that can be done to facilitate good communication between medical and nursing practitioners when planning discharges from hospital?
- Is there anything more that can be done to remove obstacles to good communication within hospitals in relation to discharge planning?

Findings 4, 5 and 6 are linked and all concern the use of the Mental Capacity Act. Finding 4 examines the strategic leadership of application of the Act. Finding 5 examines the ways in which practitioners avoid obtaining valid consent and decision making as set out in Chapter 3 of the MCA Code 2005.

Finding 6 examines ways in which practitioners avoid both assessing capacity as set out in Chapter 4 of the MCA Code and not making best interest decisions as based on Chapter 5 of the MCA Code.

#### **Finding 4**

**It is not clear enough in the Barking and Dagenham area where the strategic lead for the MCA lies, across and within the partnership. This is impacting both upon the ways in which practitioners from all health and social care agencies are supported to apply MCA, and the quality assurance of the application**

## Introduction

The Mental Capacity Act 2005 sets out the legal framework for making decisions '*on behalf of individuals who lack the Mental Capacity to make particular decisions for themselves*', in which situations, and how they should go about this.

*'Everyone working with and/or caring for an adult, who may lack capacity to make specific decisions, must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.'*

(MCA Code of Practice Chapter 1 What is the Mental Capacity Act 2005?)

This key piece of legislation was reviewed by the Law Society in 2014 with the acknowledgement that it was never embedded into practice and systems as was initially intended.

This national issue is reflected in Barking and Dagenham where health and social care agencies appear to have few governance or quality assurance structures in place to ensure that they comply with the legislative framework. Although practitioners are aware of the principles of the Act, because there is no clear strategic steer, they remain unsure of its practical application.

### **How did the issue manifest in the case?**

During the period under review, practitioners referred repeatedly to their concerns about Lawrence's capacity to make decisions. However with only two exceptions they never completed an assessment of Lawrence's capacity.

During individual conversations and at the follow on meeting with the Case Group on the 28<sup>th</sup> September 2016, health and social care practitioners were able to quote the principles of the MCA 2005. They also confirmed that they discussed their concerns about Lawrence's capacity at various junctures with each other.

However there is limited evidence in any agency that Lawrence's capacity to make specific decisions was formally assessed and subsequently recorded. This is despite templates to support completion of an assessment available in many agencies. On the one occasion it was recorded, it was unavailable until four months after this report was presented to the Board, so apparently unavailable for practitioners to use in order to develop any strategies to support working with Lawrence's fluctuating capacity.

Although it is correct to presume capacity as a starting point, practitioners should assess formally if they believe that a person '*has an impairment ... which affects ability to make a decision*' (MCA Code 2005) and this was certainly a

possibility as far as Lawrence was concerned as he was known to have fluctuating capacity and to sometimes make unwise decisions.

The Review Team could also find no evidence of managers prompting the use of capacity assessments to support their staff's practice when working with Lawrence during supervision or peer support.

**What makes it underlying (rather than an issue particular to the individuals involved?)**

The Review Team's experience is that practitioners are not encouraged via line management or peer support supervision to consider routine use of capacity assessment or record their reasoning behind their presumption of capacity. Instead practitioners presume capacity and then focus on the mitigation of risk caused by unwise decisions.

Similarly, it is the Review Team's experience that front line managers are not using supervision as a forum of encouraging use of the MCA routinely and systematically as a tool to help them work with service users. This is backed up by little evidence of any agencies using a quality assurance framework to assess the effectiveness of the implementation of the Act overall. Even the Supreme Court judgment of March 2014 in the case of Cheshire West which massively increased the implementation of Deprivation of Liberty Safeguards under the Act has not prompted systematic quality assurance of the use of MCA. The Review Team were unable to find any evidence of review of MCA. There are a number of reasons for this including the practice of not using case notes rather than assessment forms when assessing capacity.

The review team and case group openly discussed methods of exploring different cross agency models of supervision to meet the key aspects of 'reflective supervision' and support practice with regard to MCA which included curiosity, complexity and opportunity to explore what is sometimes missing i.e. the critical eye.

