Thematic Safeguarding Adults Review in respect of hospital discharge for adults with co-occurring conditions

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Contents

Glossary

BIA	Best Interest Assessor
CMHT	Community Mental Health Team
CPA	Care Programme Approach
DKA	Diabetic ketoacidosis protocol
EDT	SCC's Emergency Duty Team
FRH	Farnham Road Hospital
HDT	SaBP's Hospital Discharge Team
IMCA	Independent Mental Capacity Advocate
JSNA	Joint Strategic Needs Assessment
KLOE	Key Line of Enquiry
MCA	Mental Capacity Act 2005
MECC	Make Every Contact Count
MHA	Mental Health Act 1983, as amended
NICE	National Institute for Clinical Excellence
NSCN	National Safeguarding adults Child's Network
RCRP	Right Care; Right Person
RMN	Registered Mental Health Nurse
SAM	Surrey Adults Matter
SAR	Safeguarding Adult Review
SaBP	Surrey and Borders Partnership NHS Trust
SCARF	Single Combined Assessment Risk Framework
SCC	Surrey County Council
SPOC	Single Point of Contact
SSAB	Surrey Safeguarding Adults Board
TAP	Team around the Person

1. Introduction

1.1. In December 2024 Surrey Safeguarding Adults Board [SSAB] commissioned a thematic safeguarding adult review [SAR] following the death of four adults between September 2021 and December 2022. All four had established care and support needs arising from co-occurring conditions. They died in circumstances that suggested a poor understanding of the legal duties to ensure continuity of care across organisations and disciplines. Within this report they will be given pseudonyms for the purposes of anonymity to protect the privacy of their surviving relatives.

1.2. The SSAB and the SAR subgroup recognised that the circumstances of all four cases may not meet the criteria for a mandatory SAR under s44 Care Act 2014[1]. However, SSAB agreed to commission this thematic review to explore what, if any, additional learning there is for the partnership.

1.3. Partner agencies involved in providing care, treatment or responding to identified risks intended to safeguard the four adults submitted chronologies. The review was asked to include information on the impact of any practice improvements since the adults' deaths. The report, therefore, has drawn from information provided by partner agencies and focus group discussions with practitioners, senior leaders across partner agencies and the SAR Panel. This report explores systems issues that, despite improvement priorities since 2022, persist to assist SSAB partners identify what more is needed to enable practitioners across partner organisations work with adults and their wider support networks to overcome system barriers to effective care and identify what more might be needed to prevent future harm.

1.4. SSAB and review author gave very careful consideration to the involvement of the four adults' families into this review. Mindful of the time that had passed since their deaths, the reviewer has relied on case records and publicly available material to avoid further distress to their families. The SSAB is asked to consider demonstrating their commitment to working with families and adults who have lived experience of co-occurring conditions by hosting a focus group with experts by experience and carers to co-produce or inform the action plan in response to the reports' recommendations.

1.5. The challenges of providing quality, trauma-informed care to individuals with complex needs arising from co-occurring health conditions is well recognised. The Second National SAR Analysis[2] reported patterns in poor outcomes for adults with care and support needs and recommended priorities for service improvement to enable effective safeguarding risk mitigation against poor quality care which, left unaddressed, could result in organisational neglect or abuse. In particular, the report highlighted:

- A lack of understanding about roles, powers and duties with regards to adult safeguarding.
- Safeguarding was not always personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs are too often left out of decisions/discussions about their support.
- Professional culture and negative attitudes: risky/distressed behaviour viewed as 'lifestyle choice', attention-seeking, non-compliance, or disengagement. Practitioners voiced resignation in the face of high risk and had low expectation of change.
- Uncertainty about when and how to share information without consent.
- Inadequate policy support and absence of risk or escalation policy.
- Poor management scrutiny, inadequate quality assurance and issues of staffing or workloads resulting in adverse outcomes.

[1] This is specified below within the case narrative for each person.
[2] 'Second National Analysis of Safeguarding Adults Reviews, 2024, Partners in Care and Health. Available at: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

- inadequate learning dissemination was also highlighted within the analysis report.

1.6. That national analysis reflects concerns noted locally within SSAB's published SARs (detailed below in section 3) and within the cases reviewed here. Despite national guidance and practice standards[3], there remains inadequate national policy to assist practitioners and hospital managers understand their own legal obligations in respect of public law and human rights obligations where gaps in service provision mean that risks from complex health needs arising from co-occurring conditions may not be safely mitigated.

