Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Investigation into the Safeguarding concerns of fifteen service users
Report for the Large Scale Investigation Early Strategy Meeting

Report Summary

On 15 February 2012 the Trust was informed, by email, that some Wiltshire Council social workers had alleged that AWP managers had instructed them to make incorrect RiO record entries.

Wiltshire Council identified and shared details of fifteen cases where concerns had been identified. All fifteen cases were internally investigated by the Information Governance Manager and by members of the Trust Public Protection and Safeguarding Team and a Lead Nurse.

The investigation found that assurance of appropriate and accurate recording of face to face contact could not be provided for 4 of the 15 service users identified. Appropriate action to assure safety of these service users is being taken.

Additional concerns regarding quality of risk assessment, care planning, safeguarding children and MAPPA documentation were identified. These concerns will be addressed by team managers lead by the Area Service Manager for Wiltshire.

Report for the Large Scale Investigation – Early Strategy Meeting	
Report Sponsor: Hazel Watson	Report Author: Alan Metherall
Director of NCAS	Deputy Director of Nursing

1. Purpose of the Report

- *On 15 February 2012 the Trust was informed, by email, that some Wiltshire Council social workers had alleged that AWP managers had instructed them to make incorrect RiO record entries.*

- *In response to these allegations Wiltshire Council set up a formal safeguarding process and a Large Scale Investigation Early Strategy Meeting was held on 29 February 2012. As a result of this meeting AWP undertook to investigate the allegations.*
- Hazel Watson established an internal AWP Investigation Group on 8 March 2012. The Group's Terms of Reference were provided to Wiltshire Council on 9 March 2012.
- Wiltshire Council identified and shared details of fifteen cases where concerns had been identified. All fifteen cases were internally investigated by the Information Governance Manager and by members of the Trust Public Protection and Safeguarding Team and a Lead Nurse.

- *A Large Scale Early Strategy meeting was held on April 4th. This report address action point number three in the minutes of that meeting which were required to be undertaken by the Trust.*

  "*Hazel Watson to be in a position to reassure the Panel appropriate safeguarding is being carried out with individual cases and within AWP as a whole. To advise how staff are supported and performance managed to undertake safeguarding procedures. To advise what gets reported to the senior management team*."
- A separate report addressing the issues of supervision and safeguarding has been submitted to the ESM.

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2. Background

The concerns raised related to inaccurate recording of face to face contact with the identified service users by some Wiltshire Council Social Workers. A lack of assurance of the safety of an identified 15 service users was reported.

All multi-professional health and social care records for AWP service users are kept via an electronic records system, (RiO), which has been fully implemented since May 2011. This system has capacity to record Health Care Practitioner diary appointments, CPA appointments, all clinical documentation including risk assessment and care planning along with progress notes.

The concerns raised relate to potential inaccuracies in the recording of face to face contacts which may have been indirect contacts.

This report outlines the investigation process and assurances of appropriate safeguarding for those 15 service users.

3. Purpose of Investigation

To provide assurance that appropriate face to face contact has occurred in the identified 15 cases.

To identify any inconsistencies and gaps in recording by health care practitioners in these 15 cases.

To propose any actions required and next steps identified through the investigation process in relation to the recording of health care activity in relation to those health care practitioners involved in these 15 cases.

4. Method of Investigation

The investigation process was two fold. Firstly the Information Governance Manager reviewed the records of all 15 cases to identify inconsistencies in recording of contacts, whether a home visit had been recorded as a review and whether care plans had been created by another staff apart from the care Coordinator, and whether this may be appropriate.

Secondly, members of the Trust Public Protection and Safeguarding Team and a Lead Nurse reviewed the records of all 15 cases to assess if appropriate clinical risk assessment and care plans were in place and if enough evidence could be seen in the record that face to face contact had been made with the service users appropriately. The criteria used to make this assessment was based on the service users having been seen by health care practitioners in addition to those identified within the information from Wiltshire Council and within an appropriate time frame.

5. Findings

The investigation by the Information Governance Manager found that there appears to be data quality issues around the recording of accurate and up to date information by both Trust and Wiltshire County Council staff. It is not possible to correlate any of these data quality issues with the reporting of performance figures as retrospect performance reports are not available (see Appendix A for summary of findings for each case).

The investigation found that appropriate face to face contact for 4 of the 15 service users could not be demonstrated. All other 11 service users were found to have been visited by healthcare professionals other than their care co-ordinators in an appropriate time frame, (see Appendix B for summary of findings for each case).

The quality of care planning, risk assessment, safeguarding children and MAPPA documentation was found to be of poor quality in 12 of the 15 cases.

5. Conclusion

The Area Service Manager for Wiltshire is arranging for contact to be made where appropriate with the service users for whom assurance of safety could not be demonstrated from the investigation. Where direct contact with the service user is not appropriate contact will be made with the GP or family members.

Safeguarding children concerns will be followed up and assurance gained that appropriate safeguarding processes have been followed will be provided by [redacted], Trust Safeguarding Children Lead.

MAPPA concerns will be raised with the appropriate team manager by the Trust Safeguarding Lead for MAPPA, [redacted].

The quality issues identified in care planning and risk assessment will be addressed with care co-ordinators through the appropriate team managers by the Area Service Manager for Wiltshire.

Appendix A – Summary of Information Governance Manager's Investigation

Appendix B – Summary of Assurance of Face to Face Contact, Care Planning and Risk Assessment

Exempt from disclosure under Freedom of Information Act section 40 where the release of personal information that would contravene the Data Protection Act 1998.

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