STOCKPORT SAFEGUARDING ADULTS BOARD

LOCAL LEARNING REVIEW

Tom

Died 2020 – 63 years of age

OVERVIEW REPORT

DRAFT 3

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1. CIRCUMSTANCES LEADING TO THE REVIEW

1.1 This Local Learning Review (LLR) stems from the sudden death of Tom, who was found deceased at his home address in February 2020.

1.2 Tom had severe memory problems and had been diagnosed with Alzheimer's disease in 2018. He had continued to live in his own home with daily support from his brother, and oversight of his medication by the specialist team for younger people with onset dementia.

1.3 Ten days before Tom's death, safeguarding concerns were raised by his bank with Adult Social Care (ASC) and the police that Tom might be a victim of financial abuse from his brother who was taking Tom to the bank almost every day to withdraw large amounts of money from his account.

1.4 An immediate police investigation concluded that there was no evidence of an offence having taken place. However, the Police did have concerns about the brother's financial arrangements and a safeguarding concern was made to Adult Social Care to assess whether David was a suitable person to be a carer for Tom and he was receiving the financial and care support he was entitled to. This referral was passed to the appropriate Community Mental Health Team (CMHT) for further enquiries to be made but Tom died before the planned visit could be made.

Parallel Processes

1.5 An investigation was carried out by the police because the circumstances of Tom's death were suspicious as he was found with significant injuries to his head and mouth. In addition, his brother had given differing accounts of events prior to Tom's death and his discovery of the body.

1.6 Following the review of all the evidence, which included further examination of issues relating to the management of Tom's finances, the decision was made that no charges would be brought.

1.7 A post mortem was initially unable to confirm the cause of death and further forensic tests were commissioned. This led to the pathologist identifying three main potential medical causes for Tom's death:-

- head injury
- epilepsy
- cardiac arrhythmia

The pathologist concluded that, on balance, the most likely medical cause of death was cardiac arrhythmia, also known as irregular heartbeat where the heartbeat is too slow, or too fast. The head and facial injuries were believed to be historic.

1.8 In the light of the above findings, the HM Coroner cleared the death at the end of September 2020 with no requirement for an inquest to be held.

2. THE REVIEW PROCESS

Decisions about the status of the Review

2.1 It was originally anticipated that the review would be carried out either as a Safeguarding Adults Review (SAR) or a Domestic Homicide Review (DHR) depending on the outcome of the police investigation. Accordingly, meetings to scope the review were held under each of those procedures in March and June 2020.

2.2 However, in the light of the outcome of the police investigation, it was agreed at a subsequent panel meeting in September 2020, after consultation with the Independent Chair of the Stockport Safeguarding Adults Board (SSAB), that the status of the review should be changed to a Local Learning Review (LLR) which would be carried out using the standard SAR process.

Purpose of the Review

2.3 The purpose of the review is not to hold any individual or organisation to account but to:-

- determine what agencies and individuals involved might have done differently to prevent the harm or death;
- review the effectiveness of multi-agency safeguarding arrangements and procedures;
- identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

Time Period Covered by the Review

2.4 The Review covered the period from August 2018 to February 2020. This start date was selected to enable exploration of what support was provided following Tom's Alzheimer's diagnosis, and also because this was the time that concerns were first identified about possible financial abuse.

Key Issues to be explored by the review

2.5 The scoping panel meeting agreed that the review would focus on 5 issues:-

1. the approach taken to the hand over of referrals;
2. whether assessments took account of David's needs as a carer;
3. the effectiveness of any multi-agency working, and specifically what consideration was given to applying the Team around the Adult (TAA) process;
4. the effectiveness of practice in identifying indicators of possible financial abuse, and ensuring an appropriate multi-agency approach;
5. the appropriateness of action taken in response to the safeguarding concerns raised, having regard to the statutory responsibilities set out in the Care Act 2014 and associated national guidance.

Agencies Involved

2.6 The Independent Chair and Overview Report Author was Chris Brabbs, a former Director of Social Services and experienced chair of SARs and DHRs. The LLR Panel, which held 3 online meetings, comprised representatives of the following agencies who submitted chronologies and Independent Management Reports (IMRs):

- Stockport Council Adult Social Care;
- NHS Stockport Clinical Commissioning Group (CCG);

- Pennine Care NHS Foundation Trust;
- Greater Manchester Police
- Stockport Homes
- Stockport TPA Prevention Alliance.

2.7 An information report was provided by Stockport NHS Foundation Trust regarding any hospital attendances, and the LLR Chair had a discussion with the Wellspring [1] to gain their knowledge of Tom where he attended daily for his lunch.

2.8 Approaches were made to the Nationwide Building Society to request an information report to learn more about their general policies and procedures when dealing with financial abuse. However, no further response has been received following the initial confirmation that this request would be considered.

2.9 It was agreed that practitioners and managers involved in Tom's case would participate in a learning event to inform the production of the draft overview report.

Involvement of Family Members

2.10 The review established that David is the only known relative still alive. Towards the end of the review process, a registered letter was sent to David to inform him about the review, and offering him the opportunity to read the report or to receive information about the findings.

3. SUMMARY NARRATIVE OF AGENCY INVOLVEMENT

Background Information prior to the start of the review period

3.1 Tom had been a long-standing tenant with Stockport Homes for over 20 years. A number of its teams were involved at various points, particularly during the last 5 years, in providing support in relation to the management of the tenancy or claims for welfare benefits.

3.2 In April 2017, David contacted ASC to ask how to apply for support as he was supporting his brother who had mobility problems and undergoing assessment at the Memory Clinic. [2] It was agreed that David would re-refer after obtaining Tom's consent for an assessment but no further contact was received.

3.3 In May 2018, five week later, following a referral from the GP, a doctor from the Memory Clinic carried out a home assessment which established that Tom had been experiencing short term memory problems for the past 2 years and this was causing him anxiety. The outcome of the assessment was Tom agreeing to have a CT scan of his brain, and a carer's assessment to be provided for David.

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1 *The Wellspring is a resource centre for homeless and disadvantaged people in Stockport town centre.* *https://thewellspring.co.uk*

2 *The Meadows Memory Clinic - https://www.penninecare.nhs.uk/services/stockport-memory-assessment-service*

NARRATIVE OF EVENTS DURING THE PERIOD COVERED BY THIS REVIEW

July / August 2018

3.4 In July, the Stockport Homes Money Advice Team requested that a visit be made to Tom by the neighbourhood team to explore further a concern that Tom might be the victim of financial abuse. This concern stemmed from the lack of response to several attempts to contact Tom to establish the outcome of the application for a Personal Independence Payment (PIP), which eventually elicited a text reply from David to say no further help was required. During the subsequent visit by housing officers, no concerns were identified. Tom was described as being lucid and he had not raised any issues about his situation.

3.5 At the end of the month, the Consultant in Older Age Psychiatry made a home visit and explained to both brothers that the results of the CT scan were inconclusive. Tom shared information that he had previously provided care for his father who had dementia. The Consultant recorded that Donepezil 5mg was to be provided in a blister pack. It was agreed that all future appointments would be arranged through David. Following this assessment visit, a referral was made to a Neuropsychologist who is part of the Young Onset and Rarer Dementia Team (YOD). [3]

October / November 2018

3.6 During the first assessment visit by the Neuropsychologist 6 weeks later, Tom described his daily routine which included going to the Wellspring for lunch each day, and that he wrote notes on his calendar to provide reminders of appointments. He could not remember having the MRI scan but agreed to a further memory test in 2 weeks time after which a further visit would be made.

