Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Adults L, M & N

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NORFOLK SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW: Adults L, M & N

Contents

1. Background to the review

Concerns were raised about Milestones Hospital in Norfolk, regarding the number of safeguarding incidents, in particular self-harming, during the two years prior to closure in February 2021. Most of the incidents involved three patients (L, M and N); the concerns centred around patient care and the lack of reporting to multi-agency partners, as self-harming and hospital admissions increased.

2. The purpose of the review

This Safeguarding Adults Review (SAR) will determine what the relevant agencies and individuals involved in the case might have done differently in the cases of L, M & N. This is so that lessons can be learned from these cases and those lessons applied to future cases to prevent similar circumstances arising again.

This SAR will:

- Encourage a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults.
- Aim to identify opportunities to draw on what worked well and promote good practice and what could have gone better and learn from this.
- Make use of any relevant research and case evidence to inform the findings.
- Seek the views of the clients on the services provided – this will take place after the initial learning review but before the publication of the final report.

In relation to cases L, M & N the specific purpose was to:

- Produce a simple and accessible chronology of pertinent events for patients 'L' and 'M' and 'N'.
- Identify key episodes when critical actions were or were not taken.
- Explore the reasons why actions were taken or not taken at critical points.
- Identify the learning that emerges in relation to how the agencies involved worked singly and jointly in the cases.
- A related interest of the SAB concerns the place of specialist private hospitals in the provision of support to adults with mental health concerns.

3. Period covered by the review

The review covered the period **1st July 2019 to 1st March 2021**. Other key events outside of this timeframe were considered if they were deemed relevant.

4. Methodology for the review

The review group identified key practitioners directly involved with the case and explored four key themes, as agreed in the case discussion at the NSAB Safeguarding

Adults Review Group in November 2021. The review used **Signs of Safety methodology** when looking at each of the four key themes.
The key questions were:

1. What went well?
2. What could have been better?
3. What is the learning for future cases?

5. Key themes identified by the review panel

At the first review panel meeting on 4th November 2021, the key themes for this review, were identified as: -

1. The multi-agency response to numerous presentations to A&E and the associated safeguarding concerns. Was the response robust and in line with statutory responsibilities? (Local authority, commissioners, police, primary care, and acute hospital).
2. How robust were the systems in place to provide patient safety and quality oversight from the commissioners?
3. How effectively were the cumulative events considered by the wider safeguarding partnership? (e.g., considering the service provision and service user cohort, was the provider an outlier in terms of incidents of this nature?)
4. Lines of communication between the placing authority and the local commissioner as safeguarding concerns increased. How did the placing commissioner assure itself about the placement?

6. Partnership review panel

An independent lead reviewer worked alongside a review panel, composed of senior managers. The membership of the Panel was:-

Independent report writer	Independent Reviewer
Norfolk Safeguarding Adults Board Manager	Norfolk Safeguarding Adults Board (NSAB) (Chair)
Director of Safeguarding and Principal Social Worker	Sussex Partnership Foundation Trust (SPFT)
Director for Patient Safety and Quality	Norfolk and Suffolk Foundation Trust (NSFT)
Transforming Care Consultant	NHS Lincolnshire Clinical Commissioning Group (CCG)
Detective Inspector	Norfolk Constabulary
Safeguarding Specialist Practitioner for Adults	East of England Ambulance Trust (EEAST)
Head of Social Care for Adult Mental Health	Norfolk County Council (NCC)
Adult Safeguarding Lead Nurse	Norfolk and Waveney CCG

Named Nurse for Safeguarding Children and Adults	James Paget University Hospitals (JPUH) NHS Foundation Trust
Named GP for Safeguarding Adults	Norfolk and Waveney CCG

The Care Quality Commission (CQC) also provided comments and fed into the report.

7. The views of practitioners

The views of practitioners were vital to the learning from this case. Views were sought using two methods:

- Interviews with ten lead practitioners and managers from relevant agencies in January and February 2022.
- A practitioner learning event – To be arranged

8. Involvement of clients

The clients were notified of the the review taking place and given the opportunity to comment on their experience of the services involved or offered as appropriate.

9. Parallel reviews and investigations

Were there any parallel/similar reviews and investigations in Norfolk around the time of this review – that will be considered and will inform the learning.
It is important to consider these to avoid duplication of learning points and to cross reference action plans and changes to practice.

