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Thematic Safeguarding Adult Review "Angela and Chris", commissioned by Hillingdon Safeguarding Partnership

Independent Reviewers: Dr. Sheila Fish and Anna Muller (SCIE), Eliot Smith (Independent Consultant)

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1 Introduction

1.1 WHY THESE TWO INDIVIDUALS WERE CHOSEN FOR A THEMATIC SAFEGUARDING ADULT REVIEW

1.1.1 The Care Act (S. 44) states as follows:

> ***44 Safeguarding adults' reviews***
>
> (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) 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, and
>
> (b) Condition 1 or 2 is met.
>
> (2) Condition 1 is met if—
>
> (a) the adult has died, and
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
>
> (3) Condition 2 is met if—
>
> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
>
> (4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.1.2 Hillingdon Safeguarding Adult Review (SAR) subgroup considered the referrals for two adults who both had identified mental health needs as well physical health conditions and challenges in responding effectively to potential self-neglect. The decision was therefore made to conduct a thematic SAR to focus on those areas of shared learning from both individuals.

1.1.3 The two adults will be referred to as Angela and Chris in this report.

1.2 SUCCINCT SUMMARY OF THE STORIES OF ANGELA AND CHRIS

ANGELA – TIME PERIOD UNDER REVIEW: 23/01/2020 TO 15/12/2020

1.2.1 Angela was a 64-year-old woman who was living in her own home in Hillingdon. Angela had a diagnosis of schizoaffective disorder that was in remission and had been managed over the years through monthly depot injections of antipsychotic medication. Of note, in September 2020, Angela missed her monthly depot clinic appointment for the first time, and this was unusual for her. Poor and declining health issues were believed to be contributory. The extent of Angela's declining physical health came to light three months later, in December, when she was seen in town by police, struggling to walk and was accompanied home where she received medical attention. It was early in the Covid pandemic and Angela did not want to go to hospital.

1.2.2 Subsequently, various agencies, including the Community Mental Health Team, Adult Social Care, police, and GP became involved, responding to concerns about Angela's access to food and drink, as well as her declining physical health, and ultimately Angela was admitted to hospital with sepsis.

1.2.3 During her admission she was diagnosed with Mesothelioma Asbestosis from which Angela sadly passed away on 23rd January 2021.

CHRIS – TIME PERIOD UNDER REVIEW: 28/04/2020 TO 14/10/2020

1.2.4 Chris was a 65-year-old man who was living in a shared home in Hillingdon. He had a diagnosis of Paranoid Schizophrenia that had been managed by his GP through bi-weekly depot injections for several years. He also had a range of physical health issues, related to blood pressure, liver, lungs, and diabetes for which he required medication.

1.2.5 Within the time under review, Chris did not attend for the first time his appointment to receive his depot injection which was out of character. As a result, the GP made a referral to mental health services.

1.2.6 Different agencies then became involved, including Mental Health Services, Adult Social Care, GP, London Ambulance Service (LAS) and Hillingdon Hospital, considering increasing concerns around Chris' mental and physical wellbeing as well as his living environment and professionals' limited ability to engage with Chris successfully. Chris remained without his depot injection and other important medicines and his physical health reached a crisis point. He was taken to A&E and discharged home the following day. Two weeks later, he required admission to hospital for his physical health needs. During this admission he was also sectioned under the Mental Health Act for assessment and treatment (s.2 MHA 1983).

1.2.7 Chris suffered a cardiac arrest whilst in hospital and sadly passed away on 28/10/2020.

1.3 METHODOLOGY

1.3.1 The purpose of a SAR is to provide findings of practical value to organisations and professionals for improving the reliability of safeguarding practice within and across agencies (Care Act Guidance Para 14.178), in order to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect.

- To promote effective learning and improvement to services and how they work together;
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm;
- To understand what happened and why;

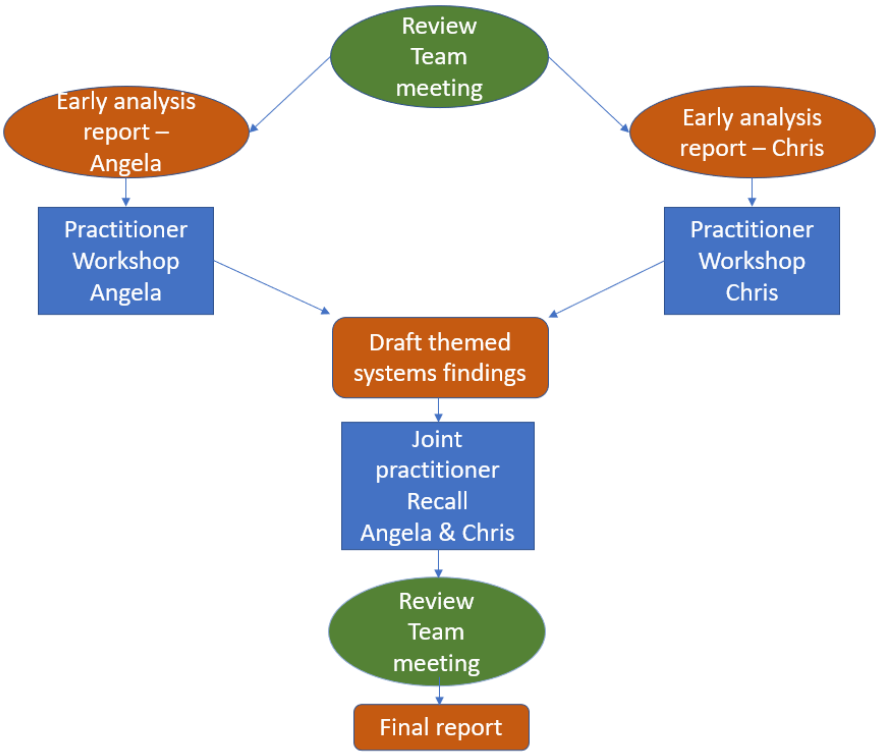
1.3.2 Hillingdon Safeguarding Partnership decided to use SCIE's tried and tested *Learning Together* model for reviews to conduct this thematic SAR (Fish, Munro & Bairstow 2010). Learning Together provides the analytic tools to support both, rigour, and transparency to the analysis of practice with the individual and identification of systems learning.

A PROPORTIONATE APPROACH

1.3.3 Learning Together allows a proportionate approach that builds on any internal agency investigations that have already been completed. A thematic approach was formulated to allow data and learning from the stories of Angela and Chris to be combined to create themed findings.

1.3.4 It revolved around 3 half-day workshops with practitioners and managers (two separate workshops with the practitioners and managers involved with Angela and Chris respectively, and one combined re-group workshop). A further half-day workshop was held with the "Review Team" (Senior Managers representing the agencies involved with Angela and Chris).

1.3.5 The process of the approach is summarized in the graph below:


Review Team meeting
Early analysis report – Angela
Early analysis report – Chris
Practitioner Workshop Angela
Practitioner Workshop Chris
Draft themed systems findings
Joint practitioner Recall Angela & Chris
Review Team meeting
Final report

A COLLABORATIVE, SYSTEMS-FOCUSED WORKSHOP

1.3.6 Information and insights from key documentation related to each individual was used to produce an early analysis report. This created a structure for the workshop. It identified Key Practice Episodes (KPEs) and raised questions where input from participants was needed. Participants were involved through the workshop in evaluating what went well and where there could have been improvements in practice with each individual through each episode. Crucially, they were also involved in identifying from a range of different social and organisational factors, what helped and what hindered them in their work at the time.

1.3.7 From that basis, the lead reviewers supported the group to move from thinking about their work with the individual, to identify if there are any generalizable issues that impacted on practice with the individual and impact on their practice more widely. By this means they drew out underlying systemic issues that help or hinder good practice beyond the practice with the individual that is subject of this SAR.

BUILDING SENIOR LEVEL OWNERSHIP OF SAR SYSTEMS FINDINGS THROUGH THE PROCESS

1.3.8 To support the identification of systems learning, the Learning Together approach requires two face-to-face meetings with senior representatives from the agencies who were involved with Angela and Chris. This “review team” plays an important role in bringing wider intelligence to the SAR process in order to ascertain which issues are case specific only, and which represent wider trends locally. Their ownership of the review findings is crucial.

TIME PERIOD

1.3.9 It was agreed that the thematic review would focus on responses to Angela and Chris to their final admission to hospital:

- Angela: January 2020 to December 2020
- Chris: April 2020 to October 2020

RESEARCH QUESTIONS

1.3.10 The use of research questions in a ‘Learning Together’ systems review is equivalent to Terms of Reference but focused on the generalizable systems learning that is sought. The research questions identify the key lines of enquiry that the Safeguarding Partnership want the review to pursue and are framed in such a way that make them applicable to practice more generally, as is the nature of systems findings. The research questions provide a systemic focus for the review, seeking generalizable learning from the single individual. The research questions agreed for this thematic SAR were as follows.

1.3.11 What can the stories of Angela and Chris tell us about:

- What is helping and hindering partnership arrangements and responses to self-neglect?
- How does the Hillingdon partnership of multi-agency professionals address /tackle issues of self-neglect and deal with new information indicating potential self-neglect?

INVOLVEMENT AND PERSPECTIVES OF THE FAMILY

1.3.12 We also sought to engage with family members to talk through the analysis, answer any queries and gain their perspectives.

1.3.13 Angela's sister initially wished to speak to the Review Team but then changed her mind and preferred not to.

1.3.14 Chris' brother wished to speak to the Review Team and met, together with his partner, with one of the reviewers and the Quality and Implementation Manager of Hillingdon Partnership.

1.3.15 Chris' brother described Chris as a private person. He advised that Chris was always very polite, and his brother was worried Chris might be taken advantage of. He experienced Chris as "thinking too deeply about things" and he often presented troubled. Although he "did not have a lot to do with him over the years… [he] still cared about Chris as his brother and wished no harm to him". After Chris' mother, and later his sister who used to look after Chris and check in with Chris, passed away, his brother started to see Chris more often and they visited each other more. His brother shared how him, his partner and Chris "had a right laugh at Christmas and spent some good times together".

1.3.16 Chris' brother thought that things were going ok for Chris, and he is still shocked how Chris could have deteriorated so quickly, over a short period of time: from a 15/16 stone guy who was well presented and clean shaven, to a fragile man, nearly half of his size, with a long beard and disheveled when he was admitted to hospital. And Chris' home also changed from being sufficiently looked after to being very neglected, dirty, unhealthy and unhygienic.

1.3.17 Chris' brother shared some of his frustrations when trying to get professionals involved quickly when he saw Chris was really unwell and felt that some responses took too long. At the same time, he is very grateful to some professionals who he experienced as very helpful, particularly hospital staff and nurses who allowed him to visit Chris in hospital and spend time with him before he passed away.

1.3.18 Chris' brother added that he appreciates that professionals are taking the time now to learn from Chris' story and is hoping that it will help people who are in similar situations like Chris. He thinks it is really important that professionals stay in contact with people such as Chris who have complex health needs and this should include visits and one to one contact, not only phone calls. He also wishes for professionals to be patient and persistent, particularly when there might be some resistance, avoidance or superficial agreement by the patient. He would like professionals to ask more questions and be interested in the person.

1.3.19 The concerns that Chris' brother raised about some aspects of how professionals worked with Chris resonated with the Review Team and the review process highlighted that they are systemic risks that the review recommends the safeguarding partnership. The concerns that Chris' brother shared relate to findings 2, 3 and 5. Those will be discussed later in the report.