3.7 During her next visit in November, the Neuropsychologist checked Tom's ability to take medication. She noted that there was no food in the house other than pot noodle, and that Tom drank 2 cans of lager before going to the Wellspring and 4 cans during the rest of the day. Although Tom was able to speak fluently, he was very repetitive. Although it was difficult to be sure of the cause of the memory problems which could possibly be alcohol related, her conclusion was that it seemed reasonable to treat Tom for possible Alzheimer's disease given the family history.

3.8 Following this visit, the Neuropsychologist discussed the case at a multi-disciplinary meeting (MDM) held by PCFT's Young Onset and Rarer Dementia Team (YOD) when it was agreed that the team would take on the case to monitor the medication and assess whether Tom had any additional support needs. However, due to the community psychiatric nurse (CPN) having recently retired, the Neuropsychologist agreed to continue managing the case until an agency nurse was in place.

February / March 2019

3.9 The agency CPN made her first visit when both brothers were seen. Tom was aware of his short term memory problems but cheerful throughout the visit, and managing his daily living activities independently. During a discussion about his daily drinking of alcohol, and the possible consequences, Tom told the CPN that he had reduced the strength of the beer, but had no intention to reduce intake. Tom's medication Donepezil was increased to 10mgs once daily, which was to be reviewed in September 2019.

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[3] *Further explanation of the role of the YOD is provided in section 7 of the report.*

3.10 During this visit, David said that he and Tom shared a bank account and he took care of all the finances. The CPN provided David with the contact details for Signpost Stockport for Carers [4] for help with applying for a carer's allowance and to ask for a carer's assessment. A follow up visit carried out 4 weeks later established that Tom was not experiencing any side effects from the increase in his medication.

3.11 In July, following a self referral, a practitioner from The Prevention Alliance (TPA) [5] started to provide support to David who explained that Tom was not managing his own finances due to his stage 3 dementia. Therefore he was helping his brother get back on track by pooling their resources and applying for benefits to increase their income. Assistance was given with applying for a carers' allowance, which was awarded, and in applying to Stockport Homes for housing nearer to Tom. David was also provided with food vouchers whilst his benefit applications were being processed when David mentioned they would be visiting the food bank after the meeting.

September – December 2019

3.12 The CPN made her next visit 6 months after the previous contact after ringing David who said that Tom's short term memory was worse, and as a consequence he was providing more support. During that visit, when Tom was seen alone, he reported that he was still managing independently at home, and the daily visits from his brother were providing sufficient support. Tom's appearance confirmed this as he was smartly dressed and well groomed. He was also settled on his medication. Tom was still visiting the food bank but not engaging with any social interventions offered by the CMHT. A plan was made to end involvement if the situation remained stable over the next 3 months.

3.13 During these 3 months, TPA provided help to David to complete an application for a Personal Independence Payment (PIP), and then to support his request for this to be reconsidered when that application was refused. On two occasions, meetings were cancelled by David as he reported that he had to take Tom to hospital.

February 2020

3.14 At their next contact during the first week of February, David informed the TPA practitioner that he wanted to apply for Powers of Attorney for his brother.

3.15 Four days later the Nationwide Building Society made a referral to ASC to report their concern that David may be exploiting Tom financially. They asked if further enquiries could be made to establish if David was working in Tom's best interest, and assess whether Tom had mental capacity to make decisions about his financial affairs. The building society's understanding was that there was a power of attorney in place but that this had not been registered with them.

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[4] *Signpost for Carers are an independent local charity who have been supporting carers for more than 30 years. https://www.signpostforcarers.org.uk/*

[5] *The TPA is made up of six not for profit organisations who work together to improve Health and Wellbeing in Stockport. The Alliance is commissioned by Stockport Council. https://stockporttpa.co.uk/about-us/*

3.16 The building society explained that their concern originally stemmed from a third party visiting the branch in late January claiming that David was using Tom's funds for his own benefit. The building society had immediately taken action to protect Tom by transferring Tom's funds to a sole account in his name with regular transfer of the PIP payment to stop David having access.

3.17 The building society's concerns had then increased further when the two brothers came into the branch in the second week of February looking to move £2000 from Tom's sole account to the joint flex account held with David in order to buy a car which would be for the benefit of both of them. Given that the branch was aware that Tom could not drive, and their observations that David was always under the influence of alcohol, the request was declined as the transfer would not be solely for Tom's best interests.

3.18 The following day, the ASC "front door" team established from the PCFT mental health team for older people (CMHT OP) that the case was an open case although the allocated nurse was currently on long term sick leave. Therefore, the referral was forwarded by email to PCFT for them to progress in line with the joint protocol between ASC and PCFT covering which agency will take the lead for responding to safeguarding referrals.

Explanatory Note

During the review period, Pennine Care NHS Foundation Trust (PCFT) provided all mental health provision through a section 75 agreement with Stockport MBC (SMBC). Under this agreement, ASC's mental health social workers were located within PCFT's CMHTs and were managed by PCFT. The safeguarding response protocol agreed by SMBC and PCFT in 2016 set out arrangements for safeguarding referrals received by the SMBC Contact Centre to be forwarded to the PCFT Access Team for action where the alleged victim was currently known to PCFT mental health services or had been seen within the previous 2 years.

3.19 Three days later the Building Society contacted the police while the brothers were in the branch to explain the concern about possible financial exploitation. The information provided to the police was different to that previously shared with ASC. During the first 2 weeks of February, Tom and David had been attending almost every day seeking to withdraw £500 for the purchase of the car. After 2 withdrawals of £500 had been made, further requests were declined because of concerns about Tom being vulnerable due to his dementia. Pending further investigation by the bank, a withdrawal of £100 had been allowed to buy food.

3.20 A police officer visited the bank immediately, spoke to both brothers, and checked with building society staff the explanations that David had given. The officer then accompanied David to his bank and checked his statements which showed that money withdrawn from Tom's account had been paid into that account. David informed the officer that he was seeking advice from a solicitor regarding an application for powers of attorney.

3.21 The conclusion of the investigation was that although there were inconsistencies in the explanations provided by David, there was no evidence that any offences had occurred and that any of Tom's money was being used by David for his own benefit. Consequently the decision was made that the police would take no further action at that stage. However, a referral was made to ASC via the Multi Agency Safeguarding and Support Hub (MASSH) [6] that same day so that assessments could be made to see if David was a suitable person to act as Tom's carer, and that Tom was receiving the support he needed in relation to his financial, health and care needs.

3.22 After the referral made by the police was forwarded to PCFT by ASC to add to the original information provided, the safeguarding concerns were discussed within the YOD multi-disciplinary meeting. The case was allocated to the team's social worker for a visit to be made to Tom the following week to assess his capacity around managing his finances, and explore the recent financial dealings involving his brother.

3.23 The same day, on receipt of the referral from the MASH, 4 days after the police investigation, ASC checked with the CMHT OP that the safeguarding concerns previously forwarded were being acted on, who confirmed that the social worker in the YOD was investigating these. Given this confirmation, it was decided that there was no further role for ASC at this stage, and ASC emailed the police referral to PCFT.

