Plymouth Safeguarding Adults Board

Core Priorities:
Risk Management and Self Neglect
Mental Health
Engagement and Participation
Quality assurance
Learning and Development Strategy
SAB management arrangements

Plymouth Adult Safeguarding Board

Update/Report to SAB

DATE	18 January 2018
NAME	Jane Elliott Tončić
AGENCY	Plymouth City Council
PURPOSE OF THE UPDATE or REPORT	Update on the regional thematic review commissioned to analyse SCR/SARs and related SW ADASS Safeguarding Leads Group Conference
STRATEGIC PLAN REFERENCE	N/A
SAB SUB-GROUP	N/A

SUMMARY UPDATE/REPORT	The conference held in Taunton in November to present findings of the regional thematic review of SCR/SARs commissioned from Prof. Preston-Shoot was well attended and received. The full report: *What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews: a report for south west region Safeguarding Adults Boards* and presentations from the conference are available to PSAB members on request to: adultsafeguarding@plymouth.gov.uk The review undertook an analysis of the nature and content of 26 Serious Case Reviews commissioned by Safeguarding Adults Boards in the South West region from 1st January 2013 up to the implementation of the Care Act 2014, and 11 Safeguarding Adult Reviews commissioned and completed since implementation of the Care Act 2014 on 1st April 2015, up to 31st July 2017. The recommendations will be considered and implemented by the SW ADASS Regional Safeguarding Leads Group: • That South West SABs, in partnership with SW ADASS consider establishing a task and finish group to review available quality markers of a good quality report, with a view to adopting them for quality assurance of future SARs, namely:

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	• That the report contains clarity on:- ○ Source of referral; ○ Terms of reference; ○ Type of review commissioned; ○ Rationale for selected methodology; ○ Period under review; ○ Timescale for completion; ○ Reviewer independence. • That the report records key demographic data, including ethnicity • That the report considers previous SCRs and SARs, especially those completed by the same SAB, where relevant to the type of case being reviewed ; • That the report concludes with clear, specific and actionable recommendations, with clarity on the agencies to which they are directed; • That SABs ensure that, where relevant to the case reviewed, commentary is included on the impact of national policy, legislative and economic contexts on the local lived experience of practice and the management of practice; • That SABs comply with statutory guidance requirement on inclusion of SAR details in annual reports that are published in a timely fashion • That South West SABs: ○ Monitor SAR referrals and their outcomes to check that SARs referred and commissioned over time are broadly representative of the pattern of reported incidence of forms abuse and neglect in their locality; ○ Review safeguarding procedures and guidance in the light of learning from this report; ○ Review SAR guidance in the light of the learning from this report, including the question of CQC involvement in reviews and the development of a framework for decision-making about commissioning; ○ Consider how best to reflect and learn from the perspectives of family members about the review process and the findings/recommendations; ○ Share the outcomes of this monitoring and review at future annual adult safeguarding conferences; ○ Consider how to use regional networks and how to involve national policy-makers to promote a whole system contribution to service development.

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	• That South West SABs in partnership with SW ADASS consider dissemination of this report to: ○ The Department of Health to inform policy regarding SARs and adult safeguarding, including how to make the advised six month timeframe meaningful; ○ National bodies representing SAB statutory and other partners, for example NHS England, Police and Crown Prosecution Service, and the Care Quality Commission, to prompt dialogue about policy regarding SARs, the prevention of abuse and neglect and the protection of adults from harm, and prosecutions under the Mental Capacity Act 2005; ○ Facilitate discussion and the development of guidance regarding: - Thresholds for commissioning different types of review; - Indications for the choice of available methodologies; - Management of parallel processes; - The interface with SCRs and DHRs when the criteria would be met for such reviews alongside those for a SAR; - Protocols for cross-boundary working, with particular reference to information-sharing regarding care home providers, and notification and subsequent review of placements “out of authority”; - Standards of good practice with respect to prevention, detection and reporting of organisational abuse and neglect; - Standards of good practice with respect to working with adults who self-neglect. • That South West SABs, with SW ADASS consider working together on further studies regarding: ○ How thresholds are for commissioning SARs are being interpreted; ○ The impact and outcomes of SARs commissioned and completed by SW SABs; ○ The advantages and limitations of different methodologies in the light of learning from this report; ○ How to facilitate transparency of information-sharing and candid analysis in IMRs, panel discussions and learning events, in order to promote service and practice development; ○ Quality assurance of final reports; ○ Effective implementation and tracking of the outcomes of review recommendations.

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RECOMMENDATIONS & PROPOSED ACTIONS	
	For information and discussion
	Updates to be received from SW ADASS Safeguarding Leads Group workstreams