Hillingdon Safeguarding Partnership

Hillingdon Safeguarding Adults Board Response to the Safeguarding Adults Review in Respect of Angela and Chris

The Safeguarding Adults Board commissioned an independently authored Safeguarding Adults Review (SAR) to consider the circumstances of, and support provided to, Angela and Chris. Angela and Chris were not known to one another, however, both had severe and enduring mental illness and had been known to local services. Both tragically died due to physical health issues in a context of self-neglect. In consequence a Thematic SAR was undertaken to understand local practice around Self-Neglect. The Reviewers made five system findings, highlighting areas for development in local safeguarding practice. These findings are accepted by the Hillingdon Safeguarding Adults Board and work has been completed, and is continuing, to embed the learning from this case across the Adult Safeguarding Partnership.

This summary provides an overview of the actions taken, and planned, in consequence of the Safeguarding Adults Review.

FINDING 1: Caseload Management in Depot Clinics - In Depot Clinics the way that cases are currently defined, and caseloads managed does not differentiate between individuals who have a number of health and care professionals regularly involved with them and those who are not seen regularly, aside from the Community Psychiatric Nurse.

This makes it harder for Community Psychiatric Nurses to identify which people need routine physical health checks as a priority. It increases the risk that even when a person presents with poor or deteriorating health, that the administering of the depot injections takes precedence and health checks are not adequately prioritised, leaving arising health issues unexplored.

The standard operating procedure and practice model for medication clinics in secondary mental health services currently is subject to in-depth review and reformulation, with a view to much clearer guidelines for staff around identifying and responding to physical health concerns amongst mental health patients.

The Community Mental Health Framework is driving a new model of working where links between secondary and primary mental health care are significantly clarified and strengthened. This will aid

clarity of leadership and accountability in the response to physical health concerns for users of mental health services.

FINDING 2: Diagnostic Overshadowing - Current mechanisms for check and challenge are not currently working in Hillingdon to identify diagnostic over-shadowing for people with a known mental health condition. This increases the risk that physical health issues are overlooked and/or explained away, leaving arising health issues unexplored.

A new Standard Operating Procedure and practice model within medication clinics will create a more robust system for reducing the risk of diagnostic overshadowing in secondary mental health care.

The Safeguarding Partnership has arranged a learning event which will include raising awareness of the risk of diagnostic overshadowing with frontline practitioners.

FINDING 3: Mental Capacity ruling out consideration of safeguarding for self-neglect - When someone with poor or deteriorating health turns down recommended input from health care professionals that could mitigate risk to their well-being, there is a pattern in Hillingdon of assessing their mental capacity to make this decision without any parallel consideration of the need for a safeguarding response. This increases the risk that refusing health advice even when it is evidently urgent, is not recognised as a potential indicator of self-neglect, leaving the reasons and risks unexplored.

Self-Neglect has been identified as a strategic priority for the Safeguarding Adults Board and a multi-agency subgroup is meeting regularly.

Furthermore, the Safeguarding Partnership has commissioned self-neglect training, which is taking place regularly. This training includes signs and indicators of self-neglect, and self-neglect as a safeguarding concern. To further scaffold practitioners' understanding tools and resources have been developed that include best practice guidance on the implementation of the Mental Capacity Act and when to set aside the assumption of capacity.

FINDING 4: Initial Review of Referrals into ASC (Multi-Agency Safeguarding Hub) - Does the set-up of Hillingdon's adult social care MASH enable multi-agency input at an early enough stage to risk assess referrals to best effect?

Practice within the Adult Social Care MASH has been developed to ensure that any new contact is considered in the context of information known about an adult. Where a contact is closed, this is reviewed by a manager. There are daily high-risk meetings that are attended by a wide range of professionals, representing the multiagency partnership.

FINDING 5: Collaboration between GP and Secondary Mental Health Services - The professional and cultural differences between general practice and secondary mental health provision currently creates barriers to clarity about relative roles, effective collaboration and options for joint working. This limits the flexibility that is necessary to provide a person-centred response, that can utilise both established relationships with patients and specialist expertise. It undermines the effectiveness of professional efforts to enable people to get the help they need.

The implementation of the Community Mental Health Framework is underway. A key focus of this work is closer working and collaboration between primary and secondary care mental health services. The Integrated Care Board has implemented Safeguarding Forums for GPs, and for Practice Managers. This provides an opportunity for collaborative working, information sharing and training across the Partnership and serves to reinforce links between professionals and agencies.

The actions summarised above are further supported by a coordinated programme of training for frontline practitioners ensuring that the learning from the loss of Angela and Chris is addressed at all levels.

Our thoughts remain with the family and friends of Angela and Chris.

Jennifer Roye

Chair of Hillingdon Safeguarding Adults Board

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