Tom's death

3.24 6 days later, paramedics responded to a 999 call from David made at 8.40 am that he had found Tom lying on the floor of the living room. Tom appeared to have been dead for some hours and the police were informed. It was noted that Tom had last been seen by David the evening before. The attending police officer raised a concern about an injury to Tom's face and the accounts given by David of events leading up to the death which led to a police investigation with regards to the circumstances of Tom's death.

3.25 Two days after Tom's death, the practitioner from the YOD visited Tom's home but was informed that Tom had died.

4. INFORMATION ABOUT TOM

4.1 Given the limited, or intermittent nature of agency contacts with Tom, there were very few observations within the agency chronologies and IMRs other than those recorded during PCFT's involvement which included brief references to his earlier life. These observations have been supplemented by the author gaining the perceptions of the Wellspring as he went there every day.

4.2 In addition to his younger brother David, Tom had an elder brother who it is believed died about 12 years ago. Tom served in the marines for many years, and it would appear that his military career was important to him, and had a lasting impact given the descriptions noted during agency involvement that he was always dressed in combat clothes. PCFT and the Wellspring made the observation that Tom took a great pride in his appearance, and how he was always well groomed and smartly turned out.

[6] *The Multi-Agency Safeguarding and Support Hub (MASSH) is the single point of contact for the public and professionals to report safeguarding concerns*

4.3 Tom consumed alcohol on a daily basis, which in the past appears to have been a contributory factor for a number of public order, or domestic incidents, which resulted in a police response and several court appearances. During the period of the review Tom told professionals he generally drank around 6 cans of lager each day – two in the morning and four during the rest of the day.

4.4 In terms of Tom's behaviour and demeanour during the review period, there were observations recorded by the CPN of Tom appearing happy, although on one occasion he said his daily routine was boring. The Wellspring said that they had not picked up much about Tom's background or circumstances because he appeared to be quite a private person who would eat his lunch and then leave. He was not one of the attendees who ever sought attention or caused any issues that required staff intervention. The manager also said that they had only seen David once at the centre.

4.5 In terms of his health, it appears that during his military service, he contracted Malaria which it was suspected may have been a contributory factor to the seizures he experienced around 2017. It is evident that Tom was anxious about the onset of his memory problems particularly as he had seen the consequences of his father having Alzheimer's disease.

5. ANALYSIS OF AGENCY INVOLVEMENT

Introduction

5.1 The following sections provide an analysis of agency involvement. These are organised to first cover the work of those agencies who had involvement with Tom and / or David up to the point where referrals were made by the building society about the possible financial exploitation. These sections are then followed by one which deals with the agency responses to those concerns.

5.2 Each section starts with a summary of each agency's own findings contained in their IMR, followed by an analysis of the key issues that flow from these in order to draw out any additional learning.

6. PRIMARY CARE (IMR provided by NHS Stockport CCG)

6.1 There was no significant past medical history in the GP records other than Tom being referred to the Neurology after having a seizure in December 2014. However, he did not attend the appointment and no follow up was arranged.

6.2 Tom rarely attended surgery and had not been seen since 2018 when the referral to the Memory Clinic was agreed when he shared his anxiety about his memory. Tom was also referred to the cardiology clinic on the same appointment because he was found to have an irregular pulse. However, there is record of him attending a cardiology appointment.

6.3 Following the Alzheimer's diagnosis, the GP prescribed medication as directed by the Memory Clinic with the blister packs collected by David from the pharmacy. The CCG IMR made the observation that the GP records included a reference to Tom's brother having taken on some caring role, but it was not possible to establish from the notes how this may have changed or developed since 2018 given the lack of contact with Tom, and David never having contacted the surgery.

6.4 The CCG IMR finding from reviewing the case record, was that the GP Practice delivered care in line with local and national practice guidance in respect of health checks and reviews. The IMR highlighted as good practice the timely, and appropriate, referrals to specialist services for assessment. In addition, age and gender appropriate health screening had been undertaken.

6.5 In the light of those findings, the IMR did not make any recommendations, but did include a request that additional information relating to the TAA process should be shared with GP Practices to raise awareness, and increase their involvement in case discussions. This issue will be picked up later in the report which considers the learning in respect of multi-agency working.

Analysis of issues in respect of Primary Care involvement

6.6 The IMR made the observation that primary care involvement was a challenge, given that Tom was an infrequent attendee, and having a history of not attending appointments with other services. It also included the comment that it is possible that had the GP Practice been aware of concerns raised, there may have been a more proactive approach to maintaining direct contact with Tom. This, however, was described as being "outwith the gift of the GP Practice".

6.7 Having regard to those observations, some events described in the chronology led to the review exploring further the following issues:-

- the way in which primary care informs patients and / or their relatives of upcoming appointments, including medication reviews or other information about their healthcare;

- the steps that should be considered when patients with dementia do not respond to letters or texts, or fail to attended appointments;

- how the GP practice ensures it has up to date and accurate information about family members who are supporting the patient.

Notification of appointments and follow up after DNAs

6.8 During the period covered by the review, Tom did not respond to letters or texts asking him to make an appointment for his medication review so that he could be involved in this structured review as recommended in national guidance. A letter was sent to Tom in mid December 2018 asking him to make an appointment. When no response was received, a note was entered on EMIS 6 weeks later of the need to contact the patient or his representative to make an appointment.

6.9 It is not clear as to whether that was acted on as the next entry in the CCG chronology refers to a diary entry made 3 months later for a medication review. This was subsequently carried out later in May without Tom's involvement. Following this, there were no further recorded attempts to contact Tom until February 2020 when a text was sent to Tom to remind him of his appointment the following day which he subsequently failed to attend.

6.10 The issue here is that the GP Practice's reliance on the standard approach of sending letters and texts to Tom increased the likelihood of Tom not responding or not keeping appointments made. Even if Tom read the letters, his short term memory was so poor that there was a good chance that he would forget about the appointment, and possibly also forget to show David the letter so that the latter could add it to the calendar, and also give him reminders nearer to the time.

6.11 There is no indication that given that the GP Practice was aware of the extent of Tom's memory problems, there was any consideration of what other steps might be taken to make contact after the repeated lack of response.

6.12 This leads into the linked issue about the GP Practice's lack of detailed information about the role David was playing as a carer. A comment noted in the chronology refers to the discrepancies in the entries made in the GP notes by two doctors who held consultations with Tom during April 2018. The first made by the doctor who carried out the cognitive assessment with David present, referred to Tom living with his brother – information that was subsequently included in the referral letter to the Memory Clinic. The second made by a different doctor 5 days later, when Tom attended on his own, recorded that Tom lived alone.

6.13 It is not known if the GP Practice's limited knowledge led to any assumption that David would be aware of any letters sent to Tom. Nor has it been established whether Tom's records included David's contact details in the event of any emergencies.

6.14 It does not appear that consideration was given to discussing with Tom, and seeking his consent, to the option of David acting as the contact point and being sent copies of any correspondence. This was the approach taken by PCFT Care and to a great extent proved effective in ensuring Tom kept appointments with the CPN.

