AGENDA ITEM 9

CWOP/24/10

Policy & Scrutiny Committee	Community Wellbeing and Older People
Date	10 June 2010

Serious Case review (home closure in Colchester)

Report by: Paul Bedwell, Business Manager
Telephone: 01245 437818
Email: paul.bedwell@essex.gov.uk

Serious Case Review Action Plan Progress

Summary

1. The Essex Safeguarding Adults Board (ESAB) have undertaken a serious case review to consider the agencies action during the period leading to the relocation of residents from HX Care home in November 2008 following safeguarding concerns and the home being unable to meet required standards of care.

2. The full report sets out to identify evidence of good practice and also seeks to take the opportunity to learn from practice to drive forward future systems and practice. The recommendations for future action from the report are set out in the attached action plan and includes progress by agencies to deliver the reports recommendations.

3. ESAB monitoring agencies implementation of the action plan to ensure its delivery.

Background

Essex Safeguarding Adults Board

1. The Essex Safeguarding Adults Board is a strategic body that oversees how organisations across Essex work together to safeguarding vulnerable adults from abuse. The Board's membership includes all statutory agencies in Essex involved with vulnerable adults for example Essex Police, Essex County Council and the NHS. The board also includes membership from private and voluntary organisations.
2. Each Local Authority has their own Safeguarding Adults Board (SAB), which is responsible for conducting Serious Case Reviews (SCR) within their area.
3. The purpose of a serious case review is not to apportion blame as to who is responsible for the death or significant harm to the vulnerable adult or how the

death or significant harm happened, that is for the criminal process or coroner's office. The purpose of an SCR is to:

- Establish whether there are lessons to be learned from the case in which local professionals and agencies work together to safeguard vulnerable adults
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result within a given timescale: and as a result to improve practice
- Inform and improve local inter agency working
- Review the effectiveness of procedures (both multi agency and those of individual organisations) and make recommendations for improvement
- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action

Serious Case Reviews

4. Each Local Authority Safeguarding Board has the lead responsibility for conducting a SCR. A SCR should be considered when:

- a vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the Safeguarding Adults Board (SAB) should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
- a vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health (or mental health) or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.
- serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

Glossary of Terms to accompany Greenways Action Plan, and ASU Safeguarding Quarterly Report

ASU	Adult Safeguards Unit
CQC	Care Quality Commission
DOL	Deprivation of Liberty
DVCHU	Domestic Violence and Hate Crime Unit (Police)
ESAB	Essex Safeguarding Adults Board
ILA	Independent Living Adovcacy
IMCA	Independent Mental Capacity Advocates
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MoWs	Meals on Wheels
NEPFT	North Essex Partnership Foundation Trust (Mental Health trust)
PCT	Primary Care Trust
Q&M	Quality and Monitoring (ECC)
RIPFA	Research in Practice for Adults
SAB	Safeguarding Adults Board
SAFE	Safeguarding Adults from Exploitation
SAMC	Safeguarding Adults Management Committee
SCR	Serious Case Reviews
SEPT	South Essex Partnership Trust (Mental Health trust)
SET	Southend, Essex, Thurrock
SETSAF	Southend, Essex, Thurrock Safeguarding Adults Form

Greenways Action Plan

Part A – actions for Essex County Council

No.	Recommendation	Desired Outputs	Audit/Evidence To ESAB	Desired Outcome	Responsible Agency	Time-scale	Progress to date
1	Quality & Monitoring should incorporate a Dementia Observation Tool within their monitoring practice	Dementia Observation Tool incorporated within practice	Dementia Observation Tool incorporated within monitoring guidance used by Quality & Development	Residents' needs better understood by Quality & Monitoring enabling more accurate assessment of the quality of care being given	Quality & Monitoring	Sept 2010	Original discussions with the Alzheimer's Society to develop these tools were held but they felt they could not assist with this and following the conclusion of those discussions we will be looking at other tools available which would require the providers care staff to be trained to gain and use their own feedback from service users. Observation tools have been designed and are being piloted where possible at present. The findings are due for review in June/July this year, and amendments made.
2	ECC Quality & Monitoring should review the Individual management review report that was prepared by HX	Discussion with HX Healthcare's holding company about their recommendations followed by a letter	A copy of the letter from ECC Quality & Monitoring to HX	Improved systems and care standards within the remaining homes in Essex that are part of HX Healthcare's Holding company	Quality & Monitoring	Sept 2010	Original discussions with the Alzheimer's Society to develop these tools were held but they felt they could not assist with this and following the

