Safeguarding Adults Executive Board

LEARNING BRIEFING

Joan's Legacy – Key Findings and Recommendations from the Safeguarding Adults Review

Sharing learning from SARs is a key priority of the Safeguarding Adults Executive Board (SAEB) and ensures that lessons in relation to safeguarding adults support best practice and encourages a culture of continuous improvement.

All staff and mangers are encouraged to discuss this briefing and the key learning and reflection points to ensure that the learning outcomes are used to consolidate best practice and support improvements in practice where required.

Safeguarding Adults Reviews or SARS

are commissioned under Section 44 of the Care Act 2014 in circumstances in which an adult has died or sustained serious harm as a result of abuse or neglect, and there are lessons to be learnt around how agencies worked together to safeguard the adult.

The aim of a SAR is to carry out a review to determine what agencies involved could have done differently that could have prevented the harm or death from taking place. The aim is not to apportion blame, but to promote effective learning and improvement actions.

The SAEB commissioned an Independent Reviewer to conduct a Lessons Learnt Review. The review examined events from 30 December 2018 to Joan's death in October 2019. The review analysed agencies involvement via chronologies and the reviewer also led a facilitated event with practitioners and managers. Joan's family were also involved in the review and met with the Independent Reviewer as well as members of the SAR Panel.

Joan passed away at the age of 88 after experiencing a significant and rapid decline in her health over the last year of her life. Joan was admitted to hospital five times, in the last 10 months of her life, and there were concerns about discharge arrangements and the care and support services set up to meet her needs, as well as frequent re-admissions to hospital. Joan lived with dementia and became very physically frail in the last year of life, leading to her no longer being able to mobilise independently and developing pressure ulcers.

As part of the review, Joan's family were able to offer powerful insights regarding their experiences. They want Joan's legacy to be that the learning from this case, means that other adults in similar circumstances should not face the same shortfalls in care and support.

The SAEB would like to thank Joan's family for their valuable contributions and open honest reflections of their own experiences and of Joan's care.

Key findings and learning outcomes

Communication and coordination between agencies and family members

The review identified an overriding theme of inconsistent communication between agencies involved as well as with Joan and her family. This led to poorly coordinated hospital discharges, delays in the provision of care services, contradictory information being given to family members and their concerns not being addressed in timely or effective ways. There was no clear lead agency and the large number of different agencies involved caused confusion around different roles and responsibilities. There was a lack of formal multi-agency meetings both in relation to planning hospital discharges as well as reviewing the care Joan received at home, as well as a lack of effective partnership working with Joan's family who knew her needs well and what was important to her.

In addition, the review found that there were missed opportunities to consider the concerns raised via safeguarding procedures. Only one safeguarding enquiry was instigated in August 2019 in relation to Joan being admitted to hospital with pressure ulcers but there were delays in this enquiry being taken forward and a lack of management oversight.

Mental capacity curiosity by professionals

There was little recorded evidence of Joan's wishes and feelings within records across the organisations. Documentation frequently referred to 'best interests' decisions being made, but without decision-specific mental capacity assessments being completed.

Reasonable adjustments and person-centred care

During Joan's hospital admissions she was often deemed by professionals to be unresponsive and uncommunicative, and they advised her family members that at times she was not eating. However, practitioners did not take into account the reasonable adjustments Joan needed to be able to engage with them. She was visually impaired and hard of hearing but often left without access to her glasses or hearing aids which meant that she could not understand what people were saying and communicate with them.

Involving families in SARs and complaints

Joan's family were strong advocates acting on her behalf but struggled to make her voice heard. Their frustrations were often perceived by professionals that they were being difficult and aggressive. The family found that their concerns about the poor quality of care were not satisfactorily addressed until they escalated matters through the complaints and Local Government Ombudsman processes.

The family have provided feedback that they found some aspects of the SAR process challenging, in relation being informed about the SAR taking place 2 years following Joan's death via letter, when their preference would have been for an initial conversation to discuss the purpose of the review.

Recommendations

Learn	Develop a partnership process to ensure that learning from SARs is disseminated effectively throughout organisations and that multi-agency learning is prioritised and tested in day-to-day practice. Ensure the adult and families are central to the process.
Raise Awareness	Build on recent developments around reviewing the national protocol of pressure ulcers. Ensure SAEB partners lead on raising awareness and working on clearer pathways across care home and statutory health sector.
Quality Assurance	Introduce a programme of multi-disciplinary audits of safeguarding practice and decision making to compliment the SAEB Assurance and Performance Framework.
Review	Review the operational model of My Care My Way in the Royal Borough of Kensington and Chelsea.
Coordinate	Develop mechanisms to ensure a more coordinated approach across acute hospital trusts and Adult Social Care to ensure effective case management.

What we are doing to respond to the learning:

- Adult Social Care has led on an audit of hospital discharge pathways and joint working across health and social care. The findings will be used to strengthen the Discharge to Assess (D2A) arrangements, including establishing multi-agency hospital hubs.
- A Training Needs Analysis with regulated provider services highlighted the need for greater awareness of the pressure ulcer protocol. In response to this bespoke training sessions will be delivered later in 2022.
- The SAEB will undertake a multi-agency audit to look at how well the Mental Capacity Act is being used in practice.
- The new SAR Protocol and Guidance has been launched by the SAEB in June 2022 and the board will deliver a series of ‘Lunch and Learn’ sessions to partners to help raise awareness of the process.
- A new SAR Guide for Families and Carers has been produced.
- The review highlighted important learning around how we work with families both within day-to-day practice as well as in SARs. The board is working with Joan’s family for dialogue around how they may wish to support sharing the learning from this review.

Key Points for Learning and Reflection

- Do you have an established process for deciding who needs to be involved in multi-agency meetings and plans, and how do you ensure all relevant agencies are involved in discharge / care and support planning? How do you ensure that agreed actions are monitored and followed up?
- How have you overcome challenges to good multi-agency working? For example, how do you take responsibility for effective information sharing and communication?
- Do you feel you have the skills and confidence to explore and understand families who are expressing frustration and dissatisfaction?
- Are you aware of the Department of Health and Social Care's (DHSC) Safeguarding Adults Protocol for Pressure Ulcers, and how to use its Safeguarding Decision Guide Assessment?
- How do you ensure you adopt a person-centred approach consider all reasonable adjustments are met when working with adults with care and support needs?
- Are you confident in applying the Mental Capacity Act in practice?

Further resources and reading

London Multi-Agency Adult Safeguarding Policy and Procedures

DHSC Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry

Mental Capacity Act Code of Practice

Making Safeguarding Personal Toolkit

Social Care Institute for Excellence – Safeguarding Adults Resources

The SAEB website is due to be launched in the near future where you will be able to find the SAR Joan overview report, the SAR Protocol and Guidance and SAR Guide for Family and Carers.

To raise a safeguarding adult concern, contact the Information and Access Teams:

Westminster: 020 7641 2176
adultsocialcare@westminster.gov.uk

Kensington and Chelsea: 020 7361 3013
socialservices@rbkc.gov.uk

For more information on this briefing contact the SAEB at makingsafeguardingpersonal@rbkc.gov.uk