**What is known about how prevalent the issue is?**

The Safeguarding Team in the Acute Trust maintain a record of MCA, but they are also aware that others are completed on the wards without their knowledge. Indeed the Capacity Assessment that was completed around Lawrence's refusal to consent to an operation was not passed to the Safeguarding Team. Between April 15-March 16 - 145 mental capacity assessments were recorded in the Acute Trust but this is therefore likely to be an under representation.

There is some more evidence of use of Deprivation of Liberty Safeguards however. Whilst there is no qualitative framework for Deprivation of Liberty Safeguards (DoLS) in place in B&D, the Local Authority appears to be managing the DoLS process more successfully than other local LAs. The Review Team is aware that Best Interest Assessors in the DoLS Team are more likely to challenge other professionals for example.

In the Acute Trust, in Quarter 1 2016-17 thirteen Independent Mental Capacity Advocates (IMCAS) were used to support patients. The Review team feel that the use of IMCAs is encouraged; the DoLS application paperwork prompts this and staff are reminded during training re the IMCA service. It is unknown how many capacity assessments are carried out in B&D but the Review Team consider that there are far fewer completed than the Act suggests as good practice.

### **What is known about how widespread the issue is?**

Concern regarding implementation of Mental Capacity Act principles and an accountable safeguarding and decision making framework is a national issue and is being increasingly recognised as such.

In 2014 a national review of how the Act had been implemented (by the House of Lords Select Committee) raised concerns that the principles of the Mental Capacity Act had not been well understood or put into practice by health and social care professionals.

The Law Commission report states:

*'its implementation has not met the expectations that it rightly raised. The Act has suffered from a lack of awareness and a lack of understanding.*

*For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. Capacity assessments are not often carried out; when they are, the quality is often poor. Supported decision-making, and the adjustments required to enable it, are not well embedded. A fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment. Professionals need to be aware of their responsibilities under the Act, just as families need to be aware of their rights under it'.*

The work of the Chief Social Worker for Adults and Principal Social Worker networks have also highlighted these concerns at a national level, as have the CQC's Annual report re MCA & DoLS.

Barriers to implementation of the Act in Care Homes identified in an article in Community Care (May 2016) include mirror those identified during the conduct of this review:

- Reliance on training formal classroom training
- MCA not built into everyday practice e.g. Team Meetings, supervision
- Managers unsure of how to practically use MCA themselves
- Assumption that only senior staff conduct MCA

Prompts and IT systems are in their infancy in identifying mandatory fields for Mental Capacity Act application, and thus oversight of practice in this area is limited. For example in RIO, the health electronic record system when MCA are completed they tend to be part of the process records as there is no specific

field designated for MCA. A recent article in Building Better Health Care (26/10/16) reported on a trial within the NHS in use of a real time report writing decision making tool to support practitioners in assessing capacity, which also includes an audit facility. Although primarily aimed at the NHS, the “*Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance*” is also of value for other care giving commissioning and provider organisations. It provides a quality assurance framework and makes suggestions about quality assurance with regard to MCA for example in Section 4:

- *Evidence that the MCA is linked into the hospital’s systems and processes relating to improving service users’ experience and the quality of their care and treatment.*
- *What data and information on compliance with the Act is collected and how are trends and performance reported to Board*
- *Evidence of the MCA featuring in audit programmes.*
- *Evidence of the involvement of clinical governance processes in best interest’s decision-making through audit and reviews.’*

The Guide also confirms that ‘*Currently there is limited evidence commissioners are asking questions about the MCA and consideration should be given to including in Quality Schedules or as part of Commissioning for quality and innovation CQINs.*’

### **What are the implications for the reliability of the multi-agency safeguarding adult system?**

Health and Social Care organisations require clear quality assurance frameworks to demonstrate that they are complying with their responsibilities under the Mental Capacity Act 2005.

