Redbridge Safeguarding Adults

Redbridge Safeguarding Adult Board (RSAB)
Safeguarding Adult Review (SAR):
'George' -
Collaborative Care for patients with complex presentations across physical and mental health specialisms

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Introduction

1. In October 2020 Redbridge Safeguarding Adults Board ['RSAB'] commissioned a safeguarding adults review in line with their statutory duty following the death of a 73-year-old man, who will be referred to in this review as 'George'. George died in January 2019 whilst an in-patient in an acute hospital, having been admitted in December 2018 following concerns that a combination of physical and mental health conditions had resulted in significant and sustained weight loss over the preceding 12 months. Following his death, a coronial inquest in January 2020 found the cause of death was starvation, with achalasia[1], depression and anxiety as secondary causes.

2. Prior to this review two Serious Incident Reports ['SI'] were completed by the NHS Trusts[2] involved in his care. These concluded there was ineffective communication between all organisations at all stages and insufficient consideration was given to the risks of malnutrition meaning this was not effectively monitored or referred for specialist dietician or to the multi-disciplinary team for nutrition support. Those reviews found George's mental health and physical health needs were treated as separate issues and the 'root cause' of this was because '*there is no nationally recognised care pathway for the coordinated and collaborative management of in-patient with physical health, mental health and social care problems'*.

The Review Process

3. This review expands on the existing system analysis, building in contributions from practitioners involved prior to George's final hospital admission and from his family. The reviewer requested access to additional contemporaneous case notes, assessments and records of multi-agency decision making. Where additional

[1] This is a rare disorder of the oesophagus, caused by degeneration of the nerves resulting in failure to contract correctly. The ring of muscle can fail to open to allow food or liquids to pass to the stomach. This can mean food and drink can become stuck and, often, bought back up. Over time, the oesophagus can also become dilated.
[2] In line with NHS England's 'Serious Incident Framework' 2015

information was made available, this was considered alongside relevant policy, case law and academic research to explore any systemic issues.

4. The outbreak of Covid-19 and the second national 'lockdown' in November 2020 prevented face to face meetings with George's family and practitioners. Frontline practitioners and services were also, understandably, occupied with managing the significant operational pressures arising from the second wave of infections. Notwithstanding this, practitioners and managers attended a learning event and were open about the barriers that prevented effective care, the impact that his death has had on their practice and what might be needed to overcome barriers to prevent against similar harm in the future. Unfortunately, due to a number of staff members changing jobs, there were no attendees who had worked directly with George from Whipps Cross Hospital.

5. The Independent Reviewer is also grateful for the input by George's family. Despite their grief, they spoke to the reviewer about the impact that the circumstances leading up to his death has had. They remain unclear, despite the inquest and previous system analysis, as to why they were not involved more closely in decision making and why practitioners did not act to prevent George suffering in the way he did. Following completion of the review, the RSAB Chair and reviewer offered to meet with George's family to explore whether they wished to comment further on the findings.

6. The Review also benefited from senior strategic safeguarding leads providing additional assistance, via the SAR Panel, to address any outstanding queries and inform the reviewer of operational or strategic actions taken to implement learning.

7. The purpose of this review is not to hold any individual or organisation to account, as other processes exist for that purpose. Rather this review is conducted to inform and improve local inter-agency practice by acting on learning and developing best practice to reduce the likelihood of similar harm occurring again. The review will cover the actions taken by agencies between February 2018, when George was first diagnosed with achalasia, until January 2019. This review will also consider actions taken since this date by agencies to improve practice following those earlier investigations and, taking into account those findings, ascertain whether practitioners and family believe more needs to be done to improve collaborative practice.

8. Using the expectations set out in local and national guidance[3] as a guide, the review has considered operational and strategic issues that hindered the safe, effective treatment and support to George. The reviewer has been asked to explore:
    - Given the sustained and significant weight loss, poor mental and physical health- why was there an absence of shared risk management in this case?
    - How does the local system overcome known barriers to establishing collaborative, holistic treatment plans for adults with complex needs?

[3] Chapter 14 Care and Support guidance, DHSC, 2015 and the London Multi-Agency Adult Safeguarding Policy and Procedures (revised April 2019).

- How should RSAB partners work together to mitigate the risks associated with service provision that is outside of the adult's normal area of residence?

Key Events and Practice Issues

9. George was, for most of his life, a taxi driver. He stopped driving due to a visual impairment in 2017 and shortly after this his family returned to live with him having lost their own accommodation. By the time of his diagnosis of achalasia in February 2018 he was experiencing low mood and unintentionally losing weight. His GP prescribed antidepressant medication in March 2018. Over the next few months he reported to his GP that he remained low in mood, despite the medication, and that he was having difficulties sleeping and continued to lose weight.

