Somerset Safeguarding Adults Board

Learning & Improvement Policy

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1 Introduction

There are a number of processes that can be used by the Somerset Safeguarding Adults Board (SSAB) for the purpose of learning lessons from incidents and practice, and to use these findings to improve, impact upon and develop local practice and service delivery or design.

The range includes:

- Safeguarding Adults Reviews (SARs);
- Audits of multi-agency and single agency practice;
- Reviews of whole service safeguarding;
- Reviews of individual safeguarding.

Throughout all learning and dissemination activity, the statutory requirements of the Care Act 2014 should be observed. The six principles of Adult Safeguarding should inform all arrangements.

The purpose of a Review is not to re-investigate an incident or incidents, nor is it to apportion blame. Its main function is to identify whether lessons can be learnt about the effectiveness of professionals and agencies working together to safeguard adults at risk.

2 Statutory requirements of the Care Act 2014

Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults 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*[1]*.*

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]*.*

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases[3]*".*

The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

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SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

[1] Care and support statutory guidance, updated 26/10/2019, section 14.162. Retrieved 19/08/2019
[2] Care and support statutory guidance, updated 26/10/2019, section 14.163. Retrieved 19/08/2019
[3] Care and support statutory guidance, updated 26/10/2019, section 14.164. Retrieved 19/08/2019

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 in order for lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for this, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission (CQC), the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and organisations are fearful of SARs, their response will be defensive, and their participation guarded and partial (s14.140).

3 Principles of the SSAB Learning and Improvement Framework

The 6 key principles of adult safeguarding should apply to SAR activity, namely:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability.

In undertaking SARs, Somerset's Safeguarding Adults Board will expect that:

- there is a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews will be proportionate according to the scale and level of the complexity of the issues being examined;
- Safeguarding Adults Reviews will be led by individuals who are independent of the case under review, and of the organisations whose actions are being reviewed;
- professionals will be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith, and their own organisations will take responsibility for supporting them through the process;
- adults at risk will be invited to be involved in a SAR about their experience; if they have any significant difficulty in being involved, an independent advocate will be commissioned to support them to be involved as possible throughout the process;
- families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Clear information will be given sensitively to families about the nature, purpose and outcomes that can and cannot be achieved through a SAR.

4 Safeguarding Adult Reviews (SARs)

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. (Care Act statutory guidance 14.141)

The SSAB recognises that a set of SAR Quality Markers are in the process of being produced by the Social Care Institute for Excellence (SCIE) and is supportive of this work.

Once completed these markers will be added as an appendix to this policy, and the draft Markers will be used for referenced by the Board in the interim.

4.1 Criteria for a SAR

SARs are concerned with the abuse or neglect of adults with care and support needs, who are not able to protect themselves because of those care and support needs. The adult does not have to be in receipt of care and support.

SABs **must** arrange a 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 (s14.133).

SABs **must** arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs may arrange for a SAR in any other situation involving an adult in its area with needs for care and support where it believes there is value in doing so.

Cases for a SAR not involving death or serious abuse or neglect may be selected by the SAB because they allow the SAB to proactively address issues of concern, for example:

- a case will provide useful insights into the way organisations work together to prevent and reduce abuse and neglect of adults;
- examples of good practice can be explored via appreciative inquiry where lessons can be identified and applied to future cases.

4.2 Decision-making Process

4.2.1 A SAR can be requested by any partner agency, the Coroner or the Secretary of State. All requests for the SAB to consider a case for a SAR are to be made by formally writing to the Chair of the Safeguarding Adults Board - see Appendix 1 for referral form.

The decision must be made within 1 month of consideration of the request by the Board's SAR Subgroup, subject to it receiving any additional information it requires in order to be able to be able to make a recommendation to the SSAB Chair.

The final decision rests with the SAB Chair; however, the Chair will be advised by the SAR Subgroup who will consider the request and make recommendations to the Chair. If necessary, the Chair may also consider peer challenge from another SAB Chair.

4.2.2 The SAR Subgroup will assess whether the criteria for a SAR have been met and the potential methodology before making a recommendation to the SAB Chair.

4.2.3 Organisations immediately involved in the case who are part of the SAR Subgroup will need to declare their involvement, and where the circumstances of the case deem it necessary, be represented by someone independent of the case in question.