10. Governance

The review panel will report directly to the monthly Safeguarding Adults Review Group (SARG) subgroup via the Board Manager, which in turn reports to the Norfolk Safeguarding Adults Board (NSAB).

11. The focus of the review

11.1. Milestones Hospital Norfolk

Milestones Hospital was managed by the Atarrah Project Limited and opened in Norfolk in 2007. It moved to a new location close to Great Yarmouth in 2019. The hospital provided support and treatment, with a rehabilitation focus, for up to 18 women with complex and challenging mental health disorders. The hospital employed approximately 40 staff. The move to the new location coincided with significant

changes in the senior team with the formal appointment of a new Hospital Manager, who had previously been in an acting position and two new Psychiatrists.

There were 39 incidents logged from Milestones on the Police system Athena, between July 2019 and closure on 20th February 2021. CQC reported 53 incidents of deliberate self-harm primarily from three patients from 1st November 2020 and 1st January 2021.

The hospital was inspected in March 2020 by the Care Quality Commission (CQC) and rated as '*requires improvement'*, the previous inspection was rated '*good*'. There was a further inspection on 19th and 20th January 2021, rated as 'Inadequate' in all domains. Some of the main areas of concerns were:

- Too many acute patients for such a small unit and no clear admissions policy to deal with patients with complex needs.
- No clear staff training policy - lack of specialist training e.g., Autism Spectrum Disorder (ASD) and personality disorders.
- Risks identified e.g., ligature points and blind spots.
- Complaints, including allegations against staff not dealt with in a timely fashion.
- Little evidence of recovery focussed rehabilitation.
- High levels of staff vacancies filled by agency and bank staff.
- Evidence of falsifying observation records, meaning that some regular checks were not made.
- Regular changes in management team, some of whom not registered with CQC.

Following the issuing by CQC of an urgent Notice of Decision to restrict further admission, the hospital subsequently closed on 20th February 2021. At the time of closure there were 12 patients at the hospital, 10 of whom were detained under the Mental Health Act 1983.

11.2. The three patients

This review focussed on three patients who are referred to as L, M and N. Their details are as follows:

Name	Gender	Age	Brief history
Patient L	Female	Age 21	Placed at Milestones by Lincolnshire NHS on 21st October 2020. Detained under section 3 of Mental Health Act (MHA). Attended A+E 21 times between October 2020 and February 2021 following self-harm incidents. Serious back injury as a teenager caused long term medical complications.

Patient M	Female	Age 20	Placed at Milestones by Sussex NHS on 15th October 2019. Detained under section 3 of Mental Health Act (MHA). Attended A+E 17 times between October 2019 and February 2021. Seven of these were in the 3 months prior to Milestones closing.
Patient N	Female	Age 26	Placed at Milestones by Sussex NHS on 14th July 2020. Attended A+E 10 times between July 2020 and February 2021. Close relationship with Patient M, some allegations of assaults between the two.

11.3. Partner references

It is important in this review to understand the relationships between key partners, and how we refer to them in this review. It will be as follows:

- **Placing Commissioners** = Sussex and Lincolnshire NHS Trusts.
- **Host* (Local) Commissioner** = Norfolk and Waveney CCG.
- **Service Provider** = Milestones Hospital, Norfolk.

*The word Host is used to define the local CCG in this review. It does not imply any statutory commissioning responsibilities for this private mental health provider.

12. Summary of key events and dates

Below is a summary of some of the key episodes, important to this review. These events were collated from several sources, primarily the combined agency chronologies and a senior manager from the provider, Milestones Hospital.

Date	
Jan 2007	Milestones Hospital opens in Salhouse, Norfolk, run by the Atarrah Project Limited.
October 2019	Milestones relocates to Catfield, Great Yarmouth. Patient M admitted to Milestones after being placed by Sussex CCG. Attends hospital 3 days later following serious self-harm.
Jan 2020	Police investigate alleged assault on Patient M at Milestones – No referral to NCC Safeguarding Team.