1.7. In light of previous learning, the reviewer was asked to explore the adults' case records between September 2021 to December 2022 and address four key lines of enquiry [KLOE], namely:

- What has changed locally following the recent SAR learning for adults with co-occurring physical and mental health/ cognitive impairments?
- Are risks associated with malnutrition more carefully monitored; is the Malnutrition Universal Screening Tool [MUST] guidance[4] socialised?
- How is learning from PSIRF and LeDeR reported to mainstream community health services?
- What more needs to be done to embed or socialise good continuity of care practice between clinical in-patient settings and community providers?

2. Case Narratives

Matthew

2.1. Matthew[5] had a history of schizophrenia and chronic depression. He was socially isolated-having reported his condition left him unable to leave his flat. He experienced self-neglect and physical health issues and frailty, believed to be linked to self-neglect (non-concordance with medication and poor nutrition). He had, prior to the period under review, had several hospital admission due to falls.

2.2. On 23.09.21 Matthew was discharged from Farnham Road Hospital [FRH]. He was assessed as mentally stable but frail. It was understood he required three daily visit to assist with his activities of daily living, including feeding. Notification of his discharge wasn't passed from FRH to Surrey Council Council's [SCC] hospital discharge team [HDT] or the care agency responsible for his care package until late on 24.09.21. His carer, however, visited later that evening discovering he had limited food in the home (cereal). FRH were advised he had no electricity at home and the flat was extremely hot (because of a longstanding disrepair issue), dirty and cluttered.

2.3. On 25.09.21, Surrey and Borders Partnership NHS Trust [SaBP]'s home treatment team [HTT] visited noting he was yellow, hot, coughing and unable to communicate. There is no evidence the care agency or HTT staff took action to seek medical input. His body was discovered on the 26.09.21, he was 61. It is believed he died from natural causes. SSAB concluded this was a single agency failing (by SaBP) to arrange a safe discharge from a mental health facility to meet known physical health and social care needs, SSAB agreed to review this case (on a discretionary basis) as they believed there were lessons for partner agencies which went beyond the learning SaBP had identified within their serious incident report.

[3] For example, NICE clinical quality standards
[4] Available at: https://www.bapen.org.uk/pdfs/must/must_full.pdf
[5] 'Matthew' was a white British man. He would have likely be considered disabled due to his mental health conditions and frailty, but there was no information available to this review as to whether he would have identified as disabled. There is also no information about whether he followed a religion, his sexuality or relationship status.

Paul

2.4. Paul[6] had a diagnosis of Treatment Resistant Schizophrenia, type two diabetes and congestive heart failure (not symptomatic). Shortly before his death he was an in-patient at Cygnet hospital, under s3 of the Mental Health Act 1983 [MHA]. Prior to this he received care from SaBP between 2009- 2021. SaBP continued to receive monthly updates on his care from Cygnet hospital staff.

2.5. On the 24.02.22 Paul was reportedly '*overtly unwell'*, his blood glucose levels were reportedly '*off the charts*'[7]. By 26.02.22 at 9am Cygnet staff agreed he needed to be urgently transferred to an acute hospital, but this didn't happen for 5 hours as the consultant psychiatrist had refused to attend Cygnet hospital. Paul was escorted to St Peters Hospital arriving at 14:37. Upon arrival there was a delay in hospital staff commencing their Diabetic ketoacidosis [DKA] protocol due to*' his non-concordant and challenging behaviour*'. It is understood he refused blood monitoring but lacked capacity (due to poor mental health) to make this decision.

2.6. Paul passed away at 19.05 following a cardiac arrest. He was 56. An inquest into his death found there were "*repeated gross failings*" to manage his diabetes. His blood sugar was not monitored regularly in accordance with the care plan. His ketones were not checked when his blood sugar levels exceeded safe levels. Staff failed to notice that Paul had lost 5kg in the space of two weeks, a well-known warning marker for severe hyperglycaemia (high blood sugar levels). Nursing staff failed to recognise or effectively escalate concerns regarding the deterioration in his health to the medical team. The medical team also had not address concerns that were raised with them. No specialist help was requested. The Cygnet MDT did not function effectively to oversee care and ward managers did not pick up on obvious gaps in the patient records.[8]

2.7. The SSAB confirmed this met the mandatory criteria for a safeguarding adult review, they commented on the learning identified in SSAB's 'Eddie' SAR[9] as well as similarities to other cases included in this thematic review.

George

2.8. George[10] required daily social care due to needs associated with Fragile X Syndrome, learning disability, epilepsy and angina. He has also suffered a previous heart attack. He resided in a SCC residential care home. In 2019 risk assessment guidelines were agreed between the home, his GP and neurology consultant to ensure he received rapid medical assessment if he appeared to be having a seizure as this may be mistaken for a heart attack and his usual treatment for the seizures could worsen his health.

