Salford
Safeguarding
Adults Board

NHS
Salford Clinical Commissioning Group

Safeguarding Adult Review JW

How are practitioners in Salford jointly identifying, assessing and managing risk for people with a learning disability and complex needs?

Presented to the Salford Safeguarding Adults Board

On 17th January 2018

Contents

1. Introduction

Why this case was chosen to be reviewed?

Following the death of JW, Salford Safeguarding Adult's Board made the decision to commission a Safeguarding Adult Review under Section 44 of the Care Act (2014) (See Appendix 1). This was because the circumstances of the case appeared to have a wider significance for practice, both in relation to hospital discharge and how different agencies worked together in the community to support JW. The SCIE Learning Together methodology was used in order to maximise wider learning from the case than might be provided by a more traditional review methodology. This was also an opportunity for the Board to trial this systemic methodology.

1.2 Succinct summary of case

JW was woman with severe learning disabilities, mobility and communication difficulties who moved back to Salford in May 2013 having lived for many years in a residential home in North Wales. She received 24 hour support in a supported tenancy from a care provider. She was put on the Liverpool care pathway during her stay at Hospital 1 in August 2013 due to a twisted bowel. She however survived this admission and returned home as successfully recovered. She was more recently readmitted in November 2015 to Hospital 2 where she later died aged 55 due to complications related to a severely obstructed bowel.

1.3 Family composition

JW had two sisters and a brother still living at the time of the review. Both sisters visited JW on a regular basis when she returned to live in Salford.

1.4 Timeframe

JW died November 2015. Salford Safeguarding Adults Board approved the commissioning of a Serious Adult Review in Feb 2017, following the Coroner's report and internal reviews by some agencies that highlighted the need for a systems review.

This Review examined activity from May 2013 when JW returned to live in Salford until November 2015 when she died.

1.5 Organisational learning and improvement

Following discussion, Salford Safeguarding Adults Board (SAB) identified that review of this case held the potential to shed light on particular areas of practice, including addressing the following Research Question posed by the Review Team;

How are practitioners in Salford jointly identifying, assessing and managing risk for people with a learning disability and complex needs?

The use of research questions in a Learning Together systems review replaces traditional Terms of Reference for a SAR. Posed at the start of the process, to provide a frame of reference for the review, research questions identify the key lines of enquiry that the Safeguarding Adults Board (SAB) believe are most relevant to current practice.

2. Methodology

Salford Safeguarding Adult Board has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 2010) to carry out this Safeguarding Adult Review. The Learning Together methodology is explained in Appendix 2.

2.1 Reviewing expertise and independence

This SAR has been led by a Lead Reviewer who was independent of the case under review and of the organisations whose actions are being reviewed. Julie Pett is accredited to carry out SCIE Learning Together reviews and has led a number of SARs using this methodology. She has not had any previous involvement with this case, or any previous or current relationship with any agency in Salford.

The lead reviewer received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and the reliability of the findings as rooted in the evidence.

2.2 Acronyms used and terminology explained

In order to explain the terms used in this report, Appendix 3 provides a section on terminology to support readers who are not familiar with the processes and language of adult social care and health provision.

2.3 Methodological comment and limitations

In order to be ‘proportionate’, the commissioner elected to use a Practitioner event, or workshop, as the central mechanism for case-specific data gathering and analysis, rather than conduct a lengthier process that included more detailed individual conversations with Case Group members. While this more proportionate use of Learning Together served the purpose intended very well, it left the Review Team with some frustrations because they were unable to delve more deeply into all aspects of the analysis in the time afforded to the review process, for example in exploring practitioners understanding of their duty of care.

Not all Practitioners involved with JW were able to attend the Practitioners event. However this gap was mitigated to some extent by the appropriate lead from that organisation attending and by one of the Review Team meeting with the GP to discuss some of the queries thrown up by the Practitioner event. Although it would have been helpful to have the benefit of the views of some other practitioners who had left the area, the Review Team do not consider that this has had a material impact on the findings below.

Although the Lead Reviewer had a telephone conversation with one of JW’s sisters, the family did not wish to become further involved in the Review process.

2.4 The Review Team

The Lead Reviewer worked closely with a Review Team consisting of a group of senior managers from agencies that had been involved with the care of JW. Members of the Review Team did not have any direct management responsibility in relation to the services offered to JW. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice and to the development of the findings from the review. Review Team members worked collaboratively with the Lead Reviewer reading documentation and analysing the data. A second independent Reviewer facilitated the Practitioners Event with Case Group Members.

The Review Team consisted of:

Substantive Role	Agency
Designated Nurse	CCG
Head of Service	ASC SRFT – ICO (Salford Royal Foundation Trust - Integrated Care Organisation)
Health Facilitator	JLDT (Joint Learning Disability Team)
Business Manager	Salford Safeguarding Adults Board
Detective Sergeant	Greater Manchester Police
Regional manager	Community Integrated Care
Integrated Commissioning Manager for Learning Disabilities	Salford City Council
Kathy Kelly Facilitator for the main Practitioner Event	Independent
Julie Pett Lead Reviewer	Independent

2.5 Structure of the review process

Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process. This review used a multi-agency workshop as the central mechanism for data gathering and case specific analysis. The Review Team also met four times to develop their analysis.

2.6 Sources of data

The systems approach requires the Review Team to learn how people saw things at the time and explore, with them, ways in which aspects of the context were influencing their work. This is known as the ‘local rationality’. It requires those involved in a case to play a part in analysing how and why practice unfolded the way it did and highlighting the broader organisational context. These practitioners/managers are known as the Case Group.

2.6.1 Data from case practitioners

During the Practitioner Learning Event on the 24th May 2017 the Review Team facilitated group discussions around key practice episodes with the following staff:

Role	Agency
Integrated Commissioning Manager	SRFT -ASC
ICO Partner	SRFT -ASC
Social Worker	SRFT –ASC JTLD
Nurse Coordinator	SRFT –ASC JTLD
Nurse Coordinator	SRFT –ASC JTLD
ICO Partner	SRFT -ASC
Head of Service	SRFT –ASC JLDT
Regional Manager	CIC
Carer	CIC
Carer	CIC
Carer	CIC
Carer	CIC
Carer	CIC
District Nurse	SRFT
District Nurse	SRFT
Manager	CIC
Designated Nurse Safeguarding Adults	CCG
Adult Safeguarding Nurse, MCA/DoLS Lead	SRFT

2.6.2 Practitioner Workshop

The Practitioner Learning Day in May 2017 brought practitioners involved with JW together to discuss their practice and was central to the Review process. Facilitated by two the Independent Reviewers and members of the Review Team, practitioners explored why and what had happened during the review period and related this to how they usually practised within the system.