Health and Social care practitioners should be supported with clear guidance and supervision to ensure best practice and compliance with the law and reduce the risk of litigation. Health and Social Care Organisations require clear quality assurance frameworks to demonstrate that they are complying with their responsibilities under the Mental Capacity Act 2005.

#### **FINDING 4**

##### **ISSUE FOR CONSIDERATION BY THE BOARD**

**It is not clear enough in the Barking and Dagenham area where the strategic lead for the MCA lies across and within the partnership. This is impacting both upon the ways in which practitioners from all health and social care agencies are supported to apply MCA, and the quality assurance of the application**

##### **MANAGEMENT SYSTEMS**

##### **SUMMARY**

To be implemented effectively, the Mental Capacity Act 2005 requires clear leadership at both commissioner and provider level. In Barking and Dagenham, Health and Social Care organisations do not have sufficiently clear strategies, resources and processes for achieving this and practitioners are not supported to implement the Act effectively.

##### **Questions for the Board and Organisations to consider**

- Is the Board aware of the impact of the lack of strategic lead in this area?
- How can the Board be assured that appropriate methods are developed to measure improvement within organisations of the application of the Mental Capacity Act and Code of Practice?

## Finding 5

**MCA emphasis on presumption of capacity is inadvertently making it more likely that some practitioners may assume capacity rather than record their rationale for the decision and this risks loss of evidence going forward.**

## Introduction

The Mental Capacity Act 2005 has five key principles:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because they make an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

This is difficult, particularly if a person has fluctuating capacity and who is difficult to engage. However, if an *'adult repeatedly makes unwise decisions that put them at significant risk of harm or exploitation, or makes a particular unwise decision that is obviously irrational or out of character'*, there might be need for further investigation (Mental Capacity Act Code of Practice, HMG, 2005, 2.11.)

The starting point of presumption of capacity has rightly been seen as the most important feature of the MCA. This person centred approach has been reinforced by other recent guidance and legislation e.g. the Care Act.2015.

This may mean that practitioners may abide by the principle of presuming capacity even if they suspect the service users lacks capacity particularly if the result of the assessment is uncertain or if the person agrees with the practitioner's opinion about the decision.

This tendency to presume capacity is compounded by practitioners' belief that completion of a capacity assessment is time consuming.

## How did the issue manifest in the case?

There are numerous examples of MCA considered but avoided despite concerns about risks to Lawrence's health and well-being:

- When Lawrence was hospitalised due to an infected foot, a life threatening condition, medical opinion was that Lawrence's toe should be amputated, but

Lawrence refused consent a number of times over four days. A capacity assessment was completed around Lawrence's refusal and a Best Interest Decision Lawrence then changed his mind and signed the consent form. However there is no evidence to show that Lawrence's capacity was subsequently reviewed. This would have been good practice to demonstrate that Lawrence had regained capacity and not had merely changed his mind due to undue pressure.

- 
- Lawrence remained in hospital until 22<sup>nd</sup> January 2016 and continued to refuse medical interventions and at no time did a MCA take place.
- There was no discussion of Lawrence's capacity at the MDT meeting on 20<sup>th</sup> January 2015 prior to Lawrence's discharge from hospital despite district nurses continuing to have concerns about the risks of Lawrence's health due to his insistence of eating and drinking sweet foodstuffs.

The Review Team speculated that a capacity assessment by the District Nurses for example around Lawrence's insistence on a diet of fizzy drinks and chocolate rather a more general assessment of 'lifestyle' may have been accepted by other practitioners and a more specific plan developed to support Lawrence when he returned to the community.

### **What makes it underlying (rather than an issue particular to the individuals involved?)**

Review Team members confirmed that many practitioners avoid completing capacity assessments even when it is in the interests of the service user to carry them out. Currently the practice appears to be that MCA is undertaken only when it is almost certain that the adult at risk lacks capacity. From their experience the Review team also consider it quite common for practitioners to keep asking if a patient or service user makes a decision that does not conform to what the practitioner deems to be 'correct'. Whilst it is good practice to provide information in different ways and allow plenty of time where it is possible, unless this is carefully managed and recorded, there is a risk of undue pressure being applied. The Review Team was also able to provide anecdotal evidence that clinicians in particular only consider MCA if the patient does not agree with medical opinion rather than if they have evidence that the person may be incapacitated.

