Hillingdon Safeguarding Partnership

# Hillingdon Safeguarding Partnership

# Safeguarding Adults Board

# Learning From Practice Framework

# 2022

## 1. Introduction

1.1 Hillingdon Safeguarding Partnership is a joint arrangement across the adult and child safeguarding networks, with a shared Executive Leadership Group. Under these arrangements The Local Authority shares responsibility with our statutory partners, the NHS North West London Clinical Commissioning Group and Metropolitan Police, to safeguard adults, children and young people.

1.2 Following the successful implementation of the new statutory arrangements for children, the same approach has been expanded to incorporate the Safeguarding Adult Board (SAB). This has enabled Hillingdon to provide a safeguarding service that is consistent, irrespective of age, and provides opportunities for innovative and responsive services in the Borough.

1.3 A central function of the Safeguarding Partnership is to quality assure local safeguarding practice. This includes meeting statutory duties in respect of the review of serious incidents, as set out In Working Together to Safeguard Children (2018), The Care Act (2014) and the Care and Support Statutory Guidance (updated 2020). The statute places a duty on safeguarding agencies to provide information to the Safeguarding Adults Board and Safeguarding Children Partnership Board to enable these reviews to take place.

1.4 Hillingdon Safeguarding Partnership is committed to the development of a learning culture that:

- is open and honest
- is proportionate and avoids hindsight bias
- identifies and addresses systemic practice issues
- supports and challenges safeguarding partners to make continuous improvements to practice

1.5 Structures are in place to ensure learning from practice to improve safeguarding practice and outcomes for adults and children. The key structures are Safeguarding Adults Review (SAR) Panel, Learning from Practice Task and Finish Group, and Practice Development Forum.

## 2. Safeguarding Adult Review (SAR) Panel

2.1 All members of Hillingdon SAB are required to notify the Safeguarding Partnership Team of a serious incident that might meet the criteria for a SAR as set out in section 44 of the Care Act 2014:

A Safeguarding Adult Board (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:

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 or suspected the abuse or neglect before the adult died).

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.

2.2 The process governing the operation and role of the SAR Panel and Serious Incident notification process can be found in the Serious Incident and SAR Panel Process.

2.3 The SAR Panel is a multi-agency senior officer group with delegated responsibility from the Hillingdon SAB. The SAR Panel reviews serious incidents notified to the Safeguarding Partnership where there is a belief that the criteria of section 44 of the Care Act may be met. The Panel decides if the criteria for a statutory SAR are met or whether a discretionary SAR or other learning activity is required.

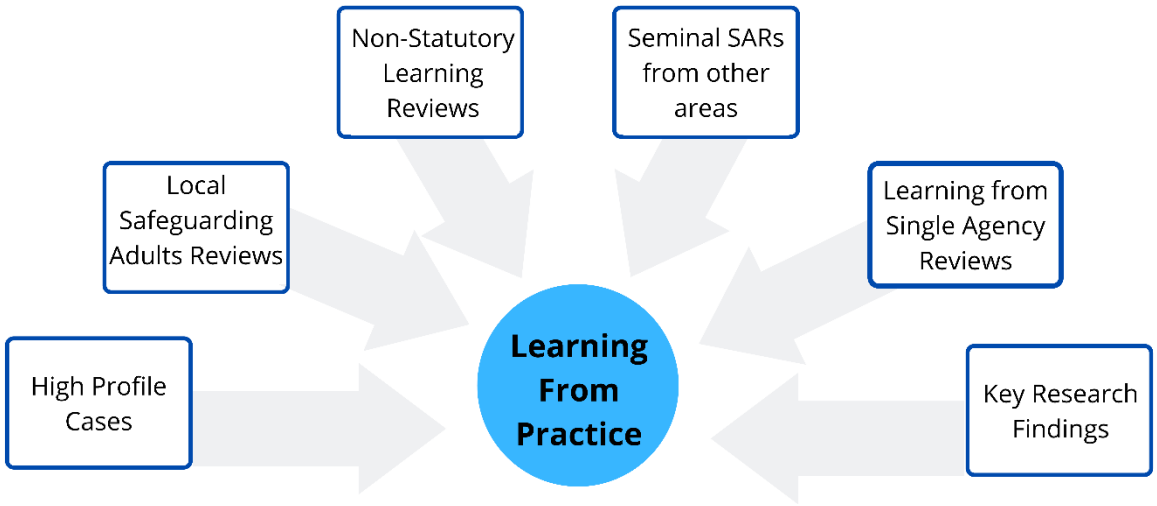
2.4 The SAR Panel will seek to identify systemic, cultural and organisational learning from serious incidents to continuously improve safeguarding practice and multi-agency working. It will consider how learning from serious incidents can be used to inform understanding of the strengths and areas for development in our partnership safeguarding systems. It will adopt a think family approach to enable learning and development to be coordinated across children and adults as appropriate.

