social care
institute for excellence

Safeguarding Adult Review Quality Markers – open training session (1)

Decision making whether a SAR is needed

Dr Sheila Fish

SCIE

06 June 2022

A flexible session

1	9.30-10.15	Welcome and main input. Statutory requirements and safety science: decision making about whether a SAR is needed
	10.15-10.30	Short break
2	10.30- 11.15	Break-out rooms. Share reflections from your different areas, helpful approaches and ways of working; what would you like more input on
3	11.15- 11.45	Quality Marker 2
	11.45-12.00	Wrap up and close

Stay with us for as many sessions as are useful to you

We'll share a link to an evaluation form at the end of each session

Learning Outcomes

By the end of the session participants will have:

- A refreshed grasp of the statutory guidance on when a SAR is mandatory as well as SABs powers to arrange discretionary SARs
- Considered what legal literacy means in terms of decision making
- Understand why defensible decision making is important
- Appreciated the need for balance between mandatory and discretionary SARs according to the ‘safety science’ evidence base

SCIE support for high quality learning from SARs

Phase 1.


Supporting SAR Quality and impact
Refreshed SAR Quality Markers
Handbook
Comprehensive checklist tool
Role-specific checklist tool
Targeted briefings on SAR QMs
Virtual workshops x3:
Setting up the review
Running the review
Outputs, action and impact
Regional SAR Quality Champions
Self-nomination
Induction
Bespoke support
Beginning with regional SAR Subgroup sessions

Phase 2.
Open training sessions to support use of the SAR Quality Markers

SAR QMs targeted training sessions - open to all	SAR QM	Agreed date
1. Decision making whether a SAR is needed	SAR Quality Marker 2	Thursday 26th May 9.30-12.00
1. Flexible and bespoke commissioning	SAR Quality Marker 5	Friday 17th June, 9.30-12.00
1. "Safety science"	SAR Quality Marker 12	Tuesday 28th June, 9.30-12.00
1. Different audiences for publication and dissemination	SAR Quality Marker 14	Wednesday 20th July, 9.30-12.00
1. Logic Model / theory of change	SAR Quality Marker 15	Thursday 15th September 9.30-12.00

Register to attend

https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022

Decision making about whether a SAR is needed

Legislation and Statutory Guidance

- The Care Act 2014 outlines a Safeguarding Adults Board's core duty to conduct safeguarding adults reviews in accordance with Section 44 of the Act: http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

- Statutory Guidance published by the Department of Health and Social Care in relation to safeguarding adults reviews: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Section 44 Care Act 2014