10. The narrowing of his oesophagus was confirmed in June 2018 by specialists within a remote clinic linked to the Princess Alexandra Hospital NHS Trust ['PAH']. It was noted he had lost 4.5kgs since the referral earlier that year, he reported mild abdominal pain, but wasn't displaying significant difficulties swallowing. In line with expected practice, he was referred for further tests to rule out other causes for his weight loss. During discussions with the reviewer, the practitioners who were subsequently involved in this case recognised that had George received advice at this time from a Dietician and Speech and Language Therapy ['SALT'] this would likely have assisted him and all those involved in his care to better understand how to modify his diet to prevent physical symptoms of the achalasia worsening.

11. Shortly after, George was admitted (via the Emergency Department, Whipps Cross Hospital[4]) as an informal patient to a mental health in-patient unit which was part of the NELFT NHS Foundation Trust ['NELFT'], having expressed severe anxiety and suicidal thoughts. On admission to this unit his weight was recorded as 65.2kg [BMI 22]. Practitioners from the unit confirmed they did not refer for nutritional or SALT support, they advised they do not always receive full discharge summaries of patients' physical health needs when patients are transferred to their care. They thought it likely, if there were concerns regarding weight loss, staff within the unit would have recommended to George that he take supplements to manage his nutritional needs. However, the Consultant Gastroenterologist explained that this would not have assisted George, because achalasia prevents liquids as well as solids from passing into the stomach.

12. After three days George was given home leave with daily support from the NELFT's Older Adults Home Treatment Team ['OAHTT']. Practitioners from the OAHHT work to support individuals with acute mental health concerns receive treatment at home, rather than requiring hospital based care. Within previous investigations staff at the unit confirmed he had eaten well and 'felt more positive and hopeful whilst in hospital'. Partial records (some fluid intake charts) indicate that, during this admission, professionals monitored his fluid intake and were satisfied he was consuming sufficient amounts. However, it wasn't made clear how his food and fluid intake would

[4] Part of Barts Health NHS Trust

be monitored whilst on leave and whether this was the responsibility of staff within the in-patient unit or the OAHTT. During this period, he was supported at review meetings by his family, who have subsequently reported feeling hostility from professionals when they questioned proposed plans. He was discharged in late July and by early August his care transferred from the OAHHT to the NELFT's Older Adult Mental Health Team ['OAMHT'] so that he could receive longer-term support to address his mental health concerns in the community. George was supported by the OAMHT under the Care Programme Approach[5] ['CPA'] and assigned a care coordinator who remained the named lead responsible for his mental health support until George's death.

13. Within a fortnight he attended Whipps Cross's Emergency Department reporting he felt suicidal; he was readmitted to NELFT's mental health unit. His weight was again recorded on admission, identifying he had lost almost 5kgs. An assessment of his cognitive function and capacity was also undertaken, though again, without input from gastroenterology, nutritional or SALT specialisms. Whilst practitioners believed he had capacity regarding his mental health treatment, the cognitive tests suggested some impairment and it was agreed to refer for neuropsychology for follow up in the community. Those follow up tests were never undertaken, nor were concerns about his cognition used to inform subsequent risk or capacity assessments. Steps were taken to monitor his nutritional intake, again only partial records were made available, but these did indicate that George was eating and drinking regularly whilst on the ward.

14. Shortly before his discharge from the unit in September, George was assessed by the OAHTT. He declined input from this service, but agreed his care coordinator (from the OAMHT) would provide support in the community. Despite difficulties contacting George (his phone wasn't working) his care coordinator did make contact in early October and reported George to be welcoming, in pleasant mood, taking his medication, eating and sleeping well. At a follow up out-patients clinic in mid-October George agreed the CPA plan to monitor his mental health with weekly contact and to a referral for Cognitive Behavioural Therapy ['CBT'] with a review in three months or earlier if necessary. However, his mental health deteriorated quickly. His family raised concerns that he was not eating or sleeping well, was losing weight and withdrawing from them, prompting a re-assessment by the OAMHT Specialist Registrar in early November. During this meeting he confirmed he was depressed, but hadn't arranged the CBT appointment as he 'wasn't ready'. He denied suicidal ideation, but explained he was anxious about his physical health. Neither his care coordinator or the Registrar contacted his GP to ascertain the treatment plan for his physical health and pain management. His plan remained unchanged, but he was urged to take up the offer of CBT. His care coordinator recognised, during discussions, how George's care would have benefitted from more active cooperation between those treating his physical health (i.e. GP and Gastroenterology) and his mental health. Practitioners were aware of the legal powers they had to seek and share information to enable the development

[5] This is an approach used to support recovery from mental illness for those with severe or enduring mental health conditions.

of a holistic plan, pointing to examples where this does routinely occur (e.g. when a patient has underlying conditions such as diabetes). They couldn't explain why that had not occurred in this case.

15. By the 21st November 2018 his care coordinator and family were aware George had stopped eating. The care coordinator was so concerned about his mental state and physical presentation that he requested he attend Whipps Cross's Emergency Department. He was rehydrated intravenously and, following a decision that he was 'medically cleared', met with Barts NHS' Acute Crisis and Assessment Team for an assessment of his mental health, seemingly without reference to the care coordinator's concerns that prompted his admission. Their assessment was based on George's self reporting; his care co-ordinator had not contacted the Acute Crisis and Assessment Team to explain the interventions previously offered and the limitations these had on addressing his mental ill-health whilst in the community. As a consequence, they concluded he was at low risk of mental health crisis and that the current medical issue was his physical health. He was discharged home, without his family being notified and with no obvious discharge plan to prevent readmission.