Practitioners also shared what had changed within services as a response to what had happened to JW. For example, the Care Provider explained the changes to their recording systems around bowel maintenance.

Feedback by participants since the workshop demonstrated that the workshop had ‘Helped to give an understanding of each area’s roles and responsibilities’ and network as well as acknowledging the pressures that other agencies come under. It was considered a ‘Great opportunity to develop learning to improve practice' and find out about 'positive changes made already'. The chance to challenge other agencies was also welcomed for example around risk assessment and roles and responsibilities.

The Review Team concluded that the Practitioner Workshop was a positive and valuable experience for both the Case Group and the Review Team as both an opportunity for practitioners to reflect critically on practice in the case as well as providing a 'window on the system' as detailed in the Findings below. The Review Team would like to commend the Case Group both for their candour and willingness to reflect on both this case and also the wider system that they work in.

2.6.3 Data from documentation

The following documentation was available for the review team:

- Adult Social Care records
- Provider records
- Hospital records including Discharge Summary
- Community Health records
- GP records

2.6.4 Perspectives of family members

The Lead Reviewer had a telephone conversation with one of JW's sisters in April 2017.She was able to give a helpful perspective on JW from the family's point of view, providing some background about JW as a young woman when she lived with her family.

3. The Findings

3.1 Structure of the Findings

Five priority Findings have emerged from this Safeguarding Adult Review. These Findings explain why professional practice was not more effective in protecting JW in this case. Each Finding lays out the evidence identified by the Review Team to show why these are not one-off or case specific issues and why they undermine the reliability with which professionals can do their jobs now and in the future. It should be noted that areas of concern that are already being addressed by individual agencies are flagged within the Findings.

3.2 Appraisal of professional practice in this case: a synopsis

This section provides an overview, both of what happened in this case and why it happened and is the view of Review team members about the quality of the practice in this case, including where practice fell below what would be expected. The Review Team has made these judgments in the light of what was known, and was knowable, at the time. Systemic issues are explored in more detail in the Findings and are cross referenced.

3.2.1 Introduction

This case is characterised by the person centred care that was provided to JW in the community. JW remained at home safely for over two years between her two hospital admissions despite the particular risks to JW both due to her unique physiology and her bowel condition.

3.2.1 In what ways does this case provide a useful window on our systems?

This case illustrates the challenge of caring for someone with both a learning disability and complex physical health needs. It also demonstrates the tendency of practitioners to minimise risk over time and the subsequent lack of a joined up approach to care.

3.2.2 April 2013-August 2013 JW Moves Back to Salford

JW's long term residential home in North Wales was closing due to a range of concerns so she moved back to Salford to supported living accommodation with a tenancy agreement in May 2013. This was via an interim placement as an emergency transfer and as a priority case so the usual handover arrangements e.g. carers being introduced to JW over time were reduced to only six weeks. This was reasonable practice due to the need to move JW quickly but meant that carers did not have the opportunity to liaise with the practitioners in North Wales who knew JW well and find out about her habits and particular needs. Written information provided about JW was patchy and sometimes incorrect (e.g. JW's birth date was incorrect) including her medical records. This was exacerbated because JW's family also did not know JW well either as they had been unable to visit often until she moved back to Salford.

In particular, there was no clear initial programme provided on how JW's physical health needs including bowel care should be managed. Instead carers used the pragmatic approach of observing JW and noting signs and symptoms. This meant that JW's bowel movement pattern of 4-5 days without a bowel movement followed by a big bowel movement was considered what was 'normal' for her. See Finding 2.

3.2.3 August-November 2013 Emergency Admission to Hospital and Discharge

On 15th August 2013 JW became unwell at lunch time and her carers became concerned as JW was not her usual self. They arranged an emergency appointment with the GP the same day, which was appropriate given her symptoms and long term conditions.

Although GP had not met JW before she was sufficiently concerned to arrange for an emergency admission to the Acute Hospital as JW was cyanosed (extremities turning blue indicating lack of oxygen) and bringing up phlegm. The GP contacted paramedics and JW was taken to the Acute Hospital accompanied by a carer which was appropriate.

Whilst at A&E, clinicians noted JW's symptoms and suspected Pneumonia. This was diagnosed following blood tests. JW was distressed and the carer was aware that JW did not like having bloods taken. She distracted JW which was good practice as the immediate need to take bloods was in JW's best interests. On, the following day JW was discharged with a prescription for antibiotics. Carers/family were consulted about this decision, as would be expected practice.

JW remained unwell for the next week and looked after by carers. A week later carers contacted the surgery again. JW remained very lethargic and wheezy and appeared to becoming more unwell despite having completed her course of antibiotics. JW's carers correctly assessed that she needed a home visit rather than a repeat prescription. As a consequence of the GP's concerns when she attended, JW was taken to the same Acute Hospital A&E by paramedics. On admission and following a chest x-ray and CT scan JW was diagnosed to have a severely twisted bowel.

JW was reviewed by an anaesthetist and the surgical team to assess her chances of recovery following an operation. As JW was physiologically weak and unlikely to recover well if she had an operation to manage the blockage, clinicians made the decision to put her on the Liverpool Care Pathway (LCP) and made comfortable in A&E. It is unclear if a stoma was considered. See Finding 5

Clinicians discussed the prognosis with JW's family but not the carers See Finding 4. The Joint Learning Disability Team (JLDT) were informed about the hospitalisation by carers but were not proactive in the important Best Interest Decision that was being made. Given that JLDT were coordinating JW's care, this was poor practice. Clinicians appeared confused about the differences between the LCP and Mental Capacity Assessment so the decision was not recorded as a Best Interest Decision.

JW then made a significant clinical improvement was taken off the LCP, and transferred from A&E to the Respiratory Ward.

Carers supported JW whilst she was in hospital during the day, with her family staying at night. JW did not like to stay in bed and became distressed so ward staff arranged for a mattress on the floor for JW to spend the day on which was a good initiative on ward staff's part.

Whilst on the Respiratory Ward JW continued to make a good clinical improvement. But she did not like the ward and continued to try to get out of bed. A clinical decision was made that, as JW continued to make improvements and as she was not receiving medical treatment, that she should be discharged as 'back to baseline'. JW's sisters were involved in this decision but carers were informed of what was to happen rather than involved in the decision. See Finding 4.

