Case "Jack"
Safeguarding Adult Review
Final Report – September 2024

Lead Reviewer: Margaret Williams

Independent Review Support: Alison Ridley

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1. Introduction

1.1 Why was this case chosen to be the focus of the SAR?

1.1.1 The Care Act 2014 Section 44 confirms that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area with care and support needs, dies or has been seriously harmed as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked together more effectively to protect the adult. Lancashire SAB considered this case and found that the circumstances met the Care Act Section 44 criteria for a mandatory Safeguarding Adults Review.

1.1.2. This Safeguarding Adult Review (SAR) was initiated following the death of Jack in 2022 and the subsequent referral made to the Lancashire Safeguarding Business Unit by the Commissioning Support Unit Whole Age Continuing Health Care Team.

1.1.3. For the purposes of this report, in relation to naming conventions, the use of pseudonyms has been agreed by the two families involved. The adult subject of the Safeguarding Adult Review will be known as Jack, his wife as Vera and the other adult involved, Paul.

1.1.4. Jack was white British and married to Vera. Jack had dementia care needs and had been living in a care home when physically assaulted by another resident (Paul), receiving injuries which appear to have contributed to the death of Jack five days later.

1.1.5. In this case review we have paid particular attention to:

a) understanding the commissioning processes that resulted in the inappropriate placement of Paul,

b) the work undertaken to manage the risks posed to other residents and staff and

c) the responses offered once it became clear that Paul‘s placement was inappropriate, and evidence to suggest the Care Home (Care Home Two) was not able to meet Pauls needs or manage behaviours that posed a risk to others that could not be safely managed.

d) It was also important for the review to understand how the views and voice of family members of Jack and other residents were listened to during this period.

1.1.6. The protected characteristics of the two adults who were the focus of the SAR

Adult	Ethnicity	Nationality	Religion	Sexual Orientation
Jack	White	British	Not known	Heterosexual
Paul	White	British	Not known	Heterosexual

2. The Terms of Reference

2.1 Involvement of the two families

2.1.1 The Reviewer wanted to ensure the families of Jack and Paul understood the review processes and what the review aimed to achieve. It was important that families had an opportunity to ask questions or seek clarity of the approach that the Safeguarding Adult Board had commissioned, and the reviewer was undertaking. Family members were informed the review would be proportionate and sensitive to the individuals involved and families impacted by this review as well as ensuring it stated learning that was evident for the system to apply.

2.2 Which areas of learning can this case help us understand about how the safeguarding system is functioning?

2.2.1. The following **Systems Questions** were devised by the Safeguarding Adult Board members to provide the key lines of enquiry for the review:

1. What can we learn from this case about barriers and enablers to the commissioning of care home placements for people diagnosed with dementia (declining brain function) who remain physically fit?

2. What does this case tell us about the barriers and enablers to listening and responding to safety concerns about residents voiced by family members?

3. What can we understand from this case about the multiple organisational and contributory factors that support or act as barriers to effective assessment and risk management in shared living settings?

3. The methodology and process of the review

3.1 The reviewer, expertise and independence

3.1.1. Margaret Williams the reviewer commissioned to undertake this review was independent having no direct link with the case or the teams that cared for Jack and/or Paul. Margaret is a registered nurse by profession with a safeguarding and quality background, gaining experience from working across several health systems. Margaret has many years of investigative experience with proven in-depth competence in writing, reviewing reports, recommendations and actions plans.

3.1.2. Additional support to the review process was provided by Alison Ridley (a registered social worker, case reviewer and safeguarding consultant who works for Social Care Institute for Excellence (SCIE) and has expertise in this review model). Alison was entirely independent of the local system.

3.2 The methodology

3.2.1. The Lancashire SAB wished to commission a responsive style of review that in addition to examining the quality of professional practice in the case, also produced systems learning that would identify underlying causes and factors that impacted on the quality of practice and the outcomes in this case and could pose potential risks for other adults who are in similar circumstances. The methodology chosen was the SCIE 'SAR in Rapid Time' methodology[1] which intends to support a pared down review process that is able to produce a fairly succinct but focussed report within 4-6 months. The review took 6 months, from the date the reviewer was commissioned to the final draft being shared with the family and SAB endorsement.

3.2.2. Prior to the review taking place, there was a criminal investigation which was ongoing but concluded with no prosecution. A safeguarding enquiry was also completed prior to the review by the Local Authority which considered two elements of abuse both on the physical abuse and neglect/acts of omission. A coroner's inquest is also planned; the coroner's office confirmed the review could be completed prior to the inquest taking place. The scope of the review covered a 5-month period from July 2022 up to the death of Jack on 8th November 2022.

3.3 The review process

3.3.1. The main elements of the process were:

a) Liaising with family members to talk through the review processes, understand their views and concerns.

b) Setting the Systems Questions as the basis of the Terms of Reference.

c) Development of a merged chronology and early analysis of practice in the case using Key Practice Episodes.

d) Facilitation of a Practitioners' Workshop bringing together frontline staff and managers who were directly involved in the case (or working in the relevant services at the time) to draw out an understanding of what happened and why professionals responded as they did and what was influencing their practice and decisions.

e) Work with the System Leads review group made up of local senior managers to confirm the systems findings and gather the necessary local evidence to support the findings.

f) Completion of (i) the analysis of professional practice in this case and (ii) the systems findings. Consultation with the System Leads Group and practitioners.

g) Development of the questions and recommendations for the board.

h) Submission to SAB for the usual quality assurance process.

3.4 The structure of the report

3.4.1 The main body of the report is divided into **two main** parts with a focus of the review to:-

[1] Safeguarding Adult Reviews (SARs) In Rapid Time - SCIE

(a) better understand and appraise the professional practice and decision-making that occurred in this case.

(b) to gain an understanding of the system factors that impacted how the case was responded to by the professionals involved.

