Hillingdon Safeguarding Partnership

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Safeguarding Adults Board

Learning From Practice Framework

2024 v1

1. Introduction

Hillingdon Safeguarding Partnership is a joint arrangement across the adult and child safeguarding networks, with a shared Executive Leadership Group. Under these arrangements the three statutory partners: the local authority, NHS North West London Integrated Care Board and Metropolitan Police Service, share responsibility to safeguard children, young people and adults. This enables the provision of a safeguarding service that is consistent, irrespective of age, and provides opportunities for innovative and responsive services in Hillingdon.

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 (2023), The Care Act (2014) and the Care and Support Statutory Guidance (updated 2022).

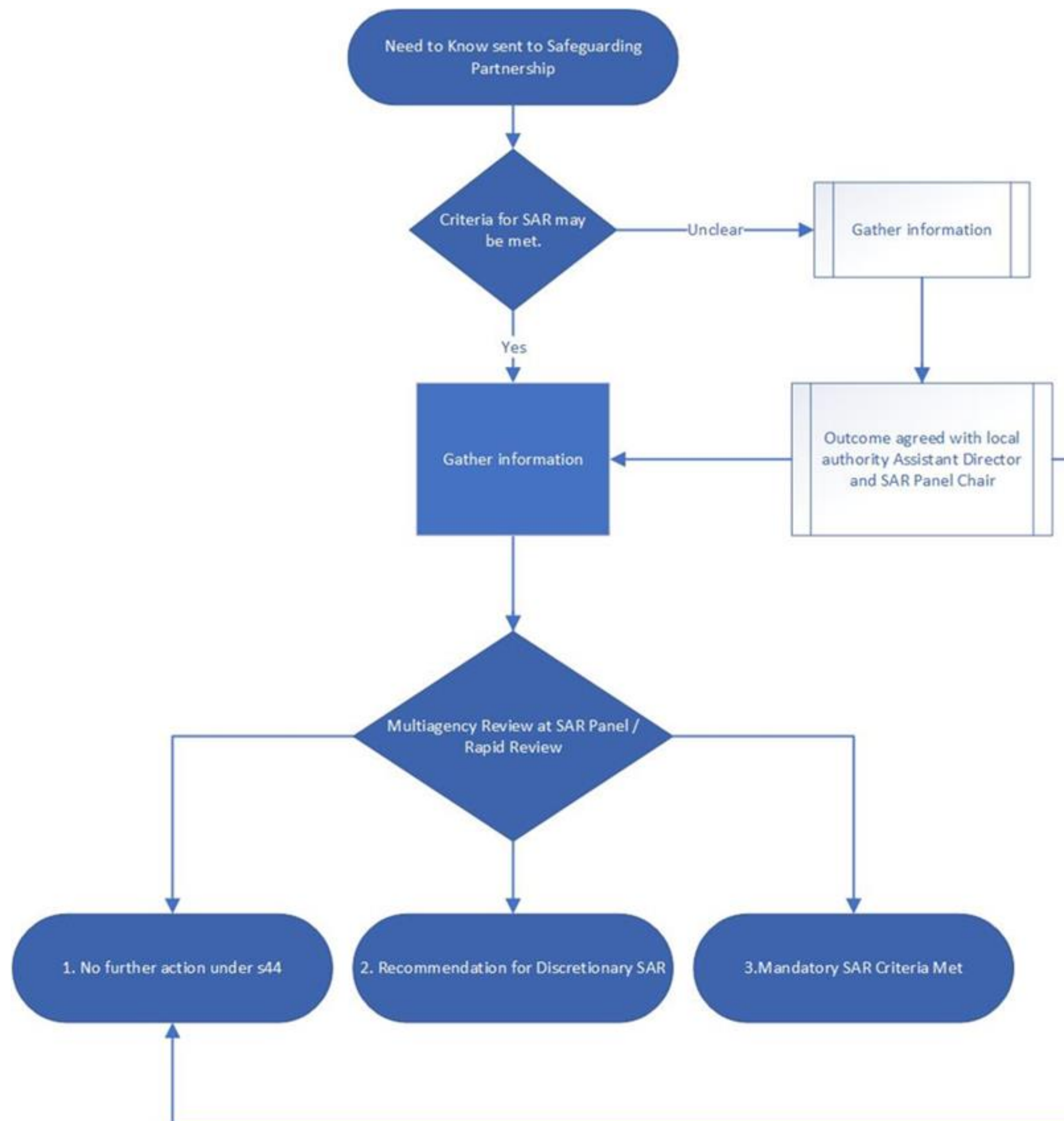
> A Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether, or not, the local authority has been meeting any of those needs) if:
>
> a. There is reasonable cause for concern about how the SAB, members of it 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.
>
> (S44, The Care Act 2014)

