SAFEGUARDING ADULTS REVIEWS

Exploring questions on commissioning, managing and learning from SARs

Wood Review (2016)

- A review of Local Safeguarding Children Boards, which includes a critique of SCRs, namely:
  - Insufficiently systemic, not answering “why?”
  - Repetitive findings and recommendations
  - Lessons not learned effectively
  - Insufficient engagement of practitioners
  - Inadequate process, variable quality, not timely
- Reform through the Children and Social Work Act 2017:
  - Rapid local inquiries
  - National inquiries
  - Dissemination

How do SABs and SARs measure up in response to the critique?

New statutory beginnings

- SABs must arrange a SAR when:
  - An adult 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.
  - An adult has experienced or is suspected of having experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.
- SABs may arrange a SAR in any other situation involving an adult with needs for care and support where there is potential to identify valuable learning.
- SARs may cover all types of safeguarding cases, including modern slavery, self-neglect, domestic violence, institutional abuse, financial abuse, sexual and physical abuse.
- SARs may explore good practice outcomes to improve partnership working.

Would you commission a SAR?

- A mother and son have been unlawfully killed by a husband/father who then took his own life. Risk profiles and observation of the father's behaviour concluded that there was a significant risk of self-neglect although the main focus of agency practice was his mental ill-health. When his wife sought to separate from him, because of his behaviour (severe mental distress and domestic violence) there was a dramatic deterioration in his self-care, which appeared to be his response to change and stress. The case was not known to adult services. The GP, Mental Health Trust and the Police were the main agencies involved in attempts to engage the father in treatment and to manage his behaviour.

Would you commission a SAR?

- Over several months the police are contacted by people in the community concerned about the behaviour of an adult. These concerns centre around his increasingly extreme religious beliefs, which he disseminates in public places, and bizarre behaviours which are thought possibly to be evidence of an enduring mental illness. The individual is not registered with a GP. The police refer the case directly to the Mental Health Trust and to Adult Social Care. Adult Social Care pass the referral onto the Mental Health Trust. Some referrals to the Trust are lost, others delayed because of staff absence or the fact that he is not registered with a GP. An assessment of his mental health is not done. Police officers appear uncertain about the circumstances when they can use powers under mental health legislation and PACE. Without warning and with no previous history of violent behaviour, the individual murders his neighbour.

Questions for Independent Chairs and Business Managers - Commissioning

- Organisational abuse and self-neglect prominent in London and SW SAR surveys but higher representation of other types of abuse/neglect in SW. What might influence the referral process here?
- Are referrals appropriate and do all agencies refer?
- How do we understand differences in the number of reviews being commissioned by different SABs (found in London and SW)?
- What are the explicit and implicit thresholds being used for commissioning different types of review?
- Statutory SARs dominate. What influences are at work here? How do we balance proportionality with commissioning the familiar? How do the six principles work here? Is the statutory guidance too restrictive? When might we use shared learning events?
- Finding reviewers?
- What influences choice of methodology?

Statutory guidance on process

- Consultation with the adult and their family on their involvement
  - How? With whom? When? Implications of parallel processes? What if litigious, even vexatious?
- Agree and publish terms of reference
  - Where?
- Agree any interface with other investigations (Coroner, IPCC, HCPC, NMC, CQC) and reviews (DHR, SCR)
  - In principle
  - For specific cases
- Complete within six months – when is the beginning and end? Feasible?
- Include findings and actions taken in SAB annual reports

Overview and IMR writers

- It is expected that those undertaking a SAR will have appropriate skills and experience which should include:
  - strong leadership and ability to motivate others;
  - expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
  - collaborative problem solving experience and knowledge of participative approaches;
  - good analytic skills and ability to manage qualitative data;
  - safeguarding knowledge;
  - ways of working that promote an open, reflective learning culture.

- Do we have a JD/Person Specification template?
- How is the decision on appointment made?

Applying the six principles to SARs

- Empowerment – agencies may have been here before. How do we empower families and practitioners for whom this may be the first and only time? Involvement in commissioning decision and then in the process including decisions on publication?
- Prevention – how do we learn and use SARs to improve? Has your SAB developed a learning and improvement strategy?
- Proportionality – how do we determine appropriate methodology in terms of complexity and scale of case?
- Protection – how do we ensure safety from future harm for this individual and for others in similar circumstances? What do we learn and how do we implement this learning?
- Partnership – how effective are local information-sharing protocols? How do we work with professionals to ensure their involvement without fear of blame for actions taken in good faith?
- Accountability – how willing are local agencies to be scrutinised? Legislating for transparency will not make it happen. Is the review led by those independent of the case?

