Serious Safeguarding Adults Reviews: Guidance note on options for London

1 Background

Although still in relative infancy within the adults arena, Safeguarding Adults Reviews have been largely based upon traditional childrens' Serious Case Review (SCR) models, where there is a longer history of serious concerns and subsequent reviews. There is some concern about the validity and benefit of the application of the children's methodology to adult safeguarding reviews, given the differing context of legislation and policy principles of individual choice and control.

There is increasing acknowledgement within the children's sector that the SCR methodology is not necessarily the most conducive to optimising learning. Thus, alternative review models have been developed, particularly in response to cases which do not meet the mandatory thresholds for full SCRs.

Some developing models in relation to adults have built upon these more recently established and successful approaches in children's safeguarding reviews and considered how to capture learning in a more effective and efficient way.

A recent review of 18 serious Safeguarding Adults Reviews in the London region within the previous 2 year period found most adopted a very resource intensive methodology and evidenced both considerable commonality of the key findings and a need to disseminate the learning. Traditional SCRs can be very costly, with some exceeding £15,000, while some practice learning models costing a fraction, of a few thousand pounds may achieve better outcomes.

Thus, there is a clear case for change and alternative safeguarding review model options, which are both robust and more efficient than more traditional approaches. It is felt important that a mechanism is developed so that 'lessons learnt' can be disseminated across pan-London safeguarding partnerships.

2. Impending legislation

The development of this options framework is timely, given the changes signalled within the White Paper, 'Caring for our future: reforming care and support' and the draft Care and Support Bill.

The impending legislation re-affirms the preventative agenda, including within safeguarding.

In terms of adult safeguarding, it is proposed Safeguarding Adults Boards will become statutory and with formal duties upon some partner agencies to co-

operate. It is expected that Boards thus will be better equipped, both to prevent abuse and to appropriately respond where it does occur.

Further, there is a clear expectation within the Bill that Safeguarding Adults Boards should be commissioning and learning from serious safeguarding reviews, namely where an adult at risk dies or there are concerns about how agency/agencies have worked within the safeguarding arena, individually or collectively.

Pending any guidance that may be issued regarding the undertaking of such safeguarding reviews, this options menu embraces the direction of travel of adult safeguarding and within the context of methodologies that can be flexible according to local need, and which facilitate more effective learning.

Further, it accords with the ethos of the White Paper/Care Bill: the undertaking of safeguarding reviews to reflect upon and improve practice, which ultimately inform preventative strategies.

3 Use of the options menu

This paper is not intended to be definitive guidance, but is designed to provide a number of options which may be considered by local safeguarding partnerships, to inform decision making in relation to optimising the learning from adult safeguarding reviews.

Ultimately, local Safeguarding Adults Boards will determine whether to consider or adopt any options, as outlined.

It also recognises that although the pan-London Safeguarding Procedures have been adopted, most local partnerships retain protocols on criteria and methodology for undertaking SCRs. This paper is intended to compliment such guidance, primarily by providing a wider spectrum of methodologies for undertaking serious safeguarding adults reviews for local consideration and to meet individual needs.

All review methodologies outlined have some degree of flexibility, for instance as to external or internal facilitation and the extent of review remit.

There are a number of external organisations/professionals who have considerable experience in facilitating reviews, some of whom are referred to in the Appendix. This does not represent an endorsement per se, this is provided for information and to assist with option choices. There will undoubtedly be other sources of expertise, both within and external to partnerships and which may build up across the region over time.

4 Underpinning principles

This options menu is underpinned by a set of principles that Safeguarding adults Board would need to adopt across partnerships.

These are:

- all reviews should form part of a continuum of auditing and reflective learning, from routine safeguarding practice to serious safeguarding adults reviews
- all key statutory Safeguarding Adults Board partners should contribute to the funding of multi-agency reviews
- frontline professionals and immediate line managers should be actively involved in reviews
- wherever possible reviews follow action learning principles, to identify and disseminate the lessons to be learned

5 The proposed model for London

The options menu model is designed to be flexible, allowing for local Safeguarding Adults Boards to consider the most appropriate methodology for an serious safeguarding adults reviews in each individual case.

a. Purpose of Safeguarding Adults Reviews

For all methodologies outlined, their primary function is to:

- determine what lessons can be learnt about how local professionals/agencies individually and together work to safeguard adults at risk
- identify clearly what those lessons are, how and when they will be acted on, and what is expected to change as a result
- improve single and inter-agency working and better safeguard and promote the welfare of adults at risk

b. Criteria for undertaking a Safeguarding Adults Review

The Pan London safeguarding procedures do not specifically outline criteria for undertaking Safeguarding Adults Reviews.

Most local protocols across London adopt criteria for undertaking Safeguarding Adults Reviews in accordance with ADASS guidance and with broad commonality of thresholds. Thus, it is recommended reviews are undertaken where:

- an adult at risk dies or sustains potentially life threatening injuries and
- abuse/neglect is known or suspected *and*
- there are issues with interagency working which would benefit from further investigation

c. Safeguarding Adults Reviews methodology options

The model has 3 methodology options for conducting Safeguarding Adults Reviews, from which local Safeguarding Adults Boards can decide upon the most appropriate in each case.

