North East Lincolnshire

Safeguarding Adults Board

Safeguarding Adult Review

&

Significant Incident Learning Process

Revised April 2017

(Review date June 2017)

INTRODUCTION

This guidance outlines North East Lincolnshire Safeguarding Adults Board (NELSAB) Safeguarding Adult Review (SAR) policy and procedures. It describes the process of referrals to the SAR panel, the thresholds for conducting SARs and Significant Incident Learning Processes (SILP) and the decision-making pathway underpinning the full SAR process.

Both the SAR and SILP processes are commissioned and overseen by NELSAB. The review process at every level is designed to learn from experience to improve practice and achieve better and safer outcomes for people living within North East Lincolnshire.

Although delegated to the DASS, it is the overall responsibility of the Deputy Chief Executive to endorse the final decision on whether or not a case will be managed via the SAR process. It is an expectation of all NELSAB partners that they participate and contribute to the decision-making process where requested. It is also required that all partners and agencies who are requested to be so are actively involved so that learning is shared as widely as possible for the benefit of partners, service providers, families and the community.

To this end, the SAB has established a SAR, SILP and Good Practice Subgroup or SAR Panel. It is the Panel's responsibility to receive referrals for case reviews and inform the Deputy Chief Executive/DASS, making recommendations as to the type of review to be conducted.

Where capacity allows, the Panel will also consider other complex cases for review and cases where excellent practice has been highlighted from which we can learn and develop strengths in safeguarding across partnerships.

The SAR Panel meets as a minimum on a quarterly basis and reports to the SAB on the progress of ongoing SAR and SILP reviews. The reporting process enables the SAB:

- To be cited on any safeguarding or practice issues emerging from reviews
- To monitor any agreed actions or recommendations arising from case reviews
- To be aware of any necessary revisions or changes to the SAR process itself
- To maximise effectiveness and learning from reviews and casework practice
- To oversee and sign off final SAR reports or SILP findings.

The SAR process reflects the six key principles underpinning all adult safeguarding work

i) Empowerment

People being supported and encouraged to make their own decisions and being enabled to give informed consent by being *asked what they want as the outcomes from the safeguarding process and by what they want directly informing what happens.*

ii) Prevention

It is better to take action before harm occurs by ensuring that people *receive clear and simple information about what abuse is, how to recognise the signs and what they can do to seek help.*

iii) Proportionality

The least intrusive response appropriate to the risk presented by ensuring that *professionals will work in the person's best interests as that person sees them and that professionals will get involved only as much as needed.*

iv) Protection

Support and representation for those in greatest need through ensuring people get the *help and support to report abuse and neglect and that people get help to be able to take part in the safeguarding process to the extent to which they want to be involved.*

v) Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. Individuals and communities will *know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. People are confident that professionals will work together and with them to get the best results for individuals who are vulnerable.*

vi) Accountability

Accountability and transparency in delivering safeguarding through ensuring all people are helped to *understand the role of everyone involved in their lives and that professionals involved know what their roles are too.*

THE LEGAL FRAMEWORK

The Care Act 2014 identifies our safeguarding duties and those to whom they apply:

14.2 The safeguarding duties apply to an adult who:

- *Has needs for care and support (whether or not the local authority is meeting any of those needs)*
- *Is experiencing, or at risk of, abuse or neglect*
- *As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*

14.133 Each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 14.2.

1. Criteria for Conducting a Safeguarding Adult Review.

The Care Act places a number of statutory requirements on the SAB including that:

14.162 SABs must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.163 SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

2. Criteria for Significant Incident Learning Process (SILP)

Not all referrals to panel will fit the SAR criteria but some may still benefit from a formal or in-depth review. This will enable learning from complex cases or serious incidents to be

shared to improve practice. Such reviews may be conducted as SILPs, in-depth individual management reviews (IMR) or in-depth practice audits. The SILP provides a multi-agency approach to reviewing significant incidents where it appears lessons can be learnt about how we can work together more effectively or where, had things been done differently, a different or better outcome could have been achieved.

The purpose of conducting a SAR or SILP is outlined in the Act:

14.168 SARs should seek to determine what relevant agencies and individuals involved in the case might have done differently that may have prevented harm or death. This is so that lessons can be learned from the case and learning applied to future cases to prevent similar harm occurring again. Its purpose is not to hold individuals or organisations to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of professional regulation, such as CQC, the Nursing and Midwifery Council, Health and Care Professions Council, and the General Medical Council.