REVIEWING EXPERTISE AND INDEPENDENCE

1.3.20 The review was led by Dr Sheila Fish, Head of Learning Together at SCIE, together with Anna Muller, Principal Auditor and Reviewer at SCIE and Eliot Smith, an Independent Consultant. All three are independent of all services in Hillingdon. Sheila is an experienced reviewer across children's and adults. She also trains,

accredits, and supervises reviewers. Anna is an accredited SCIE Learning Together Reviewer with a Social Work background, having worked in several local authorities. Eliot's specialism is in safeguarding, mental health, and mental capacity legal frameworks. He is also an accredited SCIE Learning Together Reviewer with a Mental Health Social Work background.

METHODOLOGICAL COMMENT AND LIMITATIONS

1.3.21 This is the first time that Hillingdon has commissioned a review using the Learning Together methodology. Efforts to identify all the right operational staff to contribute to the Case Group were hampered by the time that has passed since the trigger incident which meant that some people had changed roles and moved agencies, as well as by capacity issues of staff, especially in the Covid context.

1.3.22 This created a need for the SCIE Reviewers to seek some follow-up conversations with individual practitioners/ managers who were unable to attend the workshop and it impacted on the timeline of the review. Therefore, the initially planned meeting with the Review Team following the practitioners' workshops was cancelled to allow the reviewers sufficient time for the analysis and appraisal of practice and to identify draft systems findings. The second meeting with the Review Team was then extended to allow sufficient time to receive the Review Team's input and test the systems findings.

1.3.23 The collaborative process and Learning Together tools, including feedback loops, nonetheless worked well to enable operational staff to check factual inaccuracies, explain the rational for actions and inactions, and help the reviewers understand some of the contributory factors.

1.4 STRUCTURE OF THE REPORT

1.4.1 There are two main sections to the report. The Appraisal of Practice Synopsis is presented first, individually for Angela and Chris. This gives a summary evaluation of the timeliness and effectiveness of responses to Angela and Chris and their families. It captures the case findings, detailing where practice was below or above expected standards and, where possible, explaining why.

1.4.2 The second part of the report draws out the wider learning. Systems findings are presented that impacted on practice with Angela and Chris and hold true more broadly and continue to impact on wider practice today. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in the future, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in relation to Angela

2.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW:

16th April 2020
Annual Review with the Consultant Psychiatrist at the Community Mental Health Team (CMHT) - Angela voiced her wish to come off medication, but the treatment continued with her agreement. - Angela was in remission and no concerns about her mental state were noted
24th August 2020 to 7th September 2020
GP ordered blood tests as part of the physical annual health review - The GP attempted contact with Angela various times without success - The blood tests were not completed
22nd October 2020 to 30th October 2020
The first two times the Community Psychiatric Nurse noted Angela's breathing difficulties: - Angela was administered her monthly depot injection twice at the depot clinic in October as she missed the September injection (on 17th September) - Angela was observed to be in poor health, with breathing difficulties but did not wish to contact her GP; she declined support, including a referral to Adult Social Care
30th November 2020
The third time the Community Psychiatric Nurse noted Angela's breathing difficulties, and other concerns: - Angela was administered the depot injection in her home upon her request as she felt too unwell to come to the clinic - Angela was observed to be in poor health; her home environment presented as untidy and in disarray - Angela continued to decline support and did not wish to contact the GP - The nurse shared her observations with CMHT on 4th December
4th December 2020
Immediate professional responses to finding Angela collapsed in the Town Centre: - Police officers accompanied Angela to her home and made a referral to Adult Social Care (ASC) due to their concerns about her physical health and home conditions - London Ambulance Serie (LAS) attended Angela's home later that day and made a referral to the out of hours GP as Angela refused to be taken to hospital - The of hours GP attended later and made a referral to Angela's GP with the recommendation to investigate her weight loss.

6th December 2020 to 14th December 2020
Professionals' follow-up actions to Angela's crisis on 4th December 2020: - CMHT discussed Angela in the daily zoning meetings and liaised with Angela's GP - Hillingdon MASH passed the police referral on to CMHT and progressed it to the ASC Mental Health Team for a Care Act Assessment. The ASC MH Team called Angela. She said that she had food in the house, that things were a bit untidy, but she did not want any help. However, she consented to Care Act assessment. - Police completed a welfare check and contacted AGE UK for a food parcel for Angela as she was unable to leave the home; a referral was sent to MASH - AGE UK made a referral to MASH the same day as Angela declined their support; a food parcel for Angela was arranged for the following day by Hillingdon Hub - ASC received the police referral and were unable to get in contact with Angela who had been put on the waiting list for a Care Act Assessment - The GP contacted Angela and as she declined an appointment, referrals were made to Rapid Response to take bloods (which was accepted) and the Care Connection Team (which was not accepted)
15th December 2020
Home visit by the Rapid Response Team: - Angela was assessed to be in poor physical health with suspected sepsis and an ambulance was called - Angela was assessed as not having capacity to decide on her care and treatment and was taken to hospital in her best interest by LAS, with the support of police

2.2 APPRAISAL SYNOPSIS

ANNUAL REVIEW WITH THE CONSULTANT PSYCHIATRIST AT THE COMMUNITY MENTAL HEALTH TEAM (CMHT)

2.2.1 On 16th April 2020 Angela was seen by the Consultant Psychiatrist within CMHT for her annual mental health review. During the appointment Angela shared her wish to come off the medication. The Consultant appropriately explored Angela's understanding of the risks regarding a potential relapse. The outcome of the consultation was that Angela agreed to continue with her treatment plan.

GP ORDERED BLOOD TESTS FOR THE ANNUAL PHYSICAL HEALTH REVIEW

2.2.2 Between 27th August and 7th September Angela's GP surgery made three attempts to contact Angela for blood tests as part of her annual physical health review. Angela had agreed to attend the clinic, but did not, therefore the checks were never completed nor followed up by the GP or communicated back to CMHT. **This is discussed further in Finding 5.** Angela was deemed by the GP surgery to have mental capacity in this regard although the details of this the assessment remain unknown. **This is discussed further in Finding 3.**

2.2.3 This was not in the best interest of Angela as it left her without the annual review and monitoring of her physical health that is recommended for adults who are treated for psychosis or schizophrenia (NICE, 2015). **This is discussed further in Finding 5.**

FIRST TWO TIMES THE COMMUNITY PSYCHIATRIC NURSE NOTED ANGELA'S BREATHING DIFFICULTIES AND RESPONSES

2.2.4 Having missed her monthly depot injection in September, it was agreed with Angela on the timely review and advice of the Consultant Psychiatrist for her to receive two injections in October instead. Angela received her injection in the depot clinic. The Community Psychiatric Nurse (CPN) administering the injections had an established relationship with Angela, having known her for some time, and she had been seeing Angela regularly in the depot clinic.

2.2.5 On 22nd October Angela attended for her depot and presented with breathlessness. The CPN attributed Angela's breathlessness to anxiety and as a result of Angela having missed her monthly injecting in September. **This is discussed further in Finding 2.** The CPN recommended Angela to seek advice from her GP, which Angela declined, and therefore did not complete any basic physical health checks. These could have led to a more informed assessment about Angela's health, particularly considering increased likelihood to cardio-vascular problems due to long-term depot injections. Whilst the CPN's primary focus was on making Angela feel more settled in order to administer the depot injection, which was necessary and successful, it did not allow for a more holistic assessment of Angela's general health and wellbeing. **This is discussed further in Finding 1.**

2.2.6 On 30th October, Angela attended two hours late for her second appointment at the depot clinic. One of the explanations provided to the review was that she had struggled with the journey, needing to stop frequently due to breathlessness. Whilst the clinic had moved as of 25th August 2020, Angela had been able to get to the clinic the week before for the first time without stating difficulties. Evidence provided to the review was inconsistent on this.

2.2.7 The CPN at the clinic noted weight loss and continued breathing difficulties and encouraged Angela again to contact her GP, offering to do this on her behalf which Angela declined again. The CPN did not see any need to explore Angela's continued refusal of seeking medical advice, neither through a mental capacity assessment, nor as a potential indicator of self-neglect. **This is discussed further in Finding 3.**

2.2.8 Angela stated that she was unemployed, living off her savings, and not in receipt of any benefits. The CPN also appropriately discussed a referral to the Adult Social Care mental health team which Angela declined. The engagement by Angela and her answers did not raise any concerns for the CPN that made her consider taking any other action and the generally busy environment and workload in the depot clinic meant that she had to attend to other patients. This therefore offered a limited opportunity to engage Angela in a more depth conversation to explore some of the discrepancies between Angela's presentation and what she was saying. **This is discussed further in Finding 1.**

THE THIRD TIME THE COMMUNITY PSYCHIATRIC NURSE NOTED ANGELA'S BREATHING DIFFICULTIES, AND OTHER CONCERNS, AND RESPONSES

2.2.9 Angela asked if her November injection could be given in her home. At the time this was not usual practice, but the CPN wanted to ensure that Angela received her medication and agreed to visit her during her lunch break on 30th November 2020, at a time of national lockdown due to COVID 19. The nurse's approach

showed commitment to Angela.

2.2.10 During this visit the CPN noted the front of the house to have become overgrown but did not note anything of concern in the home and described the kitchen and living room as “not dirty”, and “livable”, without any odours or smells. The CPN described Angela as having breathing difficulties on arrival which she again attributed to anxiety. **This is discussed in Finding 2.** During the appointment Angela became more relaxed and shared that she had bronchitis. The CPN appropriately advised Angela again to contact her GP which Angela declined. The CPN did not see any need to explore Angela’s continued refusal of seeking medical advice, neither through a mental capacity assessment, nor as a potential indicator of self-neglect. **This is discussed further in Finding 3.** The CPN’s focus shifted, however, and she grew concerned when Angela stated that she did not have any food in the home as she was unable to go out.

2.2.11 The CPN then made the food issue her priority, after having administered the depot injection but only notified the CMHT about her other observations on 4th December, via email. This was not in Angela’s best interest as it meant that she was left without any food supply and for four days no other professionals could have known that Angela did not have any means of obtaining food.

2.2.12 The CPN’s focus on the food issue also meant that no consideration was given to Angela’s deteriorating physical health, Angela did not receive any more encouragement to attend to her deteriorating health, including for the significant aspect of her inability to leave the house, or her mental capacity to make decisions about her care and treatment needs. The lack of a more holistic approach did not allow consideration for any safeguarding concerns, such as self-neglect. **This is further discussed in Finding 3.**

2.2.13 Furthermore, the recording of Angela’s appointments at the depot clinic, and home visit, were generally limited and repetitive, and not timely. This meant that other professionals could only have access limited contemporaneous information about Angela. Concerns and observations by professionals were reported retrospectively which was not in Angela’s best interest.

IMMEDIATE PROFESSIONAL RESPONSES TO FINDING ANGELA COLLAPSED IN THE TOWN CENTRE

2.2.14 Angela was seen on 4th December (Friday) by two police officers on foot patrol in the town centre. She was believed to be in a very weak and frail state, unable to walk unaided and dressed inappropriately for the cold weather. Officers were concerned about Angela’s immediate welfare and duly attended to her. The need for ambulance attendance was identified, but due to the time of year, weather conditions, and the Covid-19 pandemic, officers were informed about a prolonged wait for an ambulance. Angela’s presenting needs required an alternative approach and the officers accompanied Angela to her home address on the bus to wait for an ambulance there.