3.4.2. The 'Analysis of practice in the case' (Section 4) provides a succinct account of how the case unfolded and examines the work of the professionals involved. We comment on the quality of practice but also seek to identify what organisational factors were either supporting good practice or hindering good practice at the time of the case.

3.4.3. The **'Systems Findings'** (Section 5) identified four findings which were influencing practice at the time of the case and remain a live issue for the safeguarding system in Lancashire today. These are the areas of learning that the Safeguarding Adults Board (SAB) will use to consider what improvement work is needed. Recommendations and Questions to the Board are posed at the end of each of the Findings, which will form the basis upon which the SAB will be able to build an action plan in response to the learning that has emerged about the functioning of the system.

4. Analysis of practice in the case

4.1 The two adults whose experience are a key focus in the review

4.1.1. **"Jack"** was born in 1951. Jack was aged 70 years at the time of his death in 2022. He had a complex health presentation since diagnosis of Dementia, Alzheimer's, and mild frailty. He had been living in the care home (Care Home Two) in Preston since January 2020. During this period since admission Jack experienced weight loss, frequent falls, periods of aggression and wandering, all symptoms of disease progression. Jack was understood to lack mental capacity in relation to his care and support arrangements.

4.1.2. **"Paul"** was born in 1963. As a younger man Paul had served in the army. Paul had a diagnosis of 'aggressive behaviour on a background of traumatic Acquired Brain Injury (ABI) in view of past physical assaults and personality disorder'. Paul was 59 years of age at the time of the assault of Jack. Paul had previously been living in his home in Bolton and had an admission to hospital under a section of the Mental Health Act 1983. He was subsequently placed in a small, specialised care home (Care Home One) in Lancashire by Bolton Council. This placement broke down in July 2022 leading to being admitted to Lancashire Teaching Hospital Trust. Paul was later placed in another care home (Care Home Two) early August 2022, he remained physically strong and active at this time.

4.2 The analysis of practice

The hospital-based assessment of need

4.2.1. Paul (age 57) had been settled in his previous residential placement for a period but in 2022 his behaviour became increasingly aggressive and unpredictable, proving difficult to manage safely even with 2:1 staffing. He was taken to Lancashire Teaching Hospitals Emergency Department on the 4th of July 2022 by the care home provider, who had no alternative option available to them.

4.2.2. The hospital discharge team began an assessment to determine next steps. Pauls behaviour whilst in the hospital remained a considerable challenge for the services as he was aggressive and unpredictable at times. The mental health liaison team assessed and recommended that as an interim step Pauls behaviour should be monitored, and he should be placed short term in a local residential unit that specialised in managing challenging behaviour for a further period of assessment.

4.2.3. Clinical expertise was not sought in relation to the implications of Paul having the combination of a personality disorder and an ABI (Acquired brain injury) with aggression. Limited historical information was available/collated to inform their assessment. Information available was held by a number of organisations, including those out of area. It was known that there had been previous safeguarding alerts into Lancashire County Council and that the then Lancashire Clinical Commissioning Group (CCG) had been liaising with Bolton CCG (the placing authority) regards Care Home One increasing reports of not being able to care for Paul. However, the care plan from Bolton CCG that Midlands and Lancashire Commissioning Support Unit (MLCSU) was in receipt of was not discussed or shared with the hospital team.

4.2.4 In Systems Finding 1 we explore how if the adult originates from an 'Out Of Area' placement (OOA) there is a heightened risk that key history may not be so easily accessible to the placement commissioners or the placement providers.

4.2.5. The hospital discharge team were directed by the MLCSU as documented on the single referral document and the Mental health liaison team, and as advised by Lancashire County Council and Lancashire Teaching Hospitals Safeguarding teams in choosing the 'Discharge to Assess' (D2A) pathway as the mechanism to source an interim placement for Paul, which would be normal practice. The 'Discharge to Assess' (D2A) pathway[2] is a national funding mechanism that enables hospital patients that are not well enough to return home (or their previous setting) immediately, to move into a nursing home for a short period of further assessment with additional support. In practice the 'Discharge to Assess' pathway is generally used to support older people who may be frail or have dementia and is not so well suited to securing short term placements for adults with a combination of aggressive behaviour, ABI and personality disorder.

4.2.6. Paul was an adult with a complex diagnosis and an existing history of residential care. Following robust assessment in 2021, Pauls previous placement had been commissioned by Bolton Council with NHS Funded Nursing Care (FNC)[3], so their involvement in the assessment would have been anticipated along with Paul himself and his family or unpaid carers. The possibility of his eligibility for NHS Continuing Healthcare (CHC)[4] funding was consideration at this point. Paul was noted to lack capacity as part of an assessment dated July 2022.

The hospital discharge planning process

4.2.7. In line with usual process, the hospital discharge team gained the support of the Care Navigation team at Lancashire County Council to source a bed in one of their range of pre-commissioned 'Discharge to Assess' (D2A) settings, a local care home (Care Home Two) for

[2] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

[3] NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees

[4] Free health and social care arranged and funded solely by the NHS.

older people which specialised in working with dementia and the behaviours that challenge associated with dementia.

4.2.8. The single referral document at the time of being sent to the Care Navigation service was also shared with the MLCSU, which was and remains normal practice. It was felt to be a placement option with an appropriate level of staffing and expertise to respond to Paul's needs. While the D2A 28-day assessment process took place, the conclusion of which would determine if a more appropriate specialist placement was sourced. National guidance[5] confirms the importance of a person-centred, strengths-based assessment and the importance of listening to the views of the adult and their unpaid carers. However insufficient attention was paid to Paul's history or the implications of his diagnosis when choosing his placement, or to what extent the placement would be able to meet Pauls needs, for example activities in the selected home were designed for people with dementia who were older and frailer. Additionally, there was an insufficient focus in the assessment and commissioning process on the potential risks that might be posed to other more frail, older residents. **Systems finding 2** explores these assessment and commissioning practice issues and the associated risks in more detail.