Principles for undertaking reviews

- ***Positive reflection***: the intention of SARs is to learn and improve services, not to blame any individual or specific agency and reviews will highlight positive and innovative practice as well as that which could have been different.
- ***Timeliness***: priority will be given to ensuring that timescales set out are adhered to and reviews are undertaken in timely manner. This will be considered at the point of commissioning.
- ***Impartiality***: the review will be conducted fairly and impartially with evidence of balance and objectivity in all reports.
- ***Thoroughness***: the review process is robust and committed to exploring each of the terms of reference in detail.
- ***Openness and accountability***: the review and its outcomes will be shared appropriately and the process will be conducted in accordance with the Board and member agencies' governance arrangements.
- ***Sensitivity***: SARs will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).
- ***Confidentiality:*** all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so

Types of Review

- The Board 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. So, what approach can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults?
- What are the advantages and disadvantages of different types of review?
- Does the Wood critique influence the picture here?
- Hybrid models (increasingly common in London and SW thematic reviews)

Questions –Managing the Process

- What aspects of the statutory guidance on SARs have proved helpful or unhelpful?
- Family involvement – how explicitly do we clarify family expectations? What are we learning from an apparent increase in family involvement? From setting terms of reference onwards? Family contributions to the report and publication of response to it?
- Practitioner and manager involvement – the rhetoric is that SARs are about learning and not blame. Is that how the process is experienced? What is the SABs contribution here? Do we really reach an understanding of “why?” How do we involve practitioners and managers – learning events, reflective conversations?
- Panel membership – CQC? Care home owners or representatives from RCA etc?
- Are SCIE and/or London ADASS quality markers being used to oversee the structure and content of the report?
- How is the process of reaching a decision about publication handled?
- How is the process of communication with the media and Coroner handled?
- What is the difference between an establishment concerns review and a SAR? Which when?
- What is the panel’s role on number and SMART content of recommendations?

Temperature check (1)

- Research evaluating adult safeguarding Serious Case Reviews in London noted: '*Robust leadership is needed within and between all partner agencies, to enable cultures that embrace reflection, learning and change. Chief Officers, management boards, local politicians and Safeguarding Adults Boards all have a role to play in setting expectations and driving this agenda forward'*.
- Question – what if agencies do not co-operate with requests for information and/or participation?
- 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 their organisations are fearful of SARs, their response will be defensive and their participation guarded and partial.
- Question – is there work to do to ensure that relationships can support critical reflection and openness? What is the impact of possible onward referral of concerns about poor practice?

Temperature Check (2)

- SARs are intended to be mechanisms for practice development and service improvement. Their purpose is not to attribute blame, for which there are other purposes.
- Question: what if the review process encounters defensiveness by an individual or agency, perhaps concerned about the implications of open reflection for on-going professional registration?
- Question: what if there are parallel investigations, perhaps by the IPCC, NMC or HCPC?
- Question: can the distinction between learning and accountability really be held? What approach is advisable when significant concerns emerge regarding professional and/or unlawful practice?

