Learning Briefing – Jane SAR 2018/19

1. What were the circumstances that led to this SAR?

1.1 Jane was 47 years old when she died in hospital in June 2018. The causes of her death were heart disease linked to high blood pressure, infected leg ulcers with septicaemia and liver disease. She had been admitted to hospital in connection with these physical health concerns a week before she died. Within the previous fifteen months, she had had five admissions to hospital related to these ongoing physical health concerns.

1.2 For most of her adult life, Jane had also lived with mental health needs arising from a diagnosis of schizophrenia. Jane had long-term support provided through the Mental Health service. Jane had lived in the County in an urban district all her life. Although she had lived independently for many years, she had shared a home with her mother, Theresa, from her early twenties.

1.3 Jane's mother, Theresa, was a family / kinship carer. Besides the ordinary pressures of the informal caring role, Theresa was also in paid employment.

2. What were the nature of the circumstances?

The Worcestershire Safeguarding Adults Board wanted to review:

2.1 the extent to which Jane's voice had been "heard" in the delivery of support and care and whether that of her mother had dominated interactions e.g. in relation to treatment choices.

2.2 whether local agencies had worked together effectively to safeguard Jane prior to her death.

3. What should we make sure we do?

3.1 Ensure that:

- when offering advice and support as part of your role; find out who else/what organisations are working with the person; and identify important relationships such as formal/kinship carers and friends/neighbours;
- with consent, communicate with colleagues and, in more complex situations, use the multi-agency team meeting process to share information and plan next steps (Remember-Any practitioner can call a multi-agency team meeting).
- where there are complex and multiple needs, ensure there is a decision made at the first multi-agency meeting, as to who is the Lead Professional, if this has not already happened (for example, when packages of care are agreed.)
- we promote relationship-based practice and are person centred. (also remember Make Safeguarding Personal)
- Managers/Team Leaders across the system, when undertaking supervision, for example, should be ascertaining who is the Lead Professional in situations where people have complex and multiple needs.

Learning	How
1. Making Safeguarding Personal and Carers • Promote person centred and relationship-based practice. What does the person you're supporting want? • Does this present a different view to what the carers thinks the person needs?	Make use of Family Group Conferences or use a Consensus Statement approach to bring people together and to seek solutions to presenting dilemmas e.g. differences in view between the cared-for/supported and the familial/kinship caregiver. Managers/clinical leads should plan and develop clinical or case reviews in a systematic way. Patients can be stratified/graded into well-defined risk groups which may be based on themes such as similar ilnessess or conditions. Where relevant these reviews should consider the requirements of the S117 After Care Planning and the Care Programme Approach.
2. Understanding statutory roles and responsibilities for care provision made under Section 117, Mental Health Act 1983 and Care Act 2014	Practitioners should be familiar with their statutory roles and responsibilities for care provision made under Care Act 2014 and Section 117, Mental Health Act 1983. Organisations and managers should ensure staff understand their roles and responsibilities through supervision/training.
3. Promote parity of esteem between mental health and physical heath	People whose primary contact with health and social care services is through the mental health system should also have their physical health needs identified and met in terms of health prevention activity as well as treatments.
4. When addressing health and care neeeds with isolated people consider whether any of these could be met though a more sociable service	Consider whether there are local services which are delivered to groups which could reduce people's experience of loneliness. Managers/clinical leads, for example could a social model of leg ulcer treatments established locally help address social isolation. Consider if a "Carer Mentor" idea might be developed to extend support to family/informal carers.