Conclusions and potential learning

6.15 The perspective of the CCG is that the gaps in the GP Practice's approach to DNAs, and the lack of full information about the caring role being undertaken by relatives, reflected a wider and recurring issue across primary care. The CCG explained that further work will be done locally to address these issues as the work that was previously undertaken at a Greater Manchester level to explore how a standard approach might be adopted across GP Practices, did not progress to a point where proposals could be rolled out and put into practice.

6.16 The LLR agreed that these issues apply equally to all agencies not just primary care, and therefore will be returned to later in the report in the section which draws together the multi-agency learning.

7. PENNINE CARE NHS FOUNDATION TRUST (PCFT)

7.1 Following the assessments carried out by the Consultant and Neuropsychologist, the case was transferred to the Young Onset and Rarer Dementia Team (YOD). The IMR explained that the YOD is a very small team of 3, comprising a team manager, a community psychiatric nurse (CPN) and a part time social worker working 3 days a week which means that intensive support is limited to the most complex cases. During the period covered by this review, the CPN working with Tom was on sick leave for a period of time which meant the team manager picking up calls on those cases in addition to her existing work.

7.2 The team's aim to provide support with the titration of drugs for people living with dementia until the right maintenance dose is achieved with no untoward side effects. [7] The team also carries out further assessments if the person is having difficulties with their activities of daily living, [8] provides advice for the patient and their family around future organisation of the financial affairs, which might include applying for powers of attorney, and offers additional support through drop in sessions, carers' groups, and peer support activities in the community. Once a patient is settled on the medication, and do not require the additional support, they will discharged from their service back to the care of their GP.

YOD involvement with Tom

7.3 Monthly visits were made between February and May 2019 through which the standard assessment, risk assessment, and wellbeing plans were completed. During these contacts, Tom appeared happy, settled, and was walking to Wellsprings for his lunch. Although Tom did have some word finding difficulties, he could communicate his situation to the CPN. He was said to be always well-dressed, very chatty and positive about his situation. Tom was functioning very well and was managing his own activities of daily living, was stable on the medication and therefore did not require any care package, or ongoing support. Consequently, the level of contact reduced after the March 2019 visit with a 6 month review visit carried out in September 2019.

7.4 The overall finding of the PCFT IMR was that the input in this case was consistent with its usual approach in such situations, and practice met the agency's standards and policy requirements. The IMR made the observation that given the situation was stable, the case should have been discharged back to the GP at an earlier stage.

7.5 The findings in the PCFT IMR were that there was never any indication that there was any financial abuse during the involvement of the various professionals involved. Although not recorded within the notes, the CPN considered that Tom had capacity in relation to his support needs and finances. Consequently, no capacity assessment was carried out because she had no reason to doubt whether there were any capacity issues, and his brother was supporting him to manage his finances.

7.6 This was the first learning point identified by PCFT that it is important to record the rationale for concluding that a person has capacity in relation to the management of their financial affairs.

7.7 The second relates to the need to seek official confirmation that powers of attorney are in place. During the visit in May 2018, the doctor from the Memory Service recorded that David had power of attorney, but it was not clear from this entry if any documentation had been seen. This meant it was unclear as to what type of power of attorney David had, whether this was for property and finances, or health and welfare, or both. On this issue, the PCFT IMR provided helpful guidance that if these documents cannot be provided, practitioners can check the status of any power of attorney by completing the OPG100 form available on the Office of the Public Guardian website.

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[7] *Drug titration is the process of adjusting the dose of a medication for the maximum benefit without adverse effects The medication is started at a low dose, every couple of weeks, the dose is raised ("up-titrated") until the maximum effective dose ("target dose") has been achieved or side effects occur.*

[8] *The YOD have access to Personal Care Budgets which are used for personal assistance if the person requires an additional level of support;*

8. THE PREVENTION ALLIANCE (TPA)

8.1 TPA was commissioned 5 years ago by ASC to provide a prevention service. Co-located with ASC and Public Health, TPA provides a wide range of 1 to 1 work to promote health and well-being – both in respect of physical and mental health. Its interventions are based on a strength-based, motivational interviewing approach. Practitioners have a caseload of 25 on average.

8.2 As outlined earlier the TPA key worker did not have any contact with Tom. In reviewing the key worker's involvement with David, the TPA IMR was necessarily based solely on the evidence in the case record as the key worker left the TPA shortly after Tom's death. Therefore it was not possible for the IMR author to have a discussion with the key worker to clarify matters further to supplement the limited information in the record about her discussions with David.

8.3 Based on the case record, the IMR findings were that the key worker's involvement did not meet the agency's expected standards of practice for the following reasons:-

- there was no exploration of the information provided by David about Tom's dementia diagnosis, and whether an assessment of Tom's health and care needs should be considered. In addition, there was no evidence that consideration was given to David's ability to provide support to Tom, and whether a carer's assessment should be offered;

- there was no probing of the information provided by David about the financial arrangements whereby the 2 brothers were said to be pooling their resources and applying for benefits to increase their income. The IMR observation was that this showed a lack of awareness of the indicators of possible financial abuse, and that the arrangements described might give rise to the possibility of Tom being exploited financially.

- there was no further probing of the information provided by David that he intended to apply for powers of attorney to establish if Tom was in agreement with this step, and whether any mental capacity assessments had been carried out regarding his capacity to manage his financial affairs.

- that given all the above issues, there was no evidence of any steps taken by the key worker to liaise with other agencies to check out information provided by David, or consideration of whether the situation would benefit from a multi-agency response, and a Team around the Adult (TAA) process.

8.4 During a discussion with the LLR Chair, the TPA manager explained that the agency's expectation was for the allocated worker to meet with each service user at least once in their home environment, as this provides the opportunity to observe at first hand the home circumstances to inform the focus of the work. However, this did not happen in this case because the key worker always met David in a café.

8.5 Usual practice would also have involved the key worker approaching ASC to check if Tom, or David, were already known, and to discuss whether assessments should be considered both in respect of Tom's health and care needs, and any support David might require in carrying out his role as a carer.

8.6 In exploring why this did not happen in this case, the TPA manager's conclusion was that this stemmed from both the key worker and agency team manager being new in post. Although they had completed the mandatory induction and safeguarding training, both were still learning about the TPA way of working. This appears to have contributed to the key worker not reporting back on developments, and the temporary manager not being proactive in checking progress which might have picked these issues up.

8.7 The TPA Manager provided reassurance that the gaps in this case were a "one-off", and the agency have robust arrangements in place to support high quality practice:-

- all the managers are experienced;
- induction is provided by TPA and the employing organisation;
- policies and procedures are easily accessible on the staff intranet;
- there is a robust safeguarding policy and procedure framework in place;
- all staff attend mandatory safeguarding adults and children training and refresher sessions;
- safeguarding is a standard agenda item for all team meetings.

Action already taken and single agency recommendations

8.8 The TPA IMR identified a number of developments that will help in managing similar cases in the future:-

- an indicator has been added to the database to capture if anyone the agency is working with is a carer to ensure key workers identify the need for assessment of both the carer's needs, and the person being cared for;
- TPA has since received specialist domestic abuse training which will assist key workers in identifying and responding to indicators and disclosures of all forms of domestic abuse, including financial abuse;
- implementation of a more robust processes for reporting, and monitoring, of issues involving safeguarding and risk.