March 2020	The beginning of "lockdown" in response to the Covid 19 pandemic resulting in significant restriction on Milestones patients and visits by placing authorities. CQC inspection on 4th and 11th March which results in downgrading of Milestones from 'Good' to 'Requires Improvement'.
May 2020	Allegations of sexual assault by manager on vulnerable patient – multi-agency planning meeting convened results in no concerns – Police investigation NFA. Further allegations of assault on Patient M – no safeguarding referral raised by hospital.
June 2020	New manager appointed but they do not register with the CQC, which is a legal requirement.
July 2020	Patient N admitted to Milestones, placed by Sussex CCG.
Sept 2020	NSFT quality and safety review takes place – 6 patients at the hospital – Decision made to cease placements at Milestones. Hospital managers have stated this decision was not shared with them. Further allegations of assault on Patient N by another patient - NFA Police investigate allegations of assault on another patient by staff member and overdosing of medication – NFA. New temporary manager appointed – not registered with CQC.
October 2020	Patient L placed at milestones after being placed by Lincolnshire CCG. Patient M reported as progressing well and attending local college. A+E attendances – Patient L (3), Patient M (3), Patient N (4)
November 2020	Allegations of rape by agency staff on a patient (not one of the 3 clients involved in this case) by an agency worker. Patient L detained under Section 3 MHA after significant self-harm. Allegations of assaults between Patient M and Patient N. A+E attendances – Patient L (9), Patient M (2), Patient N (0)
December 2020	A+E attendances – Patient L (9), Patient M (5), Patient N (6) S42 Safeguarding Enquiries commence for L, M and N following referral from Safeguarding Lead at James Paget Hospital. Concerns raised by MH Social Worker to Norfolk and Waveney CCG Safeguarding Nurse. Allegations of Financial Abuse by agency worker – NFA by Police. Meeting between Social Care Locality Manager and Hospital Directors to address concerns re multiple A+E admissions and high level of agency staff at Milestones. Head of Safeguarding NHS Lincs contacted by Norfolk CC Safeguarding Team to advise of significant self-harm and Police involvement.

January 2021	ABH by another patient – Patient L listed as the victim. Milestones contact SAM Team (Sussex) to say they are not able to manage Patient M and ask to look for alternatives. Referral to SARG Panel from Norfolk Locality Mental Health Social Worker. Joint meeting of LA, CQC, N+WCCG, Hospital Trust to discuss concerns. CQC unannounced visit on 19/20 Jan, following concerns raised by the Norfolk Safeguarding Team, results in suspension of registration under section 31 of Health and Social Care Act. Lincs and Sussex placement teams alerted to closure and discuss repatriation.
February 2021	Milestones Hospital Closes. SARG agrees to complete a Safeguarding Adults Review. 15th Feb - Patient M and Patient N moved back to Sussex. 17th Feb - Patient L transferred back to Lincs.
November 2021	Safeguarding Adults Review commences – first review panel.

13. Key Themes

1.	**The multi-agency response to numerous presentations to A&E and the associated safeguarding concerns. Was the response robust and in line with statutory responsibilities? (Local authority, commissioners, police, primary care, and acute hospital).**

Commentary

For most of the period of the review, the country was in the middle of the Covid-19 pandemic. The government guidelines in relation to Hospitals (and Care Homes) led to very significant restrictions on patients' abilities to leave the Hospital site or to receive visitors. For many of Milestones' patients, this was perceived to have a substantial negative impact on their mental health leading to a higher level of disturbance within the unit than had previously been witnessed.

In addition, Covid had detrimental effects on the levels of face-to-face visits and monitoring by practitioners. There was an increased use of IT systems such as MS Teams for meetings regarding patients. There were 12 admissions to Milestones by January 2021, 10 of these patients were detained under the Mental Health Act 1983. Many of the patients had complex diagnoses and required a high degree of support.

Milestones had very high levels of staff turnover, with a large majority of staff short-term locums or agency staff. One reason may be the locality of the Hospital, being a relatively remote location, resulting in a paucity of qualified staff. This meant that

patients often spoke of a lack of consistency in care, and staff not fully understanding their needs. There were some serious allegations made against staff members in the twelve months prior to closure, some of which are still under police investigation. These included allegations of assault and financial abuse. Several patients reported that they felt the agency staff '*took advantage of them'*.

Primary Care services were provided at least fortnightly, by Coastal Partnership General Practitioner (GP) Services after being invited to do so by NHS England, following a breakdown in relationship with previous provider. This new relationship worked well.

Some practitioners spoke of a '*group risk dynamic'* amongst a small group of 2 or 3 patients, whereby they would often communicate via social media and create a culture referred to as 'competitive self-harming'. Incidents of self-harm increased significantly after October 2020, which coincided with the admission of patient 'L' until the closure of the hospital in February 2021. CQC noted that there were 53 incidents, primarily involving 3 patients, between 1st November 2020 and 1st January 2021, resulting in 25 attendances at A+E. A very high percentage of the wounds required stapling or suturing, referrals for plastic surgery, which indicated the severity of the wounds.

