NEWS RELEASE

EMBARGO: Under strict embargo until 11.00am Thursday 25th Aug

Thursday 24th August

Safeguarding Adults Review Publication: Patients L, M and N

A report into the care of three women in a privately run mental health hospital in Norfolk has recommended greater monitoring and scrutiny of private provision.

The review, commissioned by Norfolk Safeguarding Adults Board (NSAB) focused on the care received by three women in their 20s, known in the report as L, M and N.

The women were patients at Milestones Hospital in Norfolk and the review focuses on their time between October 2019 and February 2021. L, M and N were admitted to Accident and Emergency (A&E) on multiple occasions over 18 months, after serious incidents of self-harm. L, M and N were placed at the Atarrah Project Limited hospital by NHS Integrated Care Boards in Lincolnshire and Sussex.

The review found that although agencies were quick to respond when a safeguarding referral was made in December 2020, there should have been earlier identification of trends and repeat admissions to A&E departments and multiple police incidents, which should have resulted in earlier escalation to Local Authority Safeguarding teams and the Care Quality Commission (CQC).

Patients M and N were placed by Sussex NHS Trust on October 2019 and July 2020 respectively, and Patient L was placed at Milestones by Lincolnshire NHS Trust in October 2020. These three patients visited A&E 53 times in total during their time at Milestones, primarily due to incidents of self-harm. There were also multiple investigations into allegations of various forms of abuse and assault from these patients during this time, with no further action taken after the investigation.

Heather Roach, Chair of NSAB, said “When vulnerable patients are placed in hospitals like Milestones, it’s vital that our whole system works together to keep them safe. This review has shown that there are gaps in the monitoring of private provision, particularly when patients are placed in Norfolk from out of our county. The arrangements need to be addressed urgently to ensure there are the checks and balances in place to make sure those with mental ill health are safe.

“Staff were working in very difficult conditions at the height of the Covid pandemic and that placed vulnerable people at greater risk. Agencies involved have already begun to look at the recommendations made by the review and take action both in Norfolk and regionally to develop new processes and guidance for out of county placements.”

The review made 6 recommendations:

- 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 Norfolk Safeguarding Adults Board within 3 months of the publication of the report

- The host Integrated Care Board 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 Local Authority commissioned Health and Social Care services)
- Assurance from Norfolk and Waveney Integrated Care Board there is robust monitoring of all 'in county placements' and their placing authorities' care worker details. Norfolk Integrated Care Board will maintain a single point of contact for the placing authority
- Norfolk SAB to lobby NHS England for the development of statutory guidance in support of hosting Integrated Care Boards for Mental Health provision. In doing so Norfolk SAB will also engage with the relevant National Adult Safeguarding networks
- Norfolk SAB to share/publicise Norfolk Preparing for Adult Life (PfAL) guidance for 16–17-year-olds in Mental Health Services
- Board to oversee the development of training, led by Norfolk and Suffolk Foundation Trust in partnership with the Integrated Care Board. 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

Agencies involved in the review have already begun to take steps towards addressing the recommendations as outlined above. James Paget University Hospitals NHS Foundation Trust's Emergency Department and Safeguarding Teams took immediate steps to review its processes, and increased the presence of safeguarding professionals in A&E to support staff in their responsibilities to raise concerns. The Trust continues to review safeguarding reporting, with further plans to use digital systems to investigate daily A&E attendances of the most vulnerable people. The two teams within the hospital continue to work closely together and raised the initial concern in Dec 2020 after recognising a pattern of attendances for L, M and N.

Milestones closed in February 2021 following an "Inadequate" CQC inspection. The inspection was triggered when safeguarding concerns were raised by authorities in Norfolk.

The full review is available at https://www.norfolksafeguardingadultsboard.info/publications-info-resources/safeguarding-adults-reviews/ at 11am on Thursday 25th August.

END

NOTES TO EDITORS

What is a Safeguarding Adults Review?

A Safeguarding Adults Review (SAR) is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adults cases, where an adult in vulnerable circumstances has died or been seriously injured, and abuse or neglect has been suspected. As a result of a detailed review, recommendations are made to change or improve practice and services.

The aim of the process is to learn lessons and make improvements, not to apportion blame to individual people or organisations.

A SAR is about promoting effective learning and improvement to prevent future deaths or serious harm occurring again. It relies on a spirit of openness to learning about what went well, as well as what could be improved. The process is based on national guidelines and has been agreed by all agencies who are members of the Norfolk Safeguarding Adults Board.

Other notes

Heather Roach, Independent Chair of Norfolk Safeguarding Adults Board, is available for further comment and interview. Please contact nsabchair@norfolk.gov.uk. For follow up questions and clarifications, please contact the relevant agency for your enquiry.

Further information can be found in the Care and Support Statutory Guidance, Chapter 14, paragraphs 14.133 and 14.134.

Care Act 2014: supporting implementation - GOV.UK (www.gov.uk)