Terms of Reference for the Safeguarding Adults Review

Mandate

S44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adults Review (SAR).

The Case Review Working Group is the group delegated to consider SAR referrals made to the SAB. The function of the Case Review Working Group is to determine whether the SAR referral had met the criteria for a SAR.

Purpose

To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which agencies worked together to safeguard adults

Provide adults or their advocate with a voice about how professionals and services can safeguard people from abuse and neglect

Review the effectiveness of procedures

It is not the task of the review to establish how injuries were caused or by whom, to attribute blame to individuals or agencies, or to make findings as to whether an agency had fallen short of its legal responsibilities: Individual organisations will address any concerns regarding professional practice and/ or behaviours identified through the SAR process using their own policies and procedures

Criteria

An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or

An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect;

And includes one of the following;

Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;

Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;

Where circumstances give rise to serious public concern or adverse media interest in relation to an adult /adults at risk.

Requests for a SAR

Any individual, agency or professional can request a SAR, provided that it meets the criteria set out above. This should be made in writing to the Chair of the Case Review Working Group and the Havering Safeguarding Board Business Manager. Referrals must be made and copied to your agency's SAB board representative (if applicable), and the Head of Service and the statutory Director of Adult Social Services. All referrals should be made on the agreed SAB SAR referral template. This template will allow the referrer to set out the reason for making the referral and the type of review being requested.

All agencies or individuals making such a request for consideration will be expected to comply with the SAB's confidentiality policy. This will involve making a written undertaking.

The Case Review Working Group will consider the referral and the information provided by partner agencies in relation to the services offered to the client referred. The Working Group will determine, from the information available, whether the criteria for a statutory SAR are met. If the decision of the Case Review Working Group is that the criteria are met, the Chair of the Working Group will make a recommendation to the Independent Chair of the Havering SAB to initiate a SAR. The Independent Chair of the SAB will consider the information provided and decide whether to formally request that the SAB initiate a SAR to review the matters referred to the SAB.

In these circumstances all partners will be informed of the decision to initiate a SAR by the SAB Business Manager.

If the decision is that the case does not meet a threshold to initiate a statutory SAR, the working group may decide to initiate a review beneath statutory threshold. This is discussed later.

<u>Objectives</u>

The completion of a SAR is to ensure that the relevant lessons are learnt and that professional multi-agency safeguarding practice is improved, and to do everything possible to prevent the issues in question happening again.

To provide a detailed analysis of all findings and recommendations for the SAB

<u>Actions to be taken once a decision has been made:</u>

When the decision to initiate a SAR is made, it will be reported to all SAB partners, including the statutory Director of Adult Social Services.

The findings of SAR investigations will be documented within the SAB's Annual Report.

When the Board agrees to hold a SAR, the Chair of the Case Review Working Group will require the SAB Business Manager to notify all agencies involved to ensure that relevant records are secured. The SAB will then follow the process of commissioning an independent overview author to support the SAB to progress the review.

SAB agency leads involved within the process will meet to consider the case and agree the best methodology, timeline of the review and parameters for the review, including timescale for completion and engagement with the adult and their family/ representative.

A multi-agency SAR Panel will be set up to oversee the progress and quality of the SAR. The responsibility of the panel will be to consider all of the reports submitted by agencies in order to provide oversight, challenge, scrutiny and curiosity to the process.

When the Board decides not to hold a SAR, the SAB Business Manager will write to the initial referrer to explain the reasons for refusing the request. If the referrer continues to believe that a SAR should be initiated, the matter will be considered by the Independent Chair of the SAB and formally discussed during the SAB operational board meeting. The Board's decision will be final.

The SAB administrator and Business Manager will be responsible for:

- Setting SAR panel meeting dates and agendas as required.
- Inviting all nominated representatives from relevant agencies to SAR panel meetings.
- Ensuring the review is conducted according to the terms of reference and methodology.
- Notifying the SAB of any administrative/ resourcing arrangements that are missing.
- On-going liaison with the police and/ or coroner's office as required.

- Arranging early discussions with the adult(s) and their family/ representatives, and requesting the arrangement of any support they require to them to participate.
- Initiating the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice.
- Requesting any data/ evidence/ reports from partner agencies as required

<u>SAR panel members (Multi Agency)</u>

The panel will be made up from senior and experienced members of the SAB and will appropriate seniority and experience with regard to the case under review. The SAB Business Manager will contact partner agencies for nominations to the SAR Panel. Panel members must not have been involved in case management or decision making for the case being reviewed.