2.9. On the 13.07.22 George suffered a seizure, the risk assessment guidelines were not followed as medical attention was not immediately sought. It was noted to be a warm day and George was believed to be dehydrated. He was reported later that day to be '*tired but chatty and in good spirits*'

2.10. On the 14.07.22 staff contacted his GP to seek belated guidance regarding the seizure on the 13th. They were advised the GP would call later. Later that morning, as his breathing was deteriorating, they called NHS 111 who sent an ambulance. The crew provided advice (to increase his fluid intake) and noted his blood pressure lowered in response to additional fluids. They requested GP prescribe antibiotics. His GP later confirmed the prescription and gave advice re medication if George had a subsequent seizure. Later that evening George suffered

[6] 'Paul' was a white British man. He would have likely be considered disabled due to his physical health and learning disability. Case record note his faith as 'Church of England/Anglican', but not his sexuality or relationship status.
[7] Taken from chronologies collated for this review.
[8] Taken from the Inquest report made available to this review.
[9] Available at: https://www.surreysab.org.uk/wp-content/uploads/2024/09/SSAB-SAR-Eddie-Executive-Summary-Report-August-2024.pdf
[10] 'George' was a white British man. He would have likely be considered disabled due to his physical health and learning disability. Case record note he was Christian, but not his sexuality or relationship status.

a subsequent seizure, 999 was called and CPR was started. Paramedics attended within 5 minutes but were unable to revive him. He was 64 at the time of his death.

2.11. A s42 enquiry was undertaken (as was the usual practice at that time) following George's death. As part of that enquiry, George's sister commendably explicitly requested that care home staff were not blamed for his death. Instead she wished to understand if the outcome may have been different had he been taken to hospital following Ambulance crews' first attendance. The report concluded George had been neglected by the care home on the 13.07.22, because '*there was no Tier 1 management presence on site. Guidance is within date but, there are discrepancies in information available for the carers to follow… guidance was confusing. There was a lack of oversight on knowledge that carers actually had from manager'*. The enquiry officer noted, however, care home staff '*they did everything they could to support [George]'.*[11] The s42 enquiry did not believe care home staff had been neglectful on the 14.07.22, but that he was neglected by health professionals that day as, in their view, he should have been taken to hospital. It is important to explain (given findings detailed below in 2.12) that the s42 enquiry was comprehensive. There is clear evidence that the enquiry officer undertook this role with an open, investigative mindset and evaluated the information carefully. The s42 enquiry was subject to quality assurance by SCC's Assistant Director for Safeguarding, who concluded with the findings.

2.12. The SSAB concluded in July 2023 this case met the mandatory SAR criteria due to concerns about how ambulance, GP and care home worked together. For clarity, contrary to the findings in the s42 enquiry, we could find no evidence of neglect but believed staff providing care to George, (his GP, Ambulance crew and care home staff) had responded in line with policy and good practice expectations. His experiences have therefore been considered within this review as within the discretionary powers of the SSAB because they will assist take forward the learning from SSAB's Eddie SAR.

Jon

2.13. Jon[12] lived in a supported living placement as he required assistance with all activities of daily living due to a severe learning disability, following a brain injury sustain in childhood. He was well known to SaBP's community district nursing and Speech and Language Team [SaLT] as well as SCC's Community Team for People with a Learning Disability [CTPLD]. In October 2022 he was admitted to hospital with sepsis resulting from a chest infection. During his admission there was evidence of good communication between the home, community services and the ward staff. This was overseen by the Learning Disability [LD] liaison nurse. A SaLT (dysphagia triage) advised on a special diet due to risks of choking and referred him to CTPLD's weighing clinic to address concerns regarding his recent weight loss.

2.14. Jon was discharged home on 22.11.22 in a frail condition to his previous residence, despite this not being registered to provide personal or nursing care. His discharge summary was led by the LD liaison nurse, but included SaLT advice. The CTPLD' SaLT completed a dysphagia assessment on 26.11.22, addressing directly (to the care home) concerns they had that a carer had tried to feed Jon with a syringe. During focus group discussions SaBP explained that whilst they were satisfied Jon was able to be discharged from hospital, they accepted more should have been done to ensure staff at the supported living placement had the requisite knowledge and skills to secure appropriate care and treatment for him.