8.9 Further action planned by TPA will be a review of the processes for the induction of new staff, and the recruitment of temporary agency managers.

9. STOCKPORT HOMES

9.1 The IMR provided a comprehensive summary of the agency's involvement during the tenancy and described how Tom was a long-standing tenant with some low-level issues that were managed by in-house resources. The involvement of the Neighbourhood Housing Officer (NHO) role was the constant throughout, with appropriate referrals made internally to specialist teams who became involved on a time limited basis. The IMR finding was that generally most contacts with Tom relating to standard tenancy management issues were dealt with appropriately and met the expected standards.

9.2 Although there were some concerns about Tom and his ability to manage and maintain his tenancy over the years, the concerns were not of significant magnitude for officers to make referrals to external organisations or conclude that a TAA process was necessary. From discussions during the preparation of the IMR, officers shared different perceptions and experiences of TAA processes. Many officers had been involved in these, and some had arranged and chaired these. Some Officers felt that they were more likely to use the MAARS process than TAA for complex cases.

9.3 The same positive finding applied to the Money Advice Team who are always alert and proactive in addressing any indicators of possible financial abuse. This was evident in the team raising the concern with the Neighbourhood Housing Officer in July 2018. Although there was no concrete evidence of abuse, and it was more of a "hunch", the Money Advice Officer was uneasy that David was overly interested in Tom's finances and appeared to be taking a lead role in dealing with these. The internal referral was therefore appropriate in requesting the Neighbourhood Housing Officer to explore the situation further.

9.4 In respect of the follow up visit made by officers from the Anti-Social Behaviour (ASB) Team and the Housing Support Team, the IMR finding was that practice did not meet the required agency standards, because the safeguarding policies and procedures were not applied appropriately. The IMR clarified that its findings were necessarily based on the evidence of the agency records as one of the officers has since left the organisation and could not be interviewed, and the other could not recall the specific detail of the case.

9.5 The reason for the IMR finding was because only a single visit was made, and the assurances provided by Tom that there were no grounds for concern, were taken at face value. Consequently, no follow-up action was taken nor the need for a multi-agency approach considered. The IMR explained that standard practice would have resulted in further visits being arranged in order to gain a clearer understanding of the situation and the brothers' financial arrangements. In addition, building a rapport with Tom through continuing contact was more likely to elicit any disclosures and referrals being made to other agencies as appropriate.

9.6 The IMR made the observation that the officers in both these teams are some of the most experienced in dealing with safeguarding issues, but acknowledged that financial abuse is probably an issue less commonly encountered in their work. Nevertheless the same level of approach would have been expected in respect of the exploration of the possibility of financial abuse as is applied to other types of abuse.

9.7 The IMR explained that on speaking to managers in these teams, it was clear that the failure to follow the guidance was not due to lack of knowledge of what was required, but that for unknown reasons this was not applied in this case. Although the managers of these teams felt this was an isolated incident, the IMR identified that refresher training will be issued to all relevant staff.

9.8 The other action that the agency is taking is to remind staff about the need for each officer to complete their own notes on all local record systems where joint visits are completed. This action stems from the limited coverage of the visit in the agency records which appeared to have resulted from an assumption being made by the officers that their colleague would be writing up the visit.

10. RESPONSE TO THE SAFEGUARDING CONCERNS OF POSSIBLE FINANCIAL ABUSE

Action taken by the Nationwide Building Society

10.1 Following the scoping meeting in September, a request was made to the building society for their assistance with the LLR to address some specific questions about its involvement in this case, and to provide more general information about its policies and procedures for action to be taken when concerns about possible financial abuse are identified. The response received was that legislation prevented them from sharing information about specific cases except with the police to assist a criminal investigation.

10.2 In the light of this explanation, and after advice was sought from GMP's financial investigator, a revised list of questions was sent to the building society asking for general information about their policies and processes for responding to suspicions of possible financial abuse, and a copy of their safeguarding policies. Despite several progress chasing emails, and a formal letter no further response was received. The lack of response was brought to the attention of the Financial Conduct Authority (FCA), the national regulator for financial institutions. Further information about the FCA's role is included later in the report.

10.3 The consequence of the lack of response, and the apparent constraints on sharing specific case information, leaves some important questions unanswered about the actions taken by the building society, and whether these were compliant with its policies and procedures. One is whether the building society might have referred their concerns earlier - first when they were informed during January that Tom was being exploited financially, and second, in the light of this allegation, when the brothers first attempted to withdraw large sums of money. A further issue is why the building society had not apparently asked for verification from David that he had powers of attorney.

The police investigation

10.4 The police demonstrated best practice in its response to the concerns raised by the building society. The response was immediate, the investigation was thorough, and an appropriate referral was made to ASC. The fact that the outcome of the investigation was inconclusive in terms of whether exploitation might be taking place, illustrates the challenges that professionals face in trying to unpick what is going on in what can be complex family situations.

10.5 The police made the observation during the LLR that had they been approached by the building society at an earlier stage, this would have enabled a strategy meeting to be held to plan any further enquiries to avoid the reactive response that had to be made on the day when it was reported that the brothers were in the branch. The LLR agreed that ideally the building society should have made a referral as soon as they were informed of possible financial exploitation.

10.6 The police also shared its view that too much emphasis had been placed on the conclusion reached by the police officer that no offence had occurred, and that a full exploration of the brothers' financial arrangements was only picked up after Tom's death. That further police investigation did not find any evidence of exploitation, and it was not possible to establish how the money David was taking out of this joint account was being spent. This was an account that had been in place for many years. It was established that Tom did have plenty of money in his own bank account at the time of his death.

ASC action on receipt of the referrals

10.7 Prior to the safeguarding concerns being raised by the building society and the police, ASC had not had any involvement with Tom other than the contact from David in 2017.

10.8 The finding of the ASC IMR was that the practice of the "Front Door" Team met the required agency standard as the decision made through the triage process was in accordance with the joint protocol with PCFT that it was appropriate for the latter to progress the further enquiries, and the decision was quality checked by the manager. The IMR also made that observation that this decision was consistent with "Making Safeguarding Personal" principles as the YOD would have access to the previous assessments, and therefore have a greater understanding of Tom's situation and the relationship with his brother.

10.9 The ASC IMR also clarified that the "front door" team did not give consideration to convening a strategy meeting because under the joint protocol, responsibility for organising this was vested in the team that would be progressing the referral.

10.10 The LLR established that after the initial telephone call with the CMHT OP which established that the YOD was involved, all further contact between the front door team and the YOD team leader was by email. There was no telephone discussion to discuss the referral and agree what further action would be taken by PCFT as might have been expected so that ASC could reassure itself that the referral would receive an appropriate response. The contributory factors for there being no telephone discussion will be explored later in the section covering the learning in respect of the safeguarding processes.

PCFT's response to the referral

10.11 The referral was discussed at the YOD MDM 6 days after the receipt of the referral which was just outside the 5 day timescale set out in SSAB's procedures. The IMR author confirmed that this was classed as a strategy discussion. The finding of the PCFT IMR was that the outcome of a visit being planned for the following week was a proportionate response, and in line with PCFT policies and procedures.

10.12 The date set for that planned visit meant that 14 days would have elapsed since the first referral was received from ASC before any further enquires were made regarding the concern. The issues around this timescale, and the process by which the decision was made, will be explored in the next section on the learning around the response to possible financial abuse.

