1. Rationale for Safeguarding Adults Review (SAR)

Under the Care Act 2014, Safeguarding Adult Boards are responsible for undertaking a review of cases that involve adults with care and support needs where:

- an adult has died or suffered serious harm;
- the SAB suspects or knows that this was because of neglect or serious abuse and;
- there is concern that agencies could have worked better together to protect the adult from that harm.

The purpose of reviews is to ascertain how systems can be improved to protect against future harm.
In May 2018, a request was made to review the case of LB who died following miscommunication around his discharge from hospital. The learning review was undertaken through practitioner workshops to:
- share the findings from organisational investigations and safeguarding enquiries arising from LB's death;
- identify areas for development across the partnership in relation to planning for emergency hospital attendance for those with care and support needs;
- agree actions needed and monitoring arrangements for the SSAB;

2. What happened?

LB was a 90 year old man who lived in his own property, he required social care support and had been in receipt of 4 visits a day. LB also had a private arrangement with Age UK Sutton for the provision of shopping and cleaning services. In March 2018 LB suffered a fall and was taken by ambulance to Hospital. He was monitored in A&E overnight.
Notifications were sent from the hospital to ask the care agency to restart care from the following day at midday, but his transfer home was delayed. The care provider were advised at midday that he was still in hospital and wrongly understood that he had been admitted onto a ward. Had he been admitted, this would have required hospital staff to notify the local authority before discharging so that any suspended care package could be reinstated. In fact LB was only in the hospital awaiting transport home. Later that day he was taken home by patient transfer staff, who were unaware that his care had been suspended. Social care staff, having made enquiries regarding his welfare, visited his home the following week where they discovered he had sadly passed away.

3. Making safeguarding personal: Was LB involved in decisions about his safety?

Prior to his death, social workers had concerns about his ability to continue to reside alone and had started to discuss other options including sheltered accommodation. Proper consideration was given to his ability to make decisions, advice was taken from his GP about the need to wait a short while to enable him to overcome an infection. Housing staff were also involved in this assessment and a referral was made to ensure that LB had support from an Independent Advocate before any decision was made about his future accommodation and care needs, in line with statutory obligations under the Mental Capacity Act 2005. Before this could be put in place, LB was taken to A&E.
Recommendation: The SSAB's QPP subgroup will monitor key performance indicators that services use advocates and apply MSP principles in safeguarding enquiries on a quarterly basis through their score card. The SSAB will conduct a survey and audit regarding appropriate use of advocacy as part of our 2020 workplan. The outcome of these findings will be published via our regular newsletters and in our annual report.

4. Prevention: Did systems work well to identify opportunities to assess risk collectively?

During the review, practitioners identified that LB was at high risk of serious harm and that protocols already existed that could have further helped reduce that risk. There was evidence that staff had referred in line with the local falls pathway and he was known to the service. However, given his limited mobility, the pressure ulcer protocol might also have provided a useful tool to identify a multi-agency risk management plan.
Recommendation: The SSAB review multi-agency protocols and pathways and disseminate good practice examples so that practitioners have a clear grasp of collective risk management and communication plans so as to reduce risk that adults with care and support needs experience harm.
Action taken: In 2019 the SSAB launched a refreshed website, including dedicated pages for practitioners and links to national and local policies and protocols. This is supplemented with a regular newsletters to all partner agencies, providers, community and voluntary sector to provide opportunities to share practice improvements, e.g. new practice tools.

5. Duty of Care

The local authority, care providers, brokers, hospitals must when fulfilling their functions, ensure they have met their duties to adults at risk. This includes being familiar with the statutory duties, standards and protocols related to hospital admissions, attendance at A&E and discharge planning obligations. It is crucial that staff working across health and social care find common language so that handovers between different agencies don't inadvertently become 'hand offs'.

Recommendation: The practitioner workshop identified a need for training sessions and forums to share learning and build knowledge.

Action taken: SSAB provide numerous multi-agency safeguarding training and events to enable the development of common language and shared understanding of each agencies specific duties and processes and the limitations of these. The SSAB will also provide quarterly briefings to disseminating learning arising from SAR and assurance work across the wider partnership as well as hosting links on its website.

6. Communication between partners

Learning point: A number of assumptions were made as to whether LB was admitted onto a hospital ward and insufficient checks were made to understand what this would mean in terms of the processes for restarting suspended care packages.
Recommendation: All parties agreed to develop a localised, multi-agency protocol which has a clear pathway and links to the statutory obligations for safe hospital discharge. This should clearly set out communication, risk processes and assurance with expected outcomes and how we can measure that these have been achieved.
Action taken: Work is being undertaken to complete this, and SSAB intend to have provider and service user input into this. In the interim, partner agencies have also amended practices (see step7) to reduce risk of miscommunication in future.

7. Clarity of process regarding suspension of care package on hospital attendance

Learning point: All parties were clear that a care package stops on admission to hospital ward. The miscommunication occurred because the care provider understood that LB had been admitted onto a hospital ward and so assumed that the hospital discharge notification process would be triggered at a later stage when he was ready to return home. This was incorrect, he remained at all times within A&E so there was no legal requirement for hospital staff to provide further notification than had already occurred.
Recommendation: All parties review internal protocols, policies regarding attendance at hospital and the suspension of care.
Action taken: LBS have set up a spreadsheet to ensure that within 24 hours of discharge, checks are made to confirm whether an individual has returned home and has received appropriate care and support.
Staff responsible for commissioning care and support now have clear communication channels with provider agencies and the Hospital Pathway Social Worker. The social worker is also required to communicate with the adult or their family/ representative.