Briefing Document for SAR Jayne

This short briefing gives an overview of the key themes and learning following a Safeguarding Adults Review (SAR) undertaken by Salford Safeguarding Adults Board (SSAB).

Salford Safeguarding Adults Board

1. About the Adult

Jayne was 49 years when she died, she always lived with her parents but was a sister and aunt to many nieces and nephews; she was described as a bubbly character who was loved by all.

As an adult, Jayne suffered a number of long-term medical conditions including type 2 diabetes, asthma, hypertension, high cholesterol, migraines, gastro-oesophageal reflux disease, severe osteoarthritis of weight bearing joints and sleep apnea. In 2011 Jayne was successfully treated for large B cell lymphoma[1] in the floor of the mouth.

Despite her own problematic health, Jayne continued to support her mother, who she lived with, and they would shop together and enjoy hobbies such as needlecraft. In addition, Jayne enjoyed online gaming and would regularly connect with her nieces and nephews to play with them.

Jayne struggled with weight management but always remained mobile at her own pace and continued to holiday, be actively involved with her extended family, and enjoy life.

Family have informed this review of Jayne's frustrations and low self-esteem borne from perceived weight prejudice. The family have also described the loss of dignity Jayne felt requiring bariatric equipment and care when she became immobile and dependent on others.

In March 2020, the United Kingdom was placed in lockdown due to the Covid pandemic. Jayne was told to shield by her GP.

2. What happened?

On the 30th of May 2020 Jayne had been shopping with her mum but later in the evening found herself unable to get out of her chair. The following day paramedics attended and transported Jayne to the Accident and Emergency department at the hospital where they raised concerns about Jayne's living conditions to hospital staff.

Examination of Jayne uncovered excoriated pressure sores (the medical meaning of excoriation refers to a place where the skin is scraped or abraded). These were dressed and concerns were raised for recurrent lymphoma. Jayne was admitted into the hospital.

Hospital staff submitted a safeguarding referral to Adult Social Care outlining unkempt home conditions. Upon receipt and upon learning that Jayne was an impatient at the hospital, a practitioner at the Adult Social Care Contact Team contacted the referrer and advised that Jayne be referred to the

[1] A cancer of the lymphatic system of the body involving immune cells. This causes swelling of lymph nodes in neck, armpit or groin, fever, night sweats, difficulty in breathing and weight loss.

Hospital Social Work Team.

Following confirmed relapse of lymphoma, Jayne remained an inpatient of the hospital and embarked upon a course of chemotherapy. Jayne's hospital admission continued for a number of months due to the treatment needed, which had to be provided within the hospital setting and due to her requiring bariatric care which created challenges transporting Jayne to and from hospital.

Jayne was discharged from hospital in September 2020 needing specialised equipment, daily support from carers and medication and care administered by community nurses. Anita (Jayne's mum) has expressed the intrusion both her and Jayne felt as multiple professionals entered their home daily and the confusion regarding the different roles and remits of those involved. Whilst Jayne's discharge from hospital was safe, the omission of a discharge planning meeting between family, and the professionals who were to support Jayne in the community, meant that the opportunity was missed to clarify the care Jayne would need and who would provide it.

Despite her own health problems, Anita with much support from Anne (Jayne's sister), became Jayne's main carer. Both Anita and Anne have told this review that they do not feel that professionals gave them enough information about Jayne's health and prognosis to support them in their role as carers. Similarly, the domiciliary carers report confusion regarding which professionals had visited in their absence and what care had been provided. Communication between everyone involved in supporting a person of ill health in their own home, needs to be effective.

Jayne's immobility and bariatric needs left her unable to attend hospital appointments and as a result she was left without urology care and discharged from hematology whilst outstanding a scan. In addition, Jayne's experience of the hospital ward had affected her, and she was adamant that she would not return - even when suffering intense pain. Professionals who had built a trusted relationship with Jayne were rewarded with some insight into this decision, but it is not known if Jayne chose to keep some of her experiences to herself. Jayne's intensifying pain resulted in an increasing refusal to accept professional care at home. Developing a 'pain management in the community pathway' could help professionals to navigate pain control.

