West Sussex Safeguarding Adults Board
Making Safeguarding Personal

Safeguarding Adults Review (SAR) Learning Briefing: MS

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.

In order for a SAR to have an impact on practice and systems, changes are needed and the Safeguarding Adults Board (SAB) need to know of this to have assurance that a risk of a similar incident would not happen again given the learning found from the SAR. 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, you will also be asked to complete page 5 with your reflective commentary on how learning has been embedded.

Background

This Safeguarding Adults Review, following the death of MS at the age of 90 in December 2017. MS, who lived in Kent, and her older sister, JF, had both fallen at the latter's home in Goring, West Sussex on 25/12/17.

After many hours waiting on an ambulance which did not arrive, they were supported to their feet by Police Officers who attended the home address. On the following day or shortly after, MS and her sister fell again at the home address, were unable to summon support, and MS had died by the time that she and her sister were found on the floor by a friend on 28/12/17.

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

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Key Theme 1: Multi-agency responses and risk assessments

What we've learned	In your practice	Action plan
The review found: When MS fell to the floor, despite repeated calls over several hours to the Ambulance service (via the Police), the calls were not linked as an issue that was growing in severity. These calls were dealt with individually and dealt with by four separate members of staff, who were call handlers without clinical expertise. **We've learned that:** It has been acknowledged by SECAmb that discussion with a clinician at an earlier stage may have linked calls and supported a more urgent response. Triaging of calls and linking them to an address/incident may have heped support this.	**How to think about this in your practice:** • How does your agency monitor and link calls across numerous contacts/visits to services? • How is this escalation of priority and the impact of resources relayed to the patient?	**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: Proactive use of Telecare and 'virtual support'

What we've learned	In your practice	Action plan
The review found: It was noted by agencies that there was a Telecare 'Lifeline' system at the house; community support health and support staff, as well as the emergency services, did not utilise this additional support that may have reduced the impact and assisted in escalating an emergency response. **We've learned that:** Telecare 'Lifeline' systems can be used proactively to alert Lifeline staff of concerns and actions taken and could be used to undertake 'virtual' welfare checks with individuals, whilst waiting for further support from emergency or healthcare services.	**How to think about this in your practice:** • Would your frontline staff know how to recognise and use Telecare systems in a person's home? • What other measures could your agency use to complete 'welfare checks' on people who are being left at home without professional support? Learn more here: https://www.scie.org.uk/socialcaretv/video-player.asp?guid=9be2764a-d81e-4c5f-8a83-b15eeedffa7e	**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: Impact of resources

What we've learned	In your practice	Action plan
The review found: The level of pressure on resources within SECAmb were of a very demanding nature during the Christmas period. This impacted on a number of services across the Health and Social Care Sector. SECAmb have introduced new SURGE protocols to reduce the likelihood of this happening. **We've learned that:** The resource pressure in responding to falls is of significant concern to the whole of the Health and Social Care economy and has effects in to other Blue Light services, who attempt to support and relieve the pressures. The Safeguarding Adults Board will be raising this and discussing this with other partnership Boards.	**How to think about this in your practice:** • How can your agency work in partnership with others to promote an earlier support for people who fall to the floor at home or in public places? • What are your organisations current procedures and protocols around supporting older people with falls?	**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?*