2.2.15 Angela presented amenable to the officers and accepted their help to make her feel comfortable at home with tea and turning on the heating, whilst waiting for the ambulance, and she allowed them to check her home. Officers were concerned about the overgrown, restricted access to the front door. They observed the home to be cold on arrival and were concerned about the generally neglectful and dirty state, including bags of rubbish and the odour of mold and faeces indoors. There

was no food in the home, and whilst Angela shared that she had no family nearby, she reassured the officers that she was living with her partner who was out drinking at the time.

2.2.16 The officers demonstrated a dedicated and person-centered approach when attending to Angela's immediate needs but also used the opportunity to explore their observations of the home further. This resulted in a full and detailed referral to ASC MASH highlighting their concerns. However, ASC MASH do not work over the weekend, and the visit occurred on a Friday, therefore good practice would have been for the officers to also phone the Adult Social Care Out Of Hours Service to advise of the urgent nature of support needed, given the severity of their concerns about the home environment and Angela's wellbeing.

2.2.17 The police officers had to leave before the ambulance crew arrived. With Angela's agreement they left the front door ajar for access which would have eased some of the odours. However, this also meant that the ambulance crew was not able to receive a first-hand account of police interventions and by the time they arrived the smell had dissipated. The ambulance crew focused on Angela's immediate health and welfare, without being able to access the background information about her mental health, treatment, or other underlying conditions that would have enabled a more comprehensive assessment, including observations of the home environment. Whilst this is not an unusual situation for paramedics to encounter, it was not in Angela's best interest.

2.2.18 Angela was assessed as needing hospitalization, but she declined. Angela's mental capacity in relation to admission was appropriately considered and she appeared to be aware of the risks of not going. At the time, LAS was also trying to keep people out of hospital as much as possible due the increased demand on health services considering the COVID pandemic. As an alternative, paramedics obtained Angela's consent to make a referral to an Out of Hours GP. This was good practice and this person-centered and flexible approach allowed for Angela to still receive some medical attention for her presenting needs.

2.2.19 The Out of Hours GP responded to the referral timely and obtained a handover from the ambulance service before making phone contact with Angela who agreed to a home visit. The handover did not include any observations about the home because the ambulance crew had not gone far into Angela's home, and neither had they been privy to the police officers' concerns about the condition of the home as their paths had not crossed as the police had had to leave ahead of the arrival of London Ambulance Service. This meant that valuable information about Angela's health and home environment got lost which was not in her best interest.

2.2.20 The medical assessment by the GP was detailed and noted improved health readings and improved general presentation. The GP advised Angela that she required further investigation for her weight loss. The GP was not aware that Angela had stated to the CPN some days earlier and to police officers that she was unable to leave the house to go shopping. In part, this was because the referral to him was from the London Ambulance, who had not asked Angela about this themselves which was a limitation. The result was that this continued to leave Angela without food or medical investigation of why she had not been able to leave the house, which was not in her best interest. The out of hours consultation notes were sent to Angela's own GP in a timely fashion. They did not include any

observations about Angela’s home.

PROFESSIONALS' FOLLOW-UP ACTIONS TO ANGELA'S CRISIS ON 4TH DECEMBER 2020

2.2.21 The referral to the Multi-Agency Safeguarding Hub (MASH) from police was reviewed the next working day (a Monday). The MASH review identified that Angela was open to CMHT, and the information was forwarded to them for information only. The need for an urgent Care Act Assessment was identified and tasked to the Mental Health Social Work Team to explore what support needs Angela had. What was missing at this stage was any information exchange between the ASC MASH and CMHT to share any concerns from their recent engagement with Angela, including potential safeguarding concerns. This was particularly important because the ASC MASH had not been made aware at this point of the CPN's concerns. Without this information, it meant that Angela did not benefit from the opportunity that the police safeguarding referral had created for comprehensive information gathering in a multi-agency setting, a shared risk assessment, or a decision about safeguarding and whether a section 42 (Care Act 2014) enquiry might be required in relation to self-neglect. **This is discussed further in Finding 4.**

2.2.22 The duty worker in the Adult Social Care Mental Health Social Work Team contacted Angela the same day by telephone on 7th and spoke to her about the concerns raised in the police referral. Angela acknowledged some aspects raised and denied others. Angela stated that she was doing fine, was eating and that her partner was looking after her. This was contrary to the information provided by the police to whom Angela had said that she had not eaten in days and had not been able to leave the house, and their concerns about the home environment. This discrepancy was not explored further, which was a missed opportunity to comprehensively assess Angela's situation. Angela agreed to a Care Act Assessment but she would have benefited from a visit on the same day due to her presenting, urgent needs. This was, however, not possible at the time due to there being only one worker on duty. This left Angela's urgent needs unassessed and unsupported for a longer period of time.

2.2.23 The duty worker did not identify any need for urgency through the assessment, and the referral was passed to the duty manager for routine allocation. This took two weeks, which was usual practice at the time, due to the increased demand and pressures on the service in light of the global pandemic. However, this timescale was not timely enough for Angela's needs, or to address the concerns identified by police officers, ambulance service, or GP, nor her inability to obtain food.

2.2.24 Following the email sent by the CPN to CMHT on 4th December, Angela was discussed in CMHT's daily zoning meetings, the details of those discussions were not available, and this raised questions about the purpose and effectiveness of those discussions and was not in Angela's best interest. The CMHT contacted the GP for information and also sent an email to ASC MH team stating there are concerns about Angela's depot and they are not aware of John. These were appropriate actions but did not demonstrate the appropriate sense of urgency. ASC confirmed that Angela needed urgent allocation for a Care Act Assessment.

2.2.25 One of the police officers who attended Angela's home on 4th December went back to Angela's home unannounced to conduct a welfare visit on 9th December. This was above expected practice, and not usual – a result of the officer's dedication

and sense of responsibility and reflective of the level and urgency of concern they had identified. The police officer raised further concerns through another referral to Adult Social Care Multi-Agency Safeguarding Hub. The police officer also acted swiftly to address Angela's lack of food by contacting support agencies. Age UK offered a food parcel to Angela which she declined due to the cost attached and they made a referral to the Multi-Agency Safeguarding. An urgent food parcel was delivered to Angela the following day through the Hillingdon Hub, a Covid related initiative. Despite all the professional activity, the response to Angela's urgent need for food occurred, 10 days after Angela told the CPN that she was unable to leave the house and go shopping, and 6 days after police officers had noted the lack of food in the home. This created a delay in meeting Angela's urgent need for food.

2.2.26 The second referral made to the Multi-Agency Safeguarding Hub by police was received and screened in a timely manner when received, two days after the visit. This referral provided the Multi-Agency Safeguarding Hub with a second chance to identify the risk of self-neglect and consider a safeguarding response. The screening process was followed. This showed Angela having unmet care and support needs and awaiting allocation for a Care Act Assessment. The contact was therefore passed to the MH SW team and the need to prioritise allocation was highlighted. While the response therefore made sense at the time based on information accessed, what was missing again through this process, was access to all relevant partner information systems through their representatives within the MASH, to see what additional information there was to add to that contained in the referral. Without this, the opportunity to identify the need for a safeguarding response was missed. **This is discussed further in Finding 4.**

2.2.27 The duty worker in the Adult Social Care Mental Health Team who reviewed the referral was aware of the delivery of a food parcel to Angela the day before which decreased the sense of an urgent response by the team. It was attempted to contact Angela via phone which was unsuccessful. As Angela was awaiting allocation for a Care Act Assessment it was logged as information. This continued to leave Angela without a timely and comprehensive assessment.

2.2.28 Having received the notes from the Out of Hour GP on 7th December, when they were also timely reviewed in the GP's surgery, a duty GP called Angela on 14th December only. This delay was not in Angela's best interest. Angela was offered an appointment which she declined. Noting the urgency, the GP then instead made a referral to Rapid Response for them to visit Angela in her home to take bloods which was an appropriate decision and responsive to Angela's needs. The reason why the GP also made a referral to the Care Connection Team, which was denied, remained unclear to the Review Team.

HOME VISIT BY THE RAPID RESPONSE TEAM

2.2.29 Before visiting Angela on 15th December, the practitioner from the Rapid Response team reviewed information on different systems, using a bespoke template. This was good practice as it allowed for all available information to be taken into consideration. This included what was known by the GP, out of hours GP, the depot clinic, and police to be taken into consideration. This was a turning point because it was the first time that information gathering from all relevant agencies occurred to inform an understanding of Angela's circumstances.

2.2.30 The practitioner showed a persistent and patient approach when Angela initially did not answer the door and used the time to make further enquiries with other

agencies such as the CMHT and Adult Social Care. This not only supported the information gathering process but also allowed sufficient time to Angela to answer his knocks and eventually allowed a home visit and an assessment. The information from other agencies, informed by the practitioner's own medical assessment, highlighted the need for urgent medical attention. The practitioner also showed a respectful and person-centered approach to get Angela to agree to the recommendation which was good practice.

2.2.31 The practitioner gained Angela's agreement for an ambulance to be called and stayed with her until the ambulance arrived, supporting a hospital admission due to sepsis despite Angela's reluctance. Practitioners from both agencies knew and respected each other and they accommodated Angela's pace and concerns to assess her mental capacity to take the decision. Angela was assessed as having fluctuating capacity and police attendance was requested to convey Angela to hospital in her best interest considering the immediate health needs. This may not represent a good use of police resources, but ambulance staff do not feel there are alternatives to them in this context and they are not equipped to force someone against their will.

3 Appraisal of professional practice in relation to Chris

3.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW:

30th July 2020 to 4th August 2020
1st time GP raised concerns about Chris following his non-attendance to receive his depot injection and professional responses - Referral to the Single Point of Access (SPA) - The Home Treatment Team (HTT) became involved short-term - A Mental Health Act assessment was completed
7th August 2020 to 18th August 2020
2nd time GP raised concerns about Chris following his continued non-attendance to receive his depot injection and professional responses - The GP made a referral to SPA - This was initially passed to the Primary Care Mental Health Team, but then to CMHT
27th August 2020 21st September 2020
3rd time GP raised concerns about Chris following his continued non-attendance to receive his depot injection and professional responses - CMHT continued attempts to engage Chris - A referral for a Mental Health Act assessment was made - The decision was made to attempt to offer Chris a Care Act Assessment instead - Chris declined support when visited by a Mental Health Team Social Worker
22nd September 2020 to 25th September 2020
1st and 2nd time Chris' brother raised concerns about Chris' mental and physical wellbeing and professional responses - Chris' brother contacted SPA and CMHT raising concerns - CMHT visited Chris with police and found him physically unwell; Chris was taken to hospital - A Mental Health Act assessment was completed, criteria was not met for compulsory admission to hospital and Chris was discharged home
28th September 2020 to 14th October
3rd time Chris' brother raised concerns about Chris' mental and physical wellbeing and professional responses (28 Sept – 14 October 2020) - Chris' brother raised his concerns with CMHT - There was a two-week delay to the request for another MHAA - A S135 MHA 1983 (Power of Entry) warrant was obtained - Prior to the S135 being carried out, Chris was found at home, physically and mentally unwell; he was taken to hospital in his best interest

3.2 APPRAISAL SYNOPSIS

1ST TIME GP RAISED CONCERNS ABOUT CHRIS FOLLOWING HIS NON-ATTENDANCE TO RECEIVE HIS DEPOT INJECTION AND PROFESSIONAL RESPONSES

3.2.1 The GP was alerted in a timely manner by surgery staff when Chris did not attend for his fortnightly depot injection on 30th July for the first time. The GP had known Chris for several years and his missing his appointment was out of character and raised concerns for the GP. It was good practice that they initiated timely and relevant enquiries with the pharmacy, hospital, and police. Staff members from the surgery also visited Chris, which was good practice, and reported that he was not engaging much with them, and the GP made a referral to the Single Point of Access (SPA) alerting them to Chris' missed injection and expecting this to be addressed by them.