Anita's subsequent protection and defence of Jayne was sometimes seen as uncooperative, but Anita was fundamentally Jayne's mother and was doing what came naturally to her. Anita did not label herself 'Jayne's carer,' but professionals must ensure that family members understand, recognise, and know how to seek support should they need it.

Safeguarding concerns were raised for Jayne on four occasions within the scoping period of this review. Most resulted in multi-agency meetings, but other key episodes within Jayne's care (for example, when discussing treatment options, treatment preferences and/or gaps in care) would have benefitted from

further multi agency meetings. Such meetings would have afforded professionals the opportunity to merge their expertise, observations, and decision-making.

Jayne's experience of being an inpatient in hospital was heavily affected by the Covid pandemic. The loss of visitors and volunteer services whilst on the ward resulted in boredom, isolation, a lack of physical and emotional support from those who knew her best and decreased relational practice between health professionals and Jayne's significant others.

The unprecedented pressure on the hospital bereavement service developing from the Covid pandemic, also resulted in a less professional support provision for family after Jayne had sadly been found deceased in her hospital bed on the 26th of March 2021.

3. Reason for the Review

A decision was made by the SSAB SAR panel that a Mandatory SAR would be completed to understand and identify any learning to understand how agencies worked together.

Independent Reviewer, Allison Sandiford was commissioned to author the final report.

Key episodes are periods of intervention that are deemed to be central to understanding the work undertaken around Jayne. The episodes do not form a complete history as they are key from a practice perspective and summarise the significant professional involvements that informed the review. Professionals at panel meetings and the reflective sessions explored the following key episodes.

Key Episodes	Date
Key Events Prior to, and at the Beginning of, the Scoping Period	Pre 30/05/2020
Jayne's Admission to, and Discharge from, Hospital	30/05/2020 – 14/09/20
On-going Care Provided to Jayne at Home	14/09/2020 – 24/02/2021
Jayne's Further Admission into Hospital	24/02/2021 – 26/03/2021

Copy of the full report can be found on the SSAB website

4. What worked well

- There is evidence of much good practice within several agencies who supported Jayne and it is equally important to develop learning from this good practice as it is from any shortcomings:

- Professionals at the reflective session noted that the community tissue viability nurse lead had provided excellent and continuous support to others with re-ablement.
- Carers from the second domiciliary care provider have evidenced that they built good relationships with both Jayne and Anita and their reflections demonstrated good appreciation of how Anita may have felt caring for her daughter and losing privacy in her own home.
- It was recognised there was good examples of collaborative working between the tissue viability and district nurses.
- The District Nurses and Urgent Care Team worked well together when the domiciliary care provider terminated care.
- Good practice identified from staff in the Accident and Emergency ward who recognised the safeguarding concerns.
- Nurses have told this review that the second domiciliary care provider worked well with them.

5. Key Learning from the Review

The review has asked the SSAB to deliberate the following questions. It is the responsibility of the SSAB to use the ensuing debate to model an action plan to support improvements to systems and practice.

Question 1 for the SSAB: How can the SSAB learn of the current challenges professionals face when attempting to support people experiencing obesity who are at risk of harm, and how can the SSAB and their partner agencies improve or develop practice which will encourage people in their area to engage with dietetic support?

Question 2 for the SSAB: How can healthcare agencies assure the SSAB of improved management of the transportation of bariatric patients to and from hospital to support timely discharge and appointment attendance?

Question 3 for the SSAB: How can the SSAB guide professionals from all agencies and organisations to ensure that all professionals supporting a person are clear about whether a person is consenting to their information being shared with loved ones, and understand concerns when consent may need to be overridden?

Question 4 for the SSAB: How can the SSAB be reassured that partner agencies are working and developing their collaboration with a service users' family, and within that practice, supporting individuals to raise concerns about either their own or another's care?