Because of JW's complex needs, the Review Team consider that there should have been a discharge planning meeting to ensure that every agency involved in caring for JW understood her diagnosis and care needs. See Finding 1. The discharge summary was sent only to the GP. The GP liaised with the District Nurses. JW's sister received a copy which she showed to the carers. As Community Services including JLDT were responsible for day to day care of JW, they should all have received their own copy.

A week after her admission to A&E, JW was discharged home with a range of medications. The Review Team consider that there should have been a specific bowel management plan included in the discharge plan due to the risks of reoccurrence. See Finding 2

The GP practice liaised with carers around bowel medication and the carers agreed to liaise with the Pharmacy when these were required. The GP checked with carers regarding administration of enemas and appropriately arranged for District Nurses to visit to administer. The practice by community services was appropriate.

District Nurses visited three times. JW was discharged from the service as she did not require enemas as her bowels were being managed by a combination of medication and diet.

3.2.4 December 2013 Handover to new Care Provider

In December a new Care Provider took over care of JW and the two other service users living in the house. Three carers remained within the supported home with JW which demonstrates appropriate and considerate management of staffing

The Provider Care plan was reviewed but did not relate to the JLDT Review or GP Health check. See Finding 1.

Observations were recorded in a person centred way by the carers but as in a narrative format which made it difficult to identify any specific issues or patterns over time. (Note paperwork has now changed to include specific sections including Bristol bowel charti, GP and other professional visits)

As part of the handover, it was good practice that JW was seen by a dietician. JW was found to have returned to her weight prior to her hospitalisation due to use of fortified foods. JW then returned to her habitual diet with lots of soft foods. The dietician suggested hiding medication in JW's food which, although arguably pragmatic, was not appropriate unless processes outlined within the MCA Act had been followed. JW had been discharged from hospital with Senna tablets but she had a choking incident in September 2013 and continued to have problems with taking her tablets.

In December, during a consultation about an unrelated health matter, Carers discussed JW's swallowing with the GP. They told her JW preferred to take medication with food. The GP changed JW's bowel medication to liquid products, which was appropriate, and Carers agreed to trial the alternative liquid medications. The Carers began to record JWs bowel movements but the records were imprecise and intermittent.

A speech and language appointment reviewed JW's abilities to swallow.

3.2.5 January 2014-April 2015 JW Remains Safely at Home

In January the Practice Nurse conducted JW's LD Annual Health Assessment and as this did not throw up any concerns the GP did not review the patient,- which under the circumstances was usual practice. The Review was not shared with any other agency supporting JW,which again was usual practice at this time See Finding 1.

Carers continued to support JW in attending routine health appointments and contacted the Practice by phone when they needed to. They also supported JW when she attended A&E, which JW required, for example, when she sustained a minor head injury. This was appropriate practice on the part of the carers.

In March 2014 carers had a telephone consultation with a GP regarding constipation. The GP advised increasing lactulose to three times a day. Although JW had no symptoms of obstruction the GP agreed to an appointment that afternoon which was responsive and good practice. That same day, as JW had a bowel movement, the carer cancelled the appointment.

This fifteen month period is notable in that apart from routine health concerns, most of which were not related to her bowels, JW remained at home safely able to live life as she wanted to live it. This included outings to local shops and pubs as well as visits from her family and friends and supporting JW to do this demonstrated good practice. See Finding 3.

3.2.6 April 2015-November 2015

In April a social worker from the JLDT conducted JW's Annual Review. This review took place late, two years after JW returned to Salford, when according to procedures, JLDT should review service users once a year.

The paperwork used was not a standard form but devised by some team members themselves as the standard form was not always relevant to people with a learning disability and other long term conditions but was aimed at the needs of older people. It should be noted that paperwork is currently being revised to a more appropriate form.

The review document included mention of risk of JW's twisted bowel 'so it is important for JW to consume fibre and constipation medication'. However, as JW's life was only considered over the past year, the consequences and potential risks of her hospitalisation in August 2013 did not form part of the Review. See Finding 1

Carers continued to record JW's bowel movements intermittently and care for JW appropriately. In September carers were able to take JW away for a week's holiday.

JW was taken to A&E in April 2015 as she was finding it difficult to breathe, this prompted the development of an admission avoidance care plan, for JW by the GP Surgery which was appropriate.

3.2.7 JW Becomes Ill and is taken to A&E.

On 23th November 2015 JW appeared tired on getting up, she ate most of her breakfast and drank her drink. At lunchtime carers noticed that her stomach was a little distended and by mid-afternoon JW's complexion had become yellow. Carers dialled the non-emergency NHS help line. Carers continued to treat JW's physical symptoms as constipation despite JW having had a bowel movement on the day before. Carers would not have known that JW may have had an impacted bowel despite having had a bowel movement. As records did not record JW's bowel movements consistently, care staff acted initially as though constipation was the cause of her physical symptoms See Finding 2.

By late afternoon, carers noticed that JW's breathing had changed and that her lips had turned blue and so rang 111 with their increased concerns. Following a consultation with a clinician on the NHS Helpline, an ambulance was called.

JW was taken to Acute Hospital 2 by ambulance and arrived within 30 minutes accompanied by a carer. The carer was sent to wait outside, although if she had been a family member she may have been allowed to stay with JW. See Finding 4

As JW was in such a poor physical and physiological state, the A&E Consultant Surgeon and Consultant Anaesthetist made the difficult decision to provide palliative care only but a best interest decision was not recorded. Strenuous efforts were made by phone to contact JW's sister who was not able to arrive until after JW had died three hours later.

3.3 Summary of Findings

The Review Team have prioritised five findings for the SAB to consider. These are:

No.	Finding	Category
1.	In Salford agencies are planning and reviewing service users' complex needs with limited interface with other professionals, so that risk assessment for service users takes place in silos rather than being holistic and coordinated.	Professional norms – longer term work
2.	A significant number of practitioners in Salford are unaware that people with a learning disability have a higher incidence of bowel complications compared to the general population, resulting in a risk that the condition goes unrecognised.	Professional norms longer term work
3.	In Salford services for people with complex needs and a learning disability are commissioned creatively and effectively, allowing carers the flexibility to support service users in a person centred way	Management Systems
4.	In Salford clinicians do not always uphold the rights of vulnerable people in relation to Best Interests under the Mental Capacity Act or fulfil their own duty of care because they do not consult others	Family – Professional relationships
5.	In Salford clinicians prioritise family opinion over that of paid carers because they are 'next of kin'. This diminishes the value of knowledge carers hold so that decisions made about treatment may not be based on best evidence	Professional norms – incidents

3.5 Findings in detail

3.5.1 Finding 1

In Salford, agencies are planning and reviewing service users' complex needs with limited interface with other professionals, so that risk assessment for service users takes place in silos rather than being holistic and coordinated.