It is worth noting that on only three occasions were the patients attended to by the same doctor when attending A+E. JPUH uses a computer system called EDIS and is one of only a handful of hospital trusts not using System1 in the country. There is currently no way of identifying trends when patients regularly attend from the same provider. It is understood that this is something that is being considered following this case.

Police recorded 39 incidents on Athena, the majority since July 2019. These included allegations of rape, financial abuse, assault, and exploitation. These resulted in 11 multi-agency planning meetings. (These 39 incidents were separate and did not include the self-harm incidents)

Practitioners from the placing authorities didn't always receive regular updates of copies of care plans from the hospital. This could be best described as *'intermittent'* and most of the communication took place, once concerns started to escalate, prior to closure.

It was not until late December 2020, that a Safeguarding referral (for 3 patients) was made by the Named Safeguarding Nurse at James Paget Hospital. This coincided with concerns being raised by the Social Care Practice Consultant regarding the number of self-harm incidents <u>not</u> being raised as Section 42 (Care Act) Safeguarding concerns, either by Milestones or JPUH.

This was raised with managers at Milestones and their reporting duties under the Care Act* outlined to them by the Social Worker, who felt the concerns were not taken seriously. There seemed to be a feeling from managers that *'this is what patients with complex needs do sometimes'.* The manager also questioned the Social Worker's lack of Mental Health experience. There had been several changes to management at the hospital in the previous 12 months, raised as a concern by CQC and NSFT, which contributed to the lack of consistency and management at the hospital.

When S42 Safeguarding enquiries commenced in December 2020, the allocated Social Worker initially had some difficulty in getting the contact details for the case responsible person(s) in the placing authorities. Eventually these details were provided by Milestones and the appropriate contacts made, but it did result in a delay to the S42 enquiry and initial information sharing.

A concern was raised by a practitioner regarding the length of time some patients had been in the hospital, especially as this was a rehabilitation unit. This was also noted in the NSFT review in September 2020. The concern questions the potential lack of discharge and reintegration planning for longer term, more complex patients.

(*where there is a known risk around self-harm to a person(s) and the organisation fails to assess or manage that risk leading to further self-harm it becomes a safeguarding issue with the provider as perpetrator).

What went well?

- Quick and effective S42 enquiry once the concerns had been escalated.
- Generally, patients reported to external practitioners that they were treated with compassion and kindness at Milestones.
- There were some effective and caring practitioners at Milestones who delivered high levels of care.
- The environment at Milestones was of a high standard and well equipped. Patient's rooms were personalised.
- There were positive relationships with local education providers, with some patients attending, and happy, at college.

What could have been better?

- To reduce the high levels of staff turnover and temporary staff which resulted in a lack of consistency of care.
- It is unclear if the decision by NSFT to stop placing patients at Milestones in September 2020 was effectively shared with Milestones managers.
- The increased incidents of self-harm, particularly during October-December 2020, did not result in safeguarding referrals to the Local Authority from Milestones or James Paget Hospital.
- The increased attendances at JPUH did not result in an early safeguarding concern on the EDIS system or effective information sharing with the placing Authorities, or the Host Commissioners (CCG).
- There appeared to be a lack of understanding, or ignoring of, Care Act safeguarding duties by the management team at the hospital.
- 39 incidents were recorded on the Police system Athena between July 2019 and closure, these were all investigated. 18 of these related to the three subjects of this review during the review period, with 11 multi-agency planning discussions, led by Social Care. These, alongside the previous repeat incidents of self-harm and repeat attendances at A+E, should have resulted in earlier, escalation to the CQC.

- The '*group risk dynamic'* of three patients, was not effectively recognised or risk assessed. This resulted in a significant increase in self-harm by three patients, prior to closure.
- There was some difficulty identifying case responsible contact information at the placing authorities when the S42 enquiries started in December 2020.
- There were concerns around effective rehabilitation plans for patients at the hospital for over 12 months.
- Updates on patient progress were not sent to placing authority case workers as a matter of course.

