Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Adults L, M & N

Summary Report

FINAL – PUBLISHED

DATE 25 August 2022

Author	Paul Nicholls – Independent Reviewer
Issue Number	FINAL – PUBLISHED
Document Owner	Norfolk Safeguarding Adults Board
Date Approved	12 July 2022
Date Published on NSAB website	25 August 2022

NORFOLK SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW: Cases 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.

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' (see main report).
- 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 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. The focus of the review

6.1. 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 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.

6.2. 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.

6.3. 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.

7. 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.

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.

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.

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.

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. 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 not 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'.*

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.

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.

(For discussion of these arrangements and a breakdown of the quality assurance, patient oversight and responsibilities between the key partners, see main report)

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 as set out in the regulations.

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.

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 were also concerns raised regarding the admissions process at Milestones. Effective communications only started in earnest when Milestones was about to close, which was too late.

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.

8. 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.

9. Recommendations/Actions to effect change

The recommendations and actions to effect change are included in the main report and the multi-agency action plan. They will be implemented in line with the development of the Integrated Care System in Norfolk from July 2022.

10. Appendix – 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