44 Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

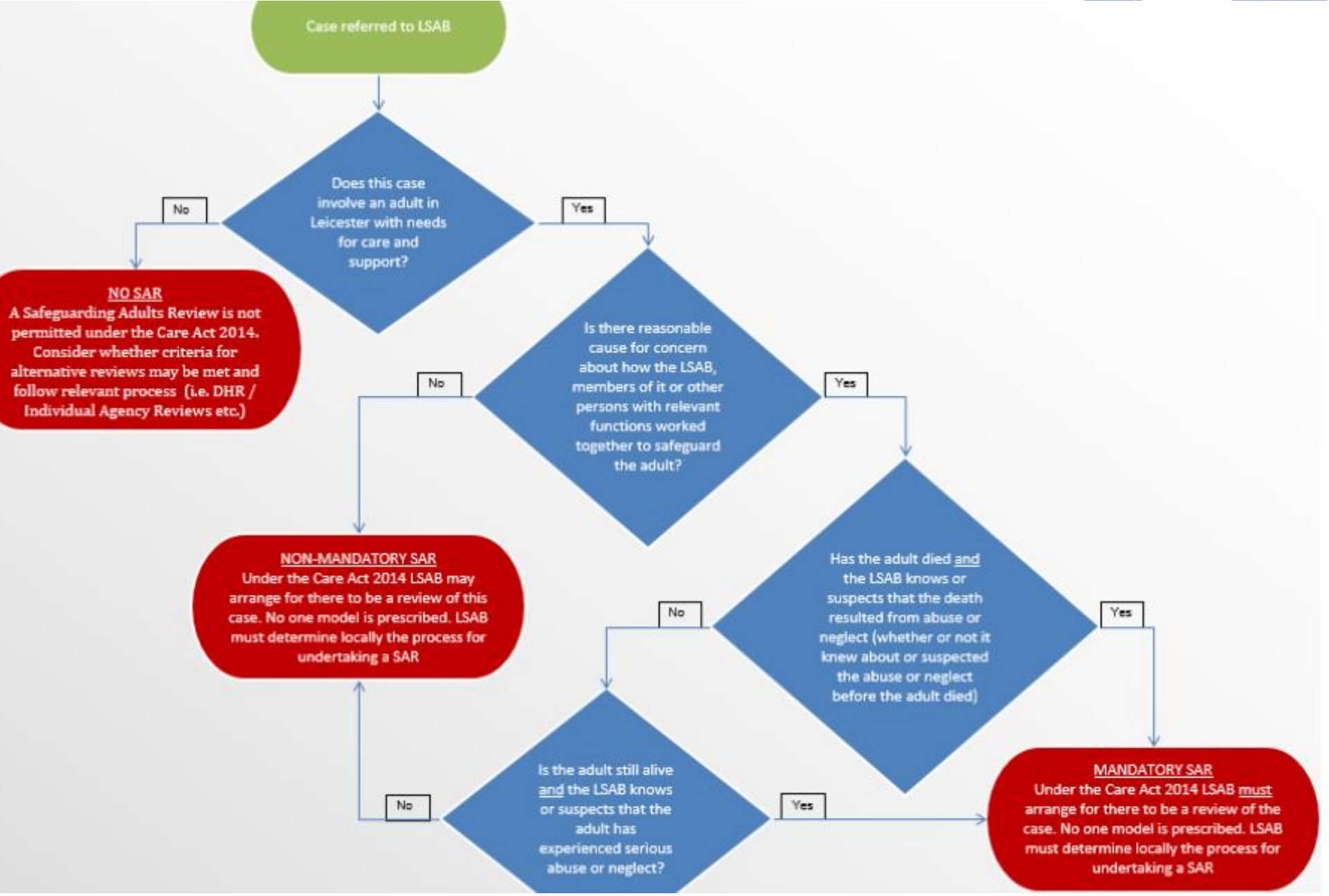
(b) applying those lessons to future cases.

Statutory guidance

Safeguarding adults reviews (SARs)

14.162 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.

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.



Leicester SAB https://www.leicester.gov.uk/media/185725/lsab-sar-policy-2018.pdf

Not always straightforward to determine whether …

- The person had/has care and support needs (whether or not the local authority has been meeting any of those needs)
- The person's death 'resulted from' abuse or neglect (known or suspected)
- The person experienced 'serious abuse and/or neglect'
  - the statutory definition is not tightly delineated
  - in line with **Making Safeguarding Personal** needs to take into account the person's own views views about what they have experienced.
  - The impact of abuse and neglect can include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness.
- What constitutes concerns about how partner agencies worked together

The national analysis evidence SAB use of section 44(4) power to conduct a discretionary SAR

- Because the cause of death was not related to abuse and/or neglect, or
- Where it was uncertain whether the individual had care and support needs, but where learning could be derived from how services worked together.
- Where financial abuse was known or suspected but was not the cause of death, or
- Where there was evidence of self-neglect or neglect but where health complications had been the cause of death.
- To review cases involving suicide, homelessness, immigration issues and no recourse to public funds.
- One case in the sample where the SAR found no evidence of abuse or neglect

https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

Also found likely non-compliance with statutory requirements

- All SABs in England, a total of 132, were approached for this information.
- 129 SABs responded, representing a response rate of 98 per cent. 231 SARs obtained
- 29 SABs (22 per cent) had not completed any SARs in the two-year time period for this national analysis

And more widely that greater precision needed

- “Not all SABs appear to have grasped the distinction between mandatory and discretionary reviews”