3.2.2 The Single Point of Access swiftly attempted to contact Chris on 31st July but were unsuccessful and made an urgent referral to the Home Treatment Team (HTT) who visited the same day. This provided a timely response to the concerns raised and was good practice.

3.2.3 The Home Treatment Team located a man at the address who they were unable to identify. They therefore returned the following day which was good practice and they met Chris. They were able to engage with Chris and sought his agreement for him to attend the surgery as soon as possible (the HTT does not administer depot injection as part of their involvement, therefore administering the depot to Chris at home at that time was not an option; **this is further discussed in Finding 5**. Chris was agreeable to attending the GP surgery the following week but did not wish to engage with the team. This was respected in line with a person-centered approach, however, HTT practitioners observed signs of a potential mental health relapse and therefore appropriately arranged for a Mental Health Act Assessment, which was completed on 4th August.

3.2.4 Chris engaged in the assessment and agreed to attend the GP surgery to receive his depot injection on 6th August. Chris was deemed to have mental capacity to make that decision and not believed to be deteriorating in mental state. Chris was not assessed as being in crisis and therefore the HTT concluded their involvement on 6th August and informed the GP via email on the same day which was expected practice.

2ND TIME GP RAISED CONCERNS ABOUT CHRIS FOLLOWING HIS CONTINUED NON-ATTENDANCE TO RECEIVE HIS DEPOT INJECTION AND PROFESSIONAL RESPONSES

3.2.5 When Chris did not attend the GP surgery for his missed depot injection as agreed, the GP contacted the Single Point of Access to inform them. The GP was asked to complete another referral. This caused a degree of frustration however the GP nevertheless completed a referral in a timely fashion which was good practice. The referral then bounced between the CMHT and Primary Care Mental Health Team (PCMHT) until the managers of PCMHT and CMHT agreed for Chris to be allocated to a worker within CMHT with the aim of getting Chris to attend the GP surgery to receive his depot injection. The decision-making process around which team was responsible and better suited created a delay and meant that 7 days had lapsed between the GP's referral and Chris being seen. This was not in his best

interest. **This is discussed further in Finding 5.**

3.2.6 When Chris was seen by the CMHT practitioner on 15th August, however, no immediate concerns were raised about his mental state and the practitioner had felt assured to some degree by the recently completed MHAA. Chris was again encouraged to attend the GP surgery for his injection, and information provided to the Review Team has not allowed it to understand if/ what attempts were made to understand why Chris had not attended the GP surgery. As there was no direct contact between the CMHT practitioner and the GP, this was a missed opportunity for partnership working. **This is discussed further in Finding 5.** Whilst Chris' agreement was given due weight and available information (recent MHAA) was considered, it would also have been good practice for the CMHT practitioner to contact the GP who had known Chris for several years and had made the referral. This could have offered an opportunity to better understand the GP's concerns for the ongoing assessment and to also consider a joint visit as part of it.

3RD TIME GP RAISED CONCERNS ABOUT CHRIS FOLLOWING HIS CONTINUED NON-ATTENDANCE TO RECEIVE HIS DEPOT INJECTION AND PROFESSIONAL RESPONSES

3.2.7 Again, Chris did not attend the GP surgery to receive his depot injection on 27th August. This meant that he had been without his depot injection since 9th July and weekly oral medication for his physical health conditions since 6th August. Chris had physical health conditions that required management and the GP grew concerned. The GP showed a high level of commitment, with a focus on Chris' mental health, and an urgent referral was made to SPA who passed it on to CMHT for allocation.

3.2.8 Over the next few days, attempts were made by CMHT practitioners to visit Chris, but they remained unsuccessful and the CMHT contacted the police to report concerns that they were unable to locate Chris. CMHT asked police to do a welfare check and were advised to attempt to search the property first before reporting Chris as missing. This was in line with expected practice as the CMHT had not identified and reported any immediate threat to life.

3.2.9 CMHT practitioners showed commitment and continued to make attempts to locate Chris. This included gaining access to the property through an unlocked door. Attempts were hampered by visiting practitioners who had not met Chris before. For example, on one occasion they found a male asleep in bed but were unable to establish his identity as he did not react to their presence. They decided to leave a note and return later that day. On subsequent visits, although the male remained unresponsive to their presence, they noted signs of life (he had changed position). It was good practice that the practitioners attempted several visits in one day.

3.2.10 In discussion with management on return to the office, considering Chris' missed depot injections and concerns about physical and mental health a discussion took place, and a referral was made for a Mental Health Act assessment. The AMHP manager had been in Hillingdon for several years and had some knowledge of Chris' circumstances. It was felt that a Care Act Assessment was a less restrictive option and more appropriate to the situation. In this context, potential safeguarding issues for Chris, such as self-neglect, also needed to be considered but were not, because the focus remained on compliance with medication. This was a missed

opportunity. **This is discussed further in Finding 3.**

3.2.11 On 7th September Chris was referred for a Care Act Assessment. This was a significant delay as the usual workflow and allocation processes were not followed. The reasons for this remained unclear to the Review Team. The waiting list for allocations at that time was around two weeks. This delay presented problematic and did not appropriately reflect the level of concern in relation to Chris.

3.2.12 When the Social Worker visited Chris unannounced on 21st September their approach to Chris presented as appropriate. Chris was informed about the purpose of a Care Act assessment was asked questions about his self-care skills. Chris was clear that he did not wish to receive any support and as he grew increasingly agitated, the Social Worker decided to leave. In the absence of any background knowledge and context or other agencies' input prior to the visit, as this had not been made available in the referral, the Social Worker did not see any need to seek discussions with other agencies, including the referring AMPH manager. This is problematic practice and would have impacted the Social Worker's ability to complete a comprehensive and holistic assessment. It presented also as a missed opportunity to consider Chris' situation through a safeguarding lens, such as self-neglect. **This is discussed further in Finding 3.**

1ST AND 2ND TIME CHRIS' BROTHER RAISED CONCERNS ABOUT CHRIS' MENTAL AND PHYSICAL WELLBEING AND PROFESSIONAL RESPONSES

3.2.13 On 22nd September, Chris' brother contacted SPA, raising his concerns about Chris as he had been unable to get Chris' attention through the window when visiting and he did not open the door. The brother's concerns were passed to the CMHT prompting them for an urgent review which was appropriate, and Chris' brother was informed about it.

3.2.14 CMHT sent an email to the AMPH manager to enquire about the progress of the Care Act Assessment. Further contact from Chris' brother and his increasing concerns about Chris led the CMHT to attempt a visit which was the right thing to do but was unsuccessful.

3.2.15 Recognizing the seriousness of the recent concerns, CMHT appropriately requested a police welfare check and agreed to visit Chris jointly with police later that day. Chris was found physically unwell on the floor in his home, and he appeared disorientated and incoherent. An ambulance was called, and Chris was taken to the hospital in line with his needs and his best interest.

3.2.16 An administrative error meant that Chris' medical records were not matched to his attendance at A&E. This is problematic and meant that Chris' medical history could not be considered for the medical assessment and that his GP was not notified about his A&E attendance. This created a gap in Chris' medical history.

3.2.17 In a parallel process the CMHT had notified the Psychiatric Liaison Service and requested a Mental Health Act assessment and Chris' correct details were passed on to the service. When Chris was medically cleared the Mental Health Act Assessment was completed out of hours, with limited information on Chris' mental health and social care involvement due to limited time available and access difficulties to the recording systems[1]. Chris was assessed as having capacity to

[1] The AMHP was later provided background information during a reflective discussion with the AMHP Manager and confirmed that this would not have changed the decision not to detain Chris under the Mental Health Act 1983.

make decisions about his care and treatment needs, and he was discharged home. The reason for Chris' conveyance to A&E, his medical needs, seem to have fallen out of focus following the positive Mental Health Act Assessment which is problematic practice, and this **is discussed further in Finding 2.**

3.2.18 There was no clear plan in place and confusion about which mental health team Chris was referred to. This left Chris without support or a contingency plan. Chris' brother was also not informed about the outcome by any agency which was problematic practice, particularly as he had made the recent referrals.

3.2.19 The AMHP manager contacted the out of hours AMHP the following day when they learned about the outcome of his MHAA for Chris the day before and engaged in a conversation about the rationale for the assessment, in which they also shared her background knowledge about Chris' history that was not easily available and accessible. Having considered the information that was previously not known to the AMHP, it did not influence their decision of the MHAA. This conversation was good practice.

3.2.20 When the CMHT timely visited Chris at home the day after his discharge, Chris could be seen in the property through the window, but he did not respond to practitioners' knocking on the door. Another referral was made to the AMHP service for a Mental Health Act assessment. Again, at this point there needed to have been a consideration of safeguarding issues, or risk of self-neglect but this did not happen. **This is further discussed in Finding 3.**

3RD TIME CHRIS' BROTHER RAISED CONCERNS ABOUT CHRIS' MENTAL AND PHYSICAL WELLBEING AND PROFESSIONAL RESPONSES

3.2.21 On 28th September, four days after Chris' discharge from hospital his brother again raised concerns with CMHT as he was unable to engage with Chris but could see him through the window. This triggered CMHT to follow up on their referral for a Mental Health Act assessment.

3.2.22 Communication between the AMHP service and Social Work Mental Health Team regarding the Care Act Assessment outcome to inform the decision about a Mental Health Act assessment lacked timeliness. This is problematic as it meant it was not effective or responsive to the increasing risks and concerns in relation to Chris. This would have also offered an opportunity to consider a safeguarding response considering the presenting concerns. **This is further discussed in Finding 3.**

3.2.23 On 13th October, three weeks after the MHAA was completed for Chris in hospital, it was shared by the AMHP service with CMHT. This was not timely and is problematic practice.

3.2.24 On 14th October, the AMHP service obtained a section 135(1) MHA 1983 warrant from Uxbridge Magistrates court to attend Chris' home to gain access and assessment Chris formally. The warrant was to be executed on 16th October.

3.2.25 Triggered by the communication between the managers of the AMHP service and the ASC Social Work Mental Health Team earlier, on 15th October, the allocated Social Worker from the ASC Mental Health Team returned to Chris' home address following the visit on 21st September for a follow up. This delay was not in Chris' best interest.

3.2.26 Chris did not respond to knocks on the door and could be seen through the window lying on the floor. Emergency services were appropriately called and when entry

to the home was gained, Chris was found in a very poor and neglected physical and mental state. He was refusing to go to hospital and but as he was assessed as not having capacity to his care and treatment needs, he was taken to hospital in his best interest. The responses to this emergency were good practice, in line with expectations.