Learning

- Identification of trends and repeat admissions by Police and Hospital A+Es should result in early escalation to Local Authority Safeguarding teams and CQC as the regulatory body.
- Details of the care co-ordinator/allocated worker in the placing authority should be easily accessible and stored (by Host CCG?) at the time of placement and made available in the event of an incident or a safeguarding referral.
- Ensure that managers of private providers of mental health services are aware of their safeguarding responsibilities and are monitored (by Host CCG?) to ensure they are followed.
- Awareness of the consequences of 'group risk dynamic' to ensure this is recognised and risk assessed where appropriate.
- Placing authorities to monitor care and rehabilitation plans for long term patients to ensure that rehabilitation plans are effective.
- Transitions – more involvement of LA (Adult Social workers) 6 months before client reached 18. Especially if they have been in mental health unit prior to 18.
- Transformation programme - Use national good practice example - Transitions forum 16–25-year-olds.

2. How robust were the systems in place to provide patient safety and quality oversight from the commissioners?

Commentary

Quality assurance (QA) responsibilities in this case were described as *'shared'* across placing Local Authorities, Host CCG and Local Authorities and CQC. It is worth clarifying where statutory duties lie, and question if systems were in place for sharing information and intelligence across the partners, when concerns were raised.

There is no evidence of formal contracts or quality assurance arrangements between the placing authorities and the host CCG at the time of placements in this review. Contract arrangements were implemented directly between the two placing authorities and the provider. The assumption from the placing authorities was that private providers must comply with statutory guidance and local arrangements relating to safeguarding concerns etc, and report through these routes. This relies on systems being in place.

It may be simpler to break down the quality assurance responsibilities and patient oversight and responsibilities between the key partners in this review.

Placing commissioners (Sussex and Lincolnshire)

Depending on the exact circumstances of each placement, operational teams are tasked with managing the relationship, supported by corporate contracting and commissioning teams. The Specialist Assessment Multi-Disciplinary (SAM) Team in the Sussex Partnership NHS Foundation Trust, and equivalent team in Lincolnshire, check the following prior to out of county placements:

- Quality of the placement – CQC reports and previous intelligence.
- Extensive discussions with patients to ensure needs are understood and met at admission.
- Ensure treatment goals are appropriate.
- Due diligence for admission e.g., the Sussex Partnership NHS Foundation Trust Quality and Nursing team will review the provider and review policies and procedures as part of the contract.
- Contract for case reporting back to placing authority*
- Proforma for weekly provider checks (Lincs).
- Information sharing agreement (Sussex).
- Site visits within 10 days of placement.
- Discharge plans when appropriate.

*The direct agreement with the provider (independent or otherwise) is that the clinical and contract teams must be made aware of incidents (reaching Serious Incident - SI, or not) or safeguarding referrals within 48hrs of the identification of the incident/safeguarding referral. Detail is then passed to the relevant clinician/practitioner for direct contact, depending on the notification route.

Hosting Commissioners (Norfolk and Waveney CCG)

There was no statutory duty on the host CCG as they were not the placing authority in this case and didn't commission services directly from Milestones. There was no formal contract between the placing authorities and host CCG. However, there is a statutory duty in commissioning a service that it meets a person's needs and is safe.

CCG Mental Health teams are involved in the monitoring of local placements such as Milestones, but this is based on individual relationships between CCG staff and NSFT colleagues. Inspections were described as *'ad hoc'*.

There are 3 monthly meetings between the CCG Senior Mental Health Nurse and Local Authority Safeguarding Teams to share intelligence regarding the two other private mental health providers in Norfolk.

There is no legal duty placed on hosting commissioners of acute mental health provision as of January 2021. However, there is guidance (published in January 2021) for hosting authorities of Learning Disability and Autism provision. This can be accessed here:

Learning Disability and Autism – Host Commissioner Guidance Quality oversight of CCG-commissioned inpatient care for people with a learning disability and autistic people

Report - NHSI website (england.nhs.uk)

There was no communication at the time of placement or when concerns started to escalate, the only formal arrangements in place were those listed above (Placing commissioners). This raises the question of the quality of information held at the hosting CCG regarding out of county placements i.e. did they hold details of out of county patients placed in county? CCG staff attend an NSFT complex case panel where new placements are discussed. The CCG currently have no oversight of the current list of NSFT placements out of county.

Norfolk and Suffolk Foundation Trust (NSFT)

NSFT had service users placed in the unit at the time of closure but had stopped making new placements. This followed a Quality and Safety review in September 2020 when a decision was made to no longer place patients. There were concerns that the unit was not providing the therapeutic environment to aid recovery as commissioned. All service users were transferred back into NSFT services or if the need was indicated to other specialist units as soon as the Trust was informed that the unit was closing.

When NSFT did place patients in 2019-20, a Specialist Placement Matron monitored the appropriateness and safety of NSFT patients, using a weekly quality and safety dashboard.

