Executive Summary Report

Safeguarding Adult Review into the Hepatitis B Outbreak

Independent Report Author: Allison Sandiford

1. Introduction

1.1. The North Lincolnshire Safeguarding Adults Board agreed to undertake a discretionary Safeguarding Adult Review regarding a hepatitis B1 outbreak within a Care Home in North Lincolnshire. Whilst there is no evidence that any adults died as a result of abuse or neglect, there is evidence that there were adults involved that had needs for both care and support and there were concerns in relation to how partner organisations worked together to protect them.

1.2. This Safeguarding Adult Review is not reinvestigating the outbreak. It has been commissioned because there are concerns that the information supplied by agencies involved in the investigation process, may not have been consistent, and there may have been missed opportunities for agencies to share relevant information. This may have potentially affected professional decision-making and risk assessment.

1.3. The circumstances that led to this Safeguarding Adult Review being undertaken are as follows; seven months after a resident of a Care Home had been admitted to hospital and diagnosed with acute hepatitis B, a subsequent case from the same Care Home was identified.

1.4. The UK Health Security Agency led an investigation into the outbreak; and a whole home screening of residents and staff (initiated by Yorkshire and Humber UK Health Security Agency and North Lincolnshire Health and Care Partnership) identified a further three cases - which included two residents and one staff member.

2. Conclusions

2.1. Following:

- examination of the information gained from the agency reports/documentation shared with this review,
- discussions with professionals at a learning event, and
- discussion and analysis with panel members

The review concluded that despite the added strain that the COVID-19 pandemic brought to the management of the hepatitis B outbreak, all professionals involved clearly worked hard to assess the threat to public health, action measures to mitigate risks, and monitor the situation.

2.2. This review evidences the competency and diligence of all partner agencies - but did identify that at times they have not co-ordinated their work with one another as whilst there is evidence of multi-agency meetings and information sharing - there is also evidence of agencies not having and/or understanding all of the information, mainly because of inconsistency in relation to information sharing and communication.

2.3. The review acknowledged that agencies have already made some important amendments to practice since the scoping period of this review but discussions around the key lines of enquiry highlighted further learning.

2.4. The below questions (in italics) have been generated for North Lincolnshire Safeguarding Adults Board and partner agencies to consider, with the expectation that the resulting debate will drive North Lincolnshire Safeguarding Adults Board and its partner agencies to develop an action plan that will respond directly to the learning.

2.5. The review identified that:

2.6. Whilst information is available in relation to learning more about, and responding to bloodborne viruses and containing infection in general, there is no national or local guidance to specifically support a care home when a person working or residing in the home is diagnosed with hepatitis B.

2.7. Consequently, Care Homes will respond differently - potentially dependent upon the understanding that the Care Home manager has of the infection in the first place and knowledge of the available information. If introduced, a national toolkit could support care homes to better understand the virus; and could trigger a more uniformed response to cases.

2.8. This review would therefore ask:

2.9. W*hat written guidance can the UK Health Security Agency and the North Lincolnshire's Health Protection Team develop and share with the Safeguarding Adults Board to support care homes when outbreaks occur?*

The learning panel agreed that the following should be considered when developing any guidance:

- *Signposting to resources*
- *Infection, Prevention and Control advice*
- *A reminder of safeguarding duties*
- *Explanation of the role of the Incident Management Team, and*
- *Useful contact information*

2.10. It was identified that information sharing and communication between partners could have been strengthened in this case.

2.11. A representative from the Care Home had not been invited to partake in the Incident Management Team meeting therefore the meeting did not have complete and accurate

information relating to a staff members prior diagnosis, nor the care home's internal practices around infection prevention and control.

2.12. Communication could have been improved had a representative from the Care Home been invited to partake in at least part of the Incident Management Team meeting.

2.13. This review would therefore ask:

2.14. *How can the UK Health Security Agency assure North Lincolnshire Safeguarding Adults Board that the learning identified in this review is shared across national and regional Health Protection Teams?*

2.15. Not all agencies attending effectively filtered the information about the Incident Management Team to their staff, and consequently not all professionals were sure of their responsibilities in response to the hepatitis B outbreak.

2.16. This review acknowledged that it can be challenging to act in accordance with a process or procedure which is unfamiliar. Staff would have benefited from further understanding the purpose of the Incident Management Team, what it aims to achieve and what was expected from them. Also, guidance around what information could and could not be shared outside of the Incident Management Team meetings and with whom would have facilitated more effective communication between staff and partners.

2.17. This review would therefore ask:

2.18. *How can the UK Health Security Agency provide assurance to the Safeguarding Adults Board that agencies are clear to their roles and responsibilities within Incident Management Team meetings?*

2.19. Although staff, residents and their families were informed, not all professionals visiting the Care Home were aware of the outbreak of hepatitis B when it happened.

2.20. Nursing and residential homes have a duty to maintain standards of infection prevention and control and should be able to evidence compliance with the 10 criterions, as set out in the Health and Social Care Act. Specifically, criterions 4 and 6 relate to systems which ensure contractors, volunteers and visitors are provided with accurate information on infection prevention and control issues.

2.21. This review would therefore ask:

2.22. *How can partners (including the CQC) assure the Safeguarding Adults Board that processes are in place to ensure providers are complaint with the 10 criterions, as set out in the Health and Social Care Act?*

2.23. The large volume of multi-agency meetings evidences how competently professionals responded to the outbreak. However, because of the sheer number of meetings, and stakeholders involved in the process, there was often confusion around roles and responsibilities which could have been perceived as intimidating to the Care Home Management Team.

2.24. This review would therefore ask:

2.25. *In order to support more effective multi agency working, how can partner agencies assure the Safeguarding Adults Board that practitioners from partner agencies involved in Incident Management Team meetings have an understanding of the purpose of the meeting, what is expected from those who attend and what each other's roles and responsibilities are?*