**Pan-Sussex Learning from SARs Script**

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**Introduction**

**Lucy:** Hello, welcome to this Podcast that is being delivered by the three Sussex Safeguarding Adults Boards (known as SAB) Managers. This podcast is to summarise Shared Learning from Safeguarding Adult Reviews undertaken across Sussex.

**Gu**y: Hello, I’m Guy and I manage the Brighton and Hove Safeguarding Adults Board.

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

**Lucy:** And I’m Lucy and I am the Manager of the East Sussex Safeguarding Adults Board.

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**Guy:** As part of National Adults Safeguarding Week the three Sussex Safeguarding Adults Boards (SABs) are undertaking , co-ordinating and supporting a range of activities to support learning and development in relation to adult safeguarding.

This podcast is being produced with three aims:

1. Increasing knowledge and awareness amongst professionals of Safeguarding Adults Reviews, known as SARs, which are a statutory requirement for Safeguarding Adults Boards.
2. Increasing knowledge and awareness of key shared themes being seen in SARs undertaken across Sussex, both in relation to good practice as well as areas for development.
3. Sharing improvement actions that have been undertaken in response to these themes and considering further actions that professionals can consider as part of continuing professional development.

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**Section 1: Safeguarding Adults Reviews**

**RU:** Safeguarding Adult Reviews known as SARs (and referred to as ‘reviews’ in this podcast) are a statutory requirement of the Care Act. The criteria for a review is that someone has died, or experienced serious harm, and it is felt that partner agencies could have worked more effectively to protect the person.

Independent Reviewers undertake our reviews. This is with a focus on multi-agency learning and to identify how we can improve practice and services.

Reviews also look at what might have been done differently which could have prevented harm or death. This is so that lessons can be applied to future situations.

A review is not another investigation, it does not replace a complaints process and it does not apportion blame to an individual or agency.

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**Section 2: Shared Themes**

**Lucy :** Across Sussex there have been 15 reviews published in the last two years and with several more underway.

In Brighton and Hove there is Christopher, James, and Andrew. A Thematic Learning Review is also due to be published shortly.

In East Sussex there is Adult B, Adult C, Anna, Ben, and a Thematic Review.

In West Sussex there is Patricia Pelham, Jean Willis, BK, TD, an Organisational Review into Kingswood Care Home, a Covid related review and a Thematic Review.

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

We also identified a number of similar themes, and we will be focusing on four of these here in this podcast which are; Mental Capacity, Application of Safeguarding Procedures, Making Safeguarding Personal, and Multi-agency communication and Information Sharing.

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**Mental Capacity**

**Guy:** The first theme is mental capacity**.**

James was a 42-year old man with an acquired brain injury who received care and support from a range of organisations. However, concerns were identified in relation to substance misuse, anti-social behaviour, and exploitation and despite the support provided James’ overall condition deteriorated over a period of time before he died in 2019.

The Independent Reviewer identified some good practice. James could be challenging to work with and often did not engage and there was a great deal of inter-agency communication and attempts to identify services that could support James. The efforts to support and promote James’ independence were also recognised.

There were areas for Development too. No mental capacity act assessments were undertaken during the review period with capacity often assumed, despite evidence of increasing risk. This was attributed to James’ lifestyle choices without further exploration of the reasons for this. There could also have been more done to escalate concerns that were raised by some agencies around James’ mental capacity.

Improvement Actions that have been undertaken include existing local authority mental capacity training being reviewed and enhanced to include complex decision-making, a multi-agency audit on mental capacity undertaken by the BHSAB and learning resources developed in response. A Sussex SAB Escalation and Resolution Protocol has also been developed to support improvements in escalating safeguarding issues, including in relation to mental capacity.

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**Ru: Safeguarding Processes**

Working to safeguarding policies and procedures has significantly, been a feature in 5 of our Reviews. I am therefore going to share with you what the issues are in each of these reviews rather than talking about individual cases. However, please do have a look at our reviews with accompanying learning briefings and podcasts; the links of these are on this slide.

Our BK Review identified that there was a lack of knowledge of policy and procedures about the Mental Capacity Act, the Care Act, and self-neglect.

Our Thematic Review tells us that necessary actions were not always taken, information was not shared appropriately, and timescales were not met. There was also a failure to recognise and consider the need for multi-agency planning, risk assessment and the leadership role with escalating risk and safety.

Our Kingswood care home Review 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.