16. Following a further request from his care coordinator, his mental health was reassessed on the 23.11.18. This also concluded he did not require support from the OAHTT as the issue was primarily a physical health matter. His GP again referred George for further investigation to the gastroenterology service, with an appointment in three weeks. The GP also requested a community matron monitor George for signs of dehydration. George declined support from the community matron. Despite this being the only identified mechanism for reducing the risk of dehydration and harm that may cause, no action was taken to escalate or review whether alternative support should be offered.

17. By the evening of the 26.11.18 George was again showing signs of dehydration and, concerned about his mental ill health, two family members supported him to attend Whipps Cross's Emergency Department. He was assessed in the early morning of the 27.11.18 by a psychiatrist and disclosed he was unable to eat due to throat pain and that he had a split personality believing there was '*another me that is getting stronger making me not eat*.'[6] It is understood that hospital staff considered George to have capacity to '*understand, retain and consider information discussed, able to explore outcomes and clearly express choice.*'[7] It isn't clear what was discussed and what treatment options were presented to George at that time, but he was reported to have refused OAHTT input, stating they would be unable to alleviate his physical health problems. Risk assessments identified a 'medium risk arising from physical health, other issues and self-neglect'. The risk regarding self-neglect was primarily based on his appearance rather than dehydration or malnutrition, though it was noted he'd had '*two cups of tea and some biscuits*' whilst in the Emergency Department. Emergency Department staff recognised the difficulties managing George's needs and the

[6] Taken from the PAH's SI report [p24]
[7] Taken from the NELFT's SI report [p13]

'*increased tensions for the family*' should have triggered a referral to the local authority in line with s42 Care Act 2015 as George was:

- **in need of care and support**- the complexities of his physical and mental ill health had been established by this time and were well understood by those in the Emergency Department.
- **at risk of neglect**- a high risk of 'self-neglect' had previously been identified by his care coordinator prior to his Emergency Department attendance (21.11.18); and
- **unable to protect himself from this harm**- there was repeated examples of George agreeing during an assessment to access psychological support, but then failing to follow up and refusing support to monitor risks to his physical health.

18. The safeguarding concern was never raised with Redbridge Council. Had it been this would have triggered consideration of whether to conduct a safeguarding enquiry. George was sent home following confirmation from his care coordinator and OAMHT that they would follow up his care in the community. Neither George or his family were part of the hospital after-care planning discussion and nor were they given advice on pain management or nutritional advice to safeguard his wellbeing whilst he waited for the next gastroenterology appointment. His family were not notified and remain distressed that he was sent home in the early morning in a taxi with no means to pay the driver. In conversations with the reviewer George's family explained that this experience frightened George and he was thereafter noticeably more withdrawn and wary of professional support.

19. By early December George's health had again deteriorated. On the 04.12.18 he was taken by ambulance to PAH. This was outside his usual area, as he had requested not to be taken to Whipps Cross. On arrival at PAH it was noted he was under their care for gastroenterology and, based on information provided by his family, an urgent psychiatric referral was sought. Staff noted contact should be made with Whipps Cross for background information, but not NELFT (responsible for the OAMHT service) or his GP. Staff began treating his physical medical issues (with intravenous fluids) and were advised to complete a capacity assessment and, if necessary, seek authorisation that it would be in his best interest to remain in hospital for treatment under the DoLS procedure.[8] The assessment of his capacity was not completed until 13.12.18.

20. He was admitted the following day to Ward 1, where staff, using the Malnutrition Universal Screening Tool, concluded he was underweight (weighing 52.25kg, BMI= 18.5) and at high risk of malnutrition. He was referred to the dietician, SALT and to gastroenterology for review and management advice. Initially ward staff did not complete food and drink charts, despite this being understood as expected practice. The following day he met with the dietician, but refused their recommendation to have a Nasal Gastric feeding Tube ['NGT'] fitted and food supplements to be prescribed. In

[8] Under schedule A1 of the Mental Capacity Act 2005 a person can be deprived of their liberty for medical treatment within a hospital setting provided a supervisory body is satisfied (following an application by the hospital) the relevant criteria are met- most notably that the person lacks capacity to determine their treatment options and it is in their best interests to receive treatment in a hospital setting.

discussion with the reviewer the Consultant Gastroenterologist explained that food supplements may not have assisted as the achalasia would have made it just as difficult for George to take liquids. George agreed to further examinations of his oesophagus, commenting at that time he may not have much time to live.