4.3 Type of review

The SAR Subgroup will consider a SAR approach proportionate to the complexity of the issues to be considered.

In considering the approach, the SSAB will consider:

- how best to promote effective learning and improvement actions to prevent death or serious harm;
- how to avoid a hindsight bias which may obscure analysis of complex situations;
- how to promote a broad organisational learning approach and reflect current practice realities.

4.4 Review methodology

No single model is prescribed for SARs.

The choice of approach for each SAR is significant as how a review is conducted will influence the learning and whether the process is constructive and educative for those involved (SCIE 2015).

4.4.1 The SCIE Learning Together model: *the Learning Together approach has been used in both safeguarding adults and safeguarding children's reviews. The model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture. Practitioners are part of the case review team, and their perspectives are used to inform all aspects of the Review, including lessons learned.*

4.4.2 Significant Incident Learning Process (SILP): *this approach explores a broad base of involvement including families, frontline practitioners and first line managers' view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.*

4.4.3 Root Cause Analysis (RCA): *RCA has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systemic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.*

4.4.4 Appreciative Inquiry (AI): *This approach is rooted in action research and organisational development and is a strengths-based, collaborative approach for creating learning change. SARs conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded and shared honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements.*

4.5 Lead Reviewers/Chairs and panel membership

It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership and the ability to motivate others;
- expert facilitation skills and the ability to handle multiple perspectives and potentially sensitive or complex group dynamics;
- collaborative problem-solving experience and knowledge of participative approaches;
- good analytical skills and the ability to manage qualitative data;
- safeguarding knowledge;
- inclined to promote an open, reflective learning culture (s14.143).

The lead reviewer/SAR Chair is responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the stages described and outlined within Appendix 2. All panels, regardless of whether they are convened as part of a SAR or other process will be chaired by either an independent individual, or an individual representing an organisation that the SAB Independent Chair considers to be sufficiently independent.

Each agency participating in the SAR needs to identify a representative who has:

- sufficient seniority and authority to represent the agency and commit it to actions agreed as part of the review;
- relevant professional experience to allow them to analyse information and acknowledge evidenced weaknesses in their agency's involvement.

While it is recognised that it may be appropriate to involve individual members of staff with involvement in the case in the panel in order to support the identification of learning it is essential that each organisation represented at panel meetings also needs to ensure there is independent oversight as part of the panel process. At the nomination stage each agency will confirm any arrangements it will put in place to ensure that, where an individual has had involvement, both the individual and the organisation are appropriately supported and that the panel member will be available to participate fully in the review until its conclusion.

Responsibilities of SAR Panel Members:

- to represent their agency in review discussions;
- to liaise closely with whoever is preparing their agency's Individual Management Report (IMR - where one has been requested) to ensure that the report addresses all the relevant issues and is submitted according to agreed timescales;
- to clarify any information sharing issues;
- to seek legal advice on behalf of the agency if required;
- to ensure the report and IMR (where requested), and subsequent actions arising from the review, have received approval at the appropriate level;
- to arrange for a chronology of their agency's involvement in the case to be produced;
- to analyse and contribute to panel discussions about the various agency reports to assist the panel in reaching its conclusions;
- to identify who within their agency will be responsible for monitoring and reporting on the relevant sections of the action plan;
- to act as a critical friend to other panel members.

4.6 Timescales

4.6.1 A decision as to whether a referred case meets the threshold for a SAR will be communicated to the referrer within 1 month of receipt of the referral.

4.6.2 *SABs are expected to complete a SAR in a 'reasonable period of time' and within 6 months of initiating the review. A longer period is permitted, for example, because of potential prejudice to related court proceedings (s14.144).*

4.6.3 *The SAB will complete each review within 6 months of the SAR initiation meeting, attended by the lead reviewer. If the SAR is not complete after 6 months, the reasons for this will be published with the SAR and referred to in the SAB annual report*

4.6.4 *Every effort will be made while the SAR is in progress to capture points from the case about improvements needed, and to take immediate corrective action where possible.*

4.7 Duty to cooperate

4.7.1 SAB partners will ensure there is appropriate involvement in the review process of professionals and organisations involved with the adult subject to the review. Agencies that are members of the Board are expected to fully cooperate with it in regard to any review that is initiated, whether it is a SAR or other process for identifying learning from a case where the threshold for a SAR has not been reached. Where an organisation declines to cooperate, a formal request will be made by the SAB under Section 45 of the Care Act 2014. This states:

If a SAB requests a person to supply information to it, or to some other person specified in the request, the person to whom the request is made must comply with the request if conditions 1 ***and*** *2 are met* ***and*** *conditions 3* ***or*** *4 are met.*

Condition 1 is that the request is made for the purpose of enabling or assisting the SAB to exercise its functions.

