**Pan-Sussex Learning from SARs Script**

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**Introduction (Any Order)**

**Presenter 1:** Hello and welcome to this Podcast that is being produced by the three Sussex SAB’s and is on Shared Learning from Safeguarding Adults Reviews that have been undertaken in Sussex.

**Gu**y: My name is Guy Jackson and I am the Business Manager of the Brighton and Hove Safeguarding Adults Board.

**Ru:** My name is Ru Gunawardana and I am the Business Manager of the West Sussex Safeguarding Adults Board.

**Lucy:** And my name is Lucy Spencer and I am the Development Manager of the East Sussex Safeguarding Adults Board.

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**Presenter 2:** This podcast is being produced as part of the pan-Sussex SAB contribution to National Adults Safeguarding Week and with the aim of increasing knowledge and awareness in relation to Safeguarding Adults Reviews and some of the similar themes being seen across these reviews.

We hope that increasing knowledge and awareness of these shared themes amongst professionals involved in adult safeguarding, and the actions taken in response to these, will help to support continuing professional development.

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**Section 1: Safeguarding Adults Reviews**

**Presenter 3:** So what are Safeguarding Adults Reviews?

One of the primary purposes that Safeguarding Adults Boards have are to undertake Safeguarding Adults Reviews, commonly known as SARs. SARs are a statutory requirement under section 44 of the Care Act and the eligibility criteria is when someone has died, or experienced serious harm, and it is felt that partner agencies could have worked more effectively to protect the person.

SARs are comprehensive, multi-agency reviews that are undertaken by Independent Reviewers. The purpose of SARs is set out very clearly in the statutory guidance that accompanies the Care Act.

It states SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

It's important to remember that SARs are focused on learning and improvement actions.

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**Section 2: Shared Themes**

**Presenter 1:** Across Sussex the three SABs have undertaken a range of SARs in the last two years.

In Brighton and Hove three SARs have been published; Christopher, James, and Andrew. A Thematic Learning Review has also just concluded that is due to be published shortly.

In East Sussex four SARs have been published; Adult B, Adult C, Anna and Ben and there are several reviews in progress.

In West Sussex a range of SARs have been undertaken and published; there has been a Learning Review in respect of Patricia Pelham, a Thematic Review, an Organisational Review into Kingswood, a review in Rapid Time, Desktop Reviews into BK and TD, and a review in respect of Jean Willis.

These SARs have explored a range of circumstances that have included Acquired Brain Injury, Learning Disabilities, Multiple Needs, Domestic Abuse, Organisational Abuse and Self-neglect.

These four themes are Mental Capacity, Application of Safeguarding Procedures, Making Safeguarding Personal, and Multi-agency communication and Information Sharing.

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**Mental Capacity**

**Guy:** Starting with Mental Capacity and the need for increased knowledge and application of the Mental Capacity Act was identified in both the Christopher and James reviews. In both cases formal capacity assessments weren’t undertaken despite concerns being raised. Mental capacity was assumed despite evidence of increasing risk and this was attributed to lifestyle choices without sufficient exploration of the reasons for this.

**Lucy:** In East Sussex SAR Ben sought assurance from partners that legal literacy is included in single agency safeguarding training, commissioning multi-agency training on law relating to mental capacity and seeking assurance about use of advocacy for people who lack capacity in respect of assessments, reviews and safeguarding activity.

**Ru:** In West Sussex two desktop reviews, BK and TD, identified Mental Capacity as a theme. In the case of BK, there was found to be a lack of knowledge and implementation of the MCA. Specifically in relation to management of finances and tenancy arrangements, despite evidence of increasing risk. In the case of TD, MCA and Best Interest decisions were not evident and MCA training and recording were identified as requiring improvement.

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**Safeguarding Processes**

**Lucy:** Moving on to Safeguarding Processes and SAR Anna identified effective joint working between Finance and ASCH staff when undertaking safeguarding enquiries, systems around other financial decisions were less robust and identified a need to review the systems in place to make decisions about pursuing debts from relatives and to consider any risks to vulnerable adults and to develop plans to fully protect the individuals concerned.

**Ru:** Compliance with safeguarding processes was a theme in our Thematic Review and the BK Review. In the Kingswood Review it was found that there was a lack of reporting of safeguarding and quality concerns and, that these were not always followed up, with no pattern being identified and responded to. The Rapid Review found that raising safeguarding concerns may have been avoidable had there been improved, clarity, decisive action and accountability.. The TD Review suggested improvements to thresholds decisions and enquiries, as It was found that there was a lack of action to address risk factors and a lack of line management oversight and recording.

**Guy:** In both the Andrew and Christopher reviews knowledge and application of safeguarding processes was identified as an issue. This included abuse and neglect that was occurring being identified and safeguarding concerns raised appropriately. There was also a need identified for greater knowledge and understanding of the Safeguarding Adults Review (SAR) process that led to delays in referrals being made.