4 Systems Findings

4.1 IN WHAT WAYS DO ANGELA'S AND CHRIS' STORIES PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

Five systems findings have been prioritised from Angela's and Chris' stories for the Safeguarding Partnership to consider. These are:

	Findings
1	FINDING 1: **CASELOAD MANAGEMENT IN DEPOT CLINICS** In Depot Clinics the way that individuals are currently defined, and case-loads managed does not differentiate between individuals who have a number of health and care professionals regularly involved with them and those who do not see any regularly, aside from the Community Psychiatric Nurse. This makes it harder for a Community Psychiatric Nurse 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 the administering of the depot injections takes precedence and health checks are not adequately prioritised, leaving arising health issues unexplored. (Management system issue)
2.	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. (Innate cognitive bias)
3.	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 assuming and/or 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. (Professional norms and culture)

4.	FINDING 4: **INITIAL REVIEW OF REFERRALS INTO ASC MASH** Does the Hillingdon Adult Social Care MASH risk missing referrals that require a safeguarding response, because there is no routine access to multi-agency information as standard at the earliest stage of review? (Management system issue)
5.	FINDING 5: **Collaboration between GP and Secondary Mental Health** 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. (Professional norms and culture)

4.2 FINDING 1: CASELOAD MANAGEMENT IN DEPOT CLINICS

FINDING 1: **In Depot Clinics the way that individuals are currently defined, and case-loads managed does not differentiate between individuals who have a number of health and care professionals regularly involved with them and those who do not see any 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 the administering of the depot injections takes precedence and health checks are not adequately prioritised, leaving arising health issues unexplored. (Management system issue)**

4.3 CONTEXT

Depot injections: A depot injection is a slow-release form of liquid medication, so it lasts a lot longer. The injection is made into a large muscle. This is usually either the buttock or the largest muscle of the shoulder. The injection is usually administered by a healthcare professional, either in a depot clinic or in a GP surgery. It is for adults with mental health issues who have been prescribed the medication at specific intervals. A depot injection might be a good option for people who find it difficult to swallow medication, find it difficult remembering to take medication regularly and/ or prefer not to have to think about taking medication every day. Patients are usually offered a depot injection if they have been on the medication for a while, they know it is working for them and they expect to keep taking it for a long time.[2]

Depot Clinics are currently part of secondary healthcare and administer depot injections to adults with mental health issues. Clinic appointments are usually brief, involving administration of an injection and enquiries and examination for side effects. In Hillingdon, the Clopazine and Depot Clinic is now based at Uxbridge Health Centre, where it moved to in August 2020 from Mead House.

Community Psychiatric Nurse (CPN): a CPN is a mental health nurse who may work in a depot clinic, in a community setting or in the community. They can give medication and support individuals with the management of their health in the community.

4.4 HOW DID THE FINDING MANIFEST IN THIS CASE?

This finding was brought to light by Angela's story.

Angela belonged to the group of individuals whose monthly depot injection for schizoaffective disorder had been managed through the depot clinic, by the CPN, for several years. This depot clinic in principle provided the opportunity for regular checks on Angela's physical health, and therefore the opportunity to notice any emerging health issues and deterioration. This was particularly significant, with hindsight, considering Angela's later diagnosis of Mesothelioma Asbestosis which led to her death in January 2021. Yet, poignantly, despite noticing Angela 's breathing difficulties, poor health, and visible weight loss, both in the clinic and later in a home-visit, no health checks or observations were conducted. The opportunity to bring some medical specificity Angela

[2] **https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/depot-injections/**

and professional's understandings of her health was missed and with it, the potential to recognise the need for urgency of response. Instead, the CPN recommended to Angela to contact her GP for advice which Angela declined. She also offered to contact the GP on Angela's behalf and a referral to Adult Social Care for an assessment, which were also declined. These were not followed up later, when the CPN's concern and focus shifted to Angela's lack of food rather than the medical causes of her notable deterioration which meant she was no longer able to go out of the house to do shopping.

This oversight at the Depot Clinic was particularly significant in Angela's story because Angela did not have any other healthcare or care professionals involved who she saw regularly. Therefore, there were no other opportunities to rectify the oversight of basic health checks and observations.

For the CPN, however, the absence of other professionals in Angela's care and treatment was not evident on Angela's file. Nor had additional time been allocated to the CPN working with Angela, to mark the need for and enable health checks to be conducted routinely given the lack of routine involvement of other professionals in her life. Practitioners and the Review Team highlighted to us that the busy environment of a depot clinic would not necessarily allow a CPN to consult an individual's records in such detail prior to administering the injection and the CPN's focus would be predominantly on giving the injection.

4.5 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

When we explored this issue in more detail, we heard that such a scenario was not a one-off in relation to Angela's story. Instead, the way that individuals are defined for the Depot Clinic and the way caseloads managed, does not take account of whether the individuals are supported by a wider network of health and care professionals or, like Angela, only have the depot clinic as their point of contact. Therefore, there is no ready way for clinic staff to know who they should prioritise for health checks and wider health oversight, and who not. This is particularly true given the pressurised context which means alternative workarounds are not feasible.

Input from the Review Team also highlighted that in Hillingdon this pressure is compounded by logistical pressures and scare clinic space. Following a de-integration of health and social care services, the depot clinic moved out of previous local authority premises, to a space in a health centre. The impact of this on the service was additional pressure on the clinic. The physical set-up of the clinic room has also prevented physical health checks from being effectively completed.

While in Hillingdon there is an aspiration for patients who are only seen in the depot clinic to receive their depot medication from their GP practice, in reality there are a number of barriers to this, including cost and nationally "a small number of patients may have their depot administered via their GP" (RCPSYCH, 2020).

4.6 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

The Review Team shared that around 200 people attend the depot clinic in Hillingdon at any one time. The identification of those patients who, like Angela, do not have any other healthcare professional involved routinely, is a challenge and it has not been possible to

provide a number, or an estimate, of people likely to be affected.

In Hillingdon, as in many other areas, the depot clinic also functions as a Clopazine clinic. Clopazine is an oral anti-psychotic with serious side-effect profile, requiring differential white blood cell monitoring. Blood samples are taken locally and submitted to the national Clopazine Patient Monitoring Service (CPMS). The phlebotomy and physical observation function (blood pressure) is integrated into the depot clinic – this finding will likely be of relevance to these patients also.

Depot clinics are an established feature of community mental health services offering administration of anti-psychotic medication and maintenance medication and monitoring of potential side effects. Specialist Community Mental Health Services offer service users a mixture of medicine and psychosocial interventions as treatment of mental health difficulties, including case management, and a multi-disciplinary approach. However, for many individuals who respond well to medication treatment, few other non-medical treatments may be required. A significant number of individuals may be seen purely for medical management of their situation through regular but infrequent medical review and oversight by a Consultant Psychiatrist and a medication regime. Conversely, other individuals may not be prescribed any medication at all but see one professional for psychosocial support in a therapy or practitioner clinic. This means that the likelihood that a particular service user within the depot clinic does not see any other healthcare professional is high.

Evidence provided to the review indicated alternative workarounds are unlikely to be feasible across the country because depot clinics were and have remained under significant pressure through the pandemic. In March 2020, the Royal College of Psychiatrists published guidance on managing long-acting antipsychotic depots during Covid-19 which offered advice on how to ease the pressure on depot clinics, for example by increasing the interval between depots or considering alternative medicines that could be given less frequently (RCPSYCH, 2020).

4.7 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

The pressure on depot and maintenance medication clinics means that they cannot be relied upon to undertake physical health checks or monitoring for all patients, to identify patterns or changes in a person's underlying condition, or to deliver a service beyond administration of an injection and cursory examination for the known side-effects of that medication. This focus on the administration of a dose of an anti-psychotic medication by a psychiatrically-trained nurse does indeed increase the risk that even when a person presents with poor or deteriorating health the administering of the depot injections takes precedence and health checks are not adequately prioritised, leaving arising health issues unexplored. Without the means to flag to a depot clinic CPN that a patient is known only to their service, and that their physical and mental health are not being monitored by any other professional, professionals have no way of identifying and prioritising those patients most impacted by dint of not being connected with other health and social care networks.

FINDING 1 – CASELOAD MANAGEMENT IN DEPOT CLINICS

FINDING 1: **In Depot Clinics the way that individuals are currently defined, and case-loads managed does not differentiate between individuals who have several health and care professionals regularly involved with them and those who do not see any 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 the administering of the depot injections takes precedence and health checks are not adequately prioritised, leaving arising health issues unexplored. (Management system issue)**

SUMMARY OF SYSTEMIC RISKS

A pressurised environment fosters 'tunnel vision' whereby we put blinkers on and reduce what is in focus. This is a sensible means of making demands manageable. The drawback is that that some issues are placed out of sight when in fact they need consideration. A safe system manages these risks by supporting the prioritisation of time and fuller attention where it is most needed, so the cognitive 'blinkers' are removed when appropriate. This finding highlights the gap in such an adjustment in the management of individuals in Depot Clinics, which increases the risk that those who most need additional oversight of their health will not get it, even in the face of evident deterioration.

4.8 QUESTIONS FOR THE SAFEGUARDING PARTNERSHIP TO CONSIDER:

4.8.1 How can the identification of individuals and workload allocation for Depot clinics be amended to address this finding, and enable depot clinic nurses to know which patients required a more in-depth records review?

4.8.2 What are the ways in which other professions or agencies could support in addressing this finding? What processes could be put in place in the booking system or patient record to highlight when a depot clinic patient was not seen by any other professional?

4.8.3 What would enable a depot clinic nurse to identify when a patient may be at an enhanced level of risk due to physical health, or indeed lifestyle behaviours, or social circumstances?

4.8.4 How would the SAB know if practice in this area had improved?

4.9 FINDING 2: DIAGNOSTIC OVERSHADOWING

FINDING 2: **Current mechanisms for check and challenge are not currently working in Hillingdon to reduce the risk of 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.** (Innate cognitive bias)

4.10 CONTEXT

Diagnostic overshadowing: Diagnostic overshadowing is a judgement bias where practitioners misattribute legitimate symptoms of physical illness to a manifestation of mental illness rather than a genuine physical complaint[3]. While generally considered to be primarily a medical problem, with the diagnosis and explanation of symptoms, the term holds wider applicability across health and social care, and across professional disciplines and, put simply, can also be understood as "physical health issues falling off the radar in light of presenting mental health issues."

4.11 HOW DID THE FINDING MANIFEST IN THIS CASE?

We could see that this finding, with its wider definition and applicability of "diagnostic overshadowing" played out across several different contexts and relationships in relation to Angela and Chris, including showing some variations.

Angela

When Angela met the CPN on three occasions in October and November, she presented with breathing difficulties. The CPN also described Angela as somewhat anxious on arrival and explained Angela's presentation as a side effect of coming off her medication as she had missed her monthly depot injection in September. The CPN observed that having given Angela time to catch her breath and have water to drink, she presented as more settled and calmer. This gave the CPN reassurance that Angela's breathing difficulties were a temporary state that did not require any exploration and that did then allow the CPN to administer the depot injection. The CPN thought and hoped that the depot injection would in fact help Angela to feel better again. However, Angela's physical health issues persisted and deteriorated during the CPN's involvement, and, with hindsight, we now know that they were the early manifestations of Angela's later diagnosis of Mesothelioma Asbestosis.

There was no evidence provided to the Review Team of any opportunity for the CPN to test and challenge her explanation and assessment of Angela's physical health during her involvement, i.e., through supervision or discussion with peers, which left Angela's arising health issues unexplored. And it was those health issues and later diagnosis which led to Angela's death in January 2021.

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[3] **https://journals.rcni.com/mental-health-practice/diagnostic-overshadowing-a-potential-barrier-to-physical-health-care-for-mental-health-service-users-mhp2013.12.17.4.22.e862#:~:text=Diagnostic%20overshadowing%20is%20a%20judgement,interpreted%20in%20a%20psychiatric%20lexicon**.