11. LEARNING FROM THIS REVIEW

11.1 The analysis of the IMRs has identified 4 areas of potential learning:-

(i) Identification of, and response to, possible financial abuse;

(ii) "front door" arrangements for responding to safeguarding concerns;

(iii) Arrangements to secure engagement with people who have dementia;

(iv) Multi-agency working particularly in respect of application of the "Team around the Adult" (TAA) arrangements.

12. IDENTIFICATION AND RESPONSE TO POSSIBLE FINANCIAL ABUSE

12.1 Most of the IMRs identified learning, and included planned actions, to develop their staff's skills in identifying possible indicators of abuse. The issues identified within the IMRs related to professionals:-

- not recognising the possibility of financial exploitation from the information supplied about the pooling of resources; *(TPA)*

- not showing professional curiosity to probe the information provided by David about his intention to apply for powers of Attorney *(TPA)* or accepting at face value his assertion that he already had obtained power of attorney without asking for verification of this. *(PCFT & TPA)*

- accepting at face value the assurances provided by Tom that he was happy with the financial arrangements, and not carrying out further visits to build a relationship and explore the situation further. (*Stockport Homes)*

12.2 The absence of any consideration to initiating any enquiries with other agencies was a significant contributory factor to no agency picking up the inconsistencies in the accounts David gave to different agencies. David told the Consultant from the Memory Team in May 2018 that he had powers of attorney, but later in February 2020, he told the TPA key worker and the police that he was planning to do this.

12.3 The findings from this LLR therefore reinforce the messages in previous national research that while practitioners may be experienced in recognising adults at risk, identifying, and responding to, possible financial abuse presents very specific challenges.

12.4 The findings from this LLR suggest that Stockport SAB should consider building on its existing guidance on financial abuse, which currently appears to be quite limited in scope, by developing a Financial Abuse Toolkit – a step that has been taken by several SABs. These toolkits aim to provide professionals with advice, and practical information, to help recognise where financial abuse may be occurring, and the steps that can be considered to address this.

12.5 The toolkits vary in the amount of detail included, and the style varies according to whether they are written for professionals only, or both the professional and public audience. Most are intended to be used primarily as an electronic version because they rely heavily on web-links to signpost professionals to relevant information.

12.6 Regardless of style, all bring added value by going beyond listing the indicators of possible abuse to provide information on:-

- all types of financial abuse including scams;

- financial abuse involving ASC monies, or within a regulated service;

- the legal framework, and action that can be considered to end the abuse, and safeguard victims from the risk of further abuse;

- the role of, and contact arrangements for, specialist teams, local services and national organisations who should be approached for advice and support for investigations and protective action.

12.7 The toolkit adopted by East Sussex, [9] which is regarded as a model of best practice, goes further by including more detailed processes on how enquiries should be conducted. These include a Financial Abuse Screening Tool, and proformas to assist the drawing up of plans to shape the enquiries - setting out what information needs to be gathered and by whom.

12.8 Another comprehensive toolkit is that adopted by Kent's [10] which also includes a number of case examples covering different types of financial abuse which are presented in a way that can be used in training events.

The role of financial institutions

12.9 None of the toolkits examined include any coverage of the responsibilities of financial institutions, what the statutory agencies can expect of them, and the opportunities for closer collaboration to support an effective multi-agency approach when indicators of possible financial abuse are identified.

12.10 Given this, in addition to the information sought from the building society, the LLR chair made contact with the Financial Conduct Authority (FCA), which is the national regulator for financial institutions, in order to find out about any national guidance or expectations in respect of these issues.

12.11 This contact established that, from 2015, one of FCA's priorities has been work on the development of guidance setting out the FCA's expectations of firms on the fair treatment of vulnerable customers. [11] This work has resulted in the FCA developing a dedicated web page [12] which explains progress on driving this priority forward and provides links to all the key documents.

12.12 After some preliminary publications to raise awareness of the issues around vulnerability, the FCA launched a two-stage consultation process in 2019 on the draft guidance. In July 2020 the second consultation paper was published seeking comments on the updated draft guidance. [13] The final guidance is scheduled to be issued during the first quarter of 2021 and will set out how firms will be held accountable through the FCA's supervisory role where monitoring identifies that firms are not treating consumers fairly.

12.13 The guidance explains how the development of support for vulnerable consumers might include referral to third party organisations or specialist agencies. However there is little coverage of action that should be taken to address the type of potential financial abuse that was a concern in this case. In addition, the situations described where a referral to the "relevant authorities" should be considered is limited to those where there is immediate, or serious risk, to health or life. [14]

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9 *https://www.eastsussex.gov.uk/socialcare/providers/safeguarding-resources/financial-abuse/*

10 *https://www.kent.gov.uk/__data/assets/pdf_file/0004/52969/Financial-abuse-toolkit.pdf*

11 *The FCA's definition of vulnerability is "someone who, due to their personal circumstances, is especially susceptible to harm, particularly when a firm is not acting with appropriate levels of care."*

12 *https://www.fca.org.uk/firms/treating-vulnerable-consumers-fairly*

13 *https://www.fca.org.uk/publication/guidance-consultation/gc20-03.pdf.*

14 *The example cited is where there are credible risks of suicide or threats to harm family members.*

12.14 Looking at the organisations who responded to the consultation, although these included a number from the third sector, [15] the list did not include any of the statutory safeguarding partners, or national bodies such as the Association of Directors of Adult Services (ADASS). This may be why issues around financial abuse did not feature more prominently.

Next steps

12.15 In the light of this, and the potential national learning, the LLR agreed that consideration should be given to approaching the FCA offering to share the relevant findings from the review. This would enable the FCA to consider the possible benefit of issuing further guidance to signpost financial institutions to information on possible indicators of financial abuse, and referral pathways where concerns are identified. If that approach to the FCA was to include an offer of collaboration, and that was accepted, it would place Stockport at the "cutting edge" of development work to raise the profile of financial abuse across the financial sector at a national level.

12.16 The LLR Panel also agreed that SSAB should bring the findings and recommendations from this LLR in respect of financial abuse to the attention of the Safer Stockport Partnership (SSP) [16] given its lead responsibility for the protection of vulnerable people which is one of its four strategic priorities. This will allow consideration to be given as to how the recommendations from the LLR might link with the SSP's existing work streams, including some parallel work being undertaken by Trading Standards.

13. "FRONT DOOR" ARRANGEMENTS FOR RESPONDING TO SAFEGUARDING CONCERNS

13.1 The LLR heard that the current safeguarding processes are under review, and SSAB will be holding a multi-agency workshop, as soon as COVID-19 restrictions allow, to agree what changes will be made to strengthen these. Issues which have already been included in the agenda are:-

- clarification of agency responsibilities;
- the referral and care pathways;
- the processes and target timescales for each stage of the safeguarding enquiry process.
- how the "Making Safeguarding Personal" approach can be further embedded.

13.2 The findings from this LLR provide additional evidence and insights to inform both this work, but also the planned review of the interim guidance covering the arrangements between ASC and PCFT for handling safeguarding concerns where the latter is already involved. SSAB may also wish to take into account the findings to inform decisions on the focus of future multi-agency case file audits (MACFAs), and requests for dip sampling by each agency to check that SSAB's procedures and practice standards are being met.