2.15. Following his discharge, in contravention to the discharge plan, Jon was not bought to the weighing clinic on 30.11.22. The SaLT immediately sent an email to the home to remind staff this would be important. Care home staff were then advised that SaBP didn't have a hoist scale

[11] Taken from the s42 enquiry report made available to this review.
[12] 'Jon' was a white British man, he would have been considered to have a protected characteristic of disability. There is no information available from case notes made available to this review regarding his sexuality, faith or relationship status.

available, so would be unable to weigh him at the clinic as he was non-weight bearing. CTPLD completed a nursing appt on 02.12.22 on request from the hospital and wrote to his GP to request diet supplements as the care home had exhausted the supply sent with him at the time of his hospital discharge.

2.16. On 05.12.22 district nurses attended to provide pressure ulcer care to Jon, they noted this had improved. A CTPLD dietician attended and completed an assessment on the 06.12.22. The care home advised that Jon couldn't take fluids or food, they started a chart and agreed to call the GP, but later reported GP '*wasn't helpful*'[13]. The dietician visited on the 07.12.22, noting he was emaciated. Advice was given to care home staff, including when to contact the GP. His annual review by the district nurses was also conducted that day by phone.

2.17. Jon died the following morning (aged 51). The SaLT and LeDeR reviewer submitted referrals for a SAR, concerned that the discharge wasn't safe and that the care he received may have amounted to neglect. Whilst an enquiry under s42 Care Act did not conclude his care was neglectful, SSAB agreed for Jon's experiences to inform this review using their discretionary powers under s44 Care Act.

3. Case Analysis

KLOE 1: Managing Risks of Co-occurring Conditions

This section will explore what has changed recently in response to wider learning for adults with co-occurring physical and mental health/ cognitive impairments?

3.1 Two of the people within this review (Matthew and Paul) had physical health conditions alongside enduring mental health conditions. Two (George and Jon) had physical health conditions and were learning disabled. All four died prematurely, namely under the age of 75. All four were dependent on others to recognise and respond to their increased frailty, arising from their needs including to ensure their nutritional needs were being safety met.

3.2 There is already a well-established body of evidence[14] detailing the impact that such co-occurring conditions have including, too frequently, on accessing appropriate health care resulting in avoidable deaths at a much younger age that the general population. Such evidence formed the basis of national programmes to improve early identification of life limiting, but preventable illness through better access to health. Those national programmes have shaped local services, coordinated through the local Health and Wellbeing Strategy which was revised in 2022 and identified it would be a local priority to provide better care to people with long-term health conditions experiencing the poorest health outcomes. The local strategy aims to take a public health approach to reducing health inequalities for those with co-occurring conditions. Oversight of the delivery of the strategy and outcomes sits with the Health and Wellbeing Board.

3.3 There is evidence within the case files that these strategic priorities are starting to germinate changes in practice, not least the fact that all four cases were referred for consideration of how their experiences could provide lessons for future practice. This and the rigour employed within the s42 enquiry, Inquest and LeDeR processes, demonstrates the value given by senior leaders and frontline staff to such learning processes and the importance attributed to human stories contributing to an evidence base for better, multi-agency collaboration.

3.4 In addition, attendees at the learning events wished to commend the LD liaison nurse's input to support Jon access appropriate treatment within the hospital and following his discharge. SaBP

[13] Taken from the chronology prepared for this review.
[14] For example, research published by the Office for Health Inequalities including 'Premature mortality in adults with severe mental illness' [2023] available at: https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi

also wished to highlight the good practice from the LD liaison nurse who actively sought to ensure Jon received support for his ongoing medical needs, but they accepted this liaison was primarily with the CTPLD team and that there are further opportunities to develop links with GPs and district nursing services, particularly as they will have established links care home in the area. They also explained there is support currently in place to develop these, via the primary care liaison leads within the ICB.

3.5 In conversations during the learning events senior managers explained that so much had changed in response to the strategic priority to reduce health inequality, they explained there were now much clearer guidance to district nurses, including new pressure ulcer tools, which specifically requires evaluation of the person's protected characteristics and history to explore if they would more likely require reasonable adjustments or specialist care to overcome system barriers and prevent poorer outcomes. Similarly, SaBP have published a policy aimed at requiring specialist mental health clinicians to consider physical health as part of a holistic care and treatment plan. Whilst initially this was focused on the provision of in-patient care, it has now been rolled out to community teams through training. Practitioners reported such training was welcomed, but explained limited availability continued to restrict the socialisation of that policy so requested consideration be given to extending this, including to private care provider staff so they too are aware of the expected practice standards under the policy.