Introduction

Multi-agency working is about providing a seamless response to service users with multiple and complex needs from all agencies working with that individual. This includes involving family and other agencies working with service users in any reviews and joint risk assessment.

Recent legislation and guidance e.g. the Care Act 2014 has emphasised the need for Health and Social Care agencies to adopt a person centred approach and support service users in a holistic and coordinated way.

Similarly, Mental Capacity Act 2005 Code of Practice (Chapter 5) highlights the importance of consulting family or other agencies '…for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values'.

How did the issue manifest in the case?

Every agency working with JW conducted reviews and risk assessments but did not involve other agencies in those reviews. JW had an unusual physiology (undiagnosed until after her death) which meant that the risks of bowel complications were much greater for JW yet these risks were not reviewed holistically across agencies.

There was a lack of multiagency meetings to manage risk or JW's care needs the Review period despite her complex conditions and care needs. The exception to this was when carers were sometimes involved in discussions at the GP Surgery and the JLDT Review.

Noted instances of a lack of multi-agency approach include;

- No discharge planning meeting at Hospital 1 in August 2013
- JLDT were aware that JW was very ill but did not pro-actively become involved in decision about Liverpool Pathway or discharge
- The GP LD annual review was carried out by the Practice Nurse and separately from annual medicine review completed by GP as is usual practice.
- In April 2015 the JLDT review did not include the significant episode of JW's being on the Liverpool Pathway as it was more than a year since that incident.
- Although a Dietician was involved in JW's bowel management, this was not connected to the GP review or JLDT Review.

What makes it underlying (rather than an issue particular to the individuals involved?)

At the Follow On Meeting with the Case Group on 21st September 2017, both the Case Group and Review Team agreed that it was not unusual practice to hold Review Meetings in isolation from other agencies and not to share the results of reviews to other agencies. Also the timing of the JLDT Annual Review, GP LD Review and Medicine Review is rarely coordinated to allow for a more joined up approach. That they are held at different times does allow for regular professional oversight, but that is by default rather than being explicitly planned.

The Review Team considered that it was the role of the JLDT to lead and coordinate care for service users when there are other agencies involved in care and treatment and that they should be responsible for the dissemination of knowledge alongside the GP.

The JLDT has already recognised that the Annual Review is not as holistic as it should be. It is currently reviewing the document to improve multi-agency involvement. The intention is to ensure that JLDT will be able to develop a holistic view of service users' needs and associated risk in partnership with other agencies.

Although some Case Group members believed that there was some evidence that discharge planning had improved, there were also some examples provided where this was not the case. At the Practitioner Day on 25th May 2017 a further example was provided where the discharge planning for a person with complex needs was insufficient.

Carers described another recent case of another person with LD and complex physical needs where hospital staff asked if she was 'back to baseline'. She was then discharged without a discharge planning meeting that would have enabled any changed risk to care or conditions to be shared.

What is known about how prevalent or widespread the issue is?

The tendency to work in silos is not unique to Salford or indeed to Adult Services. The Triennial Review of (Children's) SCR 2011-14 2016 concluded:

'Although there were good examples of communication between professionals, practice in this area was not consistently good and some professionals did not actively look to seek or share information to assist assessment processes. There was a tendency for professionals to work in 'silos' i.e. to view aspects of need narrowly, solely from the perspective of their own discipline. This was compounded in part by a lack of awareness of other agencies and how they operate'.

A recent SAR conducted by the Lead Reviewer but not yet published, also highlights silo working and lack of multi-agency involvement in review processes due to:

Practitioners pressures of work

- Assumptions about other agencies' roles
- Rapid changes to services

Research has also indicated that multi-agency working is still viewed as time-consuming, hard to co-ordinate and, with multiple agencies involved, a difficult means by which to reach consensus decisions. However, research also shows that when multiple agencies involved with an individual service user work in isolation, they are less effective than those who work closely together, resulting in poorer outcomes in managing risks.

There are a number of examples nationally where partnerships are attempting to coordinate reviews and NHS England is supporting these initiatives and providing examples at #CareTransformed. (NHS England/Learning Disabilities/Case Studies). Derbyshire Transforming Care Partnership (TCP) have used Care and Treatment Reviews (CTR) to focus on patient's medicines, physical health and communication, particularly in the pre-CTR process. The physical health review form takes a holistic look at the person's physical health including whether the person has had an annual health check from their GP, whether they have been given a care plan as a result, and what physical health needs they might have such as constipation, pain and dental care.

A dedicated specialist LD Nurse based in acute hospitals is able to support ward staff when caring for someone with a Learning Disability and there are examples of this locally but we currently do not employ anyone in this role in Salford.

What are the implications for the reliability of the multi-agency safeguarding adult system?

Failure to work jointly is wasteful of resources. If practitioners in Salford are not working in a collaborative manner to support service users with complex needs, then risks will not be identified or reduced. A greater ‘partnership approach’ in Salford will facilitate practitioners sharing skills, knowledge and expertise. Shared decision making, shared ownership and responsibility will protect service users and mitigate risk as well as offering the best range of support they require in a timely manner.

FINDING 1 SUMMARY

ISSUE FOR CONSIDERATION BY THE BOARD

In Salford agencies are planning and reviewing service users' complex needs with limited interface with other professionals, so that risk assessment for service users takes place in silos rather than being holistic and coordinated.

(Professional norms – longer term work)

SUMMARY

Service Reviews are conducted in order to check that services provided are suitable and to reassess any changes in need or risks to a service user.

In Salford, although services are reviewed these tend to be single agency and therefore in isolation from other agencies involved with the service user.

For service users with complex needs it is particularly important that any agency involved in care and support is consulted during planning and reviewing of services in order that care is holistic and appropriate and that risks are shared and minimised as far as possible.

Questions for the Board and Organisations to consider

What value is placed on the importance of partnership working locally and how far is this reflected in shared tools and processes?

Is the Board confident that managers are encouraging multi-agency working enough?

How will the Board be assured that practice-and behaviours-have changed?

What multi-agency procedures would you like to see in place to ensure a more joined up risk assessment process?