The interim placement, clinical and case management arrangements

4.2.9. The care provider (Care Home Two) agreed to proceed with the placement, which was outside their usual registration criteria on the basis that they had sufficient skills and staffing to respond to Pauls needs. They accepted Paul based on a written assessment with quite limited background as opposed to a face-to-face assessment, a practice they have now stopped.

4.2.10. Paul moved to Care Home Two on 3rd August 2022 on the D2A pathway with the responsibility for case management then being passed to the Lancashire & South Cumbria Integrated Care Board (LSCICB) CHC team, with medical oversight provided by the local GP surgery.

4.2.11. Given the complexity of Paul's needs and presentation, a CHC team case manager should have been allocated soon after he moved to the new placement in Care Home Two, to start the work of co-ordinating a full review of needs to inform planning, consider the views of the patient and his family and co-ordinate considerations of funding.

4.2.12. It soon became apparent to the staff at the care home that Paul was inappropriately placed. Practitioners from Care Home Two who attended the SAR Practitioner's Workshop confirmed that his needs, interests and behaviours were entirely different from the other residents. The staff did their best to work with him, devising a bespoke, tailored schedule of input, however the nature of Paul's aggression and unpredictable outbursts led to concern that Paul's behaviours needed additional more specialist input and advice. The care provider (Care Home Two) contacted the local Community Mental Health Team (CMHT) a week after Pauls admission and liaised with the Rapid Intervention and Treatment Team (RITT). However, although the home was able to approach both the CMHT and RITT services for support no meaningful support or advice was provided as Paul did not meet the eligibility criteria of either

[5] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

of those services. The RITT do not work with adults with ABI and the CMHT commissioned team, work with adults' users where criteria is met.

4.2.13. The care provider (Care Home Two) recognised that the placement was unsafe and tried to clarify commissioning responsibility. However, when the provider contacted Lancashire Teaching Hospital to ask who the commissioner was, they were misdirected to Bolton Council when they should have been directed to the Lancashire South Cumbria Integrated Care Board, Continuing Healthcare Team (LSCICB CHC team).

Initial safeguarding enquiry in relation to physical assault by Paul

4.2.14. On 10th September Paul assaulted another resident causing a cut to his eye. The social worker (SW1) leading the safeguarding enquiry contacted the hospital discharge team to ask for an urgent review of Paul's placement, and subsequently corresponded with Bolton Local Authority and the LSCICB CHC team to seek clarity on commissioning and case management responsibilities. ICB funding was subsequently increased to support 1:1 care for Paul, initially to 12 hours a day and later to 24 hours a day.

Absence of meaningful case management activity by the placement commissioner

4.2.15. Specialist commissioning advice was sought by the commissioner on more suitable placements for Paul's age and diagnosis. However, the commissioner's search for an alternative placement was not successful due to the scarcity of appropriate specialist resources including competent workforce to provide the required care interventions in managing challenging behaviour in individuals with an ABI. An initial assault of Jack by Paul occurred on 21st September, which occurred despite the presence of 1:1 staffing with Paul at the time. The care staff contacted the local GP surgery for advice, however feedback from the Practitioner's Workshops suggests that the local GP surgery was not well placed to provide specialist clinical advice. The lack of specialist support available to assist care providers and the limited availability of specialist placements in these circumstances remains a local and national issue and is explored in more detail in **Systems finding 3.**

4.2.16. A second assault on Jack by Paul occurred several days later (24th September). During this period there were further incidents of physical assault by Paul against staff members and other residents. A section 42 safeguarding enquiry was co-ordinated by the local authority safeguarding social worker (SW2), who assessed the risks to Jack and other residents and made contact with Vera to understand her concerns and wishes.

4.2.17. SW2 took steps to seek clarification about who had commissioning and case management responsibilities for urgently sourcing and funding a more appropriate long-term placement. On 29th September SW2 received written confirmation from Bolton Council that the LSCICB CHC team were fully funding the existing placement until 28th October 2022, that they accepted that Paul was inappropriately placed, and were seeking a more suitable placement.

4.2.18. SW2 recommended that a multi-disciplinary meeting should be held as a mechanism to support the vital commissioning task and case management work that was needed to progress the management of immediate risks and the search for an appropriate placement for Paul. In these circumstances it would have been appropriate for either the Local Authority safeguarding team or the CHC team to have arranged and chaired a multi-disciplinary meeting, either under section 42 framework or in line with usual good case management and

commissioning practice to share information and agree shared risk management plans, but no meeting was held.

4.2.19. **Systems finding 4** explores in more detail the tendency towards silo working and lack of collaboration which seems to have been a factor in this situation and was flagged by frontline staff at the SAR Practitioner's Workshop. Efforts by the CHC team to locate a more appropriate placement proved fruitless, and a further 13 incidents of aggressive behaviour from Paul to staff and residents occurred between 6th – 30th October. During this period 17 providers were contacted by the commissioners, but all felt unable to accept Paul due to the complexity of his needs or because they had no vacancy.

4.2.20. Since that time the ICB have put in place significant process and structural improvements in relation to the oversight of CHC casework. Now weekly case discussion meetings (with input from other agencies) are held to discuss and escalate cases where necessary.

Professional response to a further assault against Jack

4.2.21. On 17th October Jack was assaulted by another resident (not by Paul). Care home staff increased observations to every 15 minutes to keep Jack in the sight of staff all the time. Promoted by Vera, a consideration was given to moving Jack to a different unit. Discussions were undertaken at the request of Jack's wife to understand her views. On 2nd November tragically a further assault against Jack occurred which seems to have led to a bleed on Jacks brain and his admission to hospital. Jack sadly died in hospital on 8th November 2022.

Listening and responding to safety concerns voiced by family members

4.2.22. Though this review discussed these issues at the Practitioner Engagement event this did not generate any specific systems issues that could be developed further to apply to system learning.