Condition 2 is that the request is made to a person whose functions or activities the SAB considers to be such that the person is likely to have information relevant to the exercise of a function by the SAB

Condition 3 is that the information relates to—

(a) the person to whom the request is made,

(b) a function or activity of that person, or

(c) a person in respect of whom that person exercises a function or engages in an activity.

Condition 4 is that the information—

(a) *is information requested by the SAB from a person to whom information was supplied in compliance with another request under this section*, and

(b) is the same as, or is derived from, information so supplied.[4]

4.7.2 The SAB may decide as part of the SAR to ask each relevant organisation to provide information in writing about its involvement with the adult who is the subject of the review. The form in which such written material is provided will depend on the chosen review methodology, the circumstances of the case and consideration of proportionality.

4.7.3 The request will be sent to the organisations lead representative on the Board to request that that they:

- ensure all agency records relating to the case are made secure;
- identify a single point of contact for all further requests, including representation on the Panel;
- confirm whether there are any other investigations/review processes taking place or proposed.

4.7.4 The SAB will formally notify each of the three strategic partners of the SAB of the decision to initiate a SAR. This notification will be sent to the lead representative or, if they have direct involvement in the case, the Chief Executive of the relevant organisation.

4.7.5 The SAB will provide an update on referrals and progress at each meeting of the SAB Executive Group

4.8 Links with other reviews

4.8.1 In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Practice Reviews (CSPR), a Domestic Homicide Review (DHR), a LeDeR (learning Disabilities Mortality) Review, a criminal investigation or inquest. Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for the organisations involved. Where intelligence can be shared across reviews, there should be no organisational barriers to information sharing.

4.8.2 It will also be helpful if running a SAR, DHR or SCR in parallel to establish at the outset all the relevant areas that need to be addressed to reduce potential for duplication for families and staff.

4.9 Any SAR will need to take account of a coroner's inquiry and/or any criminal investigations related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay to the review process.

[4] http://www.legislation.gov.uk/ukpga/2014/23/section/45/enacted

4.10 Findings from SARs

SAR reports will:

- provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence wherever possible;
- be written in plain English;
- contain findings of practical value to organisations and professionals;
- be suitable for publication without needing to be amended or redacted;
- wherever possible, contain the response of the adult and/or their family to the findings of the review.

An accuracy check will be undertaken of the contents of all SAR reports as part of the quality assurance process led by the SAR Subgroup. This may include contacting the organisations/individuals involved to verify statements as well as cross-referencing documentation.

All SARs will be published in full unless the Report could be deemed to be detrimental to the person's wellbeing or the person or their family members who act/acted in the persons best interest asks for them not to be. The fact that the report will be published will be taken into consideration throughout the review process, with reports written in such a way that publication will not be likely to harm the welfare of any adults at risk or children involved in the case.

Consideration will be given on how best to manage the impact publication on those affected by the case. The anonymity of adults is not protected in law; this must be borne in mind when considering impact.

The SAB will comply with the Data Protection Act 2018 and any other restrictions on publication of information, such as court orders.

The SAB will include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take, in relation to those findings. If the SAB decides not to implement an action, it will state the reason for that decision in the Annual Report.

Published reports will be permanently retained on the SSAB website

4.10.1 Agreeing Improvement Action:

- The SSAB SAR Subgroup will oversee the process of agreeing with partners what action they need to take in light of the SAR findings prior to it being considered by the Executive Group then Board. The draft will be sent to all organisations for whom there are actions for them to ensure that the wording of the action is applicable to their organisation and is SMART (specific, measurable, attainable, relevant and timely).
- The SAR group will then agree the final version. This will be sent to the Learning and Development Subgroup for any areas that it needs to consider.