Some concerns were raised during this period, including not providing the weekly quality assurance returns to the matron. NSFT currently uses other mental health providers in Norfolk and their quality assurance framework reports regularly into the NSFT complex placements panel.

NSFT have several people placed out of area because of lack of beds in Norfolk. These are reported weekly to the CCG.

Local Authority (Norfolk)

There was no quality assurance duty (unlike Care Homes) for the host Local Authority in this case. Norfolk Local Authority's only responsibility would be in relation to safeguarding as the authority in which the person(s) is located at the time of the incidents.

The responsibility for quality assurance of a private hospital such as Milestones, sits with the local health commissioner i.e., Norfolk and Waveney CCG. Local Authority quality assurance duties under the Care Act would sit with the placing Local Authorities.

Care Quality Commission (CQC)

The CQC monitored Milestones and other similar providers, under their statutory duties. The relevant part of the legislative framework is outlined below:

*All providers of mental health services are required, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to meet **Regulation 18**. Mental health providers must have enough suitably qualified, competent, skilled, and experienced staff to meet the needs of the people always using the service*.

*Also, **Regulation 13** - The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.*

What went well?

- Robust quality assurance processes were in place in Lincolnshire and Sussex NHS Foundation Trust when placing out of county.
- Good communication between Local Authority (Norfolk) and CQC, in line with statutory duties, when safeguarding concerns were raised.
- Evidence of meetings between CCG Senior Mental Health Nurse and Safeguarding Teams to share intelligence, is good practice.

What could have been better?

- Greater clarity about the quality assurance responsibilities of the host CCG for 'in county' placements at private providers.
- A system for recording details of 'in county' placements in private providers if they are not placed by NSFT or the CCG.
- Guidance from NHS England for hosting authorities for patients in Mental Health provision.

Learning

- There was no regular monitoring or QA of Milestones by any agency, once NSFT stopped placing patients in September 2020. CCG inspections are conducted on an ad-hoc basis.
- Statutory guidance from NHSE for Hosting CCGs for Mental Health provision, to sit alongside the guidance for LD+A provision published in January 2021.
- Develop system to record 'in county placements' from placing authorities other than those placed by NSFT.

3. How effectively were the cumulative events considered by the wider safeguarding partnership? (e.g., considering the service provision and service user cohort, was the provider an outlier in terms of incidents of this nature?)

Commentary

There is evidence to suggest that partners may have *'lost sight'* of Milestones, once NSFT stopped placing patients there in September 2020. This meant that there was no regular, weekly onsite monitoring by NSFT or the CCG. There is obviously little incentive for any private provider of mental health services to widely share concerns regarding staffing and other potential safeguarding issues, therefore the system relies on partners' close monitoring and scrutiny. CQC would expect all providers to be transparent about any issues. There are clear requirements on providers to report particular occurrences to CQC, as set out in the regulations that they should adhere too.

The impact of the Covid pandemic was significant, both in terms of the direct impact that the consequences of the "lockdown" had on the mental health and behaviour of the patients at Milestones and the difficultly of making face to face visits by the placing authority.

There is little evidence to show that the cumulative events were shared effectively and considered across the partners, except when the provider was about to close and safeguarding referrals were made. Numerous incidents, particularly those involving the Police and attendances at hospital, should have resulted in the identification of trends and multi-agency planning discussions before December 2020. The question we need to address in this review is whether Milestones was an outlier, or could this happen again in a similar provider?

There are two other Mental Health independent providers in Norfolk. Both are regularly monitored by the bed management team at NSFT and report into their Complex Placements panel. They will also be monitored by the CCG Mental Health Nursing Team as part of their ad hoc inspection regime, but only when patients are placed by NSFT.

The Social Worker who made the referral in this case, outlined good, proactive communication from one of the other private mental health providers. This results in the frequent seeking of advice regarding safeguarding concerns. This model should be encouraged and replicated.

What went well?

- Once the Safeguarding referral was made in December, the process worked effectively with a multi-agency planning meeting and CQC involvement the following month.
- Good evidence of proactive communication regarding safeguarding from another private mental health provider.

What could have been better?

- More involvement with the provider from host CCG, if there are no placements by either NSFT or host CCG
- More effective intelligence sharing processes across the host CCG/LA, NSFT and placing Local Authorities wasn't effective.
- Closer inspection and scrutiny of the provider by the CCG and placing authorities, with alternative arrangements in place during Covid pandemic.