Our Covid Rapid Review told us that safeguarding concerns may have been avoidable had there been improved, clarity, decisive action and accountability.

Our TD Review suggested improvements to threshold 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.

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In response to the Improvement needed, we have:

* Completed multi-agency case file audits resulting in action plans to take forward learning
* Created and promoted learning briefings and podcasts on: self-neglect, risk assessment and, on ‘What is Safeguarding’ to promote raising concerns
* Re-promoted the Sussex safeguarding [thresholds guidance](https://www.westsussexsab.org.uk/media/nbxn1fvb/2022-safeguarding-thresholds-guidance.pdf);
* Drafted a learning briefing and podcast on safeguarding policy and procedures

And, escalated the need to refresh the pan-Sussex policies and procedures website to make this more user-friendly for practitioners and, are leading on advising on the design for this

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**Lucy: Making Safeguarding Personal**

**Background**: Adult B was a 94 year-old woman who had died in hospital of natural causes but, when admitted, was found to have 26 unexplained injuries including a fractured nose and jaw, as well as old and new bruising to her face, arms and legs. She had been living firstly with her grand-daughter and then with her son and his family. They were providing most of her day-to-day care but with support from private care workers and community nurses.

**Good Practice:**

* The level of documentation provided by district nursing staff was good, and professional curiosity shown by the nurse who removed the make-up concealing her injuries as this was the trigger to raise a safeguarding concern.
* Staff in Accident & Emergency provided a very detailed review of her injuries with a list of their concerns triggering a further safeguarding response.

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**Areas for Development:**

* A lack of confidence by practitioners in challenging family members who were providing care for a relative.
* Practitioners never saw her physically alone.
* Concerns about her care were addressed to the family without asking her how they had occurred.
* The review highlighted differences in how child deaths and adult deaths are investigated and identified shortcomings in the final safeguarding investigation

**Improvement Actions:**

There is a dedicated Making Safeguarding Personal section on East Sussex SAB website including Guidance on Making Safeguarding Personal.

The Sussex Adult Death Protocol was developed. Its main purpose is to identify deaths of vulnerable adults where there is an indication of abuse or neglect by a third party. It provides a rapid, multi-agency response to identify and ensure any potential criminal investigations are undertaken in a timely manner.

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**Multi-agency Communication and Information Sharing**

Guy: Background: This theme is frequently identified in reviews including being a feature in the Reviews we have just shared with you.

Our Boards’ response has been to take forward a range of actions.

Ru: In West Sussex, we have sought assurance from the Self-Assessment process and case file audits and, highlighted the need for information sharing in our Reviews’ accompanying learning briefings and podcasts. We also, have two well established, monthly multi-agency subgroups. These are the Multi-Agency Risk Management where information is shared to manage risk of those with high risk and complex needs and, our Quality Assurance and Safeguarding Information which works to share and respond to risk with providers.

Lucy :In East Sussex a Multi–Agency Risk Management (MARM) [Protocol](https://www.eastsussexsab.org.uk/documents/multi-agency-risk-management-marm-protocol/) has been launched with accompanying Guidance: [*Assessing and supporting people with multiple and complex needs*](https://www.eastsussexsab.org.uk/documents/assessing-and-supporting-people-with-multiple-and-complex-needs-guidance-for-positive-practice/)*.* It been designed to provide guidance for practitioners on working adults with multiple complex needs and managing cases in which there is a high level of risk, but the circumstances may sit outside the statutory safeguarding framework.

Guy: In Brighton and Hove learning briefings have been produced in response to published reviews that highlight the need for information sharing, and an audit undertaken on multi-agency safeguarding.

A Sussex Information Sharing Guide and Protocol has also been produced to support information sharing across Sussex in relation to safeguarding.

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**Section 6: Conclusion**

Ru: Thank you for wanting to know about our Reviews. The way you work is vital to lowering the risk of these situations happening again so, please don’t doubt the importance of your contribution.

Guy: As the key take away from this podcast, again, the main issues for you to please, consider in your work, are:

* Mental capacity
* Following safeguarding processes
* Making safeguarding personal
* And, multi-agency information sharing and communication

Lucy: Finally, please know that our Boards continue to work closely together to take forward learning from our Reviews. We are creating a range of resources to help you understand and know of the Reviews to support your learning. Please do visit our websites to access all of our Reviews and learning tools. Many thanks.