5. The Review Findings

5.1 The process of identifying the findings

5.1.1. The learning is derived in the first instance from aspects of practice that happened in the case and an understanding gained from practitioners about the factors that influenced their practice and decisions at the time. Knowledge of practice and how local services work is brought by the practitioners, managers and strategic colleagues in the system leads review group, which supported identification of the systems findings. The system findings highlighted specific organisational issues within the local systems that are either helping or hindering effective safeguarding outcomes for service user in cases where there is a need to identify and commission specialist support and settings for an adult with complex needs in order to keep residents and staff safe.

5.1.2. The structure of each systems finding seeks to build a clear picture of the systems issue or challenge, how it occurred in this particular case, the evidence that suggest it is in addition a wider and current issue for other adults in similar circumstances and lastly what the implications are for the system.

5.2 Findings Headline Chart

1.	When a placement is breaking down, if the adult originated from 'OOA' there is a heightened risk that key history is not shared or not easily accessible to the placement commissioners or the placement providers, resulting in delay in securing the most appropriate and necessary support or alternative placement and with an increased likelihood of prolonged, unmanaged risk to residents.
2.	The 'Discharge to Assess' pathway is not well suited to securing placements that can safely manage the needs of adults who have a combination of aggressive behaviour, ABI and personality disorder, creating a risk of harm to the adult, other residents and staff.
3.	There is a scarcity of specialist expertise, support and placements available in the Lancashire area for adults with an acquired brain injury, increasing the likelihood of inappropriate placement or admission to hospital.
4.	A tendency towards silo working and a lack of connectivity minimizing opportunities to gain further insight and clarity of information to support placement.

5.3 Finding 1.

'When a placement is breaking down, if the adult originated from 'OOA' there is a heightened risk that key history is not shared or not easily accessible to the placement commissioners or the placement providers, resulting in delay in securing the most appropriate and necessary support or alternative placement and with an increased likelihood of prolonged, unmanaged risk to residents'.

5.3.1 How did the finding manifest in the cases?

Good information sharing is essential for providing safe and effective care. Health and care leaders are directed nationally to ensure local partnership and / or information sharing agreements are in place as well as adhering to relevant national guidance specific to care requirements i.e. Care and Support Statutory Guidance issued under the Care Act 2014.

Communication is often a more complicated process when information is to be shared with services that sit outside usual geographical boundaries. A complicating factor can be the different ways services and their delivery are configured. Additionally, regular communication usually builds knowledge, trust, and rapport between areas and systems, this can be more difficult with out of area services that are less frequently connected with.

5.3.2 What happened in this case?

Paul's specialist home placement broke down in July 2022 (Care Home One) and Paul was escorted to Lancashire Teaching Hospitals Emergency Department. Lancashire Teaching

Hospitals commenced a trusted assessment in line with the discharge to assess pathway in July 2022. This process required a full review of current and past clinical care and other pertinent information to ensure appropriate provision was sourced. The Hospital Discharge Team reported they did not receive all background information. They received information relating to safeguarding alerts raised into Lancashire County Council via the Council electronic patient record. They were additionally aware at that time funding for Pauls care was jointly funded nursing care via Bolton Council and Bolton CCG and was aware from the records that Care Home One had been advised to contact the funding authorities to request a review. The care plan was not shared with the Hospital Discharge Team.

The Discharge Team did have access to a recent Mental Health Liaison Team (MHLT) assessment, undertaken by the MHLT in July 2022 while Paul was being cared for in the Lancashire Teaching Hospital Acute Medical Assessment unit. However, the MHLT did not have a copy and it is not clear if they requested a copy of the November 2021 Trusted assessment so were unaware of Pauls previous Mental Health inpatient care and assessment. The Trust sought clinical expertise of Paul following the placement breakdown at Care Home One in the form of Mental health advice on admission and later following a full assessment that suggested that Paul should be admitted to a challenging behaviour unit under a Discharge to assess pathway to allow for a period of assessment away from the acute environment to allow facilitation of an accurate plan of care to be formulated.

5.3.3 Is this a one off?

It was clear from discussions held within the Practitioner event that staff have limited access to other organisation's systems and this is made more challenging in relation to accessing information from OOA. The Reviewers were informed that clinical assessment undertaken by services in other organisations is often not available to the Hospital Discharge Team. This may be due to the information simply not being shared, or colleagues from OOA not being clear who the information needed to be shared with.

We note that currently access to electronic information systems including sharing of records across local area health and social care can be challenging, for example, the Hospital Discharge Team informed the Reviewer that the Home of Pauls placement breakdown in July 2022 did not share detailed history or information. Paul arrived at the Hospital Emergency Department escorted by Police Officers who held detail only of the recent assault. There appears to be no clear process or expectations in relation to information sharing when a placement breakdown results in a default transfer to Emergency Departments, reporting there is nowhere else for them to go.

5.3.4 How widespread?

Access to information from the OOA placing Local Authorities was clearly described by all agencies in attendance at the Practitioner event to remain difficult. The reviewers heard at the Practitioner event a variety of ways the system now works together to mitigate information sharing risk across Lancashire including, team connectivity, daily triage of complex cases, networks, engagement events and communications within and across the partnerships. However, this tended to address local 'in boundary' issues of information sharing, while the

‘OOA’ information sharing processes relying heavily on professionals’ cross boundary connectivity and their understanding of the importance to share information timely.

Reference to National SAR LSAB Eileen Dean SAR Report.pdf (nationalnetwork.org.uk) Case ED referenced that information is not always transferred with the individual, further complicated by frequency of moves between care provision in case ED. Additionally, similar to case ED information was not always easily accessible or transparent.

5.3.5 Significance of the finding?

In this case the Hospital Acute Discharge team did not have access to all relevant information which limited pertinent information being available at the time of assessment. They had not received, reached out to in boundary or out of area organisations to request previous care plan information from which the previous placement had broken down or past trusted assessment including Mental Health Act 1983 assessment from Bolton CCG. This led the advising organisations, Lancashire County Council, MLCSU, MHLT and the Hospital Discharge Team to assess Paul as being appropriate for the Discharge to Assess pathway which quickly following placement started to break down.