21. Previous systems analysis reported he'd refused to engage with a mental health assessment, requesting the mental health nurse practitioner '*read his notes instead.*'[9] However, case notes available to this review demonstrate the mental health nurse practitioner did conduct an assessment on the 11.12.18. This mental health practitioner worked within the mental health liaison team who, whilst situated within the PAH's building, were part of a separate NHS Trust (Essex Partnership University NHS Trust ['EPUT']). Before undertaking the assessment, the practitioner had first spoken to George's family to understand the background, but had not made contact with his care coordinator or GP. This assessment explored the risk he may pose to himself or others, the assessor was also aware of previous allegations of domestic abuse and concerns expressed by his family that they did not always feel safe when George was at home, particularly at times when he was feeling suicidal. The assessor concluded that George had capacity to understand the issues causing him stress and reasons for attending the Emergency Department. The assessor did not believe George was exhibiting '*active symptoms of mental illness that warranted immediate intervention… possible* [George] *has mental health problems but currently symptoms seem under control'*. The assessment recognised he may benefit from a follow up assessment by a local mental health team, but concluded George did not lack capacity to participate in the assessment process and had '*clearly communicated his decision of not wanting support from mental health services'*.[10] The capacity assessment did not explore the more pressing risk, namely his anxiety around eating/ drinking and his refusal of treatment (the proposed fitting of a NGT) to alleviate risks of malnutrition.

22. George was moved to Ward 2 (a designated gastroenterology ward) on the 11.12.18 where it was recorded he continued to refuse medication, food, drink and blood tests. Ward staff reported to the review that they sought to encourage him to accept supplements, but by the 13.12.18 his weight had reduced to 48kgs (a loss of 1.9kgs in 6 days). It was agreed food and drink charts should be completed, though practitioners involved in this review accepted this wasn't routinely done and often lacked the detail of attempts made to encourage and support George to eat or take liquids. During conversations with the reviewer, practitioners accepted that had they complied with accurate record keeping it would have been easier to demonstrate (to George, his family and other professionals involved) the level and type of support that had been offered by ward staff and the dietician and, because this remained unsuccessful, that may have triggered escalation to explore other legal or treatment options to prevent his continued deterioration. They explained that often such escalations did happen, including during the period under review for another patient on the ward.

[9] Taken from the PAH's SI report [p5].
[10] Taken from the medical records, supplied by PAH as part of this review.

23. He was recommended for an Oesophago-Gastro-Duodenoscopy ['OGD'] with Botox[11] and it was agreed he should have an NGT fitted during that procedure. George would not consent to this, so the consultant gastroenterologist (unaware of the mental health assessment conducted on the 11.12.18) delayed this procedure, requesting a psychiatrist evaluate his mental state and capacity. This was subsequently undertaken on the 18.12.18 concluding that George did not have capacity to refuse treatment and that it was in his best interest to undergo the OGD, Botox and NGT insertion. Despite this assessment, a different gastroenterologist carried out the procedure on the 18.12.18, but did not insert the NGT believing it unnecessary as the Botox treatment should have alleviated the physical symptoms of achalasia within a few days. The previous system analysis concluded the '*failure to insert a NG tube… was a 'missed opportunity to enable to patient to receive nutrition*.'[12]

24. Throughout this time there is evidence of regular contact with EPUT's Mental Health discharge coordinator, including a family meeting (held with George's consent, though he wasn't in attendance) on the 17.12.18. During this meeting, the family notified practitioners of their concerns and requested he be detained for treatment under the Mental Health Act 1983. EPUT staff explained there were physical reasons why George was unable to eat and swallow medication and that he wasn't exhibiting any of the psychotic symptoms on the ward that the family reported occurred at home.

25. Following this meeting a psychiatric review was scheduled for the 19.12.18. This was conducted by EPUT's Liaison Consultant concluding George probably had a severe depressive disorder. He was prescribed additional medication, though notably not in liquid form, and a recommendation was made for admission to an in-patient mental health unit in his usual area as soon as possible. Following this assessment, a liaison worker called NELFT to request an in-patient placement within his local area. NELFT staff requested clarification regarding the acute mental health presenting issue and was notified the EPUT Consultant would call to discuss. This call did not take place, instead the mental health discharge coordinator called the following day to request George be reassessed at home once he was discharged as they were '*unclear of what his acute mental health crisis were'*.[13] Records from EPUT, however, reported that NELFT had '*refused to agree for admission but rather suggested community intensive support*'.[14] The Mental health discharge coordinator also spoke with George who confirmed he was not happy to be discharged home as still couldn't eat. However, on the 21.12.18, George was advised that NELFT had confirmed they would support him on his return home and records note he '*did not object to this*' but '*does not seem happy to go home as he feels that his physical health is not yet addressed'*.[15]

[11] This is the recommended treatment for achalasia and is expected to be highly effective, with patients relieved of the symptoms within a few days.
[12] As reported within the SI report undertaken by PAH, p6.
[13] Taken from NELFT's case records made available to this review.
[14] Taken from EPUT's medical records made available to this review.
[15] Taken from EPUT's medical records made available to this review.