3.6 Community NHS providers spoke of changes made to their policy and recording systems to reflect learning from safeguarding and domestic abuse reviews to enable managers with supervisory responsibilities to, through data analysis, identify those at highest risk of poorer health outcomes. They also welcomed the introduction of safeguarding champions, which has seen a significant increase in resources to support better clinical decision-making including awareness raising activities, such as webinars. The ICB highlighted they have successfully secured wider understanding from health partners for the need to have 'was not bought' policies to protect adults who are dependent on others to bring them for appointments. Such policies are now much more widely adopted and, as can be seen in Jon's experience is providing an important safety net to enable adults with co-occurring conditions stay visible where they have an outstanding health need.

3.7 Whilst these green shoots are encouraging, it is difficult to ascertain how impact of local strategies and new service models is evaluated or reported more widely. This report is being written at a time of considerable structural reform for local NHS quality assurance and safeguarding processes[15]. How these reforms and funding cuts will impact on the sustainability of recent practice improvements will need to be carefully considered by SSAB partners and local Health and Wellbeing Board. Recommendation 6 should assist these discussions.

KLOE 2: Providing Safe Care for Adults Needing Support to Manage their Nutrition

This section will explore whether changes to local policy and procedures made following these deaths have improved practice, especially in the context of malnutrition or monitoring nutritional inputs where the adult requires support due to a learning disability or mental health condition.

3.8 During learning events attendees confirmed they were aware of and used the SSAB's escalation policy if disputes or professional conflict arose regarding appropriate treatment. They explained, in practice this wasn't always easy to identify as in most cases practitioners believed they were acting in line with good practice or local pathways. They also commented that good practice guidance and national priorities were not always aligned. By way of example, they cited Jon's dietician had commented he was emaciated, but nether they or the care staff felt empowered to call 999 and/or take him to hospital. Attendees at the learning event queried if this was an unintended consequence of the clear messages from local and national health leaders to seek

[15] Proposals to reform quality assurance processes were put forward via national reports (see for example, https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/).

to avoid hospital admissions during the period under review. Throughout the review period the pressures on hospital admissions experienced during the Covid-19 lockdown periods had resulted in significant changes in policy and strategic focus to prevent 'avoidable admissions'. Whilst practitioners involved in this review fully appreciated that admission avoidance was a legitimate strategic priority in Surrey and nationally (given the huge impact still being felt throughout the review period in acute trusts following the Pandemic), terminology used was subjective and therefore difficult to apply consistently.

3.9 The pandemic was extraordinary; the impact of decisions made during that period are currently being reviewed through the Independent Public Inquiry, so outside the scope of this review. However, the circumstances which preceded the deaths of all four adults highlights the importance for nuanced guidance, especially in the context of nutrition. Practitioners felt this was too often assumed to be 'business as usual' for social care providers, meaning that critical indicators of worsening health conditions are not recorded or reported effectively. In these cases, failings to consider nutritional needs and/or monitor nutritional intake effectively meant that risk evaluation of worsening conditions was noticeable lacking. For example:

- Matthew: despite clear concerns regarding Matthew's ability to feed himself, he was discharged without any advice given to his existing care provider about ongoing monitoring or reporting if his nutritional needs were not met. Care wasn't even taken to ensure he had access to food on return to his property.

- Paul: there appears to have been no system in place to ensure Cygnet staff monitor Paul's nutritional intake despite very significant and rapid weight loss in the weeks preceding his death. This failing, according to the Coroner, directly lead to his avoidable death.

- George: carers and ambulance crew noted that he responded well to an increase in fluids to mitigate the impact of his high blood pressure. But there wasn't clear guidance (or this wasn't seen as part of the s42 enquiry) to demonstrate staff reasonably in response to his presentations.

- Jon: concerns about Jon's weight loss were identified in October 2022. However, he was discharged to supported living accommodation and his carers were only instructed on the day before he died (early December) to record his intake within a fluid and food chart.

3.10 Attendees at the learning events accepted fluid and food intake was critical to good quality care. They explained, the way in which a person's weight can affect their treatment plan (including safe levels of prescription medication) must be much more widely understood. They welcomed the chance offered through this review to highlight the importance of using objective tools to assess and monitor wellbeing, such as the MUST guidance[16] which is designed to be used in any setting and by all levels of health or social care practitioners.

3.11 During the focus group discussion attendees highlighted that seemingly simple issues (such as the lack of a hoist scale) available to weigh Jon meant that what, with hindsight, appear obvious indicators of serious risks, can easily be missed. Care homes are intended to feel like a home to their residents. It may not be safe to assume care home providers will have purchased specialist equipment that will be infrequently used as this may not be economically viable for most providers. Those attending the learning events also accepted GP surgeries would not usually have such equipment. SaBP confirmed they do now have facilities within their weight clinic to weigh people in wheelchairs and that this is routinely done as part of any annual health check. It is understood too that CQC now review, as part of their assurance visits, fluid and nutrition charts for care home residents. This would not have applied in George's case as his

[16] Available at: https://www.bapen.org.uk/pdfs/must/must_full.pdf

placement would not have been regulated by CQC- an issue that does not appear to have been considered at the point of hospital discharge.