Previous learning SAR V (Blackpool) published April 2023 although related to a person with care and support needs living within their own home with family it noted the importance of the Adult Board obtaining assurance of work being undertake which ensures cross border multi-agency communication is robust with the aim to reduce risk of vulnerable individuals moving in boundary from OOA.

The assessment was relatively limited, focussing on Pauls current presentation and though Care Home One had raised concerns regards Paul escalating behaviours it appears this led to the commissioners to focus on finding a Provider with ability to provide challenging behaviour care, not a speciality challenging behaviour unit for individuals with an ABI or previous mental health in patient care. This commission of care resulted in patients and staff being put at risk due to the lack of specialist knowledge and training within the provider service commissioned, and the consequent lack of access to relevant, accurate and up-to-date information to support care and risk planning.

5.3.6 Questions and recommendations for the board

Finding 1 When a placement is breaking down, if the adult originated from ‘OOA’ there is a heightened risk that key history is not shared or not easily accessible to the placement commissioners or the placement providers, resulting in delay in securing the most appropriate and necessary support or alternative placement and with an increased likelihood of prolonged, unmanaged risk to residents. **Recommendations and questions for the Board**
1. How can the Hospital Discharge Team be better supported to access the information they need when patients originate from OOA to undertake more effective assessments?

5.4 Finding 2.

The 'Discharge to Assess' pathway is not well suited to securing placements that can safely manage the needs of adults who have a combination of aggressive behaviour, ABI and personality disorder, creating a risk of harm to the adult, other residents and staff.

5.4.1 How did the finding manifest in the cases?

The 'Discharge to Assess' (D2A) pathway is a national funding mechanism to enable hospital patients that are not well enough to return home (or their previous setting) immediately to move into a nursing home for a short period of further assessment with additional support[6]. The approach is intended to support recovery and enable patients to subsequently return home where possible. It is not designed for adults who are understood to require long term residential or nursing care except in exceptional circumstances (pathway 3). A Trusted Assessor is a qualified professional acting on behalf of, and with the permission of, a social care provider to carry out a holistic assessment of a patient's post-discharge health and care needs.

NHS Continuing Health Care (CHC) funding is provided where an adult has a combination of complex, intense and unpredictable needs. If you are not eligible for NHS continuing healthcare, you may still receive NHS funded nursing care (FNC) when the NHS contribution towards costs relates to the care provided by a registered nurse.

5.4.2 Wider than one case?

Paul was 59 years old with a diagnosis of traumatic brain injury and a personality disorder with a long-standing history of aggressive and unpredictable behaviour. He was physically active and had been living in a small specialist placement in Lancashire with expertise in working with adults who had ABI. Paul required 1:1 or 2:1 staffing at times, and the care provider felt unable to meet his needs safely. As no other placement was immediately available, he was removed at a point of crisis to the local acute hospital by the police, where he was assessed by the liaison mental health team and the Trusted Assessor employed by Lancashire Teaching Hospitals.

Quality of the assessment process

The Reviewers were advised by staff from the Hospital Discharge team at the Practitioners Workshop that their current assessment process does not incorporate looking at all previous assessment information, even in cases where the adult has a complex presentation involving risk. The Reviewers were advised by staff from the Hospital Discharge team that they do not always have access to all agency information especially when a patient come into their care from OOA. We understand that the discharge team had limited access to relevant IT systems at this time. The acute hospital discharge team did not have access to all recent assessments and not those undertaken from OOA commissioner. The Discharge team do have access to Lancashire County Council Electronic Record, but this does not always make reference to OOA information pertinent care information of individuals, as was the case for Paul.

[6] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

The team based their decisions in part on Paul's presentation in hospital and in part on the current assessments they had available. They were also aware that Paul was in receipt of NHS funded nursing care (FNC) which suggested that when Paul was last assessed his needs were not sufficiently complex to require full NHS CHC funding.

On admission to the Trust the team had also been notified by the MLCSU, who commission and ratify health led placements, that Paul was to be discharged on the D2A pathway due to the significant change in his presentation since his last assessment.

Quality of decision to use the D2A pathway

Paul presented with a complexity of needs and behaviours. He was physically fit and given the nature of his diagnoses and complexity of his presentation, he would likely need long term specialised care and support. His behaviour remained unpredictable and unusually aggressive while he was in hospital.

The Mental Health Liaison Team recommended that as an interim step Paul should be placed short term in a local residential unit that specialised in managing challenging behaviour for a further period of assessment. It was felt that the D2A pathway would be a suitable vehicle to enable this[7]. This decision was practical in some respects, but a relatively unusual use of the D2A pathway in that (a) the pathway is primarily intended for people needing a short-term spell of rehabilitation prior to return home and (b) the vast majority of pre-commissioned D2A beds available were situated in settings for older people, many of whom would also be physically frail. Paul's circumstances and needs were not an ideal fit with the use of the D2A pathway as he needed a long-term placement.

Quality of commissioning and placement decision

The LCC care navigation team as per agreed processes (from the pre-commissioned Discharge to Assess beds available) sourced the placement of a local unit (CARE HOME TWO) that specialised in dementia care including residents with behaviours that challenge.

Following an offer from CARE HOME TWO, the care navigation team contacted the family who supported the proposal to place Paul in CARE HOME TWO. Following this agreement the MLCSU ratified and CARE HOME TWO was commissioned.

The care home was registered to accept adults over the age of 65, with a variety of conditions including dementia, mental health and physical disabilities. However, given that Paul's diagnosis was not dementia, and he was known to present behaviours that his previous smaller specialist placement had been unable to manage, the choice of this setting was not appropriate.

The care provider accepted Paul based on the assessment information that was shared with them. A greater focus is needed on the quality of the risk information that is shared by commissioners and care navigators with providers. This was also echoed in the Practitioners Workshop.

[7] Funding and commissioning responsibility for placements on the D2A pathway is held by the NHS Lancashire and South Cumbria Integrated Care Board (ICB).