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

2. Serious Safeguarding Incidents

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 through completion of the Need-to-Know template. Members of the public can also make a referral for a Safeguarding Adults Review. In practice most statutory reviews are triggered following referral from the local authority as the lead agency for safeguarding adults.



The Care and Support Statutory Guidance (2022: 14.163) sets out that: '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.'

Where an adult has died, and it is believed to be due to abuse or neglect, and there is no known wider public interest, Adult Social Care will undertake a 'light touch' s42(1) Enquiry. There will be an emphasis on establishing key information and timely transfer to the SAR Panel to reduce duplication, drift and consequent delay in establishing system learning. The focus of these enquiries will be to:

1. Establish the basic information about the subject adult
2. Confirm the presence of care and support needs
3. Confirm the circumstances of the concern
4. Establish detail of the agencies/services involved
5. Establish that there is a need for consideration under s44 of The Care Act (2014)
6. Complete the Need-to-Know document

3. Hillingdon SAR Panel

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 core membership of the SAR Panel is made up of representatives of:

- Metropolitan Police Service
- North West London NHS Integrated Care Board
- London Borough of Hillingdon Adult Social Care
- London Borough of Hillingdon Housing Department
- Hillingdon Hospital NHS
- Central and North West London NHS Foundation Trust

It is recognised that effective safeguarding work is complex and that there will be intersection with various other statutory and non-statutory learning processes. The SAR Panel operates in collaboration with the following:

- Child Safeguarding Practice Reviews

- Domestic Homicide Reviews/Domestic Abuse Related Death Reviews
- Learning from Suspected Suicide Panel
- LeDeR reviews

This collaborative approach starts from the receipt of a SAR referral (Need to Know). Checks will be made with the relevant learning panel, with an appropriate lead agreed to reduce duplication and ensure a joined-up approach to establish learning. Where required, Joint Reviews may be undertaken and learning shared.

Upon receipt of a SAR Referral the Safeguarding Partnership Team may recommend a 'Rapid Review' meeting to identify learning and weigh the known information against the statutory criteria. This will be contingent on complexity, and circumstances of the case. Panel members are responsible for ensuring the completion and return of information requests prior to the case discussion or Rapid Review.

The outcome of Panel consideration is informed by the application of the SAR Decision Tool. Each decision is informed by the following questions:

- Was there clear evidence of a risk of significant harm to an adult at risk that was:
    a) not recognised by agencies or professionals in contact with the adult or perpetrator; OR
    b) not shared with others; OR
    c) not acted upon appropriately?
- Was the adult abused/neglected in an institutional setting?
- Was the adult abused/neglected while being supported by the Local Authority or NHS Trust?
- Does one or more agency or professional consider that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?
- Does the case suggest that the SAB may need to change its local policy, protocols or practice guidance, or that protocols and guidance are not adequately being disseminated, understood or acted upon?

The outcome of Panel deliberations is recorded within the template and reported to the Safeguarding Adults Board and Executive Leadership Group. Where the Panel recommends a discretionary SAR this

is ratified by the SAB Chair. The Panel considers the methodology, terms of reference and required output of the Review.