3.5.2 Finding 2

A significant number of practitioners in Salford are unaware that people with a learning disability have a higher incidence of bowel complications compared to the general population, resulting in a risk that the condition goes unrecognised.

Introduction

People with learning disabilities get constipated for the same reasons as other people. These reasons include:

- Inadequate diet and fluid intake
- Reduced mobility and lack of exercise
- Side effects of certain medications
- Anxiety or depression

(Managing and preventing constipation in people with learning disabilities, Public Health England, August 2016, gateway number: 2016215). Part of the reason is due to genetic factors such as Down’s syndrome which can lead to a greater risk than the general population due to the complexities between physical ill health and learning disability.

A holistic, person centred approach to bowel management can help to manage or treat constipation.

How did the issue manifest in the case?

JW remained safely at home for a considerable period managed by use of diet and laxatives. However there was a lack of clarity of who was leading a holistic approach to bowel management and little understanding of the particular risks that JW faced because of her learning disability. Nevertheless, all agencies made efforts to manage JW’s constipation:

In August 2013, when JW almost died due to a twisted bowel she was discharged from the acute hospital with prescriptions for laxatives and recommendations for enemas but her particular risks were not explained to non-specialist colleagues.

JLDT Annual Review included mention of diet and JW’s key worker/co-ordinator was a nurse but again there was no mention of the higher risks of constipation due to JW’s Learning disability.

GP changed JW’s laxatives to try to encourage her to take them and discussed this with carers

Dietician recommended changes to JW’s diet including changes to softer foodstuffs

Carers recorded bowel movements (albeit intermittently) and used additional items e.g. prune juice to encourage bowel movements but carers received no specific training or support by clinicians regarding bowel management

The specialist Bladder and Bowel Service was involved with JW but only because JW required continence aids rather than as an intervention in bowel management.

After her hospital admission in August 2013, GP consultations and A&E attendance was often for reasons unrelated to constipation. This meant that different agencies had different perceptions of particular bowel risks for JW and these risks had become less important.

What makes it underlying (rather than an issue particular to the individuals involved?)

At the Learning Together Workshop held on 24th May 2017, many practitioners told the Review team that prior to the death of JW, they were unaware of the specific risks of constipation for people with learning disabilities. They were also unaware of how quickly a life threatening twisted bowel could occur. When asked only 40% of people attending the workshop, when asked, were aware that bowel problems were a particular issue for people with Down’s syndrome.

Practitioners gave a second example of a person with a learning disability recently referred to Safeguarding Adults due to an extremely poor diet and misuse of laxatives to manage the consequent constipation.

Practitioners confirmed that there is no consistent oversight for bowel management. During discussion the Review Team found a lack of awareness that bowel care is much wider than constipation including the impact of diet, exercise, etc.

At the follow on meeting on 21st September, some members of both the Care Group and Review Team were unaware of the role of the specialist Bowel and Bladder Team and did not ever interact with Thoracic Medicine in Acute Trusts. However it was considered that the JLDT, as LD specialist, had an educative role to play in supporting other practitioners to provide good bowel care. This expertise is currently not available in JTLD who would refer to the Bladder and Bowel Service.

What is known about how prevalent and widespread the issue is?

A systematic review of 31 studies, published between 1990 and 2016, on the number of people with learning disabilities who have constipation (Public Health England published Managing and preventing constipation in people with learning disabilities gateway number: 2016215) found that:

Prevalence was generally high, with rates of 50% or more being reported in 14 of the 31 studies, and 21 studies Reporting rates of over 33%;

In the most representative sample, 25.7% of people with learning disabilities received a repeat prescription for laxatives in one year compared to 0.1% of people without learning disabilities;

In one year, 18.8% of people with Down Syndrome were prescribed laxatives compared to 3.4% of people without learning disabilities.

This guidance recommends that a holistic approach to bowel management and consideration of, amongst other factors:

- Diet and exercise – constipation is mainly caused by a lack of fibre, dehydration and inactivity so lifestyle changes for the individual around their food and drink intake and movement are important
- Physical health and medication review – check for health conditions that can cause constipation and adjust any constipating medication if possible
- Abdominal massage – this can be as effective as laxatives in the treatment of constipation and there are no known side-effects
- Leadership – family carers and paid supporters have a key role in early recognition of constipation and prompt treatment. They need appropriate training to recognise signs and symptoms
- Monitoring – ongoing evaluation is needed to gauge whether interventions are being successful
- Laxatives – long-term use of laxatives is not generally recommended and may compound the problem. If long-term use of laxatives is needed, there should always be consideration of other non-pharmacological approaches

A study carried out in 2011 compared the effects of staffed and unstaffed living arrangements on the health of people with learning disabilities who live in large institutions or smaller group homes in 14 European Union countries. Their findings suggest that ‘people with severe and profound learning disabilities, mobility problems……who lived in staffed homes, are more likely to have higher rates of constipation than those who live in unstaffed accommodation’. The conclusion suggested that not only do ‘people with severe learning disabilities tend to experience constipation more than other clients but also that there is a lack of staff awareness about effective bowel care for people with severe learning disabilities, who require proactive bowel management’. (Martínez-Leal R, Salvador-Carulla L, Linehan C et al (2011), ‘The impact of living arrangements and deinstitutionalisation in the health status of persons with intellectual disability in Europe’, Journal of Intellectual Disability Research.)

What are the implications for the reliability of the multi-agency safeguarding adult system?

Whilst the Review Team acknowledges that guidance was published after this case, a significant proportion of those attending the workshop were still unaware of the higher incidence of bowel complications for people with a learning disability. This is likely to be a true reflection of the knowledge within staff in Salford. A lead should be taken by the JLDT who already have a role in coordinating care.

Unless practitioners and families have been given the maximum opportunity of understanding the implications of good bowel management, people with a Learning Disability, will continue to suffer unnecessarily from bowel issues, compromised in their dignity and with serious health conditions including a higher risk of death due to complications.

FINDING 2 SUMMARY ISSUE FOR CONSIDERATION BY THE BOARD A significant number of practitioners in Salford are unaware that people with a learning disability have a higher incidence of bowel complications compared to the general population, resulting in a risk that the condition goes unrecognised. (Professional norms – longer term work)
SUMMARY Practitioners working with people with a Learning Disability may be unaware that there is a greater likelihood that service users will have problems with their bowels and consequently a higher risk of constipation. This means that they do not always manage the problem effectively across agencies and nor recognise the increased risk of physical complications caused by constipation.
Questions for the Board and Organisations to consider What multi-agency processes does the SSAB require to be in place to ensure that everyone is aware of this risk and how to address it? Are the links between the Board and the Implementation Network sufficiently robust?