Social care assessments completed by practitioners for long term care are designed to be holistic and allow practitioners to consider capacity. However, this doesn't always happen where appropriate. The Case Group confirmed that practitioners also avoid completion of a capacity assessment because of a perception that this is a time consuming activity outside of their main role rather than it being fundamental to their support of service users. In effect they see capacity assessment as an 'add-on' rather than a fundamental aspect of their role.

## **What is known about how widespread or prevalent the issue is?**

In health and social care, practitioners are influenced by factors such as their own knowledge and values, their own willingness to take risks and the culture of their team and organisation in relation to risk.

'Confirmation bias', a well researched and documented concept, is the tendency to search for, interpret, favour, and recall information in a way that confirms one's pre-existing beliefs or hypotheses, while giving disproportionately less consideration to alternative possibilities. People also tend to interpret ambiguous evidence as supporting their existing position. Confirmation bias occurs from the direct influence of desire on beliefs. When people would like a certain idea/concept to be true, they end up believing it to be true. This leads people to stop gathering information when the evidence gathered so far confirms the views one would like to be true. Once that view has been formed one embraces information that confirms that view while ignoring, or rejecting, information that casts doubt on it.

Guidance on risk assessment from the DoH refers to risks being a '*natural and healthy part of independent living*'. Similarly the Courts support the need for a balanced approach to risk e.g. Slater v Buckinghamshire CC. Although in recent years there has been an increased focus on positive risk taking and to working in partnership with the service user and prioritising their wishes and needs, nationally it is known that the prevailing culture in health and social care tends towards risk avoidance.

Completion of a capacity assessment may also appear to be time consuming. This may mean that practitioners will abide by the principle of presuming capacity even if they suspect the service users lacks capacity, particularly if the result of the assessment is uncertain or if the person agrees with the practitioner's opinion about the decision.

The MCA Code Of Practice 2005 (paragraph 4.6) states that whilst '*Assessments of capacity to take day-to-day decisions or consent to care require no formal assessment procedures or recorded documentation, it is good practice for paid care workers to keep a record of the steps they take when caring for the person concerned*'.

It goes on to state that '*it is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records. A doctor or healthcare professional proposing treatment should carry out an assessment of the person's capacity to consent (with a multi-disciplinary team, if appropriate) and record it in the patient's clinical notes.*' There are similar suggestions for social work and care staff. Practitioners should be recording their evidence whether or not the conclusion is that a service user has capacity.

National and local drivers continue to reduce staffing levels, and time and capacity of staff and inevitably this has an impact on best practice and the level of detail being recorded.

Getting the balance right between when providing information about the risks and consequences of decision is sometimes difficult. However it is also worth noting that the MCA Code of Practice states:

*'Anyone supporting a person who may lack capacity should not use excessive persuasion or 'undue pressure'. This might include behaving in a manner which is overbearing or dominating, or seeking to influence the person's decision, and could push a person into making a decision they might not otherwise have made. However, it is important to provide appropriate advice and information (Chapter 4).*

Undue pressure on service users to make the 'correct' decision also lays the practitioner and their organisation open to legal challenge.

### **What are the implications for the reliability of the multi-agency safeguarding adult system?**

The starting point of presumption of capacity has rightly been the most important feature of the Mental Capacity Act. This person centred approach has been reinforced by other recent guidance and legislation in which a person centred approach e.g. the Care Act to counteract the prevailing cultures of paternalism (in health) and risk-aversion (in social care).

However the Act provides clear criteria to assess mental incapacity and a best interest check list approach to ensure decisions are made in the person's best interests. If the law and code of practice are followed the legislation affords protection not only for the individual but protection for the decision maker. The protection however will be of no value if the capacity assessment and best interests check list has not been followed.