4. Safeguarding Adults Review

The Care and Support Statutory Guidance sets out that the following principles should be applied by SABs and their partner organisations to all reviews:

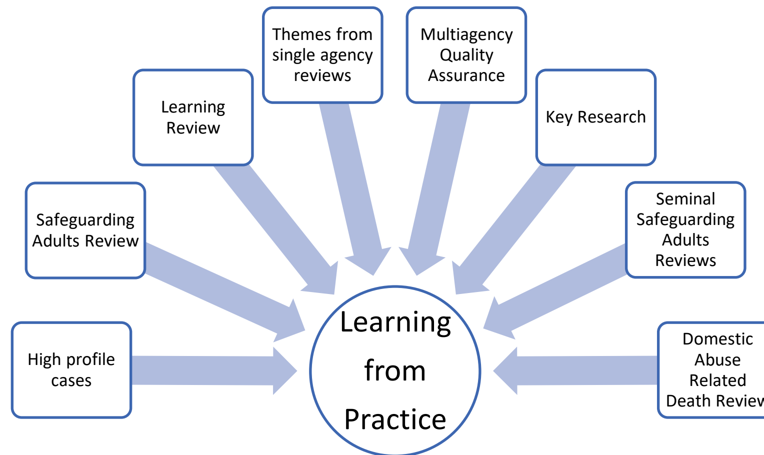
- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

The SAR Panel will consider the most appropriate methodology and approach for the Safeguarding Adults Review. This could include commissioning an independent author, or the co-ordination of a local expert panel to undertake the Review. Where a SAR is particularly complex, the Panel should seek to appoint an independent author. All Safeguarding Adults Reviews, irrespective of lead, are undertaken with reference to the Social Care Institute of Excellence SAR Quality Markers.

The adult who is the subject of the SAR does not need to have been in receipt of services for the SAB to arrange a review. The purpose of the SAR is not to apportion blame but to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults. Practitioners should be supported by agencies to participate fully. The adult, and/or their family and representatives should be consulted to establish how they wish to be involved. Family members and practitioners should be sent a copy of the relevant Partnership leaflet to explain the purpose and process of the review.

5. Learning from Practice Task and Finish Group

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, single and multiagency, locally, regionally and of national significance.



High profile cases are identified through the Safeguarding Partnership, including those that do not meet the criteria for SAR Panel, or have been considered but do not meet the criteria for a statutory safeguarding review. Any member of the Task and Finish Group can put forward a case for discussion using an agreed template. Referral to the Learning from Practice Task & Finish Group is not an alternative route for escalation, the focus is on practice development and wider system learning.

Any direct referral to the Task & Finish Group is collectively reviewed, and where there is believed to be the potential for learning, a reflective review can be undertaken. By exception there may be a request to progress a learning review from another subgroup. Where a Domestic Homicide Review/Domestic Abuse Related Death Review identifies learning that has relevance to adult safeguarding this will be progressed through the Adult Learning from Practice Task & Finish Group.

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 learning review, a single or multiagency audit, the dissemination of learning through briefing. This approach broadly mirrors the NHS Patient Safety Incident Response Framework. The Task & Finish Group reports issues of thematic learning to the Practice Development Forum.

6. Practice Development Forum

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.

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 Case Reviews
- Any cases of national importance or implication
- Any emerging issues of local importance
- The Child Death Overview Panel
- Domestic Abuse Related Death Reviews

The Practice Development Forum reports to the Safeguarding Children Partnership Board, the Safeguarding Adults Board and the Domestic Abuse Steering Executive where relevant. This is through quarterly updates summarising key work streams, progress and any issues that need to be escalated. There are two linked Learning from Practice Task and Finish Groups, one for adult cases and one for child cases. These groups develop and progress specific action plans, for example in response to a statutory review of safeguarding practice.

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 Integrated Care Partnership
- Designated Nurse, Adults, Integrated Care Partnership
- Community Safety Partnership
- Education Representative
- Child Protection Lead for Education
- 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

Version	Update	Approved
1	2021	2021
2	July 2024	