3. General Principles for Reviews

The case review processes outlined in this document reflect the following principles:

- The purpose of reviews is to learn lessons to inform practice and improve outcomes
- A multi-agency and shared approach should be adopted wherever other reviews are ongoing such as Domestic Homicide Reviews and Child Serious Case Reviews
- All reviews are conducted in a fair, transparent and balanced manner and are proportionate to the complexity and seriousness of the case
- Adults and family members relevant to reviews are invited to contribute, participate and receive feedback on the findings, learning and outcomes
- Where appropriate, independent advocates are offered and/or made available to support and represent adults and families involved with a SARs and SILPs
- All parties and agencies involved are given equal opportunities to contribute and have their views taken into consideration
- SARs and SILPs are not a part of disciplinary or investigative processes and so will be conducted in a way that promotes learning and allows for reflection

4. Procedures and Guidance

The Panel: The NELSAB SAR, SILP and Good Practice Group is comprised of representatives from key partner agencies. It meets on a quarterly basis to consider the referrals received as to whether they meet the SAR criteria or warrant some other 'in-depth review'. The Panel will advise the Deputy Chief Executive/DASS where it appears the SAR criteria is met and provide advice and recommendations to the SAB as to the most appropriate level of review.

Referrals: Any individual or agency can refer cases to be considered by the Panel. Referrals can be made by email, telephone or letter in the first instance to the Board Administrator who will log all referrals, provide a referral form for completion and instigate tracking processes.

Referrers who are unfamiliar with the SAR process and need advice or guidance on making a referral can get help by contacting the NELSAB Manager. They will advise on whether the case is relevant for referral and provide assistance to complete the referral form. They will also advise on any additional information that may be needed to inform the panel process.

Completed referrals will be returned to the Board Administrator who will log the referral as above. Depending on the nature of the referral, the Board Manager will advise the SAR Panel Chair whether or not the referral can 'wait' until the next scheduled quarterly meeting or if an urgent extraordinary meeting is needed.

Time frames: Referrals should be made within 28 days of the incident or discovery of the apparent failings in service. Once a decision has been made by the panel then the review should normally be completed within 6 months of that decision being made.

Decision-Making on the Level and Type of Review:

Since not all referrals will meet the SAR threshold, it is essential that where in-depth reviews are indicated, a proportionate response is adopted. To this end, all cases will be considered in line with Care Act and Association of Directors of Adult Social Services (ADASS) guidance:

*Using a **proportionate approach** offers a range of options to match the seriousness and circumstances of the case to allow faster and more cost effective responses, whilst maximising learning.*

(i) Option One – traditional Serious Case Review approach

In this option the SCR methodology is reflected in most local protocols and follows a traditional model, broadly thus:

- Appointment of SCR panel, including chair (usually independent) and core membership – which determines terms of reference and oversees process
- Independent report author (overview report, summary report)
- Involved agencies produce Individual Management Reports (IMRs), outlining involvement and key issues and chronologies of events
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the SAB and monitoring implementation across partnerships.

(ii) Option Two – Action Learning Approach

This option is characterised by reflective/action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

- Scoping of review/terms of reference: *identification of key agencies/personnel, roles; timeframes: (completion, span of person's history); specific areas of focus/exploration*
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the presiding procedural guidance, *via chronology, summary of events and key issues from designated agencies*
- Material circulated to attendees of learning event; *anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author*
- Learning event(s) *to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt*
- Consolidation into an overview report, *with: analysis of key issues, lessons and recommendations*
- Event to consider first draft of the overview report and action plan

- Final overview report presented to Safeguarding Adults Board, *agree dissemination of learning, monitoring of implementation*
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board.

(iii) Option Three – Peer review approach

This option is characterised by peer reviews and accords increasingly with sector-led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, (for instance, Safeguarding Adults Board members), or other agencies within the region.

Peer-led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this SCR option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the Safeguarding Adults Review. The appointed peer team/panel should agree the Terms of Reference and specific methodology with the Safeguarding Adults Board.

When considering referrals for a SAR, the group should always consider whether or not there will be media interest. The chair of the board and the deputy chief executive should be notified and where appropriate a media strategy be agreed between the three statutory agencies – the Local Authority, the Police and Health.

Whatever level of review is recommended, the Deputy Chief Executive/DASS will be notified of all cases where a SAR has been requested or is recommended. A briefing report will be completed and prepared by the chair of the SAR panel and where a decision is needed urgently, then the DASS will be notified and the Deputy Chief Executive approached directly.

The Deputy Chief Executive will consider the recommendation of the SAR Panel and the SAB and will make the final decision on whether or not a SAR is conducted. Depending on the level of review agreed, a task and finish group will be formed to manage the process and where necessary, invite others to take part; E.g. the independent author, practitioners and case managers.