Previous Learning from SAR Adult L (Lancashire, published May 2022) a review of an individual living with Dementia being care for in an home who suffered a physical assault contributing to death recommended Adults Board obtain assurance in respect of the standard of pre-admission assessments by care homes and the sharing of relevant information by services providing care and support to the person at the time the pre-admission assessment is carried out.

It became clear soon after he was placed that Paul was not appropriately suited to the setting, as his age, needs and behaviours were outside their usual experience and expertise, and markedly different from the other physically frailer residents.

5.4.3 How widespread?

Discussion at the Practitioner's Workshop suggests that some of the barriers that made it more difficult for the discharge team to undertake a sufficiently robust assessment continue. In addition, practitioners from across agencies confirmed that there remains a continuing issue in relation to scarcity of specialist residential resources for adults with ABI. Recent development work taking place to strengthen multi-disciplinary discharge planning meetings between colleagues from Lancashire Council and the Hospital Trust Discharge Team recognised that there have not been discharge meetings for patients who *were* presenting with significant behavioural challenges who then settled, who have then gone on to escalate in behaviours on discharge to a care home. Patients who had waited for lengthy periods for psychiatric admission were then deemed to no longer require this, however they were sometimes discharged to a care home without having a mental health review.

Positive improvements are underway, and there is improved collaboration between the relevant teams across agencies involved in the discharge and commissioning processes since the inception of a new service model. However there remain some barriers to accessing information and considering other commissioning pathways (not just D2A) which suggest that the case of Paul was not a one off and that there remain some vulnerabilities within the systems that mean similar circumstances could arise again.

5.4.4 Significance of the finding?

To reduce the likelihood of inappropriate placements in situation of this kind requires a number of changes. The hospital discharge team need to be enabled to access the background information they need, particularly in cases of greater complexity and presenting risk.

Patients with longer term and more specialised care needs, require a more in-depth assessment and matching of needs and provision, along with the associated attention required to the patient and family wishes and views. The D2A pathway is unlikely to suit adults under 65 years with complex and chronic needs, where long term placements are indicated.

Where local systems and processes do not support these key assessment opportunities to be sufficiently thorough, the outcomes for the patient, families and potentially other residents are likely to be poorer.

5.4.5 Questions and recommendations for the board

Finding 2. The 'Discharge to Assess' pathway is not well suited to securing placements that can safely manage the needs of adults who have a combination of aggressive behaviour, ABI and personality disorder, creating a risk of harm to the adult, other residents and staff. **Recommendations and questions for the Board**
1. How can the relevant partners ensure the availability of alternative pathways for adults who do not fit the mainstream D2A criteria, and are requiring a longer-term placement with specialised clinical oversight?

5.5. Finding 3.

There is a scarcity of specialist expertise, support and placements available in the Lancashire area for adults with an ABI, increasing in some cases the likelihood of inappropriate placement or admission to hospital.

5.5.1 How did the findings manifest in this case?

The number of people with ABI is increasing, but the support for them is not keeping up with demand. There were over 356,600 admissions to hospital with brain injury in the UK in 2019–20, an increase of 12% since 2005–6 [8] While many people will be discharged without needing further treatment, research shows that 50% of people with a traumatic brain injury will experience further decline in their daily lives because they do not always align with any specified service and their problems can be easily missed. [9]

Operationally, Acquired Brain Injury services are often an add on to wider service provision and may sit for example within a mental health provider with long term care being delivered by complex care or challenging behaviour units, these often-providing generic support not specialist care. Locally ABI services for long term care are usually spot purchase commissioned.

Commissioning an 'OOA' placement is not unusual when seeking care for an individual requiring a long-term specialist placement, however this generally takes adults further away from their known local networks and families. Good practice and government led intentions support efforts to reduce the frequency of placing individuals OOA for specialist care and support.

5.5.2 How did the finding manifest in the cases?

In this case there was compelling evidence of (a) the lack of specialist residential placements for adults with ABI and (b) the limitations on specialist community based clinical advice or support for adults with ABI.

The Reviewers heard at the Practitioner Event how during the period when the placement was breaking down the Continuing Healthcare Team with commissioning and case management

[8] Headway UK Hospital admission statistics 2019-20

[9] Parliamentary Debate Pack- Acquired Brain Injury, May 2019

responsibility, was seeking to commission a new placement for Paul, they attempted to engage with 17 Providers. The Providers approached either had no vacancy or declined to care for Paul based on Pauls age, diagnosis and presenting care needs.

Homes in Lancashire who provide elderly complex behaviour care have access to the Rapid Intervention Response Team (RITT) for over 65 years, it is a crisis response. They can assist a home for example with risk management and or medication reviews, if necessary, they can refer for an assessment under the Mental Health Act 1983. They do not provide specialist input for individuals living with an ABI team. The local Mental Health Trust has a forensic ABI team for individuals requiring secure care provision, not a service that would be available to support RITT, CMHT or a care home provider in this case.

The care home (Care Home Two) could not access support for the community and or rapid intervention teams because Paul did not meet the criteria and the home had to wait 6 weeks after first raising Pauls behavioural concerns for conformation of commissioner.

The Reviewers heard that this limited specialist service provision delayed commission teams' ability to respond in finding alternative accommodation for Paul, whose behaviour towards residents and staff members subsequently resulted in him needing to be taken into Lancashire Teaching Hospitals by the police a second time (previously by Care Home One) where Paul was subsequently detained under section 2 of the Mental Health Act 1983.

5.5.3 Wider than one case?

The Reviewers heard that local specialist ABI units reablement care are very limited and tend not to be available for those living with long term impact of ABI. Very often commissioners need to consider national chains of Providers who are known to offer specialist bespoke care. These Providers differ from the generic challenging behaviour units in view that the staff receive specific training in the care and management of risk relating to ABI in view for example trauma and post-traumatic stress.

