Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 11th February 2020

Wards: All

Subject: Learning from Safeguarding Adult Reviews (SAR)

Lead officer: John Morgan, Assistant Director Adult Social Care, Community & Housing

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care, Health and the Environment

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Recommendations:

To note the London Borough of Merton Safeguarding Adult Review (SAR) Process.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report provides Scrutiny Panel Members with an overview of the Merton Safeguarding Adults Review process (SAR) and summarises SAR activity to date from January 2018.

2 NATIONAL CONTEXT & LEGAL FRAMEWORK

2.1 A Safeguarding Adults Review (SAR) is a Multi-Agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

2.2 The Care Act 2014 requires that the local authority conduct an adult safeguarding enquiry (section 42) where it appears that a person has care and support needs, (whether or not the local authority has been meeting any of those needs) has experienced abuse and/or neglect and, as a result of those care and support needs, they are unable to protect themselves against that abuse and/or neglect.

2.3 The Care Act, (s14.162) states that the Safeguarding Adults Board (SAB) *must* arrange a SAR when an adult in its locality, who has Care and Support needs, 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.

2.4 The Act goes on to explain that 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 *and* there is concern that partner agencies could have worked more effectively either individually or together to better protect the adult (s14.133).

2.5 In addition, SABs are able to arrange for a SAR in any other situations involving an adult in its area with needs for care and support and where it is believed that we can learn from the situation or incident to improve the delivery of services.

2.6 The London Safeguarding Professionals Steering Group (Subgroup of ADASS) is made up of multi professionals across both, Health and Social care and the Police. The overarching purpose of the London safeguarding professionals steering group, is to contribute to raising the professional standards of safeguarding practice in order to improve outcomes for people who use safeguarding services as well as their families and carers.

2.7 The steering group has developed SAR guidance including principles and checklist to support all London boroughs to standardise the process of effectively conducting a SAR. This document has been designed to ensure that despite each SAR case being unique, London Boroughs and Local Safeguarding Adult Board (SAB) discharge its statutory duty using best practice.

2.8 The document supports multi-agency professionals in requesting and completing a SAR and is used in conjunction with the London multi-agency safeguarding adult's policy and procedures of which Merton has implemented and embedded in their own local system.

2.9 The guidance been designed with the aim of standardising how SARs are conducted. The aim of the checklist is to provide a reference point for Local Authorities who have a SAR protocol in place and a checklist for those that do not. Merton has implemented the Pan London guidance.

3. THE PURPOSE OF A SAR

3.1 A SAR is a statutory responsibility and the purpose is described very clearly in the statutory guidance (Care Act 2014) as to *'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'*. The aim is to promote learning and to improve practice from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring. It is not to apportion blame, hold any individual or organisation to account or to re-investigate as this can be progressed under other policies and systems, that exist for such accountability for example; criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulatory bodies.

3.2 The objectives of a SAR, include establishing:

- Lessons that can be learnt from how professionals and agencies work together
- The effectiveness the local safeguarding procedures.
- Identifying learning and good practice issues
- How to improve local multi-agency practice
- Service improvement or development needs for one or more service or agency.

4. EVALUATING AND COMMISSIONING A SAR

4.1 Merton SAB is required to agree terms of reference for any commissioned review. The SAB has established a Sub Group to evaluate and monitor SARs; the SAR Evaluation Group. The SAR Evaluation group sits quarterly and is multi-professional; it is chaired by the Assistant Director ASC and co-chaired by the Police SAB representative. Members of the group include the Local Authority, Police and Merton CCG who are the statutory safeguarding partners.