26. From this point on, focus within PAH shifted to facilitating his discharge as, from 20.12.18, he was considered to be medically fit for discharge and there was agreement that NELFT would reassess and support him on discharge. There does not appear to be any dispute that George would require ongoing mental health support given the continued refusal to drink or eat. A provisional date for his discharge was agreed with George, his family, the NELFT's care coordinator and OAHTT for the 27.12.18. A follow up review by the Mental health discharge coordinator on the 26.12.18 noted George was engaged with ward staff in conversation, but that his family remained unhappy with the discharge plan.

27. Insufficient action was taken to put in place a plan to ensure George received sufficient hydration and nutrition on the ward, despite an assessment confirming he lacked capacity to refuse medical treatment and that it was in his best interest to receive this to protect against harm. Over the next week George continued to refuse food and drink, despite being urged to eat by ward staff, the dietician and his family. He became increasingly confused and began lying on the floor. He fell on the 26.12.18 so to reduce the risk of further injury, ward staff moved him to a side ward closer to their nurses' station and placed his mattress on the floor whilst awaiting the delivery of a low-lying bed. George's family expressed ongoing distress that these decisions were made without their involvement.

28. George was not discharged on the 27.12.18 due to a deterioration in his presentations and continued refusal to eat. Concerns were raised to EPUT's liaison team by Ward 2 staff and PAH's discharge coordinator that he would not have sufficient support at home, given the presentation of his mental ill health on the ward. Ward 2 staff advised that his refusal to eat was directly related to his mental ill health and that he was also refusing to take the medication as advised by EPUT's Liaison Consultant. They asked if consideration could be given to using powers under the Mental Health Act 1983 to treat George. They were advised on the 29.12.18 by EPUT's mental health liaison to complete further mental capacity assessments regarding his refusal of the psychiatric medication and that an assessment under the Mental Health Act 1983 would be 'inappropriate'.

29. On the 02.01.19 a professionals meeting was called by ward staff, enabling the completion of a mental capacity assessment informed by practitioners with expertise in nutrition, gastroenterology and mental health. This concluded he lacked capacity to refuse medication treatment. A subsequent decision was made that it was in his best interests to undergo blood tests[16] and commence intravenous hydration. It was also agreed, including by the Consultant from the Liaison team that an assessment under the Mental Health Act 1983 for compulsory treatment should take place, that until this was completed he should have one-to-one support from a mental health nurse and be reviewed daily by psychiatric liaison. It was agreed an NGT would be inserted the

[16] The results of which showed he now needed treatment for acute kidney injury (caused by dehydration).

following day once advice had been provided by the dietician. George died at 8am the following morning, before that plan could be enacted.

Findings and Recommendations

Given the sustained and significant weight loss, poor mental and physical health- why was there an absence of shared risk management in this case?

Case Specific Findings

30. Technically, there wasn't an absence of assessments in this case. Assessments were undertaken when George attended the Emergency Department was admitted for in-patient care, required treatment or a review of his mental health support. On many of these occasions George's capacity to consent to treatment was considered and his family were involved in some of these discussions. What is striking in this case is how infrequently those assessments were undertaken in the context of what was known (or could have been known) already about his circumstances and how his physical and mental health conditions impacted on his ability to understand the risk of malnutrition and act to protect himself from harm. Practitioners involved in this review recognised how his physical and mental health were inextricably linked. George frequently told professionals he was anxious about his physical health and was in pain, that this was the cause of his anxiety and depression. Professionals could see how anxiety and depression amplified the risks of self-neglect, including his refusal of medical interventions, but couldn't explain why specialist nutritional support was not prioritised. They accepted the previous systems analysis finding that '*he was being treated sequentially for whatever was the most acute problem at the time, which resulted in his nutrition being overlooked for a considerable period of time, whilst his weight loss continued*.'

31. Mental health support was particularly fragmented and insular. For example, assessments undertaken by mental health liaison teams (Barts Health and EPUT) and NELFT's in-patient mental health unit did not consult with his care coordinator to understand why support in the community was not working. Similarly, his care coordinator does not appear to have made contact with the hospital based acute mental health team despite advising George to attend the Emergency Department. Nor did NELFT staff within seek advice from gastroenterology or his GP on how to mitigate George's discomfort or reduce the risk of malnutrition, despite the diagnosis of achalasia and George's repeated assertions that this formed the root cause of his low motivation and poor mental health.

32. Practitioners reported they still do not always have reliable access to GP or hospital assessments/ case notes and consequently it remains usual practice to rely heavily on self-reporting. They were aware of legal powers to request information, even without George's consent if this was necessary, and could see the benefit with hindsight to George if this had been done. His care coordinator explained this did happen 'sometimes' e.g. if the adult has an underlying physical condition such as diabetes.

33. Practitioners also recognised insufficient attention was given to preventing George's physical and mental health deteriorating and to the risks posed by his perceived decisions to refuse to eat, drink and accept medical interventions. They understood the expectation to refer if safeguarding concerns arose and to escalate their concerns if these were not responded to in line with the local safeguarding policy. They expressed regret that those processes had not been used in this case.