4.10.2 On receipt of the final report, the Board will:

- Agree a formal response to the findings and issues raised, and consider the improvement actions for the Board agreed by the SAR Subgroup. These must be clearly communicated and achievable within timescales considered.
- Agree arrangements to publish the report on the SSAB website and notify partner agencies, the Care Quality Commission, and the Chair of the Health and Wellbeing Board. A copy will also be submitted to the National SAR Library.

4.10.3 Accountability for oversight of the progression of the action plan sits with the Executive Group, which will report progress on it's monitoring of the combined actions from all SARs to the full Board each time it meets.

4.10.4 All relevant findings and agreed SAB actions will be shared with the Learning and Development Subgroup which will ensure these form part of the agenda of its next meeting in order to consider how the findings will be implemented and any specific activity planned.

As a minimum this should include:

- the review of training competency frameworks and recommended content;
- the production and dissemination of a SAB practice briefing note for all agencies to highlight key messages for use within individual supervision and team/staff meetings. The practice briefing note will also be disseminated to training providers to ensure the content is included within / informs safeguarding adults training.

4.10.5 Practitioners responsibilities: anyone who works with Adults who may need safeguarding in Somerset should actively engage with the learning opportunities provided by SARs. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- reading SAB SAR publications;
- reading SAB SAR briefing notes;
- attending appropriate single and inter-agency training;
- contributing to staff and team meetings / supervision;
- supporting colleagues and staff in other agencies in implementing the learning from SARs.

4.10.6 Serious Case Reviews from other SABs and Local Safeguarding Children's Boards (LSCBs): other SABs and LSCBs will regularly publish SARs and Serious Care Reviews (SCRs)s which may contain valuable learning for Somerset. The SAB's Learning and Development Subgroup will review select SARs for consideration. The findings from each will be discussed and, where it is considered that the findings merit further consideration, will be identified/referred to the SAB for action.

5 Audits of multi-agency and single agency practice

The SAB will determine audits to be carried out in the following areas:

- organisational self-audits undertaken on an annual basis;
- Board effectiveness surveys undertaken on an annual basis;
- Themed collaborative audits targeting practice, impact and experience based around the 6 key principles of adults safeguarding;
- audits of single agency and multi-agency practice.

Audits are conducted by / fed into the SAB's Quality Assurance Subgroup and reported to the SAB and its Learning and Development Subgroup with analysis and recommendations for action.

6 Other lessons learned activity

The SAB's Learning and Development Subgroup will also undertake lessons learned activity related to whole service safeguarding and individual safeguarding adults practice.

7 Dissemination and embedding learning in practice

The SAB is committed to ensuring the findings and learning lessons activity are effectively disseminated and embedded across all agency members of the SAB. The purpose of lessons learned activity is to make improvements in practice, thereby improving the experiences of adults at risk and preventing harm wherever possible.

7.1 Routes for dissemination of learning include:

- single and multi-agency training;

- SAB development days / annual conferences;
- local forums and networks
- SAB publications and briefings.

7.2 Activities to enable embedding learning into practice include:

- policy, procedure and practice guidance development;
- effective use of reflective practice and supervision;
- team/staff meetings.

7.3 Actions to be taken by all SAB partners:

- SAB partner agencies must ensure the content of training is regularly reviewed in order that it reflects and shares the learning from both local and other area SARs and lessons learned activity as disseminated via the SAB.
- SAB partner agencies will ensure that all training is consistent with the SAB competency framework and agreed content of training.
- SAB partner agencies will ensure they have undertaken activities to disseminate learning and assure that learning is embedded in practice.

8 Document History

Version	Date	Amendments	Date agreed by SSAB
Draft v.2	05/11/2015		
Draft v.3	12/02/2016	Issued to SSAB Members for approval	
Final v.4			25/02/2016
Final v1.1	22/03/2018	Reviewed by Policy & Procedures Subgroup – multiple minor amendments made	31/05/2018 - Sign off by Policy & Procedure Subgroup
Final v1.2	14/03/2019	Reviewed by Policy & Procedures Subgroup – minor amendments made	
v1.3	24/05/2019	Accuracy check added to 4.10	
v1.5	34/09/2019	Amendments throughout following review by Policy & Procedures Subgroup	24/09/2019 – Sign-off by Policy & Procedures Subgroup