Reviewers heard at the practitioner event that securing placement provision for an individual with long term specialist ABI needs was an ongoing challenge, this was particularly an issue within Lancashire boundary. Consequently, many individuals are placed and cared for out of the local area. We also heard that a delay in arranging a placement was often due to lack of suitable community provision, not necessarily the absence of collaboration and connection by any one team to aid placement, there simply is mismatch of need against provision for specialist long term ABI care provision in area and limited provision nationally.

The Reviewers were informed by the Acute Hospital Discharge team that though OOA placement only amounted to a small percentage of all discharges from Lancashire Teaching Hospitals, sourcing provision often delays patients who became categorised as "super stranded" remaining in hospital up 120 days.

The Continuing Healthcare Team and the Navigator team who seek to source provision to support complex challenging behaviour report that often they approach Providers whose placements are described under the generic term ‘complex behaviour’ due to the lack of specialist provision, and it is the subsequent process of the provider reviewing the adult’s

needs assessment that determines whether a Provider feels able to provide the individual adults care requirements.

5.5.4 How widespread?

Many Challenging Behaviour Units within care home settings can provide a broad range of support. However, they are not specialist and therefore do not have trained staff to respond to escalating behaviours of individuals with for example ABI and past trauma. The area of expertise held by the care home workforce is more commonly for dementia presentations.

There is a strong evidence base of literature available that presents a background of many individuals living with ABI not being wholly supported, these include the experiences of relatives of people with ABI and associated social and health care services.[10] Many services are set up to respond to physical and or mental health needs, for example many local areas provide 'physical disability team'. This is even though physical impairment post ABI is often not the main difficulty.

However, within the Lancashire region some positive developments are underway. Lancashire and South Cumbria Integrated Care Board have commissioned a Mental Health Liaison Team to work with the Acute Hospital Trust, this is part of the Five Year Forward View for Mental Health which introduced evidence-based treatment pathways across mental health services. It has not yet introduced the inhouse 24/7 specialist 'core 24' service that sets a minimum standard of multi professional, multidisciplinary team approach to address complex Mental Health presentations within Acute Hospital Settings.[11]

Reference to National SAR Case LSAB Eileen Dean SAR Report.pdf (nationalnetwork.org.uk) where Adult MH team unable to provide community support in case ED has ED did not have dementia, (diagnosis of Wernicke Korsakoff syndrome)

Despite this, similar to Paul (with an acquired brain injury) a dementia care home dementia was commissioned. Whilst this home supported individuals with challenging behaviour, there was a need to check ability of the home to care for an individual with ABI. Particularly that there did not appear to be a commissioned service to provide community ABI support.

A funding also noted in case ED.

5.5.5 Significance of the finding?

The Reviewers heard from teams attending the Practitioner event that risks remained of inappropriate placement. There was a mix of explanations for this including insufficient capacity of specialist provision locally, regionally, and nationally, the difficulty in securing and maintaining specialist Provision with appropriately trained workforce, the environments of care. This includes the specific training needs of staff delivering 1:1 care to individuals who have an ABI, post-traumatic stress. These individuals require different intervention and support as the individuals are often younger.

Without specialist ABI Provision the system will continue to utilise the generic services that our complex behaviour units provide. There will be an increased need to place individuals OOA to source specialist placement, impacting family and the risks associated with sharing of information and clarification of responsible commissioner. There will continue to be a risk of inappropriate placement and placement breakdown. Inappropriate use of discharge to assess

[10] Holloway M and Tasker R, 2018. The Experience of Relatives of People with Acquired Brain Injury (ABI) and associated Social and Health Care Services. Journal of Lang Term Care, 2019, pp 99-110

[11] NICE 2016

and potentially lack of expert clinical oversight for individuals living long term with ABI and post-traumatic stress.

As soon as it is evident an individual is placed inappropriately in a home on discharge to assess pathway there needs to be an escalation processes that facilitates risk management planning, clear pathways to support placement stability (we noted current over reliance of 1:1 care), protecting the individual and others living in the care home from harm and optimising immediate access to transfer to suitable provision.

Commissioners of services need to ensure sufficient availability of specialist expertise to meet the range of needs of people with ABI.

5.5.6 Questions and recommendations for the board

Finding 3. There is a scarcity of specialist expertise, support and placements available in the Lancashire area for adults with an ABI, increasing in some cases the likelihood of inappropriate placement or admission to hospital. **Recommendations and questions for the Board**
1. How do you ensure you have the right mix of specialist capacity in your local geographical area to avoid placement delay and use of OOA placement 2. Local health and social care commissioners should take steps to improve their ability to provide an effective commissioning response for people with ABI requiring on-going support, including access to specialist clinical oversight and if necessary, a specialist placement. 3. How can local health and social care commissioners work to promote an efficient and effective, timely response to care homes who raise concerns in meeting care and support needs of individuals placed in their care?

5.6. Finding 4.

More likely in complex cases that silo working and a lack of connectivity may minimize opportunities to gain further insight and clarity of information to support placement.

5.6.1 How did the findings manifest in this case?

Silo working can be described as a process whereby agencies do not share relevant information or knowledge with each other which may support better outcomes. Silos are barriers that exist between departments within an organization.[12] Many of us are aware of 'silo working', often in view of organisational procedures and processes which relate to system and hierarchies rather than professions or departments.[13]

[12] Ref-Silos, Politics and Turf Wars, Feb 2006.
[13] Health Service Management Research Nov, 2023.

Examples of best practice in assessment and discharge work will include effective partnership working to enhance communication. National guidance in relation to the Discharge to Assess Pathway confirms the important of multi-agency working.

5.6.2 What happened in this case?

The care home (Care Home Two) as early as 5 days post Pauls 3rd August admission repeatedly raised concerns of a growing inability to support Paul. The CHC team had frequent contacts with Care Home Two regards the appropriateness of the placement though it was not formally documents until the 29th of September 2022 by the assessing CHC team that the placement to be inappropriate and formal process applied to seek new placement. There were several key opportunities missed for multi-disciplinary and multi-agency partnership risk planning which is an expected, usual, and beneficial response to the increasing risks, in particular the points of crisis when safeguarding enquiries were underway. Given the clinical complexity of the case, and the criteria for assessment not being met (due to how services commissioned) of RITT and CMHT to provide support, a multi-disciplinary meeting was an appropriate step, but instead there was a failure to bring wider partners together.