Learning

- Develop a system of scrutiny and monitoring of private mental health providers, especially when NSFT or host CCG are not placing patients. This should feed into the existing quality surveillance group which monitors care homes and concerns shared with the CQC.
- Monitoring and reporting of Police incidents and attendances at A+E to the host CCG.
- Use of other similar private mental health providers in Norfolk as a model of good practice.

4.	**Lines of communication between the placing authority and the local commissioner as safeguarding concerns increased. How did the placing commissioner assure itself about the placement?**

Commentary

There was no evidence of any formal process or agreement between the placing commissioners and the host CCG at the time of placement in this review. This meant that when concerns started to escalate, there wasn't an effective communication process in place. It relied on an assumption that the provider or hosting CCG would alert the placing authority if there was a problem. The host CCG hadn't placed anyone at Milestones and was unaware of the patients placed by the two authorities, therefore the lines of communication didn't exist.

Both placing authorities felt there was a lack of proactive communication back to them from Milestones when concerns increased. It was felt they were 'glossing over' some of the issues. Practitioners were not regularly getting copies of care plans and although invited to ward meetings via MS Teams (during the Covid pandemic), communication could have been much more proactive. There was an element of surprise from some practitioners when S42 enquiries commenced, and the levels of A+E attendances, allegations of assault and other concerns, were detailed. One placing authority reported confusion regarding who paid for the transport of the client back to them once Milestones closed. This caused some delay and required greater clarity.

There were also concerns raised regarding the admissions process at Milestones. Were they promising a more intensive and higher level of care than they could deliver; especially considering the high levels of staff turnover, resulting in gaps and lack of

consistency in therapies and the increasingly complex needs of some patients? Effective communications only started in earnest when Milestones was about to close, which was too late. This caused some urgency for the placing authorities in finding suitable alternative providers.

One of the placing authorities had some earlier communication with the provider, but this was due to long standing, previous professional relationships between the manager at Milestones and a senior colleague at a placing authority.

There is a lot of evidence to show effective scrutiny and quality assurance by placing authorities prior to placement. What is less clear, is the level of expectations placed on the provider in terms of regular reporting, sharing of plans and alerts when safeguarding concerns are escalating. There was an assumption that the host CCG or LA would provide this, which was not the case until S42 enquiries commenced.

What went well?

- Evidence to support effective QA, scrutiny, and use of prior intelligence prior to the placements.
- Sussex NHS Foundation Trust practitioners reported good communications with the ward managers, using MS Teams during the Covid pandemic.
- Good communications between Lincolnshire management and Milestones, making effective use of previous working relationships.

What could have been better?

- Clearer expectations around reporting, sharing of care plans, with the provider at the time of the contract with the placing authority.
- Greater scrutiny of what the provider says they can deliver versus what they can provide, there were concerns in this case.
- The expectations on the host CCG by the placing authorities were mis-placed. The host CCG had no details of the patients placed at the hospital.
- Improved reporting between the Hospital Trust and Police and the hosting CCG, CQC, and the placing authorities when safeguarding concerns were increasing.
- Greater clarity of transport processes when clients are rehomed by placing authorities.
- Greater clarity regarding who is the care co-ordinator/allocated worker in the placing authority? This should be determined at the time of placement and made available to the host CCG.

Learning

- Clearer reporting/information sharing expectations between the placing authority and provider written into the contract when the initial placement is made.
- Greater scrutiny by the placing authority to ensure that the provider is delivering effective and consistent therapies for the most complex patients, so they don’t spend extended periods receiving treatment.

- Clear understanding of what placing authorities can expect from host CCGs and Local Authorities.

14. Learning Points from this review

1. Identification of trends and repeat admissions to Hospital A+Es and multiple police incidents, should have resulted in early escalation to Local Authority Safeguarding teams and CQC.

2. Develop a system of scrutiny and monitoring of private mental health providers, especially when NSFT or host CCG are not placing patients. This should feed into the existing quality surveillance group which monitor care homes.

3. Clearer reporting/information sharing expectations between the placing authority and service provider written into the contract when the initial placement is made.

4. Greater scrutiny and monitoring by the placing authority to ensure that the provider is delivering effective and consistent therapies for the most complex patients, so they don't spend extended periods in the hospital receiving treatment.