4.2 Referrals are made to the group by any interested parties but mainly by professionals and voluntary agencies involved in care of the customer. The group evaluates the SAR referral, to establish if it meets the SAR threshold which is;

> ***1. Actions or omissions*** in a ***number of agencies*** involved in the provision of care, support or safeguarding of an adult, or group of adults, at risk of abuse or neglect ***have caused or are implicated*** in the death or serious harm of that individual or group of individuals.
> **2.** An adult or group of adults at risk die or experience serious harm and there are concerns about how agencies have ***worked together*** to ***prevent, identify, minimise or address*** that harm and there are concerns about how this may ***place other adults at risk of serious harm***;
>
> ***And***
>
> There are clearly identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.

4.3 The group also makes a recommendation to the independent chair if the case meets the SAR threshold and determines the methodology that will be used. All recommendations to undertake SAR are presented to the independent chair who will decide and or challenge the process and decision making

4.4 Once the Evaluation Group decides to proceed with a SAR, the most appropriate methodology will be then agreed upon. This is crucial in order to encourage the best method to enable the involvement of key agencies and staff as well as those who are connected to the person (e.g. family etc.) and to ascertain the most effective way in which to learn from the situation or incident.

4.5 Different methodologies will suit different types of situations. These can range from traditional SAR approach based on a serious case review,

There are 4 methodology options under which to carry out a SAR.

Option 1- A Full SAR panel process: An Independent reviewer is commissioned to undertake a comprehensive review of all documentation including interview's with interested parties. Each agency completes individual high level reports and full chronology of involvement. This approach would may include a combination of two of the other methodologies to ensure that a full holistic review is undertaken, which meets the statutory requirements.

Option 2 - Desk Top Review, Significant Event Analysis: A lighter touch proportionate approach. It doesn't always involve family members. Factual information is gathered from a range of sources. The organisation reviews their internal process, systems and documentation to reflect on; what happened? why? missed opportunities and learning of what could have happened if we had worked differently.

Option 3-Systems Analysis: Systems analysis is a problem-solving method that involves looking at the wider system, exploring each part such as individual organisational, referral methods, information sharing, documents, records, including interviews etc. and looks at what happened and why, and reflects on gaps in the system to identify themes or areas for change and improve working better together to safeguard and support customers.

Option 4: Significant Incident Learning Process, Learning Together: a facilitated multi-agency group learning event which again looks at what happened and why, identifies what is working well and reflects on gaps in areas for change and improvement. Includes a Learning Day and two recall day's with frontline staff, the customer, family and discusses the situation based on shared information, then to share emerging findings and then to evaluate how effectively the learning has been implemented.

4.6 Whatever methodology is used it must be proportionate to the specific circumstances of the individual case. The choice of methodology is therefore significant and must be appropriate and proportionate to the case under review. Each methodology is valid in its own right and no approach should be perceived as more significant or holding more importance or value than another.

5. LINKS WITH OTHER REVIEWS

5.1 Partner agencies will have their own internal and/or statutory review procedures to investigate serious incidents. Such as;

- Child Safeguarding Practice Reviews,
- Domestic Homicide Review,
- Mental Health Homicide Review,
- Mental Health Serious Incident,
- Health Root Cause Analysis
- LeDeR (learning Disabilities Mortality) Review,
- Criminal investigation or coroner inquest.

5.3 The SAR protocol and process is not intended to duplicate or replace these other investigative processes. And as such the SAR Evaluation group and SAB will consider how the SAR process can dovetail with any other relevant investigations that are running parallel. The SAR is a statutory requirement in its own right, it must be undertaken and should be complemented by other relevant investigation.

6. MSAB SUB GROUPS AND GOVERNANCE (how the system learns)

6.1 As mentioned previously, the purpose of a SAR is to learn lessons as a system. The purpose is not to apportion blame or to hold agencies accountable, for which there are other mechanisms but for the system to learn. Social Care works with Individual customers, their families and carers who have rich, often complex lives and life histories. Working with this in comes with a certain amount of complexity and the system we work with is also complex.