An overview of methodology/process, level of flexibility and relative benefits in relation to each review is outlined below and to help inform local decision making.

(i) Option One – traditional SCR 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 Safeguarding Adults Board and monitoring implementation across partnerships

This more traditional SCR methodology is more likely to be deemed applicable 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.[1]

Advantages and disadvantages of review approach

The relative merits and drawbacks of this SCR methodology are outlined below.

Advantages	Disadvantages
More familiar to SAB/stakeholders, who may consider it more robust/objective	Overly bureaucratic
Where public/political confidence may only be assuaged via a tried and tested approach	Protracted-implementation of lessons learnt/recommendations not sufficiently responsive to time considerations
Where there is multiple abuse, or high profile cases/serious incidents	Costly-costs may not justify the outcomes
Methodology usually reflects that of Children SCRs/Domestic Homicide	Often deemed punitive, attributing blame

[1] This is similar to the SCR model adopted by Blackburn and Darwen Safeguarding Adults Board

Reviews (DHR)	
	Frontline staff often precluded, so disengagement from process and subsequent learning

Where other statutory reviews, such as a child SCRs or Domestic Homicide Reviews(DHR) overlap with an adult safeguarding review, consideration should be given to the most appropriate methodology to achieve joint outcomes and avoid duplications of process (*see also 5 below*).

(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

<u>Further variance</u>

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependant upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external

agency/consultancy can vary from not at all to a full role in documentation review, staff interviews and report production.

The table in Appendix 1 is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the Safeguarding Adults Board in consideration of the best fit and individual preferences in the light of the case in question.

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)
- Paul Tudor-*Significant Incident Learning Process*

Although embodying slight variations, all of the above models are underpinned by action learning principles. (*See Appendix 2 for contact details*). There will undoubtedly also be considerable expertise within London partnerships which could be deployed to facilitate action learning SCRs.

Advantages and disadvantages of review approach

The relative merits and drawbacks of this review approach are outlined below.

Advantages	**Disadvantages**
Significant evidence approach is much more efficient	Methodology less familiar to many
Swiftness of conclusion and embedding the learning	
Considerable reduction in overall costs compared to more traditional approaches	
Action learning approach enhances: • partnership working • mutual recognition of alternative partner perspectives • collaborative problem solving	
Involvement of both frontline staff/senior managers secures both strategic and operational perspectives	
Unique perspective of staff involved in the case, reflective of the systems operating at the time	

Approach allows for identification of system strengths/positive practice	
Learning take place through the process and there is enhanced commitment to its dissemination	

(iii) Option Three – Peer review approach

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

<u>Advantages and disadvantages of review approach</u>

The relative merits and drawbacks of this review approach are outlined below.

Advantages	Disadvantages
Objective, independent perspective to particular case/aspects of safeguarding practice	Capacity issues within partner agencies may restrict: • availability • responsiveness
Usually via trusted sources sharing common experiences/understanding	where political or high profile cases deems local oversight is preferable

Can be part of reciprocal arrangements across/between partnerships	
Very cost effective, usually no fees incurred	

d. Publishing / disseminating lessons

The local Safeguarding Adults Board has the ultimate discretion of decision making in relation to any local publication of reports relating to Serious Case Reviews. Reputational risk in the local system may be a factor and a transparent approach will add to local accountability. It is worth noting that such reports may be subject to FOI requests.

Where option 1 (SCR) approach is undertaken and where there is national learning arising from the case, it is recommended that reports are published via the local council/Safeguarding Adults Board and Knowledge Hub[2] websites. Further dissemination at regional level is recommended via the London Safeguarding Adults Board chairs forum and Joint Improvement Partnership (JIP) safeguarding network. This will provide a readily accessible resource for other safeguarding partnerships to consider the application of learning at local level.

For all other Safeguarding Adults Review options undertaken, it is recommended that a summary of the overview report- outlining the key recommendations and learning outcomes- is submitted to the London Safeguarding Adults Board chairs forum and Joint Improvement Partnership(JIP) safeguarding network, as conduits for dissemination of learning at regional level. A copy should also be placed on the Knowledge Hub website.

6. Other safeguarding reviews

The above 3 options outlined are in the context of options for serious Safeguarding Adults Reviews. However, the methodologies can be adapted to other forms of safeguarding reviews, where serious case thresholds have not been met.

Some of the circumstances where other safeguarding reviews may be beneficial include:

[2] formerly Community of Practice

- a retrospective review of a complex safeguarding case, to reaffirm or amend practice
- challenges have been made to local practice or procedural interpretation
- multiple incidents/repeated concerns with particular service providers
- auditing of multi-agency safeguarding activity or scrutiny of specific aspects of practice

(i) Single Agency Review

Single Agency Reviews can be conducted where agencies constituent to the local Safeguarding Adults Board are undertaking their own reviews, where there is a safeguarding element, but where there are no implications or concerns regarding involvement of other agencies. This would be appropriate where there are lessons to be learnt regarding the conduct of an agency and in the absence of the need for a multi-agency review.