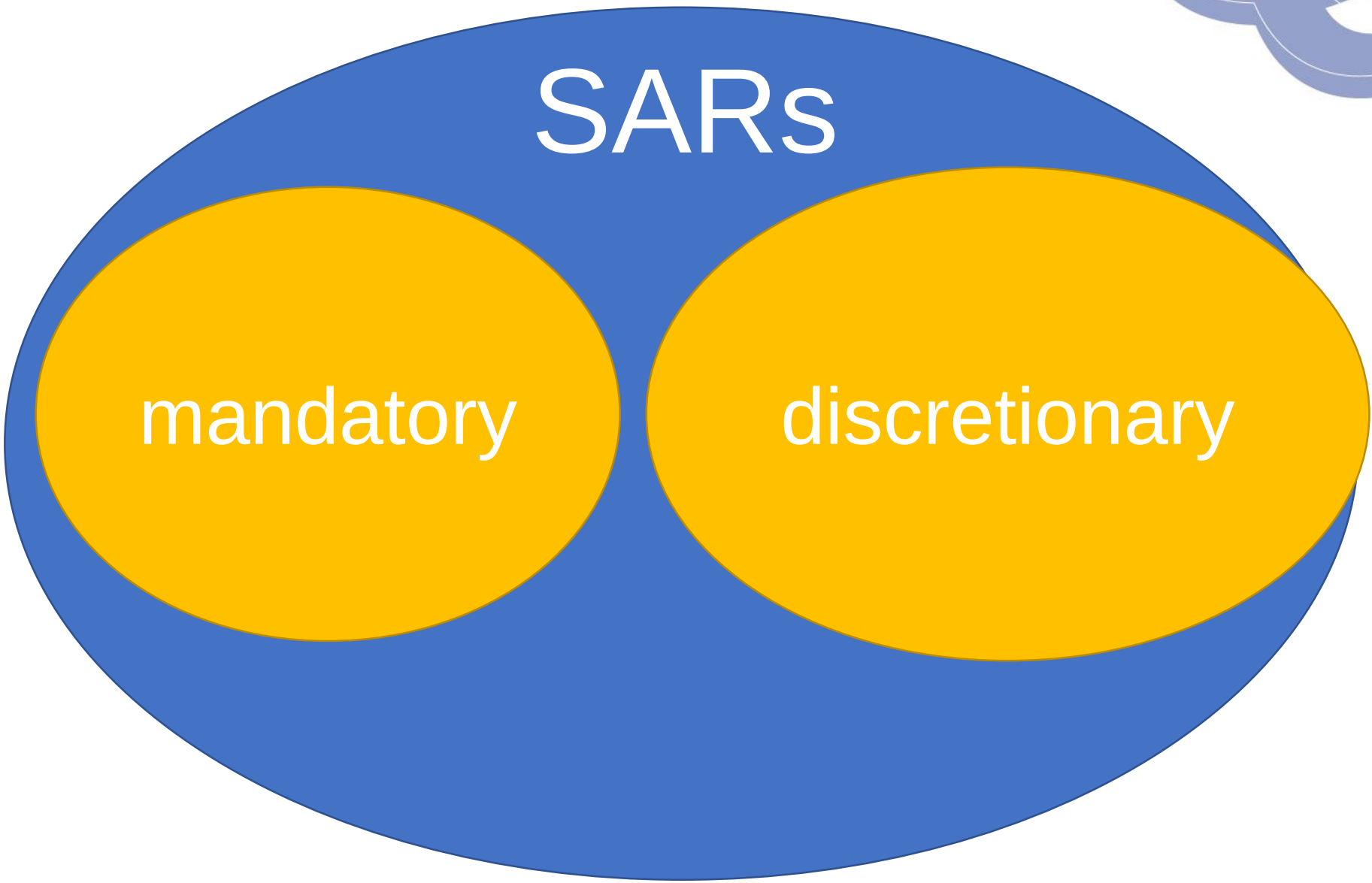
- “Greater precision is needed, which might be termed legal literacy, in order to ensure that decision making is defensible if ever challenged.”