Chris

Diagnostic overshadowing also occurred in relation to Chris. His GP made timely referrals and showed commitment and persistence in escalating her concerns with the CMHT when Chris did not attend the GP surgery for his fortnightly depot injection and continued not to attend. The GP's three referrals in July and August 2020 focused on the missed depot injection and the increasing concerns of the impact on Chris' mental health, whilst no concerns were noted around his various physical health conditions. This is particularly significant as Chris also stopped collection his prescribed medication to manage his various physical health issues. Yet, the potential impact on Chris' physical health of not taking his prescribed medication seem to have fallen off the GP's radar and was not highlighted as a concern in their referrals to the Single Point of Access/ Community Mental Health Team. This, in turn, also seem to have impacted on the response to Chris by the receiving teams: with a sole focus on Chris' mental health, and his physical health needs, despite showing signs of deterioration, fell out of sight of professionals.

Chris' deteriorated physical health required him to taken to A&E as he was found at home by an CMHT practitioner in poor physical health and disoriented. The initial parallel processes of assessing and addressing Chris' physical needs and of arranging a Mental Health Act Assessment were not followed through equally. When Chris was assessed as having capacity to make a decision about his care and treatment needs, his physical health needs (albeit no longer requiring hospital admission) fell out of professionals' focus and view and there was not discharge plan agreed with the GP to follow those up. The discharge was additionally hampered by an administrative error between the ambulance and hospital which meant that Chris' correct details were not know to the medical staff and therefore his medical history could not be considered.

This was a clear example that even when the reason for admission was physical health deterioration, the explanations sought were psychiatric and it was the Mental Health Act Assessment that received primary focus. There was no check or challenge offered by any professional as to the reasons for the decline in his physical health which left his arising health issues unexplored, and it was those health issues that later led to his final admission to hospital.

4.12 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

When we explored this issue in more detail with practitioners and managers, they were able recognise with hindsight that in the story of both, Angela and Chris, diagnostic overshadowing took place, manifesting in their health issues not being given due attention or falling out of professionals' views entirely considering their existing mental health diagnosis and concerns around their mental health. This also resonated with the Review Team.

Input from the Review Team confirmed that the pattern of diagnostic overshadowing for physical health for people with diagnosed mental health conditions had been recognised in Hillingdon. On the one hand, the Review Team shared that there were limited opportunities, formal and informal, for checks and challenges in day-to-day work to raise such issues, particularly in busy environments such as in Angela's situation in the depot clinic, or in Chris' situation in the A&E Department. Supervision with line managers was mentioned as an important tool and forum for practitioners to discuss practice challenges or dilemmas, however, it was also noted that they may not be acknowledged as a challenge or dilemma in the first place, therefore they will not be brought for discussion.

This input indicates that it was not an anomaly only in the Angela's and Chris' situations that physical health needs fell off the radar and went unchallenged. Instead, it indicates a systemic issue.

On the other hand, the Review Team highlighted various initiatives that have been started to create forums for checks and challenges. Particularly the more pressurized and high risk environments have been given priority such as hospital discharge, the daily high risk meetings in the Multi-Agency Safeguarding Hub (Adult Social Care) and through the Safeguarding and Mental Health Subgroup on a more strategic level.

4.13 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

The exact number of people in Hillingdon who might be affected by this finding is difficult to establish as the data of people who have a diagnosed mental health condition is not easy to collate, less so the number of people within that cohort who may have had issues related to their physical health needs overlooked. Having said that, the number of people potentially being affected by this finding is significant, considering the general prevalence of mental health conditions in adults, in Hillingdon and nationally.

In recent years there has been a significant policy-focus on the issue of parity of esteem between mental and physical health. This describes the need to value mental health and physical health equally, where people who have complex mental health needs should have the same access to health care services as people with physical health needs (RCN, 2021). The issue of parity of esteem has been raised before parliamentary committees and has been recognised as an underlying problem in the UK health system. Cross-disciplinary literature has highlighted the barriers faced by individuals with mental illness in accessing physical health services, including systemic biases and the human factors assumptions that lead to diagnostic overshadowing.

The social model of mental illness and disability recognises that individuals face not only the impact of their impairment or illness, but the societal, systemic, and organisational responses to it. This does not only take the form of traditional discrimination and marginalisation – familiar to individuals with mental illness, and to the professionals working in the field, but also to assumptions made about physical complaints, often put down to mental health, or anxiety.

In this context, diagnostic overshadowing can be viewed both as a human factor error in the diagnostic process, but also a result of deep systemic and instinctive responses to individuals with a mental illness diagnosis. It is demonstrably not only a local issue to Hillingdon but evident nationally.

4.14 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

Diagnostic overshadowing in the widest sense, including physical health issues falling out of any professionals' view considering presenting mental health concerns, and the absence of check and challenge means that people with mental health concerns may face more adverse physical health outcomes than people without mental health concerns. Particularly in busy and high risk work environments, it is necessary to create space for discussion and reflection and to allow professional challenge as otherwise there is a risk

that arising physical health issues remain unexplored, are misdiagnosed or their diagnosis is delayed. This can be extremely serious, including the wrong treatment being provided. or premature death of people with mental illness[4].

FINDING 2. DIAGNOSTIC OVERSHADOWING

Current mechanisms for check and challenge are not currently working in Hillingdon to reduce the risk to 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. (Innate cognitive bias)

SUMMARY OF SYSTEMIC RISKS:

Pressurized, high risk environments and professionals' hierarchy and status create opportunities for focus of assessment, intervention, and treatment of mental health issues to become too narrow, to the detriment of other presenting physical health needs that then fall off the radar as a consequence. A safe system manages these risks by creating respectful formal and informal opportunities for "checks and challenges" of assessment, diagnosis and treatment that are non-hierarchical and inclusive of all relevant professionals, regardless their role and status. This finding highlights the need for existing opportunities in Hillingdon to be further embedded and strengthened and for other, pressurized, high risk environments to be assessed for their robust offer of "checks and challenges." Without these the diagnostic overshadowing for people with mental health conditions identified through this thematic review, is likely to continue, creating a systemic risk that their physical health issues receive inadequate attention.

4.15 QUESTIONS FOR THE SAFEGUARDING PARTNERSHIP TO CONSIDER:

4.15.1 How can good practice be encouraged in diagnosis of physical health symptoms when people have an existing diagnosis of mental illness?

4.15.2 What championing of this issue has there been recently?

4.15.3 Are there innovations in other areas of London or other regions to tackle this issue?

4.15.4 What education and awareness-raising of the risks of diagnostic overshadowing might need to be considered for professionals in the partner agencies to prevent physical health problems being overlooked for people with a diagnosed mental health condition?

4.15.5 What other pressurized and high-risk environments are there amongst the partner agencies that would benefit from a self-assessment in terms of their robust offer for "checks and challenges"?

4.15.6 How would the SAB know if there had been improvements in this area?

[4] Data published by the UK Government estimate that people with serious mental illness die on average 15 to 20 years earlier that the general population (Chesney, et al., 2014). Recent commentary indicates that this gap is widening.

4.16 FINDING 3: MENTAL CAPACITY RULING OUT CONSIDERATION OF SAFEGUARDING FOR SELF-NEGLECT

FINDING 3: **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 assuming and 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.** (Professional norms and culture)

4.17 CONTEXT

Mental capacity and Mental Capacity Assessments (MCA): The Mental Capacity Act 2005 provides a legal framework for decision-making in England and Wales. A decision is a conclusion or resolution reached after consideration, and the Mental Capacity Act is concerned with the process of consideration, rather than a judgement of the decision. A person will be considered to lack mental capacity (the ability to make a decision) if at a particular time and in relation to a particular matter, they are unable to understand, retain, use and weigh-up, or communicate their decision *because of* an impairment or disturbance in the functioning of a person's mind or brain.

There are five statutory principles that need to be followed for any mental capacity assessment: presumption of capacity; support to make a decision; ability to make unwise decisions; if a person is assessed as lacking capacity, the decision must be taken in the individual's best interest and lastly, the decision must be the least restrictive option. The statutory principles in the Mental Capacity Act are focused on the right to self-determination, and protection of the concepts of best interests and respect for human rights and personal freedoms. These principles are focused on supporting autonomy in which should include engaging and working with people through the decision-making process. When a person faces a situation of self-neglect, choices about care and support are critical to their wellbeing and in this context an on/off view of mental capacity in unhelpful. It is also important to note that a person can have fluctuating capacity and it practicable and realistic, the mental capacity assessment should be undertaken when the individual has regained or is more likely to have mental capacity. For more information see **https://www.scie.org.uk/mca/practice**

The mechanics of consent, for example to care and support arrangements, medical examination, and safeguarding interventions are broadly set out in the definition of valid consent. For consent to be valid three components must be fulfilled:

- That the individual has received sufficient information in order to make the decision
- That the individual has the mental capacity to make the decision
- That consent is freely given, without duress or undue influence

Self-neglect becomes a safeguarding matter when an individual is unable "to protect themselves by controlling their behaviour" (Care and Support Guidance, 2021). This may include an individual who has mental capacity, but for some other reason is unable to exercise freedom of choice, or accept the support being offered – for example because they haven't been given sufficient information or have misunderstood a key component of the salient information.

Safeguarding adults: Section 42 of the Care Act (2014) places a duty on local authorities to conduct an enquiry to decide what action to take to support and protect the person in question. It applies to all adults aged 18 and over with care and support needs who are experiencing or are at risk of abuse or neglect and as a result of those care and support needs are unable to protect themselves from either the risk of, or experience of abuse or neglect.

There are 10 types of abuse identified in the care and support statutory guidance: physical abuse, domestic abuse/ violence, sexual abuse, psychological/ emotional abuse, financial/ material abuse, modern slavery, discriminatory abuse, organisational/ institutional abuse, neglect and acts of omission, self-neglect.

The following six principles underline the practice of safeguarding adults: proportionality, empowerment, protection, prevention, partnership, and accountability. For more information see **https://www.scie.org.uk/safeguarding/adults/introduction/what-is**

Care Act Assessment: It is the duty of a local authority under the Care Act (2014) to assess an individual's (adult aged 18 and over) eligibility for care and support, regardless of their likely eligibility for state-funded care. The focus of the assessment is on the person's needs and how they impact on their wellbeing and the outcomes they want to achieve. For more details see: **https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/**

4.18 HOW DID THE FINDING MANIFEST IN THIS CASE?

This finding manifested in Angela's and Chris' story on several occasions and contexts when Angela's and Chris' capacity was either simply assumed by professionals or assessed as positive. In the event of either finding, a refusal of support was by Angela or Chris superseded any consideration for the need of a safeguarding response, even when there were obvious risks to turning down input from health care professionals.

Angela

The first time during the period under review that Angela did not engage with health care professionals was for her annual physical health check with her GP. This happened to follow her annual mental health review with the psychiatrist. Angela's GP surgery contacted Angela on three occasions to inform her about the need for blood tests, usually via phone, but they were unsuccessful. The GP shared with the reviewers that Angela was deemed to have mental capacity to take the decision not to engage with the blood tests. This was problematic because the assessment of capacity had been made over the phone, by a member of administrative staff, which was unlikely to the right method or person to complete the MCA assessment. There was no subsequent communication with CMHT about Angela's lack of engagement and no consideration whether it may require escalation. This also meant that Angela's annual health check remained outstanding, and no consideration was given for this to possibly be an indicator of self-neglect.