34. Practitioners from PAH involved in this review accepted that insufficient regard was given to continuity of care and risks to his physical health (i.e. severe malnutrition) whilst he remained an in-patient awaiting suitable discharge provision to be agreed. They felt this was in part because the usual treatment for the physical cause (achalasia) had already been performed. They also explained, that as a medical ward, they reasonably relied on the professional judgment of mental health colleagues that his ongoing refusal to eat/ drink arose from his mental disorder and would therefore require specialist input to address. They had understood that there was a dispute between the clinical judgment of mental health professionals working within EPUT and NELFT as to how best to manage his care. In fact, this may have been misreported as it appears from the records that EPUT had accepted NELFT's assertion that he could be supported in the community, but had not communicated this directly to Ward 2 staff. This miscommunication added complexity to his treatment and the discharge planning process and resulted in conflict between staff on the ward and George's family.

35. In January 2018, prior to the review period, RSAB published a 'self-neglect and hoarding' protocol, listing indicators of this type of abuse as including (but not limited to):

- Suffering from malnutrition and dehydration.
- Appearing to be in need of services but not agreeing to a referral or not engaging.
- Consistently refusing services which can improve quality of life reasonably.
- Declining or refusing prescribed medication and or other health care.
- Refusing access to professionals in relation to care and support needs or unwillingness to attend appointments with professional staff.

36. The protocol also lists factors that can increase risk of harm, many of which were present in this case. The protocol's current focus is on harm arising from hoarding disorders and does not provide specific guidance to practitioners on evaluating risks which could arise in respect of inability to adhere to treatment or address medical needs or what legal powers/ effective interventions or approaches can facilitate multi-agency risk management. The protocol recommends a multi-agency approach in line with the duties under s42 Care Act 2014.

System Findings:

37. Throughout this case services frequently acted independently of each other, even when these services were co-located. Assessments were conducted to ascertain if George met operational service 'thresholds' and care was focused on addressing the immediate risk. Where issues were identified, this was managed by onward referrals (e.g. further tests regarding his cognition), but professionals didn't explore how their concerns might impact on immediate care and treatment decisions. There was little evidence of effective preventative planning to monitor known risks, most notably of dehydration (e.g. whilst he was on home leave from NELFT's in-patient unit) or his inability to follow up with community based and outpatient services. There was no evidence of contingency planning (e.g. on the 21.11.18) so George, his family and his care coordinator didn't know how to access support if/when his health deteriorated, as it frequently did. Similarly, though capacity assessments were frequently undertaken, these did not record what information was available to the assessor, or made available to George, and did not explore his understanding of the risks he faced by refusing food, drink and medical care.

38. Multi-agency coordination, information sharing and legal literacy (predominantly in respect application of the Mental Capacity Act) are identified frequently within Safeguarding Adults Reviews as areas requiring practice improvement, especially where the risk arises from perceived self-neglect. This is made more acute in the context of refusal or non-adherence to medical treatment where the adult is suffering from physical and mental health conditions. National analysis identifies that often a focus on specific need or behaviour obscures recognition of foreseeable risk, reporting that:

> *'even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-reporting, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary*.'[17]

39. National analysis raises the possibility that a 'rule of optimism', namely an unconscious bias towards a favourable view of the situation, makes it less likely that practitioners will imagine (and prepare for) the poor outcomes, even if these are, as they were in this case, foreseeable. The previous system analysis into this case recognised the need to ensure a standard level of knowledge and understanding across the health care system in respect of safeguarding, nutrition and application of the Mental Capacity Act so that patients with physical and mental health problems are managed holistically.

[17] National SAR Analysis. ADASS/LGA, Michael Preston Shoot, 2020 (p101]

40. The previous systems analysis identified the lack of a process to obtain a full medical history of a patient from their GP on admission and recommended this be addressed by NHS England and NHS Improvement ['NHSE/I']. They have requested a national change to the process for admission to an acute hospital so that this includes a requirement for hospital staff to contact the GP practice within the first 24 hours. They have also requested NHSE/I develop a trigger tool for initiating a multi-disciplinary team discussion for newly admitted patients when they are under the care of more than one organisation. The regional NHSE/I have responded to this request confirming this will be considered for inclusion onto their work-plan in 2021.

41. The previous system analysis also recognised a lack of resources and no robust process within primary care to be able to actively coordinate all the documentation from the patient's attendances to hospitals/appointments and review them all at a given point in time to see if additional action is required.

42. In September 2018 RSAB also published a Resolution and Escalation Policy. This would, therefore, have been available to practitioners involved in George's care to resolve any impasse regarding arrangements for his ongoing mental health treatment.

Recommendations:

I. RSAB should, in light of this review, consider a revision of their Self Neglect Protocol. This could include explicit reference to risks associated with a person's inability to maintain compliance with medical treatment or care plans. Inclusion of the Malnutrition Universal Screening Tool within that protocol may encourage a shared understanding of malnutrition and facilitate professionals surrounding and supporting the person to come together to coordinate care. They may also wish to include local referral routes for early intervention for nutrition advice and what indicators should trigger escalating concerns for multi-agency support so that relevant professionals can participate and inform capacity assessments and protection plans.