2.5 It is recognised that effective safeguarding work is complex and includes the contribution of a network of professionals and agencies. On this basis learning can be identified for individual safeguarding partners but is likely to have applicability across the wider partnership.

2.6 Where a SAR has identified areas of learning, or actions needed, in respect of local practice these will be coordinated by the Adults' Learning from Practice Task & Finish Group.

## 3. Learning from Practice Task and Finish Group

3.1 The Adults Learning from Practice Task and Finish Group coordinates the identification, consideration, and dissemination of learning from practice with adults. The Task and Finish Group considers learning from a range of sources as outlined below:




3.2 Where the section 44 criteria are not met, but there is believed to be value to further analysis of the case, SAR Panel can refer the case to the Adults' Learning from Practice Task and Finish Group.

3.3 High profile cases, single agency reviews, key research findings, and seminal SARs from other areas are identified by members of the Safeguarding Partnership. This element provides a framework for identifying learning from those circumstances where the criteria for consideration by Hillingdon SAR Panel has not been met, and yet there is believed to be value and local applicability to further analysis.

3.4 Any member of the Task and Finish Group can put forward a case for discussion using an agreed template. These are reviewed by the Group as a whole to identify learning for the Safeguarding Partnership and agree on a strategy for drawing out and disseminating that learning. This is not an alternative route for escalation; the focus is on practice development and wider system learning. There is a clear Escalation Policy to follow for escalation purposes.

3.5 A proportionate approach is taken within Learning from Practice, dependent on the need, complexity, and circumstances of review this can include:

- ➢ the development and progression of an incident specific action plan
- ➢ a formalised learning review
- ➢ single or multiagency audit
- ➢ the dissemination of learning through briefings

The Task & Finish Group reports issues of thematic learning to the Practice Development Forum.

## 4. Practice Development Forum

4.1 The Practice Development Forum leads on the planning, delivery and quality assurance of training and service development across the Hillingdon Safeguarding Partnership. The aim of the Practice Development Forum is to ensure that high quality safeguarding training is provided across the adult and children's workforce.

4.2 The Practice Development Forum reports to both the Safeguarding Children Partnership Board and the Safeguarding Adults Board. This is through the maintenance of an action plan summarising key work streams, progress and any issues that need to be escalated.

4.3 The core membership will be made up of a representative from each of the following agencies/services:

- Safeguarding Partnership Implementation Unit
- The Metropolitan Police
- Designated Nurse, Children CCG

- Designated Nurse, Adults, CCG

- Community Safety Team

- Education Representative

- Child Protection Lead for Schools

- Adult Principal Social Worker

- Children's Principal Social Worker

- Safeguarding Children and Adults Team, NHS Central North West London Foundation Trust

- Named Nurse, Adults, The Hillingdon Hospital

- Named Nurse, Children, The Hillingdon Hospital

4.4 The Practice Development Forum meets on a quarterly basis. Where members are part of a Task and Finish Group to complete a specific piece of work. The frequency of meetings will be set by the Task and Finish Group.

4.5 The Practice Development Forum considers learning from a variety of sources and ensures that this is effectively disseminated throughout the multi-agency workforce to inform and support practitioners in the provision of effective safeguarding services to Hillingdon Residents. Sources of information include:

➢ Single and Multi-Agency Audits

➢ Statutory Inspections

➢ Statutory and Non-Statutory reviews

➢ Any cases of national importance or implication

➢ Any emerging issues of local importance

➢ The Child Death Overview Panel