Briefing Note

To: Health and Social Care Scrutiny Board (5)

Date: 23 November 2016

From: Joan Beck, Independent Chair of Coventry Safeguarding Adults Board

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Subject: Safeguarding Adult Review (SAR) Progress

1. Purpose of the note

1.1. To advise Health and Social Care Scrutiny Board (5) of the progress made in relation to the three Safeguarding Adult Reviews (SARs) published in 2015 and any outstanding actions completed by Coventry Safeguarding Adult's Board.

2. Background

2.1. The Care Act, Section 44, requires Safeguarding Adult Boards to complete a SAR (previously called Serious Case Reviews) when:

2.1.1. There are concerns about how Safeguarding Adult Board members have worked together to safeguard a person with care and support needs, and:

2.1.2. That person has died, or

2.1.3. That person has suffered serious abuse or neglect

2.2. The purpose of SARs is to consider how things could have been done differently and to learn lessons for the future. The purpose of SARs is not to seek blame nor to hold individuals or organisations to account for any failings. Involvement of the family or next of kin of the person subject to the SAR is an important feature of how they are conducted as the issues are, by nature, incredibly sensitive.

2.3. SARs in Coventry are overseen by the SAR subgroup of the Coventry Safeguarding Adults Board. The SAR sub-group includes membership from social care, police, health, and emergency services and considers possible cases that may meet the criteria for a SAR and, if appropriate initiates a SAR. The sub-group also monitors progress against action plans arising from SARs and through updates to the Safeguarding Adults Board holds organisations to account for the delivery of the actions they committed to.

3. Safeguarding Adult Reviews in Coventry

3.1. In 2015 three SARs were published by the Coventry Safeguarding Adults Board and considered by Scrutiny Board 5. These SARs related to incidents that took place in 2013 and 2014. They related to incidents of fire death, septicaemia, and pelvic abscess, sigmoid perforation and fractured vertebrae.

3.2. There have been no further SARs completed in Coventry since these three published in 2015 and no SARs are currently underway.

4. Summary of recommendations and actions arising from the SARs

4.1. As a result of the SARs a series of actions were agreed by the CSAB, these included:
   4.1.1. Improving awareness of and response to fire safety risks
   4.1.2. Establishing protocols for professionals to work together on a case
   4.1.3. Working towards making safeguarding more personalised
   4.1.4. Reviewing pressure ulcer policies and information

5. Progress areas to date

5.1. Significant progress has been made in delivery of the actions and improvements required following the SARs. Examples of key areas of development in relation to SARs in Coventry is as follows:
   5.1.1. Events have taken place to disseminate learning and promote person-centred practice. A family member has attended these sessions and given a powerful account from her perspective about the care and support received. A range of organisations have attended these events including provider services.
   5.1.2. A SAR toolkit has been produced which gives a clear framework and methodology for conducting SARs.
   5.1.3. A coroner's protocol has been developed to give clarity about roles and responsibilities of both the coroner and the partner agencies including sharing information in cases where there is a safeguarding issue which may require further investigation.
   5.1.4. There has been a strong emphasis across the partner agencies on outcome-focused work with people with care and support needs. Agencies have developed their training. Coventry City Council has rolled out a Making Safeguarding Personal programme alongside a tool kit to support and embed this. In addition CWPT has rolled out a bespoke training programme to support care delivery for those reluctant to accept help which has been delivered to its Community Nursing staff group and remains a key part of their training portfolio going forward.
   5.1.5. West Midlands Fire Service have supported and delivered fire health and safety intervention training to a range of agencies, including the third sector and GPs. Alongside this, a comprehensive fire safety guidance handbook has been produced for professionals and carers who work with adults with care and support needs. This provides clear guidance where there is fire risk. There has been an increase in referrals to West Midlands Fire Service since the launch of this guidance and this will continue to be monitored by Coventry Safeguarding Adults Board (CSAB).
   5.1.6. Pressure ulcer guidance has been revised with a focus on notification and referral process. Agencies have delivered further training on this issue to increase awareness and improve response. Health partners and Coventry City Council have set up a 'React to Red' scheme that aims to prevent pressure ulcers. It offers clinical training and support to care providers. Accreditation is given to care homes that demonstrate best practice in all areas of pressure ulcer prevention. There are ten accredited care homes, with more working towards this. The performance data provided to CSAB is beginning to show a reduction in the number of pressure ulcers.
   5.1.7. Coventry and Rugby CCG, UHCW and CWPT have reported to CSAB that more robust and effective discharge planning processes are in place. This includes an integrated patient assessment tool used by UHCW and CWPT; development of Integrated Neighbourhood Teams (INT) and a Coventry Carers Trust presence at UHCW.

6. Outstanding actions and next steps

6.1. On the SAR action tracker, three actions remain incomplete. The workforce subgroup of the Safeguarding Adult Board has agreed a plan to complete these actions by the end of March 2017. They are all in relation to quality assurance and consistency of safeguarding training.

6.2. A number of multiagency audits are currently underway or are planned for the coming year which will provide CSAB with evidence of whether the learning has been embedded into practice and highlight the follow on work that is required from these findings.

6.3. CSAB will continue to analyse performance to understand the quality of practice and identify areas of improvement.

7. Recommendations

7.1. Scrutiny Board 5 are recommended to provide any additional comment to the Independent Chair of the Coventry Safeguarding Adults Board and Cabinet Member for Adult Services on progress against the SAR action plans and outstanding actions.