External interest and scrutiny

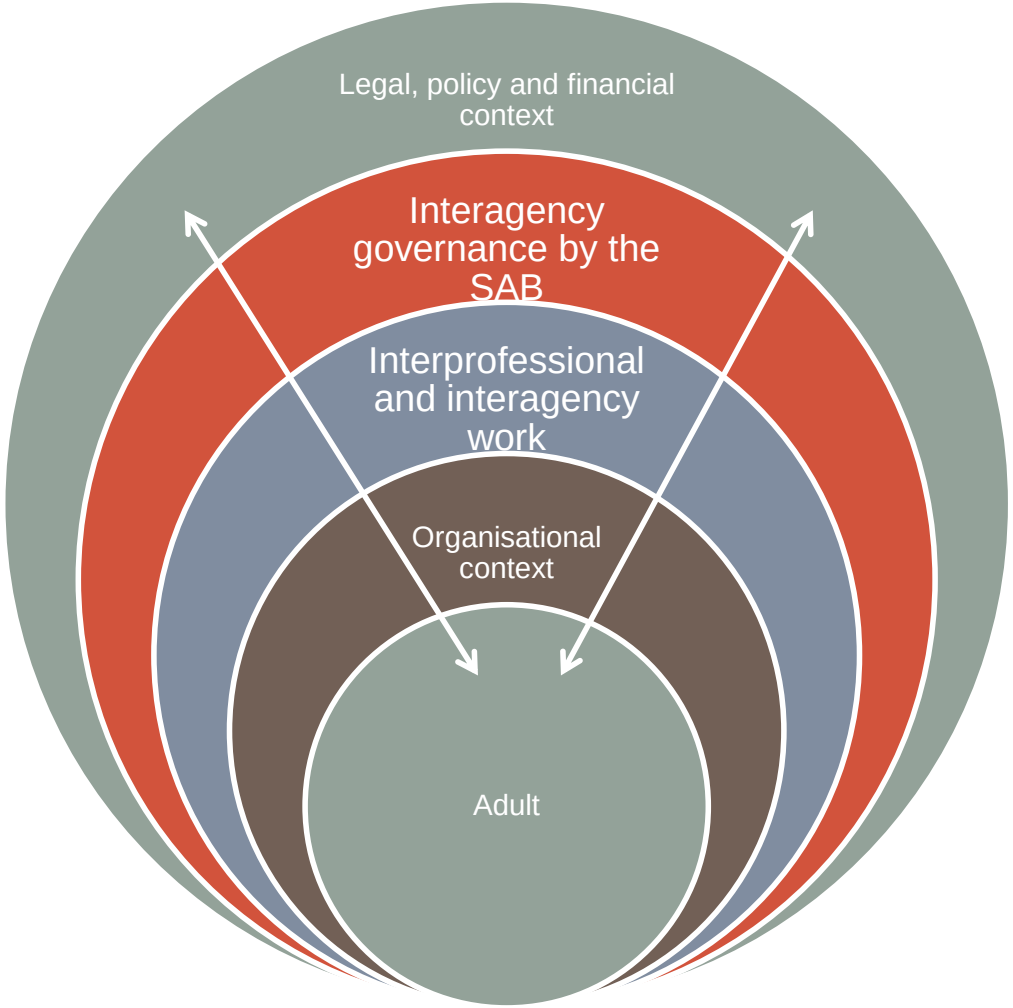
- SABs are not subject to FoI legal rules. However, what if a Coroner or solicitor acting for the family requests IMRs, a draft SAR etc? Who decides about the release of information? Who owns the information prepared for the SAR?

- Worcestershire CC and Another v HM Coroner for the County of Worcestershire [2013] EWHC 1711; R (Webster) v Swindon LSCB [2009] EWHC 2755 (Admin).

- Local Government Ombudsman may investigate terms of reference, outcomes of a SAR, the administrative support given to a SAR, family involvement, and conflicts of interest

- How much do you publish? Is your decision reasonable and rational (Re X (Judicial Review: Publication of Serious Case Review) [2014] EWHC 2522 Admin)?

A safe system has alignment of checks and balances between the different layers of the system



Another take on “insufficiently systemic”

- Why is there so little comment on:
  - The working environment and its impact on staff, such as cultures, workloads, resources?
  - The legal and policy context, and the extent to which mandates are helpful, weak, contradictory, unclear ..? Why is there so little focus on MCA 2005 and DPA 1998 when capacity and information-sharing are two recurring themes?
  - Organisational structures – partnership working grafted onto single agency structures, each organisation having its own financial challenges?
  - Whether yet more procedures can actual ensure best practice when workplace development is crucial if practice is to be evidence-based and research-informed?

Learning and service improvement strategy

- The purpose of a SAR is to ensure 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.
- Question – what dissemination strategies prove effective over long-term to sustain and embed learning?
- Question – how do SABs ensure learning and on-going service improvement from SARs commissioned and published by them and elsewhere?
- Question – is there a place for seminars to “SAB proof” lessons emerging from SARs and for auditing action plan outcomes?
- Question – where are the facilitators and obstacles to change?

Questions – Capturing Learning

- How useful have you found the different methodologies for understanding what influenced case processes & outcomes?
- What influences the decision about whether to publish and what to publish?
- Are web pages and annual reports compliant with Care Act requirements regarding publication of annual reports and their content with respect to SARs?
- There is no quality standard for recommendations – what might one contain?
- Do SABs consider it appropriate to direct recommendations to national bodies, including government? Very few recommendations about the legal, policy, financial and market contexts.

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