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| Sandwell Safeguarding Adults Board | Safeguarding Adults Review Process  |

Contents

1. Introduction

2. The Purpose and Principles

3. Referral of cases for a Safeguarding Adults Review

4. Immediate Actions

5. The SAR Panel

6. Methodology

7. Duty of Candour

8. Links to other statutory review processes

9. Production and publication of Safeguarding Adults Review reports

**Supporting Documents**

1. SAR Referral Form

2. Initial Scoping Letter

3. Leaflet for families

4. Easy read version of family leaflet

5. Initial SAR letter

6. IMR Guidance

7. IMR Template

8.Terms of reference

9. Letter post report

**INTRODUCTION**

**Safeguarding Adults Reviews (SARs)**

The Care Act 2014 introduced statutory Safeguarding Adult’s Reviews (previously known as Serious Case Reviews), and mandates when they must be arranged. The act also gives Safeguarding Adult Boards (SABs) flexibility to choose a proportionate methodology.

The prime purpose of a Safeguarding Adult Review is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of adults with care and support needs.

**Sandwell Safeguarding Adult’s Board (SSAB) extends its appreciation to the** West Midlands Adult Safeguarding SAR Guidance which is referenced throughout this document.

**Safeguarding Adults Boards must arrange a SAR when:**

An adult\* in its area dies of abuse or neglect, whether known or suspected. AND there is concern that partner agencies could have worked more effectively to protect the adult.

They 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 AND there is concern that partner agencies could have worked more effectively to protect the adult.

 They may also commission a SAR in other circumstances where it feels it would be useful, including learning from “near misses” and situations where the arrangements worked especially well.

\* Adult must be ordinarily resident in the SABs area and have needs for care and support (whether or not the local authority has been meeting any of those needs). \*\* 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.

The purpose of this guidance is to provide individuals and organisations with a local framework for the initiating and conducting of Safeguarding Adult Reviews; and a range of good practice tools and exemplars for those involved in managing the process to ensure reviews are carried out effectively and in a consistent manner.

As such, Sandwell Safeguarding Adult’s Board (SSAB) will arrange a SAR when an adult in its area who has needs for care and support, dies or sustains serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

SSAB is committed to ensuring that SARs are undertaken for the clear purposes of driving positive change and improvement in practice, rather than as a punitive or accusatory process.

**2.The Purpose and Principles**

A SAR is not an enquiry into the cause of an individual death or injury, it is not an investigation of culpability and is completely different to any investigation undertaken by police, a coroner, or regulatory bodies such as Care Quality Commission (CQC).

SARs should seek to determine what lessons can be learned from the case and how local relevant agencies worked together, ensuring learning is applied in practice to prevent similar harm from occurring again.

**Safeguarding Adult Reviews should be conducted in a way which:**

a) Recognises the complex circumstances in which professionals work together to safeguard adults with care and support needs.

b) Seeks to understand precisely what led agencies or individuals to act as they did and when they did.

c) Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.

d) Is transparent about the way data is collected and analysed.

If adults are to be protected from the likelihood of neglect or abuse or neglect in the future, individuals and organisations need to be able to learn lessons from the past. The SAR process needs to encourage honesty, transparency and the sharing of information, for maximum benefit. As such, Sandwell SAB will seek to ensure that SARs are undertaken for the sole purpose of evoking positive change and improvement in practice and that lessons learned are disseminated effectively and timely.

There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults. Professionals/practitioners should be involved fully in any SAR and invited to contribute their perspectives. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

The individual (where applicable) and their families should be invited to contribute to any SAR review. They should be helped to understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Where appropriate, arrangements should be made for an advocate or other support. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 (39D) then, unless inappropriate, the same advocate should be used. It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process. Involvement of the individual and family provides an opportunity for personal perspective, and aids professionals to understand the adult’s lived experience, personality and identity; as well as an insight into family life and professional encounters. Family narratives about services is unique and dynamic; and minimises assumptions being made solely on case records or agency records.

 **Involvement of the individual and family provides the opportunity to:**

a) Obtain a person perspective: providing professionals with the opportunity to understand the adults lived experience and a sense of the adult’s personality and identity.

b) Obtain an insight into family life and professional encounters: family narratives about services is unique and dynamic; and minimises assumptions being made solely on case records or agency records.

c) Assist the individual and family members (individually and collectively) to cope with their feelings and the aftermath of an adult dying or suffering a serious injury.

A SAR should also offer an opportunity to assist the individual and family members (individually and collectively) to cope with their feelings and the aftermath of an adult dying or suffering a serious injury.

The Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practice.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the teams / staff whose actions are being reviewed.