## **FINDING 5**

### **ISSUE FOR CONSIDERATION BY THE BOARD**

**MCA emphasis on presumption of capacity is inadvertently making it more likely that some practitioners may assume capacity rather than record their rationale for the decision and this risks loss of evidence going forward.**

### **HUMAN BIAS**

#### **SUMMARY**

In the Barking and Dagenham area it appears that although practitioners from health and social care agencies consider MCA, they do not consistently apply the principles as laid out in the Code of Practice systematically, and do not record the steps by which they make their decision. This may mean that practitioners will abide by the principle of presuming capacity even if they suspect the service users lacks capacity, particularly if the result of the assessment is uncertain or if the person agrees with the practitioner's opinion about the decision.

This means that evidence of a person's wishes and views cannot be built up over time and may leave the agency vulnerable to challenge.

#### **Questions for the Board and Organisations to consider**

- How can Board members be assured that practitioners clearly detail in their recording how they have come to their judgement of capacity, in the same detail as they would if there was a judgement of no capacity?
- What kind of training do staff receive to support their thinking around capacity – and how is its effectiveness tested?
- How will the Board assure itself that practice has improved?

## **Finding 6**

**The responsibility of making a best interest decision for a service user when they lack capacity weighs too heavily on some practitioners, which means they tend to avoid undertaking them**

### **Introduction**

MCA Code of Practice has a wide definition of who can and should carry out capacity assessments, including amongst others:

- Healthcare staff (doctors, nurses, therapists etc.)
- Social care staff (social workers, care managers, etc.)
- Care workers providing domiciliary care services
- Others who may occasionally have care of people who lack capacity to make a decision in question

It may not always be obvious amongst a group of practitioners working with the same service user who is best suited to undertake the assessment about that specific decision however consideration should be given to among other things:

- What the decision is that needs to be made
- What the decision is trying to achieve
- What are the consequences of the decision

In addition, MCA Principle 2 states: *'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.'* (MCA 2005 section 1 (3))

### **How did the issue manifest in the case?**

Despite practitioners' suspecting that Lawrence's capacity was impaired on a number of occasions and with respect to a number of important decisions, only two capacity assessments were undertaken by any practitioner throughout the period under review.

The capacity assessment was undertaken by District Nurses in July 2015 and used their standard mental capacity assessment form. The capacity assessment was very general in that it concluded that Lawrence lacked capacity to make a decision around *'self-neglect'* rather than focusing around a specific decision.

The Review Team consider that completion of the capacity assessment was driven by practitioners being risk averse about Lawrence's style of living rather than applying the principles of the Act. The District Nurses believed that Lawrence should move to residential accommodation. While this option might have provided a level of enhanced monitoring it would not have been in line with Lawrence's and his brother's expressed wish for him to remain in sheltered accommodation and so was flawed.

The capacity assessment was further challenged by other practitioners who deemed Lawrence's unwise decisions '*a lifestyle choice*'. The District Nurses did not challenge the Care Coordinator's opinion as they deemed her the '*expert*' on mental capacity. This was despite them having a greater knowledge of Lawrence's lifestyle and habits because they visited Lawrence every day for some years.

In addition, at the multi-agency meeting held on 30<sup>th</sup> July 2015 around concerns about Lawrence's ability to function in the community, assessment of Lawrence's capacity was not recorded in the notes of the meeting

A second example shows how efforts were made to avoid completing a capacity assessment for Lawrence although ostensibly complying with MCA Guidance with regard to consultation with other practitioners and family and allowing the person time before finally making a decision.

When Lawrence was admitted to Hospital 1 in November 2015 District Nurses became concerned that Lawrence's foot was not healing properly and had become infected. Initially the infection was treated with antibiotics but this was not successful. By the 21<sup>st</sup> November 2015, following the ward round, medical opinion was that Lawrence's toe should be amputated.

Later that morning the Surgeon (Registrar) asked Lawrence for consent to amputate his toe but Lawrence refused. The Surgeon discussed with the consultant and planned to discuss with Lawrence again the next day.