In looking at the Panel membership, consideration should be made to include an “Expert by Experience”. This would be subject to relevant satisfactory checks and normal requirements on confidentiality being followed.

The Chair of the SAB, in consultation with SAB partners, may wish to employ an independent person to conduct the review. This, and the terms of appointment, will be formally agreed by statutory partners.

The Panel will consider how the adult at risk and/or their family and/or appropriate representative, can be involved in the process and kept informed on its progress. The views of the adult at risk and/or their representative must be sought and reflected in discussions, in the final reports and its recommendations

<u>Alternate Methodologies</u>

When the request for a SAR does not meet the criteria, the Board can recommend that an individual agency reviews an incident. The agency should be asked to use its own internal investigation procedures to do this.

Any such reviews should be completed promptly and the findings, facts, learning points and actions to be shared with the Board who will respond to any issues requiring their consideration

Where the SAB agrees that a situation does not meet the criteria for a SAR, but agencies will benefit from a review of actions, other methodologies can be considered. These include:

- Serious Incident Review: Organisations should use their own SI procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations.
- Management Review: A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue.
- Reflective Practice Session: The original participants in the case may review identified aspects of the case as part of a reflective practice session chaired by the Safeguarding Lead.

Outcomes

An overview SAR report will bring together all the relevant information provided to the report writer by all contributing agencies and will respond to the agreed terms of reference. The report will include a clear analysis of findings, a conclusion and will clearly set out recommendations.

The draft report will be formally considered by the SCR panel to ensure that it is factually accurate and appropriately identifies themes and that these link directly to the conclusion and recommendations.

The final report will be presented to the SAB Executive for ratification. All partnership agencies will be required to confirm the draft recommendations, as they apply to their agency or more generally, are clear and will be responded to. The review formally concludes when the Action Plan has been agreed by the SAB.

Recommendations from a SAR will be shared with the adult at risk/advocate/family and their response provided to the SAB in order that professionals learn about the impact of their practice.

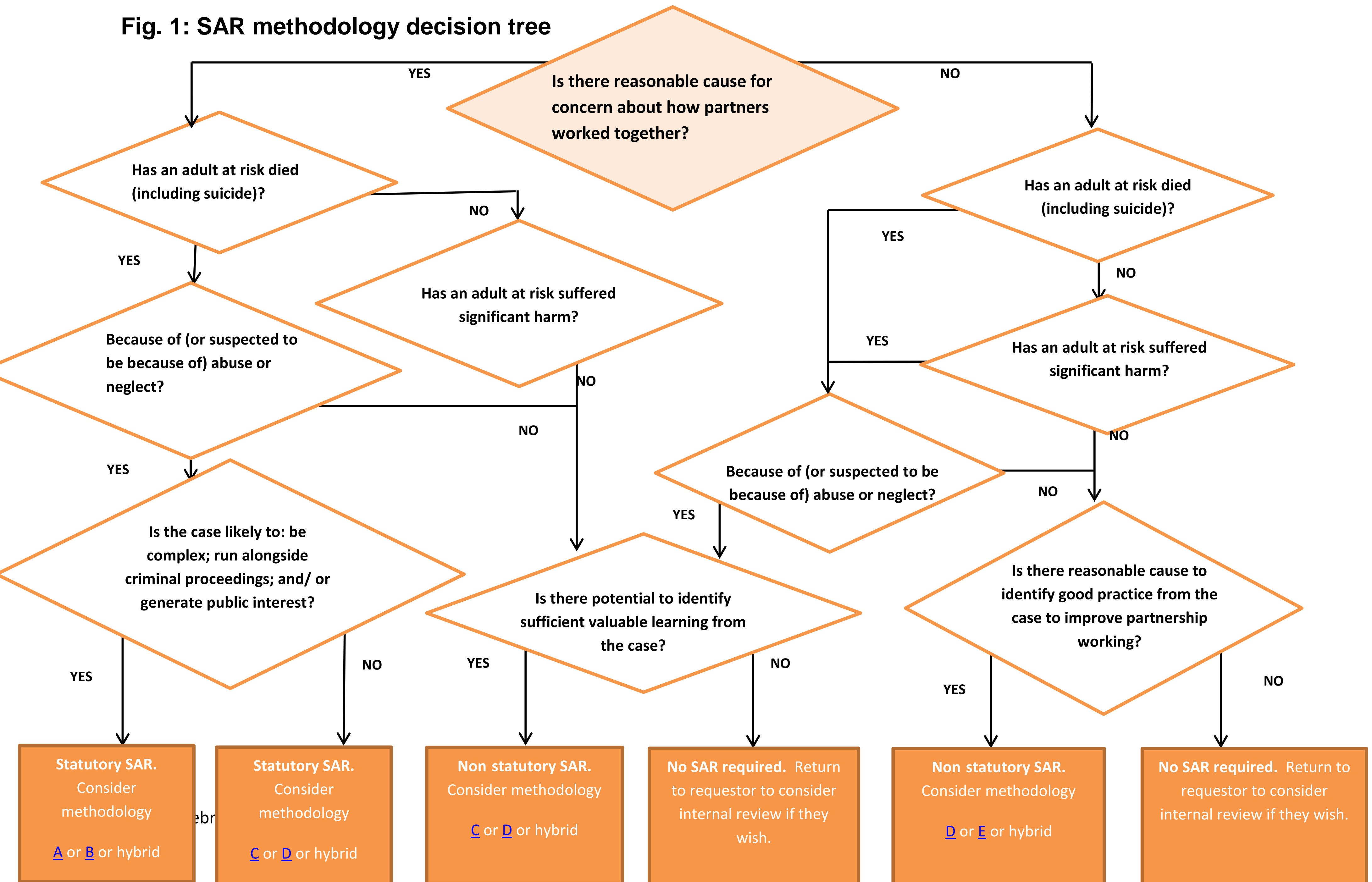
The Case Review Working Group will oversee the implementation of action plans developed to implement recommendations. Completed action plans will be reported to the operation board for agreement and sign off.