Question 5 for the SSAB: How can the SSAB ensure that information and advice for carers reaches everyone, including individuals who are not confident with a computer?

Question 6 for the SSAB: How can the SSAB explore whether partner agencies are maximising opportunities to convene multi-agency professionals' meetings, and how can partner agencies assure the SSAB of robust managerial oversight to support the incorporation of such meetings within practice?

Question 7 for the SSAB: How can the SSAB support and encourage partner agencies to share information with domiciliary care providers which will improve the quality of care offered to a service-user without breaching privacy and data protection?

Question 8 for the SSAB: How can the SSAB work with partner agencies to support the development of a 'pain management in the community' pathway?

6. What are we going to do?

- A wider learning event will be held on 03/11/2022 to share the learning with the workforce. The event will be recorded for those who are not able to attend. For further information please contact ssabtraining@salford.gov.uk
- The SSAB will develop an action plan and seek assurance on the questions the Independent Reviewer has asked to the SSAB to ensure there is learning and positive change from the review.
- Learning has been shared with all agencies which includes development of a robust action plan to address the key themes and learning which will be monitored on a regular basis.
- The SSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned and areas of good practice from SAR Jayne and other SARs in the system in due course.

7. Signposting and Resources

- **Health Improvement Connect** – Salford Health Improvement Service has been serving the residents and communities of Salford since 2004. The service aims to improve the health and wellbeing of residents in the city. They offer a wide ranging and variety of services and support; for further information visit Health Improvement Connect
- **Strength based practice** is a social work practice theory that emphasizes people's self determination and strengths. It is led by the person with a focus on future outcomes and

strengths that people have, including family and community networks. Salford Adult Social Care are working toward embedding a strength-based approach through implementation of Community Led Support. All agencies currently working in Salford can access online training on Community Led Support which includes having good conversations with people. More information is available on the SSAB website.

It is important that we have skilled conversations with the people we work with, to ensure their voice is heard and they are supported to achieve their desired outcomes. The new Salford Multi-agency Safeguarding Policy and Procedures contains information on the overarching aims, duties and principles, as well as having a whole section on The Skilled Conversation: Outcomes.

- **Making Safeguarding Personal** – this is an important when working with adult with care and support needs and aims to develop an outcome focus to safeguarding work and supports people to improve or resolve their circumstances and ensuring their voice remains central.

- **Sharing information -** Safeguarding adults from harm and abuse often requires information sharing between services, organisations and with family members. **Remember GDPR is not a barrier**, the data protection and regulation law is not intended as a barrier to information sharing but it helps information to be shared in the right way, for the right reasons.

  For further information see the SSAB website for Information Sharing and Confidentiality. There are some useful tools to support individuals like the 'Seven Golden Rules for Information Sharing'

- **Anyone can become a carer**
  Quite often, people don't consider themselves as 'a carer', they are just looking after their family member or friend and doing what anyone else would do in the same situation. It is important that just because someone declines an assessment because they don't see themselves as a carer, that support is still offered to ensure they look after themselves and to enable them to care for their loved one. See the Information for carers page on the SSAB website for more information on support available for carers.

- **If you are worried about an adult** – you can report any concerns of abuse or neglect by telephone on 0161 631 4777 or online by using the 'Report a safeguarding concern form', please see the link which provides all the necessary information to report your concern.

For professionals only

The High-Risk Advisory Panel has been introduced to support professionals who are working with adults who have complex needs and are high risk of harm.

The High-Risk Advisory Panel aims to offer support for professional by providing multi-agency risk enablement approach to offer advice and support for those adults where multi-agency responses have not been able to reduce the level of risk, whilst at the same time empowering the adult and recognising their human rights.

If you are working with an adult who is at high risk of harm, please see information about the High-Risk Advisory Panel on the SSAB website.

8. Next Steps – we ask that you

- Share the briefing within your own organisation, across your teams and share with individuals who will benefit from the learning from this review
- Make yourself familiar with the report and access the wider learning event.

For more information regarding safeguarding adults visit our website https://safeguardingadults.salford.gov.uk/