On the 22<sup>nd</sup> November 2015 there was '*a lengthy discussion*' between the vascular consultant and Lawrence who was informed his condition was '*limb and life threatening*', but Lawrence still refused consent to operate. A capacity assessment was begun by the Registrar and Lawrence was deemed to lack capacity over the decision to have his toe amputated.

Lawrence's brother did not have Deputy Appointeeship or Lasting Power of Attorney for Health and Welfare and a best interest decision could only have been made if Lawrence had been assessed as lacking capacity. The Mental Health Liaison Team Consultant advised the Surgeon that he should complete a formal capacity assessment; and this was duly completed and signed off on.

The Registrar consulted Lawrence's brother and Mental Health Liaison on 23<sup>rd</sup> November 2015 and on the following day consulted the Care Coordinator although this consultation is not recorded on the Best Interest Decision checklist. The checklist was appropriately signed by the Registrar and Consultant on 24<sup>th</sup> November 2015.

Later that day Lawrence changed his mind and signed the consent form. The procedure took place on 25<sup>th</sup> November 2015 but it is unclear whether Lawrence's capacity to make that decision was reviewed and whether the procedure took place as a best interest decision.

Lawrence remained in hospital until 22<sup>nd</sup> January 2016 and continued to refuse medical interventions and at no time did a further MCA take place.

### **What makes it underlying (rather than an issue particular to the individuals involved?)**

At the follow on meeting held on 28<sup>th</sup> September 2016 the Case Group were able to quote theoretical principles of the MCA but some admitted anxiety around completing capacity assessments themselves.

It was also an assumption amongst Case Group members that mental health practitioners were best placed to carry out assessments and it was not really part of their role. This was confirmed from the experience of the Review Team.

It is also the Review Team's experience that therapists such as OTs are more likely to use MCA as part of their holistic assessment and use them correctly as decision specific e.g. safety in returning home. Social work students also appear to be more willing than long term practitioners to carry out Mental Capacity Assessments. The Review Team speculated that this may be because they tend to be less complex decisions and also that the responsibility for the decision is less.

At the Review Team/Case Group meeting with the SAR sub-group on 15/11/16 Review team members acknowledged that training on Mental Capacity Act does not translate into practice as the "how to" is different from having theoretical knowledge of the Act. It is acknowledged that practitioners who are only undertaking a very small number of Mental Capacity assessments each year may find it hard to frame decision specific assessments. Although there are people who can support practitioners carry out mental capacity assessments (IMCAs, other practitioners, family members etc.) some practitioners feel that they carry the full weight of the responsibility. This contributes to the lack of competence and confidence in completion. There is a difference between assessing whether somebody is able to make a decision and the ability to assess executive functioning i.e. their ability to then act on that decision.

At their meeting on 18<sup>th</sup> October 2016 the Review Team also debated the question of a practitioners' ability to challenge others they consider experts. It is the Review Team's experience that Best Interest Assessors will challenge Psychiatrists' opinions of capacity when completing Deprivation of Liberty Safeguards assessments. However these are highly trained in the practical application of the MCA. In contrast, duty social care staff are less likely to challenge capacity assessments made by other professionals.

Review Team members consider that this might be less of a problem for the more confident and experienced workers. They recognise that there is no consistency in applying the MCA across the different social work teams in LBB. Social workers operate on different levels of training, experience and confidence in this area. More confident and more experienced workers are more likely to apply the MCA formally. Less confident and less experienced workers are more likely to accept the judgement of a professional who appears to be an expert in this area.

Mental Health and Adult Community Health Services have now set up a quarterly Practitioner Forum, which has raised understanding of each other's services, improved communication and promoted joint working. The next forum is booked for the 19th January 2017 which will encompass undertaking Capacity Assessments - The Practice. Further topics are also planned on understanding common long term physical health conditions and mental health problems, which will support improved competence within staff.

### **What is known about how widespread or prevalent the issue is?**

Practitioners are used to working in multi-disciplinary teams which share responsibility of the risks associated with a service user making an '*unwise decision*'. MCA gives an individual practitioner the responsibility to make the best interest decision. Although practitioners have become comfortable in making a safeguarding adults alerts themselves, for example, the alert is merely the start of a multi-agency process, whereas making a best interest decision may be the end of an assessment and many practitioners are uncomfortable with this.