The West Midlands Adult Safeguarding SAR Guidance makes clear that it is only by publishing SAR reports that organisations will demonstrate to the public the level of transparency and accountability needed to enable lessons to be learned as widely and thoroughly as possible. This should ensure professionals are able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

**3. Referral of cases for a Safeguarding Adults Review**

Any individual (including members of the public), may request consideration of a SAR, by completing SSAB’s referral form. A staff member in a partner organisation should discuss their concerns in relation to the case in question within the management structure of their own organisation before submitting the request for a SAR. The completed referral needs to explain why it is felt that the threshold for a SAR has been met, and the referral then sent to our secure email:

**SSAB\_Team@sandwell.gcsx.gov.uk** **or by secure email by arrangement**

**Please also call 0121 569 5790 to alert us that a referral has been sent or to talk to us if you do not have a secure email address that you can send the email from.**

Once received by SSAB, the Lead Officer for Protection will arrange for the case to be discussed at the next available Protection Sub Group; where it will be considered by partners against the criteria. In some cases**,** the referrer will be asked to provide further details for consideration. Where a degree of urgency has been identified, an Extra Ordinary Protection Sub Group meeting may be called to consider the referral. Wherever possible, the referrer or most appropriate person will be invited to attend the Protection Sub Group meeting to present the information in person. If the sub-group decides that SAR criteria is not met, they will consider whether an alternative review or process should be undertaken, (e.g. Serious Incident or Management Review within an agency).

To be quorate, the Protection Sub Group making this decision must always contain at least one representative from the local authority, the police, and a Health Partner. Other relevant partners should also be invited to attend or contribute, depending on the nature of the case.

After consideration, the recommendation from the group will either be:

a) the case is dealt with as a SAR, or

b) the criteria are not met and the issues are best addressed through other routes.

This recommendation will normally be made on the basis of a majority opinion. In the event of disagreement however, any member of the group can take their concerns to the SSAB Chair to seek resolution. In any event, the chair of the SSAB will be the final decision maker subject to recommendations form the Sub-Group.

A member of the public may make a complaint to the Local Government Ombudsman if dissatisfied with the response from the Chair of SSAB.

For every case referred for consideration, a written record of the rationale for the decision will be maintained, via meeting minutes and the SAR referral database.

**4. Immediate Actions**

In the event of a SAR request being accepted, the Chair of the sub-group will:

1. Notify the Chair of SSAB, the referring agency and all constituent agencies.
2. Notify all board members that a SAR has been accepted
3. Set up a SAR panel, with appropriate membership dependent upon type of case referred, and appoint an independent Chair/ Author.
4. Organise for records, from agencies involved to be secured.
5. Where applicable, notify the victim and / or their family as appropriate.
6. Inform the Care Quality Commission as appropriate.
7. Notify other Safeguarding Boards who have an interest in the case that Sandwell is conducting an SAR.

If the decision is not to proceed to an SAR, the referrer should be notified by the Chair of the Sub-Group, stating the reasons.

**5. The SAR Panel**

**The SAR Panel, will consist of members of the Protection Sub-group and will need to:**

a) Agree arrangements for informing the relatives of the adult at the centre of the review, of the decision to initiate a SAR and ensure appropriate support.

b) Agree arrangements for timescale and communication strategies.

c) Agree arrangements for learning outcomes on the basis of recommendations.

All such decisions and actions, including those that are taken by a SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability).

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

a) strong leadership and ability to motivate others;

b) expert facilitation skills, an ability to handle multiple perspectives and potentially sensitive and complex group dynamics;

c) collaborative problem solving experience and knowledge of participative approaches;

d) good analytical skills and ability to manage qualitative data

e) safeguarding knowledge; and ability to promote an open, reflective learning culture.

There is a statutory duty for agencies as requested to co-operate in the SAR process. Where difficulties are experienced and cannot be resolved in a timely manner, the SAR Panel will formally escalate the issue to the Chair of SSAB for resolution.

The time taken to conduct the SAR should be within a reasonable period but no longer than 6 months, though this may be extended by agreement with the Chair of the Sub Group (who will liaise with the SAB Chair) if the case is unusually complex or if there are other mitigating factors (e.g. it would prejudice court proceedings).

**6. Methodology**

The process for undertaking SARs should be determined locally according to the specific circumstances of individual situations. Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options. No one model or methodology will be applicable for all cases, the SAB will need to weigh up what type of ‘review’ process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

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.

The following methodologies are taken from the **West Midlands Adult Safeguarding SAR guidance and regional guidance,** no approach should be seen as holding more importance or value than another. In circumstances where the SAR criteria are not met these methodologies could still be used to aid learning and improve outcomes for adults.

**a) Traditional Serious Case Review model**

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice. This model includes

\* the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process

\* appointment of an Independent Report Author to write the overview report and summary report

\* involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning

\* chronologies of events

\* formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships

\* publishing the report in full.

The benefits of this model are:

\* is likely to be familiar to partners

\* possible greater confidence politically and publicly as it is seen as a tried and tested methodology.

\* robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

\* methodology stems from children’s arena so process to adults is not so familiar

\* resource intensive

\* costly

\* can sometimes be perceived as punitive and

\* does not always facilitate frontline practitioner input.