3.5.3 Finding 3

In Salford services for people with complex needs and a learning disability are commissioned creatively and effectively, allowing carers the flexibility to support service users in a person centred way

Introduction

Commissioning is the process by which public services plan the support that is needed by people who live in the local area.

For service users with specific social care and health needs, commissioning should be a dynamic and person centred process to design, specify and procure services to deliver personalised outcomes that enhance capability, independence and promote equality, co-produced with social care users in partnership with health and housing organisations and in collaboration with providers.

In Salford commissioning of services for people with Learning Disabilities supports this dynamic person centred approach.

How did the issue manifest in the case?

In April 2013 JW moved to a supported tenancy alongside two other service users, sharing 24 hour support. Liaison between Provider and Commissioner ensured that JW was provided with the most appropriate care and support. A member of the JLDT visited JW and used the six weekly review held in June 2013 to amend hours and other support such use of hoists and wheelchair. This was in response to concerns by the Provider that the hours originally allocated to JW were too taken up with personal care.

Carers used JW’s responses to their interventions to ensure that they provided the care that JW wanted most in order to live her life the way in which she wanted to, for example:

Carers were able to be flexible in their use of hours provided for JW e.g. 2:1 at meal times when she needed more support

JW liked time to herself so carers gave her this space in her room with her cuddlies.

JW participated in musical activities which she particularly enjoyed

JW preferred to sleep on the floor and she was able to do this and carers would cover her with a fleece when she fell asleep.

JW was able to go on holiday supported by carers in September 2015

What makes it underlying (rather than an issue particular to the individuals involved?)

At the workshop on 25th May 2017, Carers confirmed that they were able to be creative about how they used hours of support commissioned ‘we are able to give good support because we were able to use the hours given well’- Therefore it is reasonable to assume that they would do the same thing with other people and this wasn’t a one-off.

The Integrated Care Organisation where health and social care staff are based in joint teams has been in place since 2009 and has consequently matured, allowing seamless commissioning across health and social care.

The Review Team confirmed that the commissioning strategy was developed to reduce recruitment challenges in the work force. It was intentional to ensure providers didn’t over commitment and thus reduce quality of care.

Since 2014, Commissioners have used a locality model which means that contracts were tendered and awarded geographically. In addition the intentional split between housing and care provider allows care to be tailored to an individual service user needs. The commissioning process also discourages providers from over-stretching themselves beyond reasonable capacity and assists with retention of staff and promotes spirit of a community based model. The relationship between the commissioner and provider was client focused from the start, and was built on by the skills of provider staff.

What is known about how prevalent and widespread the issue is?

Local audit has shown that the landlord and care provider split has proved a more effective approach, tapping into local communities to address poor outcomes for service users. This approach is now being taken up elsewhere in the North West and has been seen elsewhere as a model of good practice.

The Care Act 2015 placed a number of statutory duties on Local Authorities around commissioning which include:

- Promotion of health and wellbeing
- Provision of preventative services - that is services which help prevent or delay the development of care and support needs, or reduce care and support needs
- Duty to carry out care and support functions with the aim of integrating services with those provided by health, housing and others
- ‘Commissioning for better outcomes’ (University of Birmingham, 2014) outlines four domains for best practice. Once domain is Person-centred and outcomes-focused commissioning, this domain covers the quality of experience of people who use social care services and considers the outcomes of social care at an individual level as well as a community level. The standards include:
- Person-centred and focused on outcomes

What are the implications for the reliability of the multi-agency safeguarding adult system?

Although there are things to learn and improvements to be made, the overarching approach to commissioning health and social care in Salford is one that makes person-centred care more possible, and as such, it is in line with the vision of the Care Act and with the rights of the individual.

The Commissioning process is shortly due to be reviewed and contracts re-commissioned and consideration should be given to retaining this positive model.

FINDING 3 SUMMARY ISSUE FOR CONSIDERATION BY THE BOARD In Salford services for people with complex needs and a learning disability are commissioned creatively and effectively, allowing carers the flexibility to support service users in a person centred way (Management Systems)
SUMMARY The use of a community based commissioning model in Salford provides an effective and stable support for service users. It allows providers to develop and retain staff and means that they do not overstretch their capability to maintain services. By both provider and commissioner being outcomes focused allows flexibility in providing a person centred based response to the needs of individual service users.
Questions for the Board and Organisations to consider Would the board would like any more detail or reassurances re the commissioning of services in Salford? are the board satisfied that the governance processes are sufficient to offer reassurance that the recommissioning of these services will retain the same flexibility/effectiveness?

3.5.4 Finding 4

In Salford clinicians do not always uphold the rights of vulnerable people in relation to Best Interests under the Mental Capacity Act or fulfil their own duty of care because they may not consult others when they make clinical decisions

Introduction

The Mental Capacity Act 2005 sets out the legal framework for making decisions ‘on behalf of individuals who lack the Mental Capacity to make particular decisions for themselves’, and how practitioners should go about this.

If a person cannot make the decision themselves because they are assessed as lacking capacity practitioners may need to make a ‘Best Interests’ decision on their behalf. If this is a medical decision, that decision will be made by a clinician but it is expected that they should consult with other people who know the person best. This may include family, friends, paid carers or other practitioners who work with that person.

It is likewise expected that clinicians will have a ‘duty of care’ when they make a best interest decision. In general terms there are two main elements to duty of care. The first is a duty to avoid acts or omissions which may cause harm to others. The second is a duty to promote the rights, independence and choices of the service user.

How did the issue manifest in the case?

At two different hospitals, decisions were made by clinicians without consultation with the carers who knew JW well:

When JW was taken to Hospital 1 in August 2013 carers were not consulted by clinicians when the clinicians put JW on the Liverpool Care Pathway. Although JLDT were informed about the decision, JW's Care Coordinator was not consulted.

In November 2015 carers were not consulted although family was when JW was admitted as an emergency to Hospital 2 and subsequently died.

What makes it underlying (rather than an issue particular to the individuals involved?)

The Review Team and Case Group all agreed that it is usual practice for clinicians to consult with family when making medical decisions. However, at the Follow On Meeting on 21st September 2017, carers confirmed that they are often side-lined and not consulted about emergency medical decisions even when they know the person better than family.