The second time when Angela declined input from healthcare professionals, and presented with poor and deteriorating health, was when she was seen by the CPN on three occasions in October and November for the administering of her depot injection. Angela was described as presenting with breathing difficulties and poor health, and this was acknowledged and discussed by the nurse. Angela declined the CPN's advice to contact her GP and also did not wish the CPN to contact her GP on her behalf. The CPN

gave this same advice on all three occasions, and it was rejected by Angela each time whilst she presented with deteriorating health. The CPN did not see any need for a formal capacity assessment. In light of Angela's presenting poor and deteriorating physical health though, the Review Team was of the opinion that this situation would have benefited from a discussion with Angela about the possible risk to her health by turning down health advice, and her understanding of such risk, of her decision not to seek medical advice. She may have needed more support through the decision-making process. The fact that Angela was assumed to have capacity was the overriding factor and meant that there was no consideration for her refusal to seek medical advice to be a possible indicator of self-neglect, and therefore a potential safeguarding issue.

Chris

This finding also played out in Chris' story: when Chris' capacity to decide about his care and treatment was assessed for the first time in the period under review, this was appropriately through a formal MHAA following the GP's referral to SPA as Chris had not attended his bi-weekly depot injection and health professionals were concerned about Chris' mental state. Chris was assessed to have capacity as, most importantly, Chris agreed during the assessment to attend his GP for the depot injection in the following days. When this did not happen, and Chris' GP made two more referrals in the following three weeks, mental health professionals continued to refer to and rely on the recently completed MHAA and Chris having been assessed as capacity and agreeing to attend the GP. However, the Review Team was of the opinion that this did not give due respect to the nature of mental capacity being time and decision specific. Chris' mental capacity became the overriding factor and superseded any consideration for a safeguarding response, even when Chris subsequently did not engage with his GP.

Another example of this finding manifesting in Chris' story was when he was taken to A&E due to poor physical health in September 2020. Chris was reported to have wanted to leave the hospital whilst being assessed for his physical health needs, indicating that he did not wish to receive medical input. Therefore, the focus moved to the assessment of his mental capacity which was assessed very timely through the out of hour AMHP provision. Chris was assessed as having capacity to make a decision about his care and treatment and therefore no further or parallel consideration was given to the need for a safeguarding response, considering Chris' turning down input for his health needs being an indicator of self-neglect.

4.19 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

When we explored this issue in more detail, we heard that this approach was not unique to Angela's or Chris' story.

Instead, the Review Team shared that there had been a lot of focus on the area of mental capacity assessments, including training and quality assurance activities. However, there was also the general agreement that often the work and assessment does not extend beyond the assessment of capacity. Particularly when a person is assessed to have capacity, there can be the tendency of citing "unwise decisions" as the person's choice/ "right" which then in turn is seen as limiting professionals' ability to offer support and intervene, including through the means of a safeguarding response.

Additionally, the Review Team reflected that whilst practice around capacity assessments might be more embedded in some agencies in Hillingdon and practitioners feeling

confident in completing them (i.e., the London Ambulance Service), it was felt that there is a continued need to train practitioners across agencies as to the relevance and need of completing mental capacity assessments in line with their work environment and clientele. This existing uncertainty and lack of confidence would then also have an impact on professionals' ability to identify the need for a safeguarding response that might need to follow on from a mental capacity assessment.

4.20 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

This is a difficult finding to quantify because the kind of data needed does not exist. The Review Team shared that there is no data available that can highlight the number of safeguarding enquiries when a person has turned down health services and has been assessed as having capacity for their care and treatment needs, but professionals have identified a safeguarding concern. There have also not been any audits completed, single agency or by the partnership, that explored this area of practice.

However, the Review Team was of the agreement that this is a relevant practice area for Hillingdon that will require further attention and exploration.

Nationally, there have been a significant number of Safeguarding Adults Reviews that identified learning in relation to mental capacity, self-neglect, and the failure to consider safeguarding responses. It has not been with the scope of this review to identify specifics. This finding therefore seems to hold relevance beyond Hillingdon, too.

4.21 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

When a person is assessed as having capacity to make decisions about their care and treatment needs, and declines those, there seems to be a common approach currently for the assessment and intervention to end, without consideration for a safeguarding response under the premises of self-neglect. This failure to explore the reasons for an individual's decision to decline health advice, care, or support, may mean that an individual is denied safeguarding protections and self-neglect interventions by professionals when they are needed because this is not explored. This can also include the denial of necessary investigation and medical treatment, or the lack of appropriate support and information they may have require making a 'free and informed choice'. This can result in missed opportunities to address self-neglect early and might allow more entrenched patterns of behaviour, and refusal of support to develop).

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 assuming and 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. (Professional norms and culture)

SUMMARY OF SYSTEMIC RISKS:

People have complex and multi-faceted lives, wants, and needs. A range of legal frameworks also exist providing the basis for professional intervention in different circumstances. Safe systems require sound legal literacy among professionals as well the analytic dexterity and disposition to consider a range of legal options in different contexts. This finding highlights a professional norm whereby a focus on mental capacity rules out a focus on safeguarding in the particular context of a person with poor or deteriorating health turning town recommended health input. The focus of a person being assessed as having capacity to make a decision about their care and treatment needs and deciding to refuse any advice or intervention creates a shorthand for professionals' withdrawal, citing a person's ability/ freedom to take an "unwise decision". This runs the risk that a safeguarding response is not considered to assess and manage potentially significant and serious health issues. The opportunity for discussion of the contextual information of refusal of health services and their potential risks in light of the person having been assessed as having capacity is therefore lost, together with routine opportunities for multi-agency discussions and risk assessments.

4.22 QUESTIONS FOR THE SAFEGUARDING PARTNERSHIP TO CONSIDER:

4.22.1 How can the link between mental capacity, supported decision-making, free and informed choices, and safeguarding be strengthened?

4.22.2 Does the Partnership have a role in garnering cross-agency focus on this issue?

4.22.3 What mechanisms could be put in place to enable practitioners to see refusal of medical treatment as a safeguarding issue in the context of self-neglect?

4.22.4 What are the current forums amongst partner agencies that allow and foster discussions of self-neglect in light of a person having been assessed as having capacity? Is there a need to create new/ additional opportunities?

4.22.5 How would the Safeguarding Partnership know if practice in this area had improved?

4.23 FINDING 4: INITIAL REVIEW OF REFERRALS INTO ASC MASH

FINDING 4: **Does the Hillingdon adult social care MASH risk missing referrals that require a safeguarding response, because there is no routine access to multi-agency information as standard at the earliest stage of review?** (Management systems issues)

4.24 CONTEXT

The set-up of Hillingdon's Adult Social Care 'MASH' works by referrals being initially reviewed by Adult Social Care (ASC) staff on a single-agency basis. Some referrals are then 'triaged' which means ASC MASH staff contact the multi-agency partners directly involved in the particular referral to assess if a full s.42 Enquiry is needed. Referrals identified as high risk (at point of receipt or after 'triage', are then put on a list that is shared with standing multi-agency representatives, for discussion at a 12 o'clock daily multi-agency meeting.

This differs significantly from the standard structure of a children's MASH which has standing multi-agency input at the initial review stage, with the benefit of allowing access to information held on databases of partner agencies to inform the initial risk assessment.

4.25 HOW DID THE FINDING MANIFEST IN THIS CASE?

This finding played out in Angela's story. The police officers attending to Angela's welfare in the town centre and accompanying her home sent a referral to Hillingdon Adult Social Care MASH outlining their concerns using the information available to them at the time and rating the referral red, meaning a high level of risk and vulnerability was assessed.

When the referral was received by ASC MASH, the screening of the concerns shared by police was completed by an ASC MASH practitioner and, based on that information available, the decision was taken to recommend a Care Act Assessment, undertaken by the ASC Mental Health Team. The screening process also brought to light the fact that Angela was open to the CMHT (depot clinic), and therefore the referral was also passed on to them, without any further enquiries by ASC MASH about the recent events in their involvement.

With hindsight, it was evident that the information in the police referral did not include all information that was relevant to Angela's welfare at the time, such as the subsequent intervention by the London Ambulance Service, nor the Out of Hours GP. Police were also not aware of the recent discussions between the CPN and Angela or that Angela had missed her annual physical health check with her GP. However, all this information was available, to some degree, on different databases, used by different agencies. But this could not be accessed or requested by the MASH practitioner from agency representatives as part of the routine screening as the setup of MASH does not include agreed co-working arrangements between partner agencies. The ASC MASH team's set up allows information sharing with partner agencies involved with the particular person, where a potential safeguarding concern has been identified by ASC MASH staff, to inform analysis about whether a s42 enquiry is needed. There is another opportunity built into the daily high risk meetings that are facilitated by ASC MASH. The issue raised in this finding is whether there is sufficient routine multi-agency input to inform the preliminary judgement by ASC MASH about whether a referral indicates potential safeguarding

concerns.

4.26 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

When this was discussed with Review Team members and Case Group, it was confirmed that the MASH is designed to work in this way, with ASC MASH performing an initial single agency triage of referrals to identify which require standard MASH multiagency input via the daily12 o'clock meeting. The current set up of ASC MASH in Hillingdon is that the initial screening is completed by an ASC MASH practitioner without access to all relevant electronic recording systems and without routine access to and information sharing with representatives from other agencies and their respective electronic databases. Therefore, the responses seen in Angela's story are not anomalies but reflective of an underlying issue.

4.27 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

This potential finding affects all referrals that are sent to Hillingdon ASC MASH that don't meet the threshold for a S42 enquiry or for the daily risk management meeting but are, at a later stage, identified as having benefitted from screening with partner agencies to support the risk assessment and decision taking. However, it is a difficult finding to quantify as such data does not exist.

There is no one prescribed model of how Adult Social Care MASH should be set up and run and nationally, there is a level of variation in terms of their set up, collaborative working arrangements with partner agencies, including co-location, as well as regarding the length of time they have been operating. It is therefore likely that this finding bears relevance to various Adult Social Care MASH across the country.

4.28 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

Safeguarding adults is the responsibility of all agencies involved, including the making of referrals and a proportionate, balanced, and informed response to the referral in line with the principles of the Care Act. The volume of referrals from a range of agencies to Adult MASH in Hillingdon is significant, creating a pressurized environment for MASH that requires effective arrangements to offer a timely, yet robust response to each referral. If this needs to be done between MASH and each individual agency involved, i.e., a specific GP, rather than a health representative who is co-working with MASH under an agreed arrangement, this will be more time-consuming and increase pressure on all agencies involved. An agreed, collaborative co-working set up between partner agencies can foster positive working relationships, increase the understanding of each other's roles, and enable easier access to the different recording systems, therefore supporting a better-informed initial screening, risk assessment and response.

FINDING 4. INITIAL REVIEW OF REFERRALS INTO ASC MASH

Does the Hillingdon Adult Social Care MASH risk missing referrals that require a safeguarding response, because there is no routine access to multi-agency information as standard at the earliest stage of review? (Management systems issues)

SUMMARY OF SYSTEMIC RISKS:

A single agency set up of the busy "front door" to Adult Safeguarding in Adult Social Care, requires ASC MASH staff to make an initial evaluation that a safeguarding concern is suspected in order to trigger multi-agency checks. This hampers routine information sharing at the earlier opportunity with relevant partner agencies to support an effective, well informed, proportionate, and balanced response. It restricts the information sharing to the referrals presenting with the highest risks only. This can be additionally compounded by a busy environment and increasing numbers of referrals. The Multi-Agency Hub arrangement was initially developed in the children's safeguarding sector in order to formalise agreed arrangements with partner agencies in place for more routine multi-agency information sharing to happen at the screening stage, therefore allowing access to information of all relevant recording systems beyond social care. This finding highlights the risk of relevant information available on different systems not being available to support ASC MASH professionals to identify potential safeguarding concerns.