II. RSAB, perhaps in conjunction with the Redbridge Health and Wellbeing Board, explore whether there are suitable arrangements locally to enable GP and primary care professionals have access to dietician or nutritional advice to prevent the escalation of needs or deterioration in a person's mental wellbeing whilst they await diagnostic tests or treatment for gastroenterological issues.

III. RSAB seek assurance that health partners have introduced clear policies for multi-disciplinary cooperation in cases where individuals have co-morbid mental and physical health problems and that they have made their staff aware of the expectation to comply with RSAB's Resolution and Escalation Policy.

IV. RSAB and health partners could conduct an audit to secure assurance that capacity assessments are conducted holistically and take into account pertinent information from other specialisms so can demonstrate capacity is assessed according to the person's

understanding of the relevant issues at the time the decision needed to be made. Guidance on record keeping and assessments should make clear that the practitioner should record the information that was provided to the person and that this correctly identifies relevant concerns and treatment options so that this can be used to assess if the person has properly understood and weighed up any foreseeable risks. This might also test whether, if there is dispute, the RSAB policy is used effectively to resolve conflict and protect the adult at risk.

How does the local system overcome known barriers to establishing collaborative, holistic treatment plans for adults with complex needs?

Case Specific Findings:

43. Good interagency collaboration is reliant on the coordination of effort from all involved and clear leadership, so there is clarity on actions to be taken and accountability for decisions. This requires that practitioners from across health and social care specialism understand respective roles and responsibilities so that referrals are acted upon. It also requires practitioners understand safeguarding responsibilities, including the duty to recognise and respond effectively to the risk of abuse or neglect and share a common language around risk so that where there is concern, this is understood in a multi-agency context, rather than by each agency according to their own perspective.

44. Holistic care also requires a person-centred approach, and processes that promote the adult's participation and voice in decision making. For the reasons set out above, practice in this case was not person centred. Unfortunately, even after confirmation that George was suffering from severe depression, lacked capacity and that there may be conflicts within his family, no consideration was given to whether he would benefit from an advocate to support his involvement in the care planning processes.

45. The involvement of families is also crucial, particularly where they have caring responsibilities. Often this is underpinned by statutory obligations (e.g Care Act 2014: s9(5) - duty to consult and s10 to assess a carer's needs for support). Practitioners from NELFT stated it was usual practice to involve families. Whilst there is some evidence of consultation and that his family were notified of decisions, there is little evidence that the family's assertions (that they couldn't safely support George at home) influenced decisions to discharge him from NELFT's in-patient unit. During the course of discussions, practitioners accepted more weight may have been given to family concerns had they fully understood the limitations of capacity assessments discussed above, and George's disclosure on the 26.11.18 that his 'other self was preventing him from eating'.

46. George had spoken about a difficult relationship with his daughter and practitioners remembered that the family dynamics were not clearly understood. They also reported that, on occasion, his family could be very forceful about what they believed was in George's best interests, and dismissive of professional opinion. Those treating his physical health issues felt justified in relying on mental health colleagues'

assessments of his capacity to refuse further mental health input, given that he demonstrated insight into his poor mental health and appeared compliant with proposed treatment plan. Practitioners felt his family may have had unrealistic expectations about practitioners' powers to compel George to eat. They confirmed they had taken time to explain assessment findings and treatment plans and thought, at the time, his family were content. The delayed discharge from ward 2, despite the successful treatment of his achalasia, demonstrates a shared understanding between staff on the ward and his family's view that he required intensive on-going mental health support.

System finding:

47. Within the previous system analysis, practitioners recognised that the conflict between professionals as to how to treat his underlying mental health conditions should have prompted an earlier multi-disciplinary discussion. They explained this didn't happen because staff were pre-occupied by managing another, more violent situation on the ward with another patient. The risks to George were, therefore, seen as less problematic. That analysis also identified practitioners often simply expected that information passed on to the next professional would be acted on. There were inadequate mechanisms to ensure necessary action was taken or to prevent against unintentional 'normalisation of risk'.

48. It also acknowledged other systemic barriers existed in this case, including:
    - a lack of an accepted definition of a complex case in the NHS;
    - limitation of IT systems and consequential sharing of information between professionals;
    - lack of ownership and overall responsibility for patient care where specialist mental health liaison teams work within acute hospital settings;
    - inconsistency of care issues where there are multiple handovers or transition between services.

49. Recommendations for actions have sought to address some of these issues. For example, staff within PAH's ward 2 report new processes for multi-agency input into care and treatment plans for those with complex needs now take place twice a day within ward rounds. In addition, the revision of the format for Consultants handovers is reported to have improved continuity of care. In discussions with the reviewer, senior managers confirmed some actions arising from the previous systems analysis remain outstanding, e.g. implementation of a food and drink policy.