Although the Review Team accept that clinicians must make difficult choices during medical emergencies and cannot be expected to have formal Best Interest Meetings, nevertheless other practitioners who know the patient best, should be consulted and their views recorded whenever possible.

At the Practitioner Meeting on 24th May 2017, Hospital staff present confirmed that carers were rarely consulted about medical decisions. This means that clinicians may not be compliant with the Mental Capacity Act with regard to Best Interest decisions or their own duty of care.

What is known about how prevalent and widespread the issue is?

The term 'duty of care' is used to cover both legal and professional duties of health care practitioners. There is no overall definition of duty of care that covers all professional bodies within Health and Social Care but all refer to it within their codes of conduct. For example the Royal College of Nursing of Nursing Direct Advice Guide says:

'To discharge the legal duty of care, health care practitioners must act in accordance with the relevant standard of care. This is generally assessed as the standard to be expected of an "ordinarily competent practitioner" performing that particular task or role.'

The Mental Capacity Act Code of Practice suggests discussing issues and decisions with other practitioners and care givers and documenting the decision with clear reasons for the decision, and therefore supports consultation with other people who know the service user.

It is notable that in 2014, a national review of the MCA by the Law Commission, raised concerns that the principles of the Mental Capacity Act had not been well understood or put into practice by health and social care professionals. The Law Commission report states:

‘Implementation has not met the expectations that it rightly raised. The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives……. A fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment. Professionals need to be aware of their responsibilities under the Act… ’.

What are the implications for the reliability of the multi-agency safeguarding adult system?

It is not always easy for clinicians to make decisions in a person’s best interest, particularly during a medical emergency and it is not always realistic to delay a decision in order to consult others. However a failure to discharge the duty to consider a patient’s best interests can not only leave the adult at risk but also does not provide the legal protection afforded to the ‘decision maker’ by the Act.

Sound professional decision-making requires individual workers to make choices and to understand not only the rationale for their decisions but also the more subtle influences that are at work. This kind of reflective practice is not always easy to achieve in the midst of the busy workplace, particularly in emergency situations. It is essential that opportunities are found and supported to enable practitioners and managers to actively reflect on their practice and decisions understanding that their ‘duty of care’ is a broad and empowering one, which supports sound risk management work.

If people who know a patient best are not involved in decisions about their care, the MCA is not being upheld and people’s rights and wishes not being heard.

FINDING 4 SUMARY ISSUE FOR CONSIDERATION BY THE BOARD In Salford clinicians do not always uphold the rights of vulnerable people in relation to Best Interests under the Mental Capacity Act or fulfil their own duty of care because they do not consult others when they make clinical decisions Family – Professional relationships
SUMMARY When making a Best Interest decision, clinicians should consult those who know a patient best about a patient’s needs and views. By failing to carry out a reasonable and proportionate consultation and recording the results, they may be failing in their duty under the MCA 2005 and also potentially their own duty of care.
Questions for the Board and Organisations to consider How realistic is the expectation that practice will change? How can clinicians be best supported to change their practice in terms of consulting with others practitioners about medical decisions?

3.5.5 Finding 5

In Salford clinicians prioritise family opinion over that of paid carers because they are ‘next of kin’. This can diminish the value of knowledge carers hold so that decisions made about treatment may not be based on best evidence

Introduction

Clinicians want to make the best decision they can when determining treatment. When it is not possible to consult the patient, they will opt for ‘next of kin’, usually the patient’s closest relative. However, a close family member may not always be the person who knows the patient best. In the case of people living long term with carers rather than family, it may be the carers who understand the wishes and beliefs of the patient best.

How did the issue manifest in the case?

In August 2013 the family were given a copy of the discharge plan as ‘next of kin’ when JW was then discharged from hospital ‘back to baseline’. Carers were not given a copy by Hospital 1 despite having the care of JW. The family passed the discharge plan onto the carers.

In November 2015, strenuous efforts were made to contact JW’s family at the second emergency admission in Hospital 2. In contrast the paid carer who had accompanied JW into hospital wae asked to wait outside the theatre and was not consulted about JW’s treatment.

What makes it underlying (rather than an issue particular to the individuals involved?)

At the Follow On Meeting on 21st September 2017, Carers confirmed that their experience when supporting JW was not a one-off occurrence. They gave further examples where clinicians consult family members about people they work with rather than themselves. In one example provided, the relative lived some distance away and never visited the patient but was consulted about treatment options whilst carers were not.

Carers also confirmed that they find it difficult to challenge the opinions of clinicians around care and treatment even though they know service users better than the clinicians, particularly those based in acute settings. However, those who had been most closely involved in JW’s care agreed that they had learnt from the experience and would now challenge in similar circumstances.

At the Workshop on 24th May 2017, Hospital staff acknowledged this hierarchy.

What is known about how prevalent and widespread the issue is?

The term next of kin has no legal definition in the United Kingdom. If a patient has not nominated a next of kin, a hospital should seek advice from who they believe to be closest to the patient and best able to reflect their wishes. There is no requirement for the nominated person to be a blood relative, although it is normally the case. However, it can be a friend, neighbour or a paid worker. Although it is proper that clinicians involve family in decisions about care, for some vulnerable adults, paid carers may know that person better than their relatives.

The Review Team speculated that clinicians may be confusing the term ‘next of kin’ with Lasting power of attorney (LPA) for Health and Welfare. The LPA is a legal tool that gives another adult the legal authority to make certain decisions for someone if they are unable to make them including decisions relating to treatment.

Health and social care practitioners operate within clear hierarchies where often the most highly qualified and trained practitioners are perceived by others as ‘knowing best’. If carers assume that the information they hold about a patient is not valuable, they are unlikely to challenge decisions about the person they care for and therefore know best. The Lead Reviewer is aware that that other LT SARs in Scotland have found a similar pattern.

What are the implications for the reliability of the multi-agency safeguarding adult system?

In Salford, the assumption that ‘next of kin’ is family can allow clinicians to make decisions about care and treatment without consulting those who know a patient best. The hierarchy between carers, family and clinicians creates a power imbalance and tension across the system and disempowers carers. Most of the time medical judgements will be correct but within an emergency situation there is always the risk that a clinician will make a bad decision that will go unchallenged. By not consulting those who know a patient best, this will increase that risk.