	Healthcare's holding company and consider whether the recommendations for changes within that document are appropriate and acceptable and would lead to improved standards of care	outlining the agreed actions.					conclusion of those discussions we will be looking at other tools available which would require the providers care staff to be trained to gain and use their own feedback from service users. Observation tools have been designed and are being piloted where possible at present. The findings are due for review in June/July this year, and amendments made.
3	Consideration should be given by ECC to the development of a dedicated team linked to the SAFE (Safeguarding Adults from Exploitation) project to respond to the intense input required in institutional abuse situations	Team in place	Team in place	Competent and experienced staff available to step in to such situations to provide effective leadership for operational staff	Adult Safeguards Unit	April 2010	The SAFE Project has now entered into a second phase of its development and will be focusing on supporting localities when institutional alerts are raised.
4	All senior staff and Associate Directors in the statutory agencies should be informed about and supplied with copies of the embargo protocol.	Embargo protocol available to all senior staff and Associate Directors in the statutory agencies	Evidence of distribution of protocol	All agencies are aware of the importance of the embargo process and the steps being taken so that they are able to contribute appropriately to the	ECC	April 2010	The embargo policy has been revised and renamed "Suspension of Care Services Protocol" and has wide involvement by Health and the Independent

				process.			Care Providers and is to be relaunched in May 2010.
5	Training should be provided on the embargo process for all senior staff and Associate Directors in the statutory agencies	Training programme developed and implemented	Training programme underway	All agencies are aware of the importance of the embargo process and the steps being taken so that they are able to contribute appropriately to the process.	ECC	Sept 2010	The revised protocol will be cascaded out once it is signed off in May 2010.
6	Consideration should be given to joint training between Operational Leads and police in supervisory roles in Domestic Violence and Hate Crime Units on the Mental Capacity Act (MCA) with particular emphasis on the elements of offences contained within the Act and the elements required for an offence to have been committed	Joint training in place	Joint training in place	Improved understanding of their role by the police in institutional abuse investigations where residents lack capacity. Improved knowledge by Operational Leads as to the appropriateness of involving the police	ECC/ Essex Police	Dec 2010	A review of the work of SAFE has led to redefining the role and function of the Project. SAFE will from June 2010 be taking the lead on major institutional abuse cases offering support and assistance to localities teams across the county.
7	Consideration should be given to a discussion taking place with Together for Wellbeing, the agency in Essex that provides Independent Mental Capacity Advocates (IMCA's) to develop a	Protocol developed with Together for Wellbeing	Protocol in place	A protocol enabling speedy access to IMCA's and early reports being received from IMCA's in urgent situations where residents have to be moved.	ECC	April 2010	The Adult safeguards Unit ensures that potential cases of wilful neglect under the MCA are raised with the Police. MCA training has been provided to the Police by the Adult Safeguards

	protocol for the involvement of IMCA's in situations where residents need to be moved well within the 4 week contractual timescale for receipt of a report from the IMCA.						Unit. Whilst there have, to date, been no charges of wilful neglect there have been active discussions on several cases with both the Police and Crown Prosecution.
8	Both provider and commissioner arms of all Health Trusts in the relevant geographical area should be involved as early as possible in cases of suspected institutional abuse.	Embargo protocol reviewed to ensure that the requirement for early involvement of both provider & commissioner arms of all Health Trusts is made clear	Updated protocol	Closer interagency working and information sharing	ECC	April 2010	A multi-agency (Health, Social Care and independent providers) approach to revising the Embargo policy has taken place and the revised policy is now known as the ***Investigation and Suspension of Care Services Protocol***. The new protocol is in the process of being signed off by all agencies.
9	A protocol should be developed for information sharing between Quality & Development, ECC and Care Quality Commission (CQC) in respect of quality of care/safeguarding issues	Protocol developed setting out what information will be shared between ECC & CQC – where concerns exist about the quality of care being delivered by a care provider.	Protocol	Trends and poor patterns of care identified and action taken in response	ECC,	June 2010	There is an agreed protocol in place for information sharing which includes quarterly meetings attended by Health and Unitary authority colleagues. Also included is contact between Service Managers for both organisations as well as Quality & Development Officers

							and CQC Inspectors on an as and when required basis. The protocol will need to be reviewed again after the next formal meeting on 07.06.2010 as the changes within CQC, may effectively remove those people/posts vital to the working of the present protocol.

Part B – actions for ESAB

No.	Recommendation	Desired Outputs	Audit/Evidence To ESAB	Desired Outcome	Responsible Agency	Times cale	Progress to date
10	SETSAF documentation needs to be reviewed to make it appropriate for institutional abuse investigations	Updated documentation	Updated documentation in use	Documentation is appropriate for institutional safeguarding alerts and investigations	ESAB	June 2010	Currently being completed as part of current guidelines revisions
11	Building on the action plan that was used in the investigation an Essex wide institutional abuse protocol should be developed.	Protocol completed	Protocol	Consistency and rigour in investigations of institutional abuse	ESAB	June 2010	Currently being completed as part of current guidelines revisions
12	A checklist should be developed covering the important indicators on standards of care for use by health and social care staff when visiting residential care	Checklist completed & incorporated within the institutional abuse protocol (see recommendation 12)	Checklist incorporated into SET guidelines	Poor standards of care within institutional settings identified as early as possible and action taken	ESAB	June 2010	Currently being completed as part of current guidelines revisions