Review Administration and Process:

When the decision to conduct a review has been made, the SAB Manager and board administrator will coordinate the following steps:

- Notification of NELSAB members of the review
- Information requests to agencies to complete Internal Management Review (IMR) reports and/or chronologies in the agreed format or templates
- Notifying and liaising with relevant adult and family members as agreed by the SAR Panel. (NB. The person appointed to liaise with the family should be the person who is best suited to that role and will be best able to engage the family)
- Scheduling review meetings and any associated consultation events
- Collation of information returns
- Preparation of submissions and updates to the NELSAB
- Consultation with practitioners, individual managers and group meetings
- The completion of interim and final reports

The Panel or task and finish group will meet between commencement and completion of the review process to consider whether any further information is needed or if there are further lines of enquiry that may affect the scope of the review. The report author should attend the group at relevant intervals so that progress of the report can be monitored by the Panel or task and finish group.

During the process, other meetings with relevant parties and/or interim learning events may also be convened to inform the analysis for the final overview report and recommendations. Where immediate learning emerges that indicates urgent changes to practice are required, actions should be implemented on a service or agency basis during the ongoing SAR process.

Once involved parties have had opportunity to comment on the report then a draft report with recommendations will be presented to the NELSAB. If agreed at SAB level, the report

will be returned to the SAR, SILP and Good Practice Group for dissemination to those agencies involved and the relevant family members for their views and comments.

Sharing and Dissemination of Learning

The SAR, SILP and Good Practice Group will make arrangements to share the recommendations with relevant agencies so that these can be translated into action plans.

The SAR group will prepare an overarching action plan with timescales to be monitored and inform updates on progress to the NELSAB.

The learning from the SAR will be shared with the Learning and Workforce Development Group and a plan put in place to disseminate learning through the most suitable means to have the broadest impact, e.g. through E-learning, joint training and learning events.

5. Publication of Reports & Report Contents

The Care Act Guidance suggests that the SAB considers publication of the full SAR reports. Depending on the endorsement of the SAB, either an anonymised version of the full report or an executive summary will be prepared for publication and distributed to all agencies.

The Deputy Chief Executive will take advice from the SAB and decide whether the full report or executive summary is published. The views of the family and where appropriate the subject of the review will be sought prior to publication and they will be notified in advance of dates of publication.

With regard to the contents of the report it should as a minimum:

14.178

1. Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible

2. Be written in plain English

3. Contain findings of practical value to organisations and professionals

14.179 In the interest of transparency and disseminating learning the SAB should consider publishing the reports within the legal parameters about confidentiality.

The referral process is detailed in a flow chart at Appendix A.

Appendix A

Referral Procedures for SAR/ SILP

SAR referral or request for case review received. Referral logged on tracking system, admin provides referral form and, if necessary, SAB maAnager provides further advice to referrer.

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SAB Manager consults with SAR/SILP & Good Practice Chair to decide if referral can wait until next scheduled meeting or whether an urgent/extraordinary meeting is needed.

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SAR/SILP & GP chair consults with panel to determine proportionate response, inform Dep. CEX and recommend level of review. Panel also considers potential need for joint communications strategy if the case is likely to go into the public arena via media.

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If SAR criteria not met or decision is for SILP or other review, the Chair will notify the DASS and report to NELSAB in normal timeframes.

If SAR criteria is met, Dep. CEX/DASS must be notified. If urgent then an extraordinary meeting is convened.

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SAR/SILP & Good Practice implement process. SAB admin and manager notify all partners. Panel identifies task and finish group, scopes and progress the review. SAB manager coordinates processes, logs and tracks progress. Review author consults agencies or individuals and arranges for required submission of reports or chronologies.

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SAR, SILP or review report presented to SAR/SILP & Good Practice Group for agreement and disseminated to relevant agencies for comment and contributions.

Overview report is presented to SAB for agreement/comments. Final draft shared with agencies and family involved for comment.

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Final reports completed. Action plan for partners agreed & distributed. Reviews and Action Plans shared with Learning and Workforce Development Group.

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Learning and Workforce Development Group, panel chair and SAB agree 'Lessons Learned' shared learning methodology and processes.

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SAR/SILP & Good Practice Chair to audit Action Plans on agreed completion dates and present to NELSAB for decision on publication.

SAB manager, Stewart Watson, and administrator, Claire Parfrement can be contacted via Claire.Parfrement@Nelincs.gov.uk.

If media interest or tandem enquiries are ongoing, an urgent meeting may be needed.

Media strategy will need to be agreed with health and police statutory partners.

An urgent meeting will be more likely where there is a tandem process e.g. Domestic Homicide Review or criminal enquiry ongoing

Timescales for responses will be sent out with guidance on completing returns.

Draft reports and findings will be presented and monitored by the SAR panel throughout the process.

Sharing learning or any training indicated will be agreed jointly with partners at SAB subgroup level. This may for example be in the form of learning events, changes to procedures or delivery of training programmes to relevant partner agencies.