**b) Action Learning Approach**

This option is characterised by reflective/action learning approaches, which does 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. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity. There are a number of agencies and individuals who have developed specific versions of action learning models, including:

\* Social Care Institute for Excellence (SCIE)-Learning Together Model

\* Health and Social Care Advisory Service (HASCAS)

\* Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles. 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 prevailing 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

The benefits of this model are:

\* Conclusions can be realised quicker and embedded in learning

\* cost effective

\* enhances partnership working and collaborative problem solving

\* encompasses frontline staff involvement

\* learning takes place through the process enhancing learning.

The drawbacks of this model are:

\* Methodology less familiar to many

\* Events require effective facilitation

\* Specific versions such as SCIE Learning Together and SILP are copyrighted

**c) Individual Agency Review**

This model would be relevant when a serious incident or near miss identifies just one agency being involved or one agency who may need to learn from the situation and there are no implications or concerns regarding involvement of other agencies.

Such reviews undertaken under the SAR process should always be instigated and scrutinised by the SAB. Additionally, any recommendations should be considered by the SAB who should produce and monitor a Board action plan as a result of the review to ensure any transferable learning is shared across the partnership...

Circumstances when this model might be appropriate:

\* Serious Incidents

\* Implications relate to an individual agency but lessons could be shared, applied and learnt across the partnership

\* Where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

The benefits of this model are:

\* Provides an opportunity for learning from a individual agency

\* Enables individual agency scrutiny into a specific area

\* Assists in implementing ‘Duty of Candour’

\* Cost effective and proportionate

The drawbacks of this model are:

\* Can be seen as outside the SAR purpose of multi agency learning

\* Individual agency opposition

**d) Peer review approach**

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasingly used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are a variety of models for peer review:

\* peers can be identified from Safeguarding Adults Board members

\* peers could be sourced from another area/SAB which could be developed as part of regional, reciprocal arrangements

The benefits of this model are:

\* increased learning and ownership if peers are from the SAB

\* objective, transparent ,independent perspective

\* can be part of reciprocal arrangements across/between partnerships

\* cost effective and proportionate

The drawbacks of this model are:

\* capacity issues within partner agencies may restrict availability and responsiveness

\* skill and experience issues if SARs are infrequent

\* potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

**e) Significant event analysis/audit**

 (SEA) SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it. NHS England has published Serious Incident Framework in March 2015 The benefits of this model are:

\* It is not a new technique – doctors have long discussed cases for educational and professional purposes.

\* Cost effective and proportionate

The drawbacks of this model are:

\* Could be seen as a model that relates only to Health.

**f) Case file audit (multi or single agency, table top or interactive)**

Case file audit can be a powerful driver in improving the quality of front line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

\* As a table-top exercise (therefore no input from practitioners)

\* In liaison with the Regional Principal Social Work Network Interactive with partners and or practitioners.

\* Interactive with the adult and or their family.

\* Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

\* Flexible – in that they can be conducted in many different ways.

\* Quicker learning can be achieved.

\* cost effective and proportionate

The drawbacks of this model are:

\* There may be limited learning from sole examination of paper records.

**g) Root Cause Analysis (RCA)**

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors, the root causes of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA

investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

\* RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes

\* to be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence

\* there is usually more than one potential root cause of a problem

\* to be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:

\* The methodology is well know and frequently used in the NHS

\* Focus is on the root cause and not on apportioning blame or fault

\* Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

\* Requires skills and knowledge of RCA tools;

\* Resource intensive

**7.Duty of Candour**

All members of a Safeguarding Adult’s Board (SAB) are required to have a culture of openness, transparency and candour within their day to day work and with the SAB. In interpreting this “duty of candour”, we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust: -

 Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators

 Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice, as members of the SAB, all agencies have a responsibility to ensure they are open and transparent with the SAB when incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incidents that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns. Every agency has a responsibility for identifying both their own learning and multi-agency learning.

**8. Links to other statutory review processes**

There are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). These reviews may sometimes be relevant to a SAR (e.g. because they concern the same person thought to have caused harm, or because they meet the criteria for more than one review). Where this is the case, consideration will be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible.

Any SAR will also need to take account of a Coroner inquiry and or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

**9. Production and publication of Safeguarding Adults Review reports**

An overview report of findings will be produced for every SAR that is undertaken.

The final draft version of this report will be approved by the SAR Sub Group based on it meeting the following criteria:

a) Sound analysis of what happened and why, and is as concise and focused as possible;

b) The report will include an introduction, terms of reference, details of facts, analysis and specific and timely recommendations;

c) It is written in plain English; and contains findings of practical value to organisations and to persons who have contact with adults who have care and support needs.

d) The final version of the report will then be presented for approval to the Chair of the SSAB; Once ratified, an overview of the findings will be published on the BSAB website. Agencies will be asked to report back to board detailing what learning has taken place as a result of the recommendations in the report. Where appropriate an additional learning event will also be undertaken.