3.12 St Peter's hospital also reported that, since Paul's death, they now include risks associated with malnutrition and sudden weight loss as part of their level 3 safeguarding training. Consequently, they have seen an increase in staff reporting safeguarding concerns which they view as positive as it demonstrates such risks are now more routinely seen as everybody's business. They felt their staff were starting to understand the nuance and felt much more confident to have conversations both with patients and carers about why careful monitoring of a person with co-occurring conditions' nutrition is so critical. This good practice should be replicated across health trusts and private hospitals. Equally important is to establish a shared language so changes in presentation are reported in a way that enables effective, rapid clinical review and support to care providers to improve access to urgent medical treatment, when this is needed. Recommendation 3 is intended to enable wider dissemination good practice in this area.

KLOE 3: Impact on Systems of Learning Previously Identified

Drawing on the learning already identified within SSAB's published SARs and LeDeR, this section explores if there are additional areas of improvement for SSAB partners.

3.13 Recently published SARs have made several relevant recommendations for SSAB partner organisations to improve effectively multi-agency working to better protect adults with care and support needs against avoidable harm. In doing so, this should also protect staff, including senior leadership, from allegations of discriminatory or organisational abuse. Many of the findings of those reports are pertinent to this review and SSAB confirmed they are currently overseeing agencies actions plans to enable:

- Improvements to co-production of care plans with adults at risk, including the socialisation of a 'Team Around the Person' [TAP] approach as recommended in the Eden and Peter SARs.
- Better systems responses so organisational neglect does not contribute to preventable deaths- identified in the Eddie and Sam SARs.
- Better systems responses so poor coordination between agencies, including information exchange regarding the adult's capacity to make decisions, as recommended in the Eddie SAR.
- More support for frontline staff to encourage shared risk management between organisations to facilitate safe hospital discharge as recommended in the Eden and April SAR reports.
- Improved training for staff to socialise pro-active use of quality assurance frameworks and escalation processes to highlight where paucity of resources does not result in a loss of focus on patient safety, recommended in the April SAR.

3.14 SaBP representatives reported they review key themes and identify emerging trends at weekly safety meetings. This practice has highlighted risks associated with physical health conditions within SaBP teams. Consequently, if a physical health issue is identified as a potential contributor to the death or serious injury of a SaBP patient, this will automatically be referred for a PSIRF review.

3.15 LeDeR reviews were conducted in respect of both George and Jon's deaths. The review into George's death wished to see the circumstances explored through a SAR to '*inform system wide actions particularly around escalation tools, quality assurance function regarding consistency in documentations, possible consideration for community matron input regarding risk assessments. A focused review is therefore required*.'[17] It is important to clarify that such an outcome should be achievable without an additional SAR, via the LeDeR process. Respectfully, this review would invite the SSAB SAR subgroup to meet with the LeDeR

[17] Taken from the LeDeR report made available to this review.

coordinator to explore how learning from those reviews can influence SSAB activity directly rather than duplicating processes.

3.16 The findings of Jon's LeDeR report was that there was no multi-disciplinary meeting prior to Jon's discharge, despite concerns identified by CTPLD. They commented on a delay in completing the detailed assessment of his nutritional needs and concluded '*had this been clinically optimised before his discharge from hospital, or discharged to a rehabilitation ward or home with nursing input, his deterioration may have been prevented*.[18]' That review also commented that his health action plan lacked sufficient detail of all his conditions and how to manage these. The LeDeR review raised concerns that the placement delayed a request for nutritional supplements which, had they been available or had supported living staff understood how to manage his conditions, his overall health condition may have improved or his deterioration at the end of his life may have been prevented or slowed down. They also noted that, whilst a RESPECT form was agreed during his hospital admission, it was not reviewed by the GP on his discharge, finding that if this had been his wishes could have been respected. This review would wish to replicate the importance of RESPECT forms being reviewed quickly and applied within community settings. This should form part of any future assurance work the ICBs and SSAB partners do to ascertain improvements to practice for co-production in light of earlier SAR recommendations. However, as with concerns detailed above (at 1.19 with regard to the findings of the s42 enquiry following George's death) the information available to this review (including within the LeDeR report) suggest that practitioners involved in Jon's discharge were motivated to ensure he returned to a placement he had considered home for many years. It is possible that it may not have been in his best interest to move to another placement at that time. Whilst staff within an unregulated setting would not have been expected to be trained to monitor nutritional intake, attention to how this would be safeguarded within that setting should have been made clear as part of a safe hospital discharge.