However the MCA Code also suggests discussing issues with other practitioners and care givers and documenting the decision with clear reasons for the decision, and therefore supports consultation with other people who know the service user.

The other issue lies in the expectation by other professionals around the role of the MH Care Coordinator who is assumed to have a lead role around actions concerning a service user. In a recent Serious Adult Review completed in 2015 in another area, it was shown that the understanding of health and social care practitioners, both of the Care Coordinator role and of their own responsibilities under the Care Programme Approach (CPA), impacted adversely upon the quality of care provided to service users whose needs are not acute. The heavy reliance placed upon the Care Coordinator within multi-agency working, is systemic, arguably across the U.K. This can be evidenced through the government response to the CPA and guidance issued in attempt to address this issue (Department of Health, 2008).

### **What are the implications for the reliability of the multi-agency safeguarding adult system?**

The Mental Capacity Act 2005 and the Code of Practice are primary legislation and provide the statutory duty of agencies to formally assess capacity whenever there is a concern that a person may lack the mental capacity to make decisions regarding their care and treatment arrangements. A failure to discharge this duty when working with vulnerable adults can leave the adult at risk and fails to consider the best interests of the individual, but also does not provide the legal protection afforded to the '*decision maker*' by the Act.

If practitioners feel the weight of making best interest decisions too deeply then they are less likely to make them and so will avoid making them wherever

possible. If practitioners also lack the confidence to complete capacity assessments there may be a tendency not to undertake assessments but assume that other practitioners working with the service user will undertake them. They may also find it difficult to challenge other practitioners they deem expert but who may have a different opinion of a service user's capacity, even if they do not know the person so well.

Although practitioners may understand the theory behind MCA, the less often they undertake capacity assessments the less likely they are to complete one.

## **FINDING 6**

### **ISSUE FOR CONSIDERATION BY THE BOARD**

**The responsibility of making a best interest decision for a service user when they lack capacity weighs too heavily on some practitioners, which means they tend to avoid undertaking them**

### **MANAGEMENT SYSTEMS**

### **SUMMARY**

Some practitioners in Barking and Dagenham may be hesitant about applying Mental Capacity Act formally because they are concerned about their own competency to do so, preferring to pass the responsibility onto another practitioner whose role they deem is more expert or appropriate. Instead the assessment is not carried out. Practitioners also consider that assessment of capacity as an 'add on' to their role rather than being fundamental to undertaking any holistic assessment of risks.

### **Questions for the Board and Organisations to consider**

- How can the Board be assured that practitioners see MCA as fundamental to their role rather than an-add on?
- How can practitioners be supported to see MCA application as an opportunity to support adults at risk rather than a burden?

## **Conclusion**

This Review has shown that there are a number of systemic issues, some of them quite significant, illustrated by the case of Lawrence. This case has provided a "window on the system" to understand the tension between pressure on hospitals to discharge patients, and the need to ensure safe discharges, and has facilitated the analysis of some of the factors that get in the way of the system working as it should. These issues are explored in Findings 1, 2 and 3. Findings 4, 5 and 6 explore the systemic reasons underlying why some practitioners are reluctant to carry out Mental Capacity assessments, even when a service user's capacity is in doubt, and have identified that one of the

reasons for this may be the lack of strategic leadership within and across the partnership.

## APPENDICES

### Appendix 1: The Learning Together model

This Safeguarding Adults Review was carried out using the systems methodology called Learning Together (Fish, Munro & Bairstow, 2010). The focus of a case review using a systems approach is on multi-agency professional practice; so the primary emphasis is on what the practitioners did, thought and felt, not on the service user.

The aim of a Learning Together Review is to move beyond the specifics of the particular case (what happened and why) to identify the underlying issues that influence practice more generally. These generic patterns become the 'Findings' from a case. Changing them will therefore help to improve practice more widely.