Legal literacy –

- An absolute duty in law is where an organisation must do something and has no discretion. Section 117 MHA 1983 is one of very few such duties.
- A discretionary duty in law is where an organisation must do something if in exercising its discretion against clear criteria, it believes it necessary to do so. **Section 44 (1) (2) (3) is a discretionary duty.** The key is where the Act says "must" "if".
- **Section 44 (4) is a power to conduct reviews**, again where the Board believes it appropriate to do so. It again exercises its discretion. The language key here is "may".
- Thus, all reviews are statutory, mandatory in some circumstances and discretionary in terms of a power in others.
- In fact there is a difference between absolute and discretionary duties, and powers that are enacted after the use of discretion.

Credit Michael Preston-Shoot personal correspondence March 2022

All SARs are statutory



Defensible decision-making – administrative law standards

- Must be lawful and reasonable, taking account of all relevant considerations
- Discretion must not be fettered through the application of blanket policies
- Reasons must be given for the decisions reached.

- Therefore, decision making about a particular referral for SAR consideration must
  - evidence decision making based on the unique circumstances of each case and reasons clearly recorded and
  - be defensible against the statutory requirements of s.44

The Local Government and Social Care Ombudsman's (LGSCO) can investigate complaints

Examples from national analysis of imprecision

- There were references to a review being “non-statutory” or generic descriptions of referrals “not meeting the criteria” or “the threshold” for a SAR.
- There were examples of SARs where the review was explicitly described as discretionary … Such reviews were termed variously as learning lessons reviews, management case reviews, multiagency reviews or partnership reviews.
- Occasionally, SARs were candid that there had been mixed views on whether the criteria outlined in section 44 Care Act 2014 had been met.

Of greater concern

Occasional strident criticisms in SARs of a lack of understanding of the criteria and process for initiating reviews, and of poor decision making, including where initial decisions not to commission a review had been overturned by the independent chair following challenge from family members.

Mirrored in commentary from a minority of SABs when submitting material for this national analysis, namely that their procedures for managing the entire SAR process were unclear.

The legal mandate

- Discretionary duties in section 44(1), (2) and (3) Care Act 2014 mean ‘if’ conditions are met, a SAR is mandatory
- Power within section 44(4) to conduct a discretionary SAR

SABs are under an absolute mandatory requirement to conduct a SAR where an adult **with care and support needs** has **died as a result of abuse and/or neglect**, including self-neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person.

There is a comparable absolute mandatory requirement where the person has experienced **serious abuse and/or neglect** but survived.

In these circumstances there is no discretion; a review is mandatory.

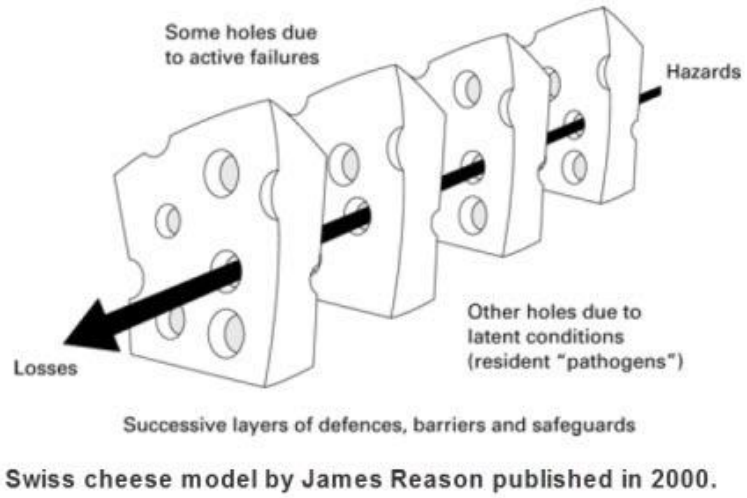
SABs may also commission reviews in any other situations involving adults with care and support needs. Such reviews are discretionary.”