6.2 The real value of a SAR is to ensure that the relevant lessons, specific or wider learning are understood. Particularly that the impact across all organisations is addressed and consolidated into improved safeguarding partnership working arrangements within and across all services supporting adults at risk, in order to do everything possible to prevent the issues happening again

6.3 To enable learning as a system and to promote the work of the board the MSAB has four subgroups who are accountable to the SAB. The groups feed into the SAB strategic plan and the SAR Process as a means of commissioning SARS. Recommendations and Learning from SARS is presented within each of the three remaining subgroups, the workforce, partners and the community, ensuring that improvements are made. All of the groups are made up of members from the key agencies within Merton and feedback to each of their respective areas.

Subgroups

1. **SAR Evaluation Group -** Made up of partners from the key statutory services and evaluates and monitors SAR activity in Merton.
2. **Communication & Engagement –**The purpose is to improve communication to and from the board to establish a consistent approach across Merton. Also to improve the engagement of the wider range of stakeholders, service users and carers on behalf of the board. A clear communication strategy and process is in place with regard to responding to high risk cases and actual/ or potential media issues and public interest. Learning from SARs is disseminated via this group to the public arena.
3. **Performance and Quality -** analyses data to evaluate the impact and importance of specific initiatives. The subgroup collects, collates and creates activity performance and information in line with national data collection requirements. It also informs the strategic development and operational practices of Safeguarding adults services in Merton. The group captures themes identified as part of the SAR process and initiates
4. **Learning and Development –** Ensures that Merton training is in line with pan London multi-agency safeguarding adult's policy. Also that pan London procedures are used within the training and delivery of safeguarding activities. There is a focus on workforce development and training delivered is reflective of any themes or recommendations from SARS. This ensures good practice is disseminated and embedded within the Local Authority and partner agencies. Each partner agency involved in the SAR process should provide and action plan of how they will in turn disseminate and embed any learning.

7. SAR ACTIVITY FOR LONDON BOROUGH OF MERTON

7.1 The SAR evaluation group was established in January 2018 as such a number of referrals have been received. Ten referrals have been made to the SAR Evaluation Sub group; 3 referrals were determined not to have met the SAR threshold (January 2018- January 2020).

Merton SAR Activity	
Number of referrals from Jan 18/ March 31st 2019	Merton had eight referrals for SAR's
Number of Referrals April 1st 2019/ Jan 2020	Merton has had two referrals for SARs
Number of full independent SARs from Jan 2018 to Jan 2020	There have been two full SAR's undertaken by an independent reviewer. These will be published in the next few months. 2 are currently in progress. (system learning events will take place once published)
Number of multi-agency learning events etc.	There has been 1 learning event, 1 desk top review and 1 internal management review undertaken in total over the period April 2018 to January 2020.

7.2 The individual and their family are of paramount importance during the SAR process. The SAB must seek to involve the person if able, and or the individual's family in the Safeguarding Adult Review process. The SAB has discretion when determining whether the SAR should be published in full or in summary form or not at all. However, The Care Act 2014 requires that the findings, recommendations and lessons learnt are published in the SAB Annual Report following the conclusion of the review.

8. National Learning from SAR's

8.1 The SAR Evaluation Subgroup has an embedded process for the review of SARs from outside of Merton as part of their annual work plan to ensure lessons are identified, disseminated and embedded:

8.2 Until recently there was no national library or repository for SARs. Therefore national dissemination of findings and associated learning, proved difficult. However, a national repository has now been established. The findings from SAR's will also be disseminated amongst London Region SAB Independent Chairs and at relevant national workshops for example, commissioning, contract management and care provision.

8.3 The Merton SAB is committed to the regular analysis of the themes and learning from nationally high-profile SARs and relevant other SARs as selected by the Board Manager and SAR Evaluation Subgroup.

8.4 The SAB Business Manager identifies key themes and learning and present summary details to the Subgroup. The outcomes and themes are reviewed to and identify any areas for improvement for Merton.

This is also shared with partners via their Subgroup member for identification and implementation of any single agency learning.

APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Number and list any attached appendices

None

BACKGROUND PAPERS

None

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