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15 *These included Age UK, Mental Health UK, and Scope.*

16 *Safer Stockport Partnership is the statutory Community Safety Partnership.*

13.3 The following paragraphs will first cover the issues and potential learning from this case in respect of the arrangements when PCFT carry out safeguarding enquiries on behalf of the local authority. The report will then move on to outline some wider system issues which emerged during the review discussions that are linked to this in respect of the response to referrals, and how there appear to be some differences in how agencies define what constitutes a strategy discussion.

The arrangements for responding to safeguarding concerns where PCFT is already involved

13.4 As covered earlier in the report, the previous Section 75 agreement was ended because the view of the local authority was that the governance arrangements and processes set out in the joint protocol, were not enabling ASC to exercise sufficient oversight of the safeguarding work to ensure its statutory responsibilities set out in the Care Act statutory guidance were being met. An additional concern was that the organisational arrangements had led to the distinct social work role becoming blurred. As a consequence, management control reverted to the local authority in September 2020, but with the social workers remaining co-located with PCFT's mental health staff to promote effective joint working.

13.5 A revised interim protocol was implemented to provide guidance on the roles and responsibilities of the 2 agencies within these changed arrangements. The LLR noted that the interim guidance has only been in place for a short time and that further joint work is planned to update the guidance taking account of a joint evaluation of its operation to date. [17]

13.6 In carrying out that review, it will be important to check that the content of the guidance, and the way it is applied, enables the local authority to comply with its statutory duties set out in the Care Act 2014 Statutory Guidance [18] where either it requests PCFT to carry out safeguarding enquires on the local authority's behalf, or where safeguarding concerns are received direct by PCFT.

13.7 The Care Act guidance explains that If it requests another organisation to make the enquiries, the local authority retains the responsibility for ensuring that the enquiry is acted upon, that there is a clear timescale for this to be carried out, and that the outcome of the enquiries, and any further actions proposed, are appropriate. Where necessary, the local authority can challenge the body making the enquiry if it considers that either the process and / or the outcome are unsatisfactory. [19]

13.8 These requirements are picked up in the North West Safeguarding Adults Policy. [20] While confirming that the local authority can ask another agency to carry out their enquiries, it emphasises that the local authority will decide when a case can be closed and if the Section 42 duty is satisfied.

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[17] *The ASC IMR also explains that the review of the interim protocol will also include consideration of how feedback is given to agencies raising safeguarding concerns when it is appropriate for this to be provided.*

[18] *Care and support statutory guidance - Department of Health & Social care Updated 24 June 2020*

[19] *See paragraphs 14.78; 14.100; 14.110 in the statutory guidance.*

[20] *http://www.safeguardingadultsinstockport.org.uk/for-professionals/north-west-safeguarding-policy/ - see page 17 "who can carry out an enquiry"*

13.9 In exploring these requirements, the LLR heard from ASC that although the interim guidance provides for more oversight of enquiries carried out by PCFT, the extent to which this can be applied is limited. This is because of the high volume of safeguarding concerns being received, linked to issues around capacity as the team only has 3 social work qualified staff. [21]

13.10 This therefore restricts the amount of initial triage work that can be carried out. Consequently where cases are passed to PCFT, there is a reliance on the latter to consider what is a proportionate response to the concern raised, and to hold strategy meetings as appropriate within the timescales set out in SSAB's procedures. The issues around capacity also limit the level of scrutiny that can be given to checking the appropriateness of the outcomes of enquiries completed by PCFT prior to closure. [22]

13.11 The LLR was informed of two initiatives being progressed by ASC to address the challenges around capacity. The first is the ongoing work with the 6 referral and information officers to raise their levels of understanding in relation to safeguarding issues. This will enable their input within the triaging process to extend beyond their previous role of call handlers when they were managed by the corporate contact centre. Line management was transferred to the ASC Front Door Team in October 2020.

13.12 The second is the development of a digital form to be used by agencies when raising safeguarding concerns to move away from the current practice where most referrals are submitted in an email. This is to address 2 issues. First, the quality of the information provided at present does not always meet the required standard to assist decisions on what response should be provided. Second, a significant number of the emails are not raising specific safeguarding concerns, but are reporting situations which require a Care Act assessment not a safeguarding response.

13.13 The proposed design of the electronic form will therefore not only include questions for referrers to complete, but will also include suggestions about more appropriate referral pathways if the circumstances do not meet the safeguarding threshold.

13.14 In implementing this new system, there is an awareness that it is essential that the referral process is not experienced as being overly prescriptive as this could lead to the risk that agencies may opt not to report concerns. The SAR panel received confirmation that the Front Door Team will be holding regular meetings with other agencies to discuss the revised approach, and keep under review the appropriateness and quality of safeguarding referrals being submitted.

Strategy Discussions

13.15 The LLR also identified that further work is required to achieve a shared understanding of what constitutes a strategy discussion as the use of this term seems to mean different things to various agencies across the safeguarding partnership. This stemmed from PCFT having used this term to describe what was in effect a single agency discussion that took place within the internal multi-disciplinary meeting in the YOD. This differed from other agencies' understanding of the term, which as described in SSAB's procedures, refers to a discussion involving statutory agencies such as the police, ASC, and relevant NHS organisations.

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[21] *Team Leader and 2 social workers.*

[22] *The proforma document to record the results of the safeguarding enquiries includes some mandatory domains that have to be completed. . If these are not filled in sufficiently, this will prompt scrutiny before ASC decide if the enquiry can be closed.*

13.16 As well as resolving the issue around the terminology, it was also agreed that further work should be undertaken to check that strategy discussions are being held in situations described in SSAB's procedures, and that the appropriate agencies / professionals are involved.

14. ARRANGEMENTS TO SECURE ENGAGEMENT WITH PEOPLE WHO HAVE DEMENTIA

14.1 The earlier analysis of primary care's unsuccessful attempts to secure a response from Tom to notifications of appointments, illustrated how the reliance on sending letters or texts to a person with some form of dementia increases the likelihood of missed appointments. This is an issue that has featured in previous safeguarding adult reviews in other parts of the UK, and applies to all agencies not just primary care.

14.2 It is essential therefore that when agencies are working with a person with some form of dementia, they give early consideration as to what agreed "fail safe" arrangements can be put in place so that information is also shared with someone who can ensure a response and appointments are kept. Achieving this will entail a number of actions.

14.3 As soon as agencies become aware that a service user has dementia, this needs to be flagged up prominently in the case record to alert all agency staff to the need to check whether special arrangements have been, or need to be, put in place.

14.4 It is also essential that action is taken to ensure the agency record contains full contact details of the primary family carer. Initially this will require the agency to take responsibility for gathering those details through its contact with the person, and / or their carer. Once this information has been obtained, and entered on the system, it will become the family's responsibility to report any changes to these arrangements so that the records can be updated.

14.5 It is acknowledged that the updating process will be a challenge where a touch screen is used for patients to log in on arrival. Those agencies will need to think through what opportunities can be created to check with patients periodically if the information remains the same.

14.6 Finally, the agency records must include confirmation of any arrangement where the person has given consent for a relative or other informal carer to receive communications from an agency. This is particularly important information for any professional becoming involved who is not familiar with the case.