FINDING 5 ISSUE FOR CONSIDERATION BY THE BOARD In Salford clinicians prioritise family opinion over that of paid carers because they are ‘next of kin’. This can diminish the value of knowledge carers hold so that decisions made about treatment may not be based on best evidence (Professional practice norms – incidents)
SUMMARY Clinicians want to make the best decision they can when determining treatment. When it is not possible to involve the patient, they try to consult ‘next of kin,’ usually the patient’s closest family member. However, this may not always be the person who knows the patient best. In the case of people living long term with carers rather than family, it may be carers who have most knowledge and understand the wishes and beliefs of the patient. If carers also feel unable to challenge that assumption then the knowledge and wishes of the patient will not be taken properly into account when making decisions about treatment.
Questions for the Board and Organisations to consider How can the Board and Organisations support practitioners to challenge more senior and/or qualified colleagues about decisions? How can the Board and Organisations ensure that clinicians view ‘next of kin’ in its widest sense i.e. those who know a patient best? How robust are the Board’s links to Provider Organisations?

3.5.6 Conclusion

This Review has shown that there are a number of systemic issues in Salford, illustrated by the case of JW. This case provided a “window on the system” and facilitated the analysis of some of the factors that get in the way of the system working as it should.

Finding 1 highlights the dangers of silo working particularly for people with complex needs and the need to jointly assess risk across agency boundaries. This was manifest despite the existence of the Joint Learning Disability Team which was set up to mitigate these issues and it is positive that some of the issues that prevent joint working are already being actively addressed.

There is need for JLDT to take more of the lead in coordinating and supporting other agencies particularly with regard to the risks of bowel management for people with a Learning Disability as explored in Finding 2.

However the positive aspects of the Integrated Commissioning Team’s role in effectively commissioning person centred flexible care as shown in Finding 3 should not be underestimated.

Findings 4 and 5 discuss the difficulties and dilemmas faced by clinicians when making medical decisions and how these can be more person centred if other practitioners from other agencies are involved in those decisions.

APPENDICES

Appendix 1: Care Act 2014

The Care Act 2014 requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

‘An adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,

And

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.’

The Care Act also states that: ‘each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to: Identifying the lessons to be learnt from the adult’s case,

And

Applying those lessons to future cases.’

The Care and Support Statutory Guidance [14:138] DoH, October 2014, sets out the following principles which should be applied by SABs and their partner organisations to all reviews:

‘There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined,

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed,

Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith,

Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.’

Appendix 2: The Learning Together model

This Safeguarding Adults Review was carried out using the systems methodology called Learning Together (Fish, Munro & Bairstow, 2010). The focus of a case review using a systems approach is on multi-agency professional practice; so the primary emphasis is on what the practitioners did, thought and felt, not on the service user.

The aim of a Learning Together Review is to move beyond the specifics of the particular case (what happened and why) to identify the underlying issues that influence practice more generally. These generic patterns become the 'Findings' from a case. Changing them will therefore help to improve practice more widely.

What is referred to as the "Methodological Heart" of the Learning Together model is made up of 3 distinct stages;

- The "View from the Tunnel" - understanding how practitioners understood the 'local rationality', allowing us to reconstruct what happened without the benefit (trap) of hindsight
- Carrying out an "Appraisal of practice" to understand what happened and explain why it happened through the analysis of Key Practice Episodes (KPE's).
- Using the case as a "Window on the system" to assess its relevance and understand the implications for wider practice

This approach studies the system in which people and the context interact. It requires the use of qualitative research methods to improve transparency and rigour. The key tasks of a Learning Together Review are therefore data collection and analysis. The data is obtained through structured conversations with the practitioners involved in the case, and from documents provided by the organisations.

Structure of the review process

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case. This is a gradual and cumulative process. Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process. All Learning Together reviews are designed to meet the particular needs of commissioners to be proportionate.

This review used a multi-agency workshop as the central mechanism for data gathering and case specific analysis. Thus central to this review was a Practitioner Learning Event where the emerging narrative and learning from case records was presented to the Case Group for consideration. The Workshop was also used to start the process of moving from the specific case to the generalisable learning that is at the core of the Learning Together model.

A combination of a Review Team made up of Managers from relevant agencies not connected with the case, together with the Case Group of practitioners involved with the JW meant that the 'window on the system' was relevant to the priorities and needs of agencies working in Salford at the present time.

The draft Findings as developed by the Review Team were presented to the Case Group at a further workshop event, referred to as the Follow On Meeting in this report.

Date	Meeting Purpose
14th March 2017	Initial meeting between Lead Reviewer and Review Team to plan and consider possible Key Practice Episodes (KPEs)
24th May 2017	Learning Event with Case Group and Review Team to review draft KPEs and consider underlying patterns
21st September 2017	Follow on Meeting with Case Group and Review Team to consider draft findings
21st September 2017	Review Team revise Findings and Appraisal of Practice and agree draft final report
17th January 2018	SAB receives final report

Appendix 3: Glossary and explanation of terms

Term	Explanation
Admission Avoidance Plan	Admission Avoidance Plans were part of an Enhanced Service at the time of the Review but are now part of the Salford Plan. The most vulnerable patients in a GP practice –those that are frequent attendees in the acute setting-are identified and the document acts as a flag to the Practice to ensure more proactive care provision which aims to avoid further admissions.
ASC	Adult Social Care
BI	Best Interest Decision: anything done for or on behalf of people without capacity must be in their best interests; (MCA 2005)
Bristol Bowel Chart	The Bristol Bowel Chart, is a diagnostic tool designed to classify the form of human faeces into seven categories. It is sometimes referred to as the Meyers scale.
DN	District Nurse
Domiciliary Care	Most people live independently in their own homes. However for people with long term care needs, this can be difficult without the help and support of other people and services. Help with personal care and other practical household tasks is called Domiciliary Care.
GP	General Practioner
IMCA	Independent Mental Capacity Advocate
ICO	Integrated Care Organisation: In Salford, Health and Social Care for people with a Learning Disability is provided through this joint organisation
JLDT	Joint Learning Disability Team is part of the ICO
LCP	Liverpool Care Pathway was a UK care pathway covering palliative care options for patients in the final days or hours of life. It was developed to help doctors and nurses provide quality end of life care. The approach has now been phased out and replaced by with an individual approach to end of life care for each patient
MCA	Mental Capacity Act, 2005. The Act provides the statutory duty of agencies to formally assess capacity whenever there is a concern that a person may lack the mental capacity to make decisions regarding their care and treatment arrangements.
MDG	Multi-Disciplinary Group- these have absorbed Admission Avoidance Plans
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review

SCIE	Social Care Institute for Excellence
SRFT	Salford Royal Foundation Trust
SW	Social Worker