These could encompass circumstances such as:

- Serious Incidents[3] conducted by health partners
- safeguarding (or other relevant) data indicating a council is an "outlier" and the need for further investigation/analysis
- the Board requesting a SAR from an agency in the light of emerging issues/concerns in relation to a particular case
- where serious harm and/or abuse was likely to occur, but had been prevented by good practice

It is recommended that the Safeguarding Adults Board is informed by any constituent agency when they are undertaking a Single Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships.

<u>Advantages and disadvantages of review approach</u>

The relative merits and drawbacks of this review approach are outlined below.

Advantages	Disadvantages
Opportunity for agency to scrutinise aspects of practice in relation to specific areas and:	Restricted scope-does not embody a wider perspective of other partners
in order to identify areas for improved practice	Lacks interface perspective(s)

[3] previously referred to as Serious Untoward Incidents

Single agency reviews represent an opportunity for an agency to scrutinise aspects of its own practice in relation to specific areas and in order to identify opportunities for improved practice. They can be carried out exclusively by the partner agency concerned or undertaken or facilitated by an external agent on their behalf.

By definition, its scope is restricted, in that it does not embody a wider perspective of the practices of, or interfaces with other partners.

7. Referral mechanisms and oversight

In accordance with its role as strategic driver of safeguarding, it is recommended that the Safeguarding Adults Board formally overviews all safeguarding reviewing activity, findings and practice developments.

Boards may thus wish to issue guidance, such as requests for specific Safeguarding Adults review options to be made in writing to the chairperson of the Safeguarding Adults Board and setting out how the case meets the criteria for the appropriate review. The Safeguarding Adults Board should be the ultimate decision making body in relation to safeguarding reviews and may recommend that an alternative review option is deemed more appropriate.

8. Interface with other reviews

There are a number of reviews, led by other agencies that may share commonality with an adult safeguarding case that is subject to review. These include:

- Childrens' Serious Case Reviews
- Domestic Homicide Reviews

However, it is of note that both children's SCRs and DHRs are undertaken within statutory frameworks and adopt a "traditional" methodology (*as in 4 b (i) above*). Indeed, Home Office guidance on conducting DHRs specifies this approach and Local Safeguarding Children's Boards have had to seek Ministerial dispensation to conduct reviews using an alternative methodology in cases meeting mandatory thresholds.

Where a safeguarding review is also likely to have a corresponding children's Serious Cases Review or Domestic Homicide Review, the appropriate local Boards should decide upon the relative benefits of joint or parallel approaches.

Thus, the panel/review chairs could together formally consider the scope, parameters and terms of reference. In particular, consideration should be given as to whether co-ordinated reviews or a jointly commissioned review would be appropriate.

Likewise, the expectation is that findings from both childrens' SCRs and DHRs are published. Thus, these issues need to be borne in mind where a jointly commissioned review is deemed appropriate.

9. Implementation and embedding

Where this model is adopted in London, it would be beneficial to capture and assess the impact of its application. It is thus suggested that a piece of work is undertaken to evaluate prevalence, experience and outcomes arising from the application of the different options and with formal report back across the region.

This provides potential for adjustments to processes in order to fine tune them and share experiences and consideration of what worked well or less well and overall learning.

Sue Bestjan

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Appendix 1

Process	Variance / option	Circumstances where may apply	Comment
Scoping, drawing up TOR Extent/breadth of review	Involvement of external agent Timespan of review focus Staff interviews	*Where external challenge may be a priority *Long history/complex case *Where agency information lacks clarity *Differing interpretations: inter-agency, variance to procedures	
Appointing report author	Can be same person as below: externally appointed from within partnership	 *High profile, stakeholders require obvious neutrality *Where person has experience, expertise *Where author has no direct involvement in case *Imperative to contain costs	
Appointing learning event facilitator	Can be same person as above: externally appointed from within partnerships	 *Where tensions within partnerships *All partners need to be involved in event *Cost considerations, unlikely to incur charge	Needs appropriate skills to ensure learning environment, support staff involved in incident

		*Where facilitator has no direct involvement in case	
Evidence review	Exclusively by external agent (eg documentation, procedures, staff interviews) Relevant partners' production of key issues & chronologies Combination of partners and external/independent agent	*Insufficient capacity in partnership *Significantly differing interpretations of events *Questions about adequacy of procedural guidance *Perceived need for complete objectivity *Benefits of "tried & tested" expertise *Where perceived need to maintain ownership and oversight *Need for ownership, but with external challenge	
Learning event	Half day to day	Longer with greater review depth, scope and complexity	
Follow up event	Half day	As above	

Possible variations to Option 2 (action learning approach)

Appendix 2

Organisations undertaking Action Learning Safeguarding Reviews

Social Care Institute for Excellence (SCIE)

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