What is referred to as the "Methodological Heart" of the Learning Together model is made up of 3 distinct stages;

1. The "**View from the Tunnel**" - understanding how practitioners understood the 'local rationality', allowing us to reconstruct what happened without the benefit (trap) of hindsight
2. Carrying out an "**Appraisal of practice**" to understand what happened and explain why it happened through the analysis of Key Practice Episodes (KPE's).
3. Using the case as a "**Window on the system**" to assess its relevance and understand the implications for wider practice

This approach studies the system in which people and the context interact. It requires the use of qualitative research methods to improve transparency and rigour. The key tasks of a Learning Together Review are therefore data collection and analysis. The data is obtained through structured conversations with the practitioners involved in the case, and from documents provided by the organisations.

### Structure of the review process

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case. This is a gradual and cumulative process. This review entailed a series of meetings between the Lead Reviewers, Review Team and Case Group members over the course of the review. The initial meeting was between the Lead Reviewers, the Chair of the Case Review subgroup of the SAR and the Safeguarding Adult Board Manager to provide an introduction to the SCIE Learning Together model and explain what would be required from the Review Team and the Case Group.

An introductory meeting then took place with the Case Group and the Review Team. At this meeting the SCIE model, and their role in the review process, was explained to the Case Group and Review team. Case Group members all agreed to be involved in the individual conversations and Review Team members signed up to assist with these.

Eight individual conversations were carried out over three days. After this there was further meeting with the Review Team to consider the Key Practice Episodes (KPEs), the “chunks” of time that are then analysed and appraised in relation to the practice of the practitioners at the time.

The next meeting with the Case Group and Review team started the process of moving from the specific case to the generalisable learning that is at the core of the Learning Together model. Following that the Review team met again to consider and re start to refine the draft Findings.

Date	Meeting Purpose
3 <sup>rd</sup> June 2016	Initial meeting between Lead Reviewers, Chair of Case Review Subgroup and SAB Business Manager
11 <sup>th</sup> July 2016	Introductory meeting with Case Group and Review Team
26/27 <sup>th</sup> July and 4 <sup>th</sup> August 2016	Individual Conversations with Case Group members
8 <sup>th</sup> September 2016	Review Team met to agree KPEs
22 <sup>nd</sup> September 2016	Follow on meeting with Case Group and Review team to consider KPEs and consider underlying patterns
18 <sup>th</sup> October 2016	Review team agreed draft Findings
15 <sup>th</sup> November 2016	Case Review subgroup considers draft report Review team and Case Group in attendance
13 <sup>th</sup> December 2016	SAB receives final report

## Appendix 2: Glossary and explanation of terms

Term	Explanation
ASC	Adult Social Care (in London Borough of Barking and Dagenham)
Brokerage	Team that commissions domiciliary care packages for ASC in LBBD.
CPA	Care Programme Approach – mechanism for supporting service users with severe and enduring mental health conditions in the community
CPN	Community Psychiatric Nurse
DoH	Department of Health
IMCA	Independent Mental Capacity Advocate
Intake Team	The ASC team responsible for assessing service users in the community not open to Mental Health or Learning Disability services.
JAD	Joint Assessment and Discharge Team – responsible for most hospital discharge for adults who require services in Barking and Dagenham
LBBD	London Borough of Barking and Dagenham
MHCC	Mental Health Care Co-ordinator – professional responsible for co-ordinating the Care Programme approach for an individual service user
MCA	Mental Capacity Act, 2005. The Act provides the statutory duty of agencies to formally assess capacity whenever there is a concern that a person may lack the mental capacity to make decisions regarding their care and treatment arrangements.
MDT	Multi-Disciplinary Team
MHLT	Mental Health Liaison Team
NEFLT	North East London NHS Foundation Trust - responsible for community health services including mental health and district nursing
RAMP	Resource Allocation Moderation Panel - considers requests for care packages within NELFT
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCIE	Social Care Institute for Excellence
SHO	Senior House Officer

### **Appendix 3: References**

BUILDING BETTER HEALTH CARE newsletter 26/10/16

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