Individuals requiring care home placement on discharge are supported by the Care Navigation team at LCC who source all 24-hour residential placements as per agreed process. If the patient is only requiring residential level services the placement will be ratified and commissioned by LCC. In this instance, for Paul, the discharge was health led and as such the ratification and placement commissioning was approved via the MLCSU.

It is not the role of the Care Navigation team to review and or challenge the trusted assessment that is submitted by the Hospital Discharge Team. Their role is to read through and source appropriate placement in line with information contained in the referral, sourcing providers commissioned specifically to support individuals placed on discharge to assess pathway.

After placing Paul on the 3rd of August 2022 the Care Navigation team was not informed of care home (CARE HOME TWO) placement issues or contacted about the emerging inappropriate placement of Paul. In other cases, the Care Navigation team have been contacted by the CHC team and have supported to source alternative placement. This may indicate inconsistencies across teams and or variation in practice.

The CHC team assessed Paul as meeting fully funded Continuing Healthcare recording this outcome on 29th September 2022. This moved any placement responsibility to the CHC and no longer the responsibility of the Hospital Discharge Team or Care Navigation Team

5.6.3 Wider than one case?

Many services were involved in one way or another, indirectly supporting safe care to Paul and other residents including Jack, investigate safeguarding incidents, liaison with family, undertaking assessment of Pauls escalating needs and seeking specialist placement. However, the reviewers did not robustly note from the chronology or practitioner engagement event the presence of multi-agency risk planning. With limited evidence how teams communicated and connected to facilitate a resolve to the emerging and escalating concerns relating to Pauls behaviour and inappropriate placement.

An example of this relates to Care Navigation team who have a wealth of knowledge and experience of the system and the providers of care including OOA provision with skill in sourcing spot purchase for specialist provision. This team were not contacted by CHC to seek input, advice, or support even when CHC reported 17 providers had declined.

It was also evident that the RITT team and CMHS team did not facilitate an escalation into the commissioner at the time of their assessments but reported to care home (Care Home Two) that they had nothing to offer the home in relation to Paul.

Additionally in SAR L (Lancashire, Published May 2022), the Safeguarding Adult Board was recommended to reflect on the level of violence tolerated in the Care Home subject to the review and consult with the regulator, commissioners, providers, their staff, residents and their families before deciding what action needs to be taken to address the issue more widely.

In this case the Provider reported an escalating number of assaults of staff and residents, some of which would be known to the Continuing Healthcare Team, attending Ambulance service, Local Authority and Police. Multi agency risk planning would include a discussion of incident reports and would have minimized a possible silo view of incidents.

5.6.4 How widespread?

The presence of silo working across Health and Social Care features regularly in academic research. It has been described by some to be evident due to lack of shared, and communicated, understanding of what type of knowledge is most appropriate and in which circumstance makes meaningful knowledge exchange challenging for decision-making and partnership.[14]

The Reviewers heard at the System Review Group that CHC team managers would welcome identifying further improvements to the commissioning team's connectivity with Local Authority Care Navigation team and the onward process of information sharing into the care home. It was additionally reflected that a greater focus is needed on the quality and clarity of the risk information that is shared by clinical staff on assessment forms provided to commissioners, care navigators and care homes. This was also echoed in the Practitioners engagement event.

5.6.5 Significance for the findings?

This case demonstrates that silo working does create large gaps in our ability to deliver safe responsive care. Whether that be lack of appropriate information hindering assessments and subsequent appropriate provision, or organisational barriers that prevent us from coming together to seek resolve.

Staying in silos leads to ineffective working practices and is evident in this review. We tend to still priorities our organisations rather than the important connectivity required as an interconnected system of services. System leaders need to lead by example moving away from encouraging and protecting each team's responsibility as an organisation encouraging a pulling together of a shared objective to do what is right by the individual at the centre.

[14] Ref BMC Health Service Research, Vol 18, 2018

5.6.6 Questions and recommendations for the board

Finding 4. More likely in complex cases that silo working and a lack of connectivity may minimize opportunities to gain further insight and clarity of information to support placement. **Recommendations and questions for the Board**
1. How can the board work with partners involved in hospital discharge to increase the mechanisms that enable cross team and cross agency communication?

6. Questions and recommendations for the board

	Questions and recommendations	Who should lead on the action?	Recommendation relates to specific finding
1	How can the Hospital Discharge Team be better supported to access the information they need when patients originate from out of area to undertake more effective assessments?		1
2	How can the relevant partners ensure the availability of alternative pathways for adults who do not fit the mainstream D2A criteria, and are requiring a longer term placement with specialised clinical oversight?		2
3	How do you ensure you have the right mix of specialist capacity in your local geographical area to avoid placement delay and use of OOA placement		3
4	Local health and social care commissioners should take steps to improve their ability to provide an effective commissioning response for people with ABI requiring on-going support, including access to specialist clinical oversight and if necessary, a specialist placement.		3
5	How can local health and social care commissioners work to promote an efficient and effective, timely response to care homes who raise concerns in meeting care and support needs of individuals placed in their care?		3
6	How can the board work with partners involved in hospital discharge to increase the mechanisms that enable cross team and cross agency communication?		4

Appendix A - The agencies involved in the review

- Lancashire County Council
- Lancashire Teaching Hospital Trust
- Lancashire Constabulary
- Lancashire and South Cumbria Integrated Care Board
- Care Home Provider One and Two, Central Lancashire.
- Lancashire and South Cumbria Foundation Trust
- Bolton Council
- Mental Health Liaison Service, NHS Greater Manchester (Bolton Locality)
- Lancashire Safeguarding Adults Board