50. National SAR analysis identified the cases that made up that thematic review typically had involvement from multiple agencies with many SARs drawing attention to silo working within those agencies, missed opportunities to engage a multidisciplinary approach and a failure to establish a shared perspective or goal. Their finding of '*a lack of robust, effective individual and coordinated multiagency work to manage his complex needs that had a cumulative impact and amounted to systemic organisational neglect*" has a resonance in this case.

51. In addition, the failure by Whipps Cross to raise a safeguarding concern, despite this having been recommended by the Senior House Officer, meant that consideration wasn't given to whether George would benefit from advocacy to be involved in safeguarding processes. In discussion with the Reviewer, senior mental health practitioners highlighted that, whilst there are arrangements in place for their staff to secure advocacy for those who qualify under s130A Mental Health Act 1983, their staff do not have access to advocacy for informal or community based patients who have families or who may need this to support in line with duties under s67-68 Care Act 2014. This could be addressed if staff across partner agencies better understood the different statutory criteria to access advocacy and utilised referral and escalation processes to ensure appropriate support is in place.

52. Again, the national SAR analysis raises the absence of advocacy as a significant contributor to poor outcomes for adults with care and support needs. It is also noted that the low referral rate to Voiceabiliy advocacy services (5.4% of safeguarding enquiries undertaken in 2019-20) has already been identified as requiring follow up action within RSAB's annual report 2019-20.

Recommendation:

V. In line with the SAR National analysis improvement priority 23, RSAB and their partner agencies should review how it seeks assurance on individual agencies' practice standards and contributes to improvement across their partnerships. RSAB may wish to focus on:
   - how needs and risks are assessed and met in respect of health, mental health, mental capacity;
   - whether key processes such as hospital discharge plans demonstrate practices that comply with Equality Act 2010 duties to make reasonable adjustments where these are necessary to securing engagement from those with protected characteristics (such as age, disability);
   - that practitioners employ a personalised approach to assessment, including the importance of understanding personal history; promoting the adult's participation and personalising interventions.

VI. RSAB should seek assurance there is sufficient understanding across the health and social care workforce (including where care planning duties are organised under the Care Programme Approach) of the legal obligation to actively consider advocacy duties. Workforce development and professional learning opportunities should seek to strengthen multi-agency understanding of when these duties arise. Clarity should also be provided on local referral criteria and access arrangements for multi-disciplinary teams to ensure adults are suitably supported during safeguarding enquiries, assessment, care planning and review processes.

VII. RSAB partner agencies may wish to review risk management tools and protocols, to ensure there is commonality of language used to describe risks and that these

encourage holistic appraisal and cross discipline challenge. Any local protocol should set out the local safeguarding processes and link with relevant RSAB's policies.

VIII. Training in relevant areas, such as Care Act duties, mental health and mental capacity should be joined-up across primary and secondary health providers and social care, with practitioners from across disciplines attending training together. This will enable a shared understanding of thresholds and responsibilities and provide opportunities for professional networks to develop which can only strengthen working relationships across teams.

How should RSAB partners work together to mitigate the risks associated with service provision that is outside of the adult's normal area of residence?

Case Specific Findings:

53. The previous system analysis into this case reported there was a low risk that a similar incident could occur again, and practitioners (particularly those from PAH's ward 2) were confident that this case had changed their practice to reduce the risk of similar harm occurring in the future. They gave as an example a recent successful discharge of someone with complex physical and mental health needs, explaining the team worked closely to ensure everyone understood their roles and responsibilities, care plans were agreed with the adult and communicated to the patient's GP prior to discharge, and ward staff followed up within 24 hours to ensure the care staff had seen the patient and had all necessary medical information. Whilst this is positive, other practitioners from Whipps Cross and NELFT were less confident of sustained local change in practice. This may be because many of the recommendations arising from the earlier review require national implementation as some of this is still outstanding.

System findings:

54. Thematic review findings recognise that adults with complex needs, particularly with physical and mental health conditions, often receive insufficient support to navigate their treatment pathway. The limited discussion between health disciplines results in an incomplete analysis of health needs and a lack of holistic planning.

55. Whilst the guidance issued to complement the Care Act 2014 sets out expectations for care planning responsibilities for each agency whenever cross boundaries placements are likely,[18] too few practitioners have a full understanding of those expectations.

56. LGA/ADASS have also published an advice note in respect of commissioning obligations that apply for out of area care and support services.[19] NHSE/I have also committed to shortly publishing guidance on safeguarding responsibility for 'host

[18] See in particular chapter 15 of the Care and Support Guidance
[19] Advice Note for Directors of Adult Social Services: Commissioning Out of Area Care and Support Services

commissioners' to support for adults with learning disabilities or neurological impairments accommodated within in-patient hospital placements outside of their local area. Whilst this is welcome, it is not intended to assist those with complex mental health issues secure appropriate, person centred physical health treatments or overcome the issues identified in this case regarding poor discharge planning.

Recommendations

IX. The RSAB, perhaps again with the Redbridge Health and Wellbeing Board, may wish to explore with partners what help is available to proactively support those with co-morbidity conditions navigate the complex health and care systems, assist with engagement and reduce the likelihood of self-neglect or organisational disconnect.