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**Making Safeguarding Personal**

**Ru:** In relation to Making Safeguarding Personal our Thematic Review found areas of improvement required for person-centred approaches and MSP, as despite lots of activity by professionals, however a lack of ‘seeing the person’. The Jean Willis review found that there was limited evidence that Jean’s wishes and feelings had been considered regarding her care and support. For the Review for TD, it was found that voice of TD, his partner and family did not appear to be actively listened to, particularly in relation to his desire to move accommodation.

**Guy:** In the Christopher review agencies focused on what was wrong rather than seeking to understand what had happened to him. Building relationships can identify issues such as trauma and the importance of community and voluntary agencies often being best-placed to develop these was identified in the James review.

**Lucy:** In Adult B interventions were clearly driven by the her wishes and feelings, with a focus on preventing harm but were aimed at achieving this with the least detrimental intervention that Adult B would accept. It was clear that practitioners were not confident to act without Adult B’s consent and, while this may have been appropriate in this case, it needs to be understood that on occasion the individual’s wishes can and should be over-ruled.

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**Multi-agency Communication and Information Sharing**

**Guy:** The last shared theme is multi-agency communication and information sharing. Both the Christopher and James reviews both identified that more effective communication and information sharing would have identified the multiple needs and increasing risk both men began to experience and supported abuse and neglect being identified. In the Andrew a particular area of focus was the information sharing between the acute hospital and community in relation to complex discharges.

**Lucy:** The ESSAB Adult C SAR identified the need to establish mechanisms for improved information sharing and recording of case activity between statutory partner agencies in cases of high risk and multiple complex needs and SAR Anna identified the need to evaluate the use and effectiveness of multi-agency meetings when undertaking safeguarding work with vulnerable adults.

**Ru: Our** Kingswood Review identified improvements regarding the sharing of information in relation to safeguarding and quality concerns. The Review for BK identified the need for recording, information sharing and onward referrals for people at risk of self-neglect. The Review for Jean Willis found that there was a lack of a multi-agency information sharing/communication to ensure a coherent, collective, and timely response to deteriorating heath needs. The Rapid Review found that ambiguous, inconsistent, and inaccurate information was not always clarified and the process of identifying leadership and responsibility required improvement. The Review for TD found that information-sharing with service users when there is joint funding responsibility needed to be more effective.

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**Section 4: Improvement Actions**

**Presenter 3:** The three Sussex SABs have undertaken a range of improvement and assurance actions in response to the four themes we have identified.

**Mental Capacity**

**Presenter 1:** A number of actions have been undertaken by the three Sussex SABs in response to Mental Capacity. In West Sussex assurance was sought in relation to how mental capacity is considered in relation to tenancy allocation processes and in the use of covert medication and a learning briefing focusing on mental capacity and self-neglect.

In East Sussex a Court of Protection learning briefing was produced and a multi-agency audit into Deprivation of Liberty Safeguards undertaken and in Brighton and Hove existing training on mental capacity has been reviewed and enhanced as well as additional relevant learning resources developed.

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**Safeguarding Processes**

**Presenter 2:** Moving on to safeguarding processes and in East Sussex actions undertaken included the creation of a safeguarding competency framework for Directly Provided Services and operational support staff. In West Sussex assurance was gained through individual case file audits and a What is Safeguarding podcast produced. In Brighton and Hove system improvements included the local authority creating a safeguarding assurance panel and online safeguarding hub and all statutory agencies working to ensure they have non-engagement policies in place.

**Making Safeguarding Personal**

**Presenter 3:** In relation to Making Safeguarding Personal all three Sussex SABs have produced a range of learning resources for multi-agency partners that include learning briefings, podcasts and links to LGA case studies, toolkits and general guidance.

**Multi-agency Communication and Information Sharing**

**Presenter 1:** The final category is multi-agency communication and information sharing. In West Sussex and Brighton and Hove the SABs have produced learning briefings for every published SAR that promote the importance of information sharing and the WSSAB have also sought assurance via Pan-Sussex Self-Assessment processes. In East Sussex a multi-agency MARM Protocol was launched along with accompanying guidance on supporting people with multiple needs.

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**Section 5: Shared Improvement Actions**

**Presenter 2:** In addition to the individual improvement and assurance actions that have been undertaken by each of the SABs we have also collaborated to produce a range of Pan-Sussex SAB Protocols.

As you can see here we have responded directly to learning in our Safeguarding Adults Reviews by developing Pan-Sussex SAB Protocols on Information Sharing, Escalation and Resolution, Unexpected Adult Deaths, Adult Safeguarding Thresholds as well as on the Safeguarding Adults Review process itself. You can find all of these on your local SAB website along with the various learning briefings, podcasts, guidance and other resources that we have discussed today.

**Section 6: Conclusion**

**Presenter 3:** Well, that concludes this podcast from three Sussex SABs Shared Learning from SARs and we hope that if you have listened to this that you found it useful.

Please do look out for more podcasts from the Sussex SABs in the future. **may be prevented from seeing or speaking to the person, or encouraged tochallenge where**