Where no improvement can be determined, the SAB may want to consider whether any additional action should be taken.

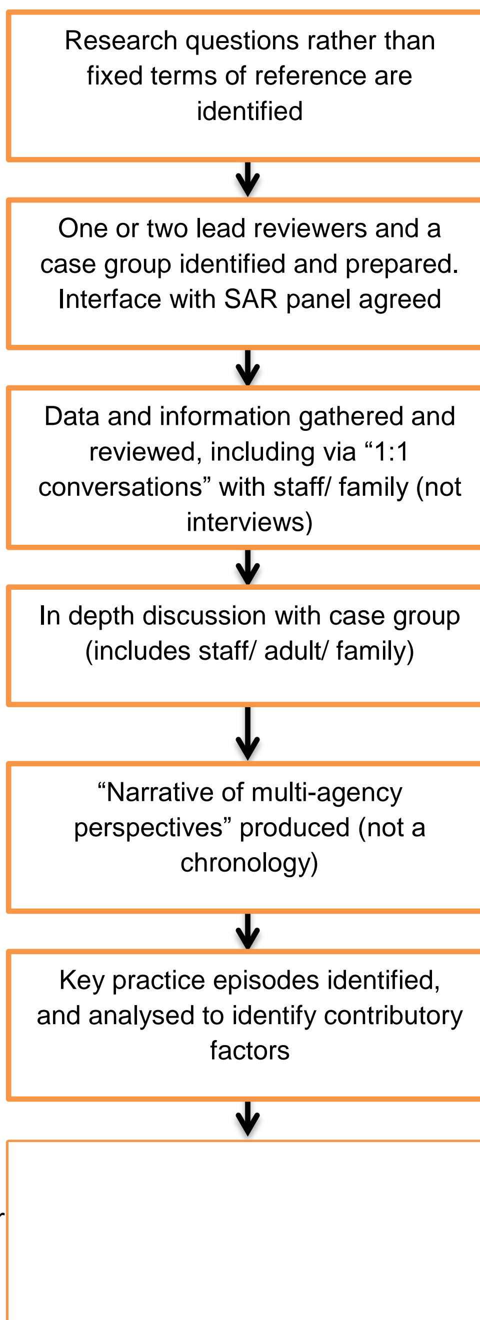
Dissemination

The findings and lessons to be learnt from such processes will be shared with partners and disseminated widely through the use of single and multi-agency briefings and learning events. The SAB will make the decision about how the recommendations and learning are taken forward.