3.17 During discussions with the reviewer SSAB partners explained their organisations were always seeking innovative new ways to disseminate learning to frontline staff. Examples given included ensuring safeguarding training had been mandated for new staff, wider use of reflective practice support with case studies developed from SAR reports, learning from audits used to shape supervision priorities and the development of short briefings and grab guides for common issues. Police colleagues explained they found the short briefings extremely helpful for their responder officers as it helps articulate key messages quickly to a wider, often inexperienced, workforce.

3.18 Many organisations within the public sector in Surrey (and nationally) honestly reflected that workforce capacity issues (particularly in respect of retaining experienced staff) impacted on the efficacy of system improvements recommended within recent learning reviews. They welcomed the increased focus on improvements being system focused, and the weight given by CQC as part of their assurance framework to safeguarding and good partnership/multi-agency responses. They commented such a focus was needed as demand for hospital admission management remains extremely high, particularly for adults with co-occurring conditions. Those involved in this review understood the necessity for active planning and clear routes for coordinating care between hospitals and community settings. They spoke of opportunities to build on previous good practice, such as the use of hospital passports, utilising 'trusted assessors' to inform capacity assessments around the ability for adults with complex needs to manage changes in their care needs. SSAB partners may also wish to explore how the impact of learning from SARs and LeDeR processes on strategic decision making and accountability frameworks could be measured and reported to demonstrate the importance of such reviews is

[18] Taken from the LeDeR report made available to this review.

to shape the whole system and not only directed at frontline practice. Recommendation 5 should enhance the opportunities for shared learning across different review methodologies.

KLOE 4: Socialising Good Continuity of Care Practice

This section explores support currently available to enable multi-agency care management and delivery of safe care between clinical in-patient settings and community providers.

3.19 As noted above, there is evidence of good, person-centred care in Matthew, George and Jon's cases. All three were provided care by staff who knew them and recognised a change in their health. What is notable in all four cases was that the deterioration in health way very rapid, and would care staff would likely have benefitted from greater clinical expertise to support earlier acute intervention to manage their physical health needs. Practitioners involved in the review commented on the increased risks of frailty at a much younger age for those with co-occurring conditions. Some staff spoke of the benefits for their teams of having frailty meetings across disciplines to help build up the relational practice across in-patient and community settings but also across disciplines. They explained this had reduce friction between professionals and services. Drawing parallels with better coordination of care when palliative care is required, they queried why frailty is still only considered as requiring 'specialist assessment and coordination' for those aged 65 or over[19] as it could play a significant role in encouraging providers to work with community-based nursing and clinical staff to prevent hospital admission. Recommendation 4 addresses this issue.

3.20 Those involved in the review felt there was important learning for partners to consider, given the findings in investigations following George and Jon's deaths which both recorded findings suggesting care or support housing providers had been negligent. The s42 enquiry officer stipulated within their report that '*Safeguarding adults' enquiries have to take account of s42 of the Care Act and the Care and Support statutory guidance, and the reporting requirements of NHS Digital. These require us to apply labels to the concerns. Where these relate to issues of possible poor practice, then the most appropriate of the categories on offer may be "Neglect" or "Organisational abuse". The intention of using these categories is to focus attention on learning the right lessons, and to produce aggregated statistics. This should not be confused with saying there is any culpability of a particular individual, or that the safeguarding enquiry is a determination of liability. Those are issues for the usual processes of the organisation(s) responsible for the services in question to address such matters'*[20] Not to be pedantic, but it is the purpose of a review under s44 Care Act to ascertain if there are lessons to be learnt. The primary purpose of the s42 duty is to ascertain if the adult is at risk and, if so, decide what action is needed and by whom. A finding of neglect in circumstances such as Jon and George's could, unintentionally, make it more likely that a few providers may withdraw agreement to provide support to adults with co-occurring conditions within unregulated environments, even if this means a change of placement or a delay to hospital discharge.

3.21 During the focus group discussions senior managers explained what was needed was to build communities of practice to better support adults with complex needs remain within their homes, including where these are settings which, with additional clinical input, could safely meet these needs. They highlight that George's case, notwithstanding the sad outcome, could showcase what good, person-centred care should look like. Staff within the placement put his needs first, they sought and followed advice from CTPLD, SaLT, LD liaison nurse, his GP and ambulance crew when an emergency response was needed. Likewise, paramedics completed their diagnostic tests and gave advice, satisfied he was able to remain at the care home.

