West Sussex Safeguarding Adults Board
Making Safeguarding Personal

Safeguarding Adults Review (SAR) Learning Briefing: Mrs Patricia Pelham

Board partner name, role, and organisation responsible for action plan:

What is a SAR?

A Safeguarding Adults Review (SAR) is a legal duty under the Care Act 2014. The aim is to learn from serious safeguarding cases to prevent similar incidents occurring. The focus of the review is looking at systems and practices across agencies. It is not to apportion blame on an organisation or individuals for any failings.

A Multi-Agency Learning Review may also be considered as an alternative to a full SAR where:
- the referral may not reach the threshold;
- partners are actively working towards shared learning;
- the complex themes identified have already been identified in previous SARs either locally or nationally.

This briefing is intended to highlight the key themes identified from the SAR so that you can consider what these mean for your practice, and what actions you need to take to embed the learning.

Please complete the action plan on pages 2-4 to evidence how you will embed learning in your practice, **and return to safeguardingadultsboard@westsussex.gov.uk by 16 December 2019.** In six months' time, April 2019, you will also be asked to complete page 5 with your reflective commentary on how learning has been embedded.

Background

Mrs Pelham was a 70 year old woman who was living at home with her husband who was her main carer up until a the incidents leading up to her death.

This multi-agency learning review focussed on the reports of neglect identified by the ambulance service when they attended her home following a call, especially in terms of the support she should have received at her own home.

Ambulance staff attended the family home to find Mrs Pelham *'in a critically unwell state. Observations and findings suggested septic shock. We noticed that both legs below the knee were necrotic and severely infected.'*

Mrs Pelham was transported to hospital where she sadly died.

A full copy of the learning review, with the full listing of recommendations, can be found on www.westsussexsab.org.uk.

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Key Theme 1: Effective communication

What we've learned	In your practice	Action plan
The review found: As part of the learning review several missed opportunities were identified in the sharing and 'handing over' of key information between agencies supporting Mrs Pelham. Information about Mrs Pelham's existing relationship with Proactive Care teams was not documented in Hospital notes, and in handovers there was no proactive care planning to enable Mrs Pelham or her husband contacting the community team for rapid support in the event of wound deterioration. **We've learned that:** Providing clear information and support guidance to partners and patients, including information around what to do if conditions worsen, can create opportunities for early intervention and support, giving people the best opportunity to recover and rehabilitate.	**How to think about this in your practice:** • How clear and consistent are your agency's handover procedures to other agencies? • How do you ensure that patients/customers are given clear and accurate information to promote rapid recovery?	**What needs to happen?** **Who will do it?** **When will it happen?** **How will you know it's been done?** **How will you know it has worked?**

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Key Theme 2: Geographical impact

What we've learned	In your practice	Action plan
The review found: Mrs Pelham's care, around accessing GP medical support and wound care dressing prescriptions, was impacted on by Mrs Pelham choosing to remain with her original GP Medical Practice, which was not local to her address. **We've learned that:** Although All adults have the right to register with a GP practice somewhere convenient for them, these arrangements are voluntary for GP practices and they can refuse to register if the practice feels it is not clinically appropriate or practical for the person to be registered so far away. Good practice would support contacting the person and giving a clear reason for refusing the registration.	**How to think about this in your practice:** • How does your agency respond to patients/customers who are 'out of area'? **References:** Patient choice of GP practices https://www.nhs.uk/using-the-nhs/nhs-services/gps/patient-choice-of-gp-practices/	**What needs to happen?** **Who will do it?** **When will it happen?** **How will you know it's been done?** **How will you know it has worked?**

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Key Theme 3: Multi-agency oversight

What we've learned	In your practice	Action plan
The review found: The information shows that single agency procedures were followed and that there was a reasonable amount of information sharing across agencies, but many of the responses were in relation to the presenting concern only, without multi-agency oversight that may have helped identify and address the wider care and support needs. **We've learned that:** An initial referral to Adult Social Care may have promoted a joined up approach to supporting Mrs Pelham with a number of the issues that impacted her.	**How to think about this in your practice:** • Are you confident at which point you would raise a Care Act/Carer's assessment for someone you support? • How does your agency monitor multi-agency involvement and ensure that changes in care and support are shared to all appropriate agencies?	**What needs to happen?** **Who will do it?** **When will it happen?** **How will you know it's been done?** **How will you know it has worked?**

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When requested, please complete this reflective commentary, **and return to safeguardingadultsboard@westsussex.gov.uk by 16 April 2020.**

Cascading learning	Actions taken	What now?
Please provide a summary of who this briefing was cascaded to, and how, e.g. in supervisions, team meetings, or a development event.	*What actions were taken as a result of this briefing?*	*What was the impact of the actions taken, and how will you take this learning forward in your practice?*