4.29 QUESTIONS FOR THE SAFEGUARDING PARTNERSHIP TO CONSIDER:

4.29.1 What discussion has there been with the children's MASH? Has there been consideration of joining the children's MASH? Are there any elements of good practice in children's MASH that could be considered for the set-up and operation of Adult Social Care MASH?

4.29.2 Are there any legal obligations/ limitations and GDPR requirements that might present as a barrier for partner agencies to more routine and collaborative screening and information sharing at the point of safeguarding referrals received by Adult Social Care MASH?

4.30 FINDING 5: COLLABORATION BETWEEN GP AND SECONDARY MENTAL HEALTH

FINDING 5: **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.** (Professional norms and culture)

4.31 CONTEXT

NHS Primary Health Care: Primary Health Care is the first point of contact for health care for most people. It is mainly provided by GPs (general practitioners), but community pharmacists, opticians and dentists are also primary health care providers.

NHS Secondary Health Care: Secondary Health Care is the specialist treatment and support provided by doctors and other health professionals for patients who have been referred to them for specific expert care. This can be in hospitals or in the community. Central and North West London NHS Foundation Trust offers secondary health care, including specialist mental health services.

Integrated Care: is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

Integrated Care Systems (ICS's): are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. For more information, see: **https://www.england.nhs.uk/integratedcare/what-is-integrated-care/**

4.32 HOW DID THE FINDING MANIFEST IN THIS CASE?

This finding manifested itself in different ways in the story of both, Angela and Chris.

Chris

It was striking to the review team that particularly in relation to Chris, the people who raised concerns, were people who had an established relationship with C Chris S, and the people who acted upon the referral were new to him. Additionally, there was an absence of collaboration across and between the different professionals and agencies, and also with Chris' brother.

One example of this was the response to the first referral made by the GP to SPA when Chris had missed his depot injection at the surgery for the first time. The referral was passed on to the HTT who offered a quick and brief intervention to Chris with the aim to encourage C Chris S to attend his GP surgery to receive the injection. Whilst mental health services raised the question of why the GP/ nurse did not visit Chris at home to

administer the depot there, the GP was expecting the HTT to administer the depot during their visit to Chris. The Review Team learned during the course of the review that these two agencies had an incorrect understanding and expectation of each other's roles and usual practice: the GP/ nurse only do home visits for housebound patients (and Chris was not seen as housebound), and the HTT never administer medicines, rather supervise, and encourage the taking of oral medication in people's homes. This misunderstanding meant that the need for Chris to receive his depot injection fell into a void between the two agencies.

Another example of this finding was evident in the disjointed response to referrals from the GP to secondary mental health provider. Chris had been with his GP practice for several years and had a relationship with his GP and the practice nurse. Whilst the GP understood the referrals to be the necessary and appropriate way to flag their concerns with the specialist mental health services, they were also expecting to be contacted to explore a joint way forward to support Chris, including a joint home visit and assessment. However, it seemed that the particular set up of primary health care and secondary mental health care meant that only one agency would or could respond, and not both together and jointly. This was further demonstrated with the attempt to bridge this gap through a referral to the Primary Care Mental Health Service who work closely with GP's, in response to the GP's second referral. However, as the risk was assessed too high for their service, Chris' referral was passed straight back to CMHT. This continued to leave Chris' needs for his depot injection unmet.

Angela

In relation to Angela's story there was a marked absence of communication between the GP and secondary mental health, particularly the depot clinic where Angela was seen monthly. It is important to note that Angela's annual physical health review fell into the time period under review. This would have offered an opportunity for communication between both agencies but was not made use of by either agency: when Angela did not engage in the review with the GP despite their attempts to contact her, they did not communicate this information back to CMHT; and the CMHT did not contact the GP to establish whether Angela had attended, or what the outcome was, and if any follow up was required. This left Angela without the encouragement to engage in the necessary physical health checks and without the regular monitoring of her physical health.

4.33 HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF?

When we explored this issue in more detail, we heard that the practice observed was not unique to Angela's or Chris' story. Evidence provided to the review informed that this finding had also been identified and recognised by agencies and whilst some attempts have been made to close the gap between the two services, i.e., through the Primary Care Mental Health Team, it remains work in progress and requires further focus to improve effective and collaborative working arrangements. The Review Team shared that whilst there are examples of successful joint working by the CMHT with some GP surgeries in Hillingdon, this depends very much on the individual GPs. Therefore, there is no consistent approach offered to patients and embedded within agencies that support effective joint working between GP's and secondary mental health.

Input from the Review Team also emphasised the impact and additional pressures that the global COVID 19 pandemic had on already stretched health services and existing resources. Angela's and Chris' story fell into the time of the pandemic and therefore were

affected by scarcer resources. This is particularly relevant as joint and collaborative working between agencies that makes use of existing relationships and necessary skills and expertise to support patients effectively requires a degree of flexibility. Such flexibility has the potential to close any gaps between agencies modus of operation, usual practice, eligibility, and threshold for action. However, a flexible approach was compounded by the additional pressures on the health system and on health professionals during the pandemic.

While the pandemic has exposed some of the challenges within the health system (i.e., between general and more specialised services) it does not explain the differences and gaps in knowledge about each other's roles which may previously have been mitigated through individual and organisational flexibility, including practices of co-working and co-location that were more restricted during the pandemic.

4.34 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE DOES IT ACTUALLY OR POTENTIALLY AFFECT?

The Review Team learned that as of January 2022, there were 2948 people with severe mental health issues living in the community in Hillingdon who were known to and receiving support from both, GP, and secondary mental health services. Specific data as to the quality of the relationships between the GPs who support those patients and secondary mental health does not exist, which makes it difficult to quantify this finding.

Review Team members informed that Hillingdon has been aware of this challenge and work continues to be undertaken to improve the ways how primary care can engage better with other partner agencies. This also includes work on both levels, operational and strategic, around the flow of information.

This finding also holds relevance beyond Hillingdon and a number of public health models have attempted to address this issue, from co-location to integration, commissioning systems, and newer initiatives such as Integrated Care Systems (ICS) and collaboration between GP practices and others in the local health and social care system through Primary Care Networks (PCNs).

4.35 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

Differences between primary care and secondary care, not only in roles but also in expectations, can act as a barrier to effective partnership working and to the flexible responses required to deliver personalised care and treatment. These differences may not become relevant or apparent until a multi-agency approach is needed most – when individuals are not engaging with necessary treatment, or are at risk of harm, including self-neglect. Often, patients have positive and trusting relationships with a health professional that has the potential to act as a key to engage them with another necessary health professional when they need it and are at their most vulnerable. Not making use of such trusted professional "to hold the patient's hand" can make it more challenging and time consuming for the receiving health service to engage effectively with the patient and to offer necessary support and intervention.

FINDING 5. COLLABORATON BETWEEN GP AND SECONDARY MENTAL HEALTH

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. (Professional norms and culture)

SUMMARY OF SYSTEMIC RISKS:

A disjointed set up of primary care and secondary mental health care expects patients to be able to independently engage with health professionals who they have no established relationship with. This would require great determination from a person who is likely to be in some form of distress already at that point and would place limitations on their engagement. A safe system readily enables the use of existing and trusting relationships between patients and health professionals when there is a need to refer the patient to specialist services, so that the expectations of the patient to engage are lessened and the responsibility to engage with the patient sits with the relevant professionals and their agency. This finding highlights systemic risks created by a lack of routine joint working when appropriate between general and specialist care, meaning citizens will not reliably benefit from the most personalised responses.

4.36 QUESTIONS FOR THE SAFEGUARDING PARTNERSHIP TO CONSIDER:

4.36.1 How can the developments in integrated care models be further enabled in Hillingdon to bring benefits to people who use services?

4.36.2 What more work can be considered between GPs and secondary mental health services to break down the barriers to and appreciate the benefits of joint working, and to help services understand each other better?

4.36.3 How can examples of effective joint working between GP surgeries and secondary mental health services be used to highlight enablers of the good practice and to build on them?

4.36.4 How would the Partnership know if there had been improvement this area?

5 Appendix

CNWL (CENTRAL NORTH WEST LONDON) NHS FOUNDATION TRUST

- **Community Mental Health Team (CMHT) East** - is one of 3 community mental health teams in the borough of Hillingdon providing care co-ordination and health care to people with serious mental health issues in the community.
- **Clopazine and Depot Clinic** – moved from Mead House to Uxbridge Health Center in August 2020; they administer depot injections to adults with mental health issues who have been prescribed the medication at specific intervals.
- **Psychiatric Liaison Service** – is based in the Emergency Department of Hillingdon hospital and undertakes mental health assessments for people who present with mental health issues.
- **Frays ward -** Adult male acute psychiatric ward- is an adult inpatient ward at **The Riverside Centre** in Hillingdon, providing a safe and therapeutic environment for people with acute mental health problems. The ward is for men over the age of 18, who are suffering an acute phase of a serious mental illness, suspected to have an acute mental illness, or a relapse of long-term mental illnesses that cannot be safely assessed and treated anywhere but in an inpatient ward.
- **Hillingdon Primary Care Mental Health Team** – work with GPs to help people better understand their mental health and wellbeing. The team supports patient live as healthily and independently as possible. The team works with the patient for a set number of sessions to focus on the particular difficulties they may have. The service is for All adults aged 18 years and over who are registered with a Hillingdon GP.
- **Single Point of Access (SPA)** – CNWL's single point of access for referrers and crisis line. SPA provides one number and one email address for referrals to secondary mental health services and support in a mental health crisis. The team consists of qualified clinicians who are knowledgeable about different services and options. This helps callers to be directed to the most appropriate service to meet their needs.
    - The team provides advice and guidance through a triage process, where the urgency of care required is assessed. The team also have the ability to make appointments for new referrals to see one of our community mental health teams.
    - The Single Point of Access works closely, at times of mental health crisis, with our crisis resolution teams and our partner organisations from across the public and private sectors, to direct people to services most able to aid their recovery.
- **Hillingdon Home Treatment Team (HTT)** helps avoid admission to a mental health inpatient ward by providing intensive support to people in acute mental crisis in their homes.
- The team includes a **rapid response** service (to respond to emergency and urgent referrals) 24-hours a day. Emergency and urgent referrals should be made through the Single Point of Access, which is open 365 days a year, 24 hours a day. All patients are provided with a crisis card with details of who to call in an emergency.

FROM OTHER AGENCIES/ORGANISATIONS:

- **Hillingdon Hospital NHS Foundation Trust**- is an acute and specialist services provider in North West London
- **London Borough of Hillingdon:**
  - Adult Social Care MASH: The team undertakes a combination of rapid actions to complete data collation started by Hillingdon Social Care Direct (HSCD) and triangulate all the details from the referrer, The Adult at Risk and multi-agency professionals to determine the most appropriate action in light of assessed risks and needs.
  - Adult Social Care Mental Health Team: The team assesses adults who appear vulnerable and appear to have social care needs to provide advice and support. The team works in collaboration with both, secondary and primary health care services. The work is undertaken using a strength based approach and promotes independence and resilience. The team also responds to Safeguarding Adult referrals.
  - Approved Mental Health Professional Service: The Approved Mental Health Professionals in the team carry out certain duties under the Mental Health Act. They are also responsible for coordinating the assessment and admission to hospital if someone is sectioned.

GLOSSARY

Acronym	**Meaning**
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
HTT	Home Treatment Team
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Assessment
MHAA	Mental Health Act Assessment
MERLIN	Police report by London Metropolitan Police
SPA	Single Point of Access