3.22 Police colleagues explained that they found no evidence of wilful neglect, including in Paul's case. They felt it was important to differentiate between a bad outcome and bad practice. They

[19] For example Royal Surrey's frailty pathway excludes those under 65 (as all four adults in this review were).
[20] Taken from the s42 enquiry report made available to this review.

agreed there is a need for clearer guidance, including for staff undertaking s42 enquires, LeDeR and PSIRF about what constituted neglect as those findings need to be consistent and evaluated against reasonable clinical standards and case law. Failure to do so will, they fear, frustrate any possibility of building strong communities of practice between hospital and communities setting and result in risk averse behaviours so as to protect organisations and professionals possibly at the cost of providing care in a manner that balances safety with wellbeing.

3.1 The focus group spoke of a genuine desire to develop just cultures which are open and transparent about where there are opportunities to improve practice through generously sharing expertise across settings. They were keen to move away from current practice, especially if this feels combative and not about learning. Recommendations 1 and 2 are intended to address this.

4. Conclusions and Recommendations

4.1 Our sincere condolences to the families of the four men subject to this review. We hope that the discussions and recommendations this review has triggered will provide some comfort that they were cared about during their lives and that the circumstances of their deaths will continue to help shape improvements within health and social care practice. Whilst there is evidence of some good practice within the cases, there are also opportunities to use this learning to prevent future harm. It is, therefore, commendable that SSAB partners wished to draw learning to a wider audience to enable communities of practice.

4.2 Mindful of the recommendations from previous SARs currently subject to action across organisations and with oversight from SSAB, this review has made the following recommendations.

Recommendation 1: Re-name hospital passports to 'health passports' to encourage wider use and promote coordinated care between hospital-based staff and community settings[21]. This should be underpinned by a standard/ expectation that each intervention or inaction with an adult who requires support to meet their basic needs due to cognitive impairments must consider the whole person.

Recommendation 2: ICB should encourage wider the use of 'trusted assessors' by encouraging staff from community settings to support in-patient evaluation of a person's capacity to understand risks to their health of poor nutrition and enable great appreciation of the role (and limitations) that support workers or community-based care staff may have in risk management for adults with complex needs.

Recommendation 3: The ICB, working with NHS Trusts and private health providers should raise awareness of best practice, particularly with respect to the careful monitoring of a person with co-occurring conditions' nutrition. Some SMART actions to achieve this could be:

- SSAB and partners develop practitioner briefings, drawing on all relevant NICE practice guidance and highlight local pathways for urgent advice where there is rapid weight-loss or presentations that suggest imminent risk of serious ill-health;

- Service tenders and contracts should including expectations on how providers should access diabetes care and frailty pathways;

[21] This would build on the success of initiatives of hospital passports for adults with co-occurring conditions and learning disabilities or neurodiversity, as practitioners wished to see these. It could mirror work done with children and families around the assessment framework triangle.

- ICB could provide descriptors of presentations to encourage care staff to develop a shared language to report in a way that enables effective, rapid clinical review;

To evaluate the effectiveness and impact of the above activity, the ICB (through their commissioning role, and reporting to HWBB and/or district health forums) may wish to audit compliance that providers care plans are coproduced, including in the areas of nutrition, urgent care and hospital admission and that RESPECT forms are reviewed by community partners (including GPs) in a timely fashion.

Recommendation 4: ICB should provide assurance to SSAB that current practice to require 'specialist assessment and coordination' to assess risks associated with frailty for those aged 65 is not discriminatory, given the increased risks of frailty at a much younger age for those with co-occurring conditions.

Recommendation 5: The LeDeR coordinator/representative present a paper to SSAB or their SAR sub-group on the lessons arising for adults with cooccurring conditions experiencing hospital discharge. This should specify if, following the introduction of the discharge to assess model, whether there are issues or trends requiring further action from SSAB partners. This could also explore if opportunities to share learning between the review processes could be strengthened including through the introduction of guidance for reviewers on the civil and criminal thresholds for neglect so that there is consistency with operational practice.

Recommendation 6: Given the proposed structural and funding reforms to safeguarding and quality assurance required in line with recent policy[22], regional NHSE leads and ICBs should consult with SSAB partners and Surrey's Health and Wellbeing Board to minimise risks that proposed funding cuts will impact on the sustainability of recent practice improvements designed to promote wellbeing for adults with care and support needs.

[22] Proposals to reform quality assurance processes were put forward via national reports (see for example, https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/).