	homes.						
13	Joint agency safeguarding institutional care practice training should be given a priority to healthcare professionals and Social Workers based on the checklist above	Joint agency training programme in place	Joint agency training underway	Poor standards of care within institutional settings identified as early as possible and action taken	Training/ Briefings in place by September 2010	Sept 2010	Work underway and on track for deadline.
14	Regular multi-agency training in the safeguarding of vulnerable adults should take place and include police from the DVCHU's, GP's and ambulance personnel	Multi-agency training programme in place	Multi-agency training underway. All agencies to send to ESAB to promote and monitor compliance	Close interagency working and a shared understanding of the issues Early identification of abuse	ECC, Essex Police Health - NHS Commissioners/Providers, East of England Ambulance Trusts,	June 2010	Training in place and available for all agencies. Work underway in many parts of the county to specifically target training for particular groups including GP's
15	ESAB should develop training for Operational Leads in all agencies who could be required to lead investigations (A draft training pack that has been developed by NEFPT could be used)	Training programme for Operational Leads developed	Training programme in place for Operational Leads	Competent and consistent management of institutional investigations	ESAB	Sept 2010	On target
16	Consideration should be given to advocacy workers being invited to debriefing meetings with colleagues from the statutory agencies	Inclusion in revised SET guidelines of requirement for Advocacy workers to routinely invited to debriefing meetings	Inclusion of requirement in SET guidelines	Information from advocates can be used to inform improvements	ESAB	June 2010	Currently being completed as part of current guidelines revisions

17	The SETSAF guidelines should include guidance that Advocacy services should be notified of any major concerns about an institution at the same time as statutory agencies.	Early involvement of advocacy services in situations of serious concern in residential establishments	SETSAF guidelines updated	Advocacy included at the outset of all Institutional / Major Abuse Investigations Advocacy services to be able to provide sufficient advocates to ensure availability to all residents and their families.	ESAB	June 2010	Currently being completed as part of current guidelines revisions
18	The safeguarding leads in Health Trusts should be alerted immediately where that Trust has any involvement in the care of the individual/s who are the subject of the safeguarding alert	1) SET Guidance should make explicit reference to ensuring that safeguarding leads in Health Trusts are alerted immediately where they have involvement in the care or commissioning of services for individuals who are the subject of the safeguarding alert or their staff who are implicated in an investigation. 2) Safeguarding training should explicitly set out the importance of the involvement of health trusts in safeguarding cases	Revised SET guidelines Training materials	Knowledge is shared across both agencies and maximum staff cooperation takes place.	ESAB/ECC	June 2010	Currently being completed as part of current guidelines revisions Incorporated into current review of adult safeguarding training

19	Clear processes for the sharing of information within each organisation both vertically & horizontally should be drawn up and understood by all partner agencies.	The SET guidance should include protocol for sharing safeguarding information	Revised SET Guidelines	All relevant staff within each agency will be notified appropriately in a timely manner to ensure maximum cooperation of all staff.	ESAB	June 2010	Achieved Information sharing protocol now in place and adopted by all key agencies across Essex
20	ESAB, CQC, Health Commissioners & Quality & Development of ECC should develop a tool for monitoring risk indicators in respect of abuse/poor standards of care within institutional settings	Tool developed and Care Homes Managers using it to produce a monthly report for Quality & Development	Tool in place. Copies of first reports from Care Homes Managers	Trends and poor patterns of care identified and action taken in response	ESAB	Oct 2010	Guidelines for investigating institutional abuse completed. On target to develop tool within timescales.

Part C – actions in regards to partnership working

No.	Recommendation	Desired Outputs	Audit/Evidence To ESAB	Desired Outcome	Responsible Agency	Times cale	Progress to date
21	All agencies need to ensure that there are clear processes to alert the police in cases of suspected institutional abuse in line with the SET guidelines	All agencies safeguarding policies set out clearly circumstances in which police should be alerted	Agency safeguarding policies	Potential criminal investigations will not be compromised	ECC, Essex Police Health - NHS Commissioners/Providers, East of England Ambulance Trust	June 2010	Implementation of this action being monitored by ESAB.
22	The Ambulance Trust should be strongly encouraged to become	Membership to ESAB from East of England	Attendance at meetings	Access to information about the number and type of call outs	ESAB, East of England Ambulance	April 2010	Achieved - EOE Ambulance Trust are full and active members of

	a full member of ESAB	Ambulance Trust		available in respect of homes where there are concerns	Trusts		the safeguarding board
23	Pharmacists should be reminded of the importance of reporting to the GP and the PCT when residential establishments regularly return large supplies of unused medication or the MARR sheets show that medication has not been administered as prescribed.	PCT's to have in place clear processes & systems to ensure that any issues in respect of medication are fed back to the Commissioners and the appropriate Safeguarding Lead in the PCT.	Evidence of processes and systems for reporting large supplies of unused medication.	Poor standards of care/abuse identified early and action taken.	Health – NHS Commissioners/Providers	Oct 2010	Work underway in PCT's to address this action