Response to missed appointments

14.7 While the above steps will minimise the risk of people not being aware of appointments, it is also important that when people do not attend (DNA), there is effective follow up action, not only to re-arrange the appointment, but also to identify any contributory factors for the missed appointment which needs to be factored in when planning future contacts. SSAB has already identified this as an important issue, and the next SSAB case audit during April 2021 will focus on the multi-agency response to DNAs.

14.8 The LLR also heard from the CCG that monitoring the robustness of primary and secondary care arrangements for following up DNAs is an important element of its assurance framework. In addition, the CCG also confirmed that the issues in respect of DNAs are being looked at a Greater Manchester level through the Adults Network.

15. MULTI-AGENCY WORKING PARTICULARLY IN RESPECT OF TomPLICATION OF THE "TEAM AROUND THE ADULT" (TAA) ARRANGEMENTS.

Use of the TAA process

15.1 The LLR heard different perspectives as to how well the TAA arrangements are working. ASC's perception is that this is not sufficiently embedded, and their experience is that other agencies tend to look to ASC to take the lead rather than initiating the process themselves.

15.2 In contrast to this, more positive experiences were shared by TPA and the Wellspring who referred to the opportunity to flag up cases at the monthly meetings, where the consistent high attendance from a range of professionals enabled appropriate support to be mobilised where a multi-agency response was identified as being beneficial. TPA and Stockport Homes also confirmed that they have taken the initiative in convening TAA meetings.

15.3 A perception shared by all agencies involved in this review is that GPs do not appear to be "in the loop", and are not always aware, or informed, when other agencies are involved. As a result of GPs usually being unable to attend TAA meetings due to surgery commitments, this appears to be resulting in GPs not always been notified of meetings, or asked for information if they are unable to attend. The CCG emphasised that GPs are willing to share information to support the TAA process, and would welcome feedback on the outcomes.

15.4 In agreeing the need to strengthen the links with GPs, and facilitate greater involvement in the TAA process, the CCG explained that it can act as the conduit in gathering information from the GP for the meetings, and feeding back the outcomes. Although some doubt was expressed within the LLR discussions as to whether this solution would be realistic given the number of meetings, the CCG provided reassurance that carrying out this role is a prime part of its safeguarding responsibilities.

15.5 It was noted that the current TAA process is under review and this would provide the opportunity to address the issue about GP involvement, and spread the message to other professionals of the need to recognise the GP as being an integral part of the multi-agency team.

15.6 It was agreed that the issue about GPs often not being aware of which services were involved, was one that applied equally to other agencies. The examples in this case included TPA and Stockport Homes not being aware of PCFT's involvement and vice versa. ASC also made the observation that when referrals are being triaged, it is not aware of which other agencies are involved, and when they were last seen.

Introduction of the Shared Care Record

15.7 The LLR noted that the implementation of Graphnet would help to address this gap. This is a Greater Manchester initiative to implement a record system which allows access to basic information which has been added by agencies about a person they have involvement with. The intention is that each agency will decide what information is added to the database which is sufficient to alert other agencies to their involvement and their most recent contact. This will enable other agencies to make direct contact with that agency to gain more information to inform their work with that person.

15.8 It was confirmed that the system would start to go live in Stockport from the end of January 2021 with data being fed into the NHS agencies systems and the Liquidlogic system used by Social Care. This feed will allow health professionals to view if there is social care involvement, what assessments have been undertaken (but not the content of the assessments), if there is an allocated worker, and also the full details of any services the person is receiving. This will include the care provider's contact details, description of the service and its frequency. In return Liquidlogic users will have access to the GM Care Record. [23]

16. RECOMMENDATIONS

1. Statutory partners in Stockport should collectively assure the Stockport Safeguarding Adults Board (SSAB) that the findings and recommendations from this Local Learning Review are considered in the workshop planned to review SSAB's safeguarding procedures and processes, and are also taken into account when agreeing the focus of future multi-agency case file audits (MACFAs) and the regular dip sampling of cases. In particular assurance should be sought that there is a shared understanding across the wider safeguarding partnership about:-

   (i) the definition and use of multi-agency strategy discussions in planning the response to safeguarding concerns;

   (ii) the process for providing feedback to referring agencies who raise safeguarding concerns, and the factors which may limit the extent to which this can be done;

   (iii) when Team around the Adult (TAA) meetings should be considered, who can take the lead for convening these, and the chairing arrangements for initial and follow up meetings;

   (iv) the importance of keeping GPs and other health professionals informed of meetings planned, and the role the CCG can play as the conduit in feeding in information from GPs who are unable to attend.

2. Stockport MBC, working in collaboration with Pennine Care NHS Foundation Trust and NHS Stockport CCG, should assure the Stockport Safeguarding Adults Board that the review of the joint guidance covering the arrangements for responding to safeguarding concerns, enables the local authority to maintain oversight of the planning, and outcome of safeguarding enquiries as set out in the Care Act 2014 statutory guidance.

3. Statutory partners in Stockport should report to Stockport Safeguarding Adults Board on steps that have been agreed to develop a multi-agency toolkit which provides comprehensive guidance for professionals on best practice in identifying and investigating indications of possible financial abuse, and the arrangements to monitor how effectively this guidance is being applied.

23 *The GM Care Record pulls patient information from several important areas of health and care including primary care, community health services, mental health services, hospitals, and the ambulance service.*

4. Stockport Safeguarding Adults Board should bring to the attention of the Safer Stockport Partnership the findings from this LLR in respect of the identification and response to financial abuse, with a recommendation that consideration be given to approaching the Financial Conduct Authority (FCA) to explore the potential mutual benefits of supporting the FCA's work on strengthening the national arrangements to protect vulnerable adults from the risk of financial abuse.

5. All partner agencies in Stockport should provide assurance to Stockport Safeguarding Adults Board on action they are taking to ensure that all agencies who are providing services to people with care and support needs, particularly those with dementia, have robust systems in place to:-

   - ensure their records contain up to date contact details for family members who are providing support;

   - agree arrangements on who else should be notified of appointments;

   - follow up any missed appointments, including exploration of any contributory factors which need to be taken into account when planning future contact.

17. SINGLE AGENCY RECOMMENDATIONS

PENNINE CARE

1. When assessing any adult who is deemed to have capacity. It is good practice for the practitioner to record how they reached that rationale / conclusion should then be recorded in PCFT Records.

2. Practitioner to have sight of the power of attorney Stamped registered documentation, if required for placement or safeguarding concerns. It is good practice to photocopy and upload to PCFT.

STOCKPORT HOMES

1. Staff will be reminded of the importance of professional curiosity and the need to establish trusted relationships with customers in order to facilitate disclosures.

2. Staff will be reminded of the importance of keeping detailed, timely records on all local systems including all actions required and by whom. Where visits are completed jointly with another officer both officers must record the visit on local systems.

THE PREVENTION ALLIANCE

1. Review the processes for the recruitment and induction of new staff.

2. Staff will be reminded of the importance of keeping detailed, timely records.

SMBC ADULT SOCIAL CARE

1. To review how feedback is provided to agencies raising safeguarding concerns when this is appropriate.

CCG – PRIMARY CARE

None

GREATER MANCHESTER POLICE

None