National analysis recommendations

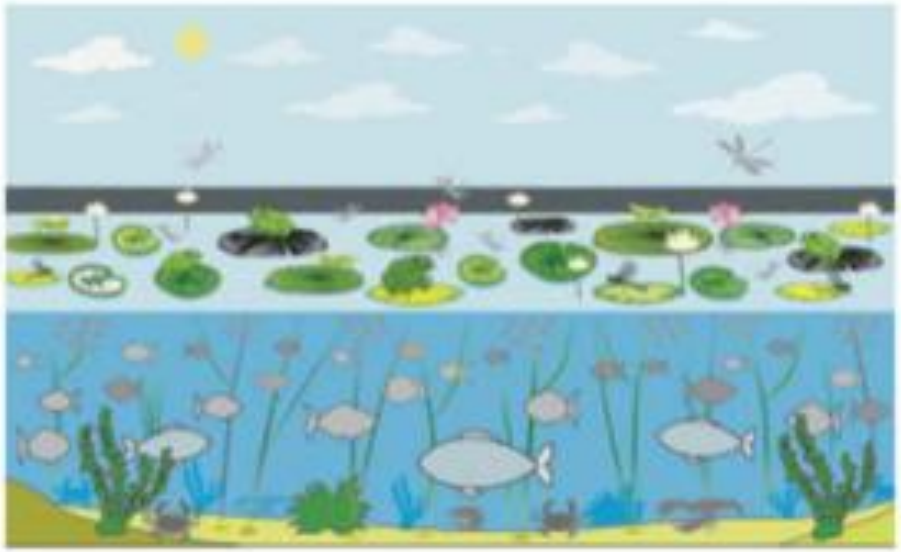
- **Improvement priority five**: SABs and their partner agencies should review their shared understanding of the relevant legislation regarding referral and commissioning of SARs to ensure this accurately reflects when a SAR is mandatory as well as ~~the absolute and discretionary duties and~~ power to arrange discretionary SARs within section 44, Care Act 2014.
- **Improvement priority six**: Regional and national SAB networks to be used to review approaches to the interpretation and application of section 44 Care Act 2014 in decision making about SAR referrals

3. Important context of the current ‘safety science’ evidence base

From Safety-1 …. to Safety-11



Swiss cheese model by James Reason published in 2000.



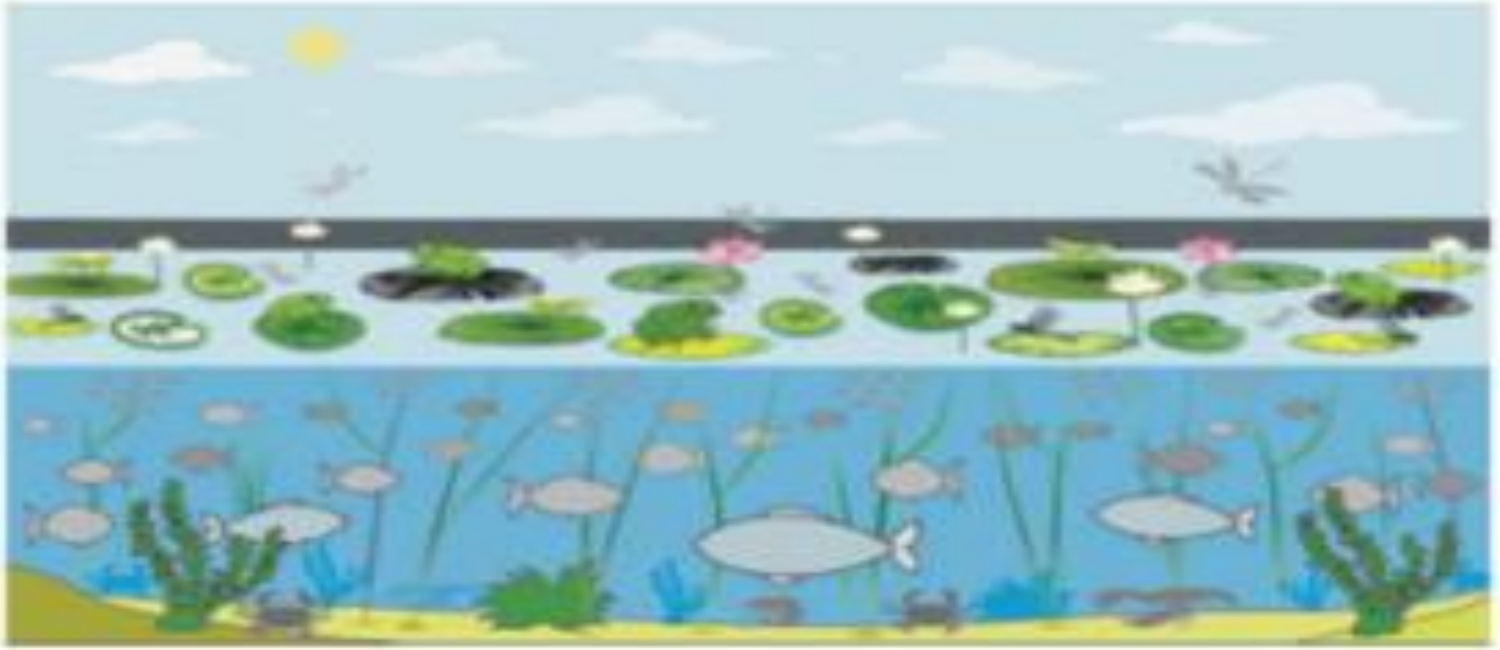
From ‘swiss cheese’ ….