5. Clearer understanding of what placing authorities can expect from host CCGs and Local Authorities.

6. Details of the care co-ordinator/allocated worker in the placing authority should be easily accessible and stored (by Host CCG?) at the time of placement and made available in the event of an incident or a safeguarding referral.

7. Ensure that managers of private providers of mental health services are aware of their safeguarding responsibilities and are monitored (by Host CCG and CQC) to ensure they are followed.

8. Awareness of the consequences of '*group risk dynamic'* to ensure this is recognised and risk assessed where appropriate.

9. There was no regular monitoring or QA of Milestones by any agency, once NSFT stopped placing patients in September 2020. CCG inspections are conducted on an ad-hoc basis.

10. Statutory guidance from NHSE for Hosting CCGs for Mental Health provision, to sit alongside the guidance for LD+A provision published in January 2021.

11. Host CCG to Develop system to record 'in county placements' from placing authorities other than those placed by NSFT.

12. Transitions – more involvement of Local Authority (Adult Social workers) 6 months before client reached 18. Especially if they have been in mental health unit prior to 18.

13. Transformation programmes 16-25 – Use/share national good practice examples.

15. Recommendations/Actions to effect change

(These will be implemented in line with the development of the Integrated Care System, in Norfolk from July 2022).

1) Review of current systems for identifying multiple attendance to ensure they are robust enough to detect patterns of concern. Norfolk Acute hospitals will conduct a review and provide assurance to the Board within 3 months of the publication of the report. – **OAMG (**Theme from the Norfolk Learning Framework – see below**)**

2) The host CCG to lead on work with partners to implement a robust quality assurance, scrutiny, and ongoing monitoring function as part of commissioning arrangements for private mental health providers (to align with that in place for LA commissioned Health and Social Care services) – **OAMG**

3) Assurance from Norfolk and Waveney CCG there is robust monitoring of all 'in county placements' and their placing authorities' care worker details. The CCG will maintain a single point of contact for the placing authority. **– CWDM**

4) Norfolk SAB to lobby NHSE for the development of statutory guidance in support of hosting CCGs for Mental Health provision. In doing so Norfolk SAB will also engage with the relevant National Adult Safeguarding networks **– CWDM**

5) Norfolk SAB to share/publicise Norfolk Preparing for Adult Life (PfAL) guidance for 16–17-year-olds in Mental Health Services **– CWDM/FDIS**

6) Board to oversee the development of training, led by NSFT in partnership with the CCG. This will focus on understanding how difficulties with social communication and interaction in autistic people and those with learning disabilities may present with self-harming behaviour, and when this should result in the escalation of safeguarding concerns **- CWDM**

16. Appendix One – Practitioner Conversations

As part of this review, it was agreed that conversation would take place with key practitioners and managers. Below is a schedule showing the practitioners and the dates of the interviews.

Agency and Job Title	Date
Transforming Care Consultant, NHS Lincs CCG/Senior Practitioner	12th Jan
Social Worker - Special assessment SAM team Sussex	12th Jan
Professional Nurse Lead – West Assessment & Treatment Service	12th Jan
Social Worker/Practice Mgr. – Norfolk Adult Social Care	2nd Feb
Social Worker – North Mental Health team – Norfolk CC	12th Jan
Named GP for Safeguarding Adults General Practitioner – Norfolk	12th Jan
Senior Nurse Emergency Department James Paget University Hospital	26th Jan
Director for Patient Safety and Quality – NSFT	17th Jan
Adult Safeguarding Lead Nurse - Norfolk & Waveney CCG	17th Jan
General Manager for the Specialist Assessment Team & Rehabilitation Lead, SPFT.	17th Jan

17. Appendix Two – Abbreviations

A+E – Accident and Emergency Department
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
EEAST - East of England Ambulance Trust
JPUH – James Paget University Hospital
LD+A – Learning Disability and Autism
LA – Local Authority
NHS – National Health Service
NHSE – National Health Service England
NSAB – Norfolk Safeguarding Adults Board
NSFT – Norfolk and Suffolk Foundation Trust
QA – Quality Assurance
SAB – Safeguarding Adults Board
SAM – Specialist Assessment Multi-Disciplinary Team (Sussex)
SAR – Safeguarding Adults Review
SARG - Safeguarding Adults Review Group
SPFT – Sussex Partnership Foundation Trust

18. Appendix Three – NSAB Assurance Framework

Norfolk SAB have ensured that this report follows the guidance as published in the SCIE Safeguarding Adults Review quality markers, link here :- Safeguarding Adults Reviews Quality Markers | SCIE