Fig. 1: SAR methodology decision tree



Option B: Learning together



Key features:

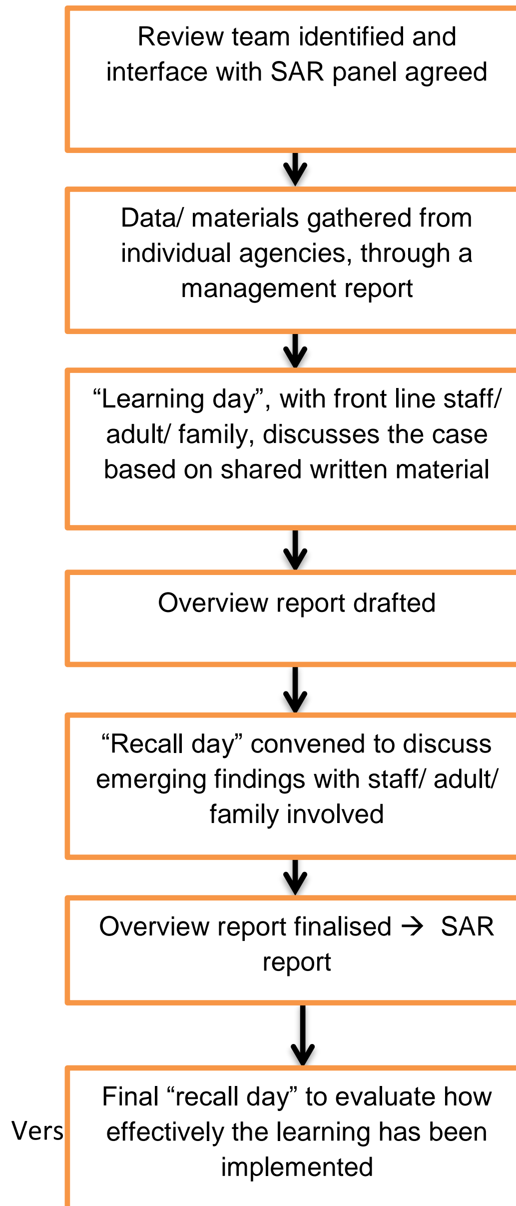
- ✓ Lead reviewer led, with case group
- ✓ Staff/ adult/ family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; no chronology
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages	Disadvantages
• Structured process of reflection	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
• Reduced burden on individual agencies to produce management reports	• Challenge of managing the process with large numbers of professionals/ family involved
• Analysis from a team of reviewers and case group may provide more balanced view	• Wide staff involvement may not suit cases where criminal proceedings are on-going and staff are witnesses
• Staff and volunteers participate fully in case group to provide information and test findings	• Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR
• Enables identification of multiple causes/ contributory factors and multiple causes	• Opportunity costs of professionals spending large amounts of time in meetings
• Tried and tested in children's safeguarding	• Unfamiliar process to most SAPB members
• Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity	• Structured process may mean it's not light-touch
• Range of pre-existing analysis tools available	

Available models:

SCIE, Learning Together

Option C: Significant Incident Learning Process



Key features:

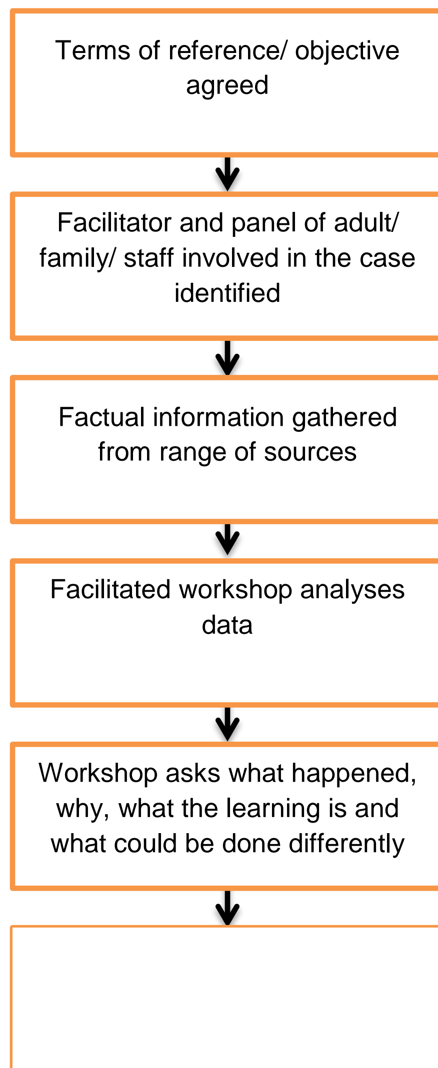
- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses

Advantages	Disadvantages
• Flexible process of reflection – may offer more scope for taking a light-touch approach • Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants • Has similarities to traditional SCR approach, so more familiar to most SAPB members • Agency management reports may better support single agency ownership of learning/ actions • Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity	• Burden on individual agencies to produce management reports • Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR • Opportunity costs of professionals spending large amounts of time in learning days • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses • Not been widely tried or tested, nor gone through thorough academic research/ review

Available models:

Tudor, Significant Incident Learning Process

Option D: Significant Event Analysis

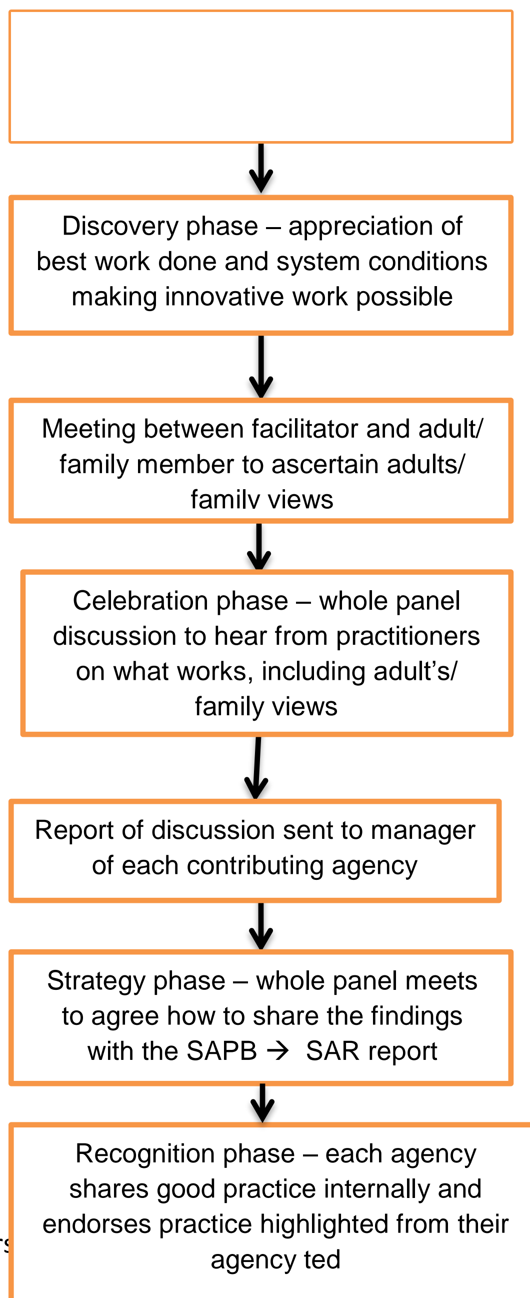


Key features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/ adult/ family involved via panel
- ✓ No chronology
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourage reflection and

Advantages	Disadvantages
• Light-touch and cost-effective approach • Yields learning quickly • Full contribution of learning from staff involved in the case • Shared ownership of learning • Reduced burden on individual agencies to produce management reports • May suit less complex or high-profile cases • Trained reviewers not required • Familiar to health colleagues	• Not designed to cope with complex cases • Lack of independent review team may undermine transparency/ legitimacy • Speed of review may reduce opportunities for consideration • Not designed to involve the family • Staff involvement may not suit cases where criminal proceedings are on-going and staff are witnesses

Option E: Appreciative Inquiry



Available models:

Care Quality Commission, Significant Event Analysis

Key features:

- ✓ Panel led, with facilitator
- ✓ Staff involved via panel. Adult/ family involved via meeting
- ✓ Aims to find out what went right and what works in the system, and identify changes to make so this

Advantages	Disadvantages
• Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days • Staff who worked on the case are fully involved • Shared ownership of learning • Effective model for good practice cases • Some trained facilitators available • Well-researched and reviewed academic model • Model understood fairly widely	• Not designed to cope with 'poor' practice/ systems 'failure' cases • Adult/ family only involved via a meeting • Speed of review may reduce opportunities for consideration • Model not well developed or tested in safeguarding. Minimal guidance available

Available models:

Newcastle Safeguarding Children's Board, Appreciative Inquiry Champions Group

Appendix 1: Flowchart for request of a SAR from Havering SAB