…. to ‘lily pond’ model

Lilypond model

https://journals.sagepub.com/doi/abs/10.1177/2516043520913420

The traditional models for workplace safety management are simple and linear. They focus only on failure; primarily the classification of it and where to apportion the consequential liability. The Lilypond model creates the opportunity for the complexity of the modern workplace to be accounted for, and non-linear processes to be incorporated into our understanding of patient safety and organisational performance. It also allows all spectrums of performance outcomes to be considered providing opportunities to learn and improve from every event.



Reflected in changes in the NHS

- The Patient Safety Incident Response Framework (PSIRF) replacing the Serious Incident Framework 2015
- Supported with the first systemwide patient safety syllabus, training, and education framework for the NHS.

	Changes related to patient safety *incident management and investigation*
A strategic, risk-based approach to PSII	• Moves **away** from reactive and hard-to-define thresholds for Serious Incident investigation and **towards** a proactive approach to safety and learning investigations. • Selects incidents for PSII based on the opportunity for learning. • Selects PSIIs for learning to ensure the wide range of outcome severities is covered. • Introduces local provider patient safety incident response plans (PSIRPs), agreed with commissioners. • Highlights alternative, proportionate and effective responses to incidents (eg case note review, timeline mapping, 'being open' conversations, after action review, audit), to better describe common review activities and address queries. • Prioritises the quality of PSII to support improvement. • Supports more balanced allocation of resources to develop

Child Safeguarding Practice Reviews similarly -

- Key change to Working Together to Safeguarding Children 2018 was a move from criteria led decisions about conducting LCSPRs, to a requirement to consider whether a review is needed

“Still too many rapid reviews focus on whether the criteria have been met, rather than on the subsequent considerations about whether there is any further learning to be gained beyond the rapid review” (Mark Gurrey, National Panel)

SAR QM2 attempts to recognise both aspects, and encourages a strategic approach

From the chat – reflections, comments, questions, concerns?

References

- Michael Preston-Shoot, Suzy Braye, Oli Preston, Karen Allen and Kate Spreadbury (November 2020). Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement. London: LGA https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

- Administrative law standards and defensible decision making. For example see, Preston-Shoot, M. (2019) Making Good Decisions: Law for Social Work Practice (2nd ed). London; Macmillan/Red Globe Press.
- Do equivalent exist from health or other sectors?

- Paul Stretton (2020) Lilypond: An integrated model of Safety II principles in the workplace. A quantum shift in patient safety thinking. Journal of Patient Safety and Risk Management 2020, Vol. 25(2) 85–90

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Coffee break

SESSION 2. Break-out rooms

- Sharing reflections on input this morning
- Any local practice / developments that are useful to share?
- What more would you like clarity about?

SESSION 3. SAR QM2 encourages a strategic approach

Thank you!

- SCIE team

Sheila Fish, Suzanne Cottrell, Anna Muller and Yvonne Watkins-Knight

Sheila.fish@scie.org.uk
Reviews@scie.org.uk