Learning and Improvement in Practice Framework

June 2017

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Welcome and Foreword

I am delighted to provide the introduction to the North Yorkshire Safeguarding Adults Board (NYSAB) Learning and Improvement Framework.

In doing so NYSAB is able to demonstrate its commitment to promoting a culture and practice such that highlights the importance of service quality, high standards of care, and a refusal to accept mediocrity. It is important that when people using services experience poor outcomes, agencies are able to reflect on the quality of their services internally and collaboratively, so that lessons learned are used to bring about improvements in future practice and partnership working in order to safeguard adults at risk.

NYSAB has developed this multi-agency Learning and Review Framework to support such work. The framework has been developed for use by all partner agencies and local organisations that work with adults at risk in North Yorkshire. Its aim is to enable local organisations to improve services by being clear about their responsibilities to learn from experience and particularly through the provision of insights into the way organisations work best together to safeguard and protect the welfare of adults at risk.

The NYSAB recognises that its member agencies and organisations already have in place their own internal governance and learning arrangements. This Framework is intended to complement and build upon these existing single agency arrangements, by adding a multi-agency approach that will enable partner agencies to work collaboratively to learn lessons from cases where there may have been multi agency failings and to use this learning to improve future joint working. The Framework is designed to provide guidance on the use of multi-agency review processes.

Reviews must not be regarded as an end in themselves, but a way of identifying and supporting the improvements required to consolidate good practice. The NYSAB and its partner organisations will translate the findings from reviews into programmes of action which, in turn, will lead to sustainable improvements. Whilst the Board has specific duties and responsibilities in terms of commissioning Safeguarding Adult Reviews, the Framework provides a range of other tools for partners to reflect and learn from cases that have the potential for important learning that can improve practice and partnership working.

Colin Morris
NYSAB Independent Chair

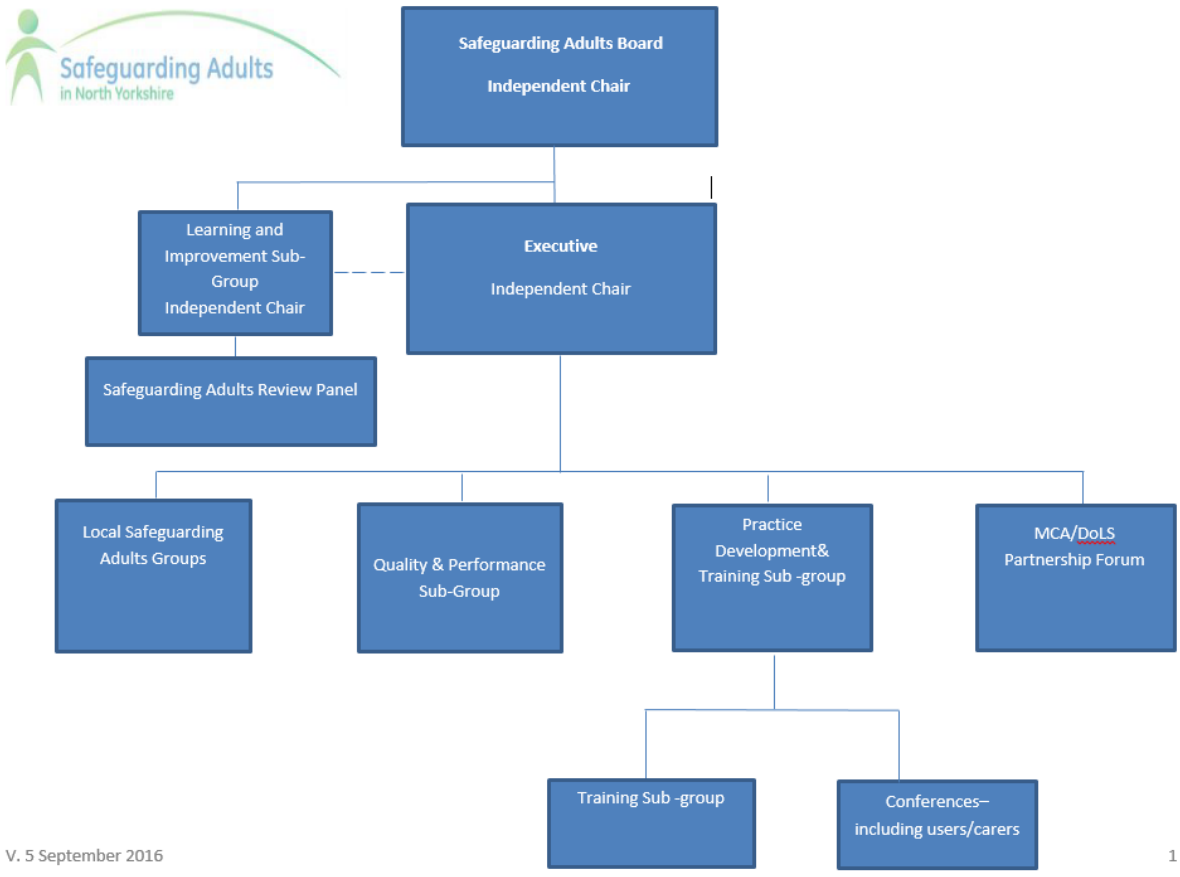
1. Introduction

The North Yorkshire Safeguarding Adults Board (NYSAB) leads and holds to account partners for safeguarding adults across North Yorkshire.

The NYSAB has an Executive Group and a Learning and Improvement sub-group which report directly to the SAB. Below the Executive sit four sub-groups, which ensure its functions are carried out. These are:

- Local safeguarding adults groups (for each local area within the county)
- Quality and Performance
- Practice, Development and Training
- MCA/ DoLS Forum

In addition the Learning and Improvement sub-group is linked with the Safeguarding Adults Review Panel. A structure chart is set out below.



For further information on the function, structure and responsibilities of the Board, please visit the NYSAB website at: http://www.nypartnerships.org.uk/sab

2. NYSAB Learning and Improvement in Practice Framework

The purpose of this local framework is to enable organisations that work with adults at risk of abuse or neglect and their families/carers to be clear about their responsibilities, to learn from experience and improve services for adults, their families and/or carers as a result.

Professionals and organisations working with adults at risk of abuse or neglect need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of further harm to adults.

This Learning and Improvement Practice Framework reflects and builds on the six safeguarding principles outlined in the Government's Statement on Adult Safeguarding published in May 2013. These should not only be the basis upon which judgements are made about events and practice, but also are the principles underpinning the process itself. These principles are:

- **Empowerment:** Presumption of person led decisions and informed consent.
- **Prevention:** It is better to take action before harm occurs.
- **Proportionality:** Proportionate and least intrusive responses appropriate to risks.
- **Protection:** Support and representation for those in greatest need.
- **Partnership:** Local solutions through services working with their communities
- **Accountability:** Accountability and transparency in delivering safeguarding

It is these principles on which the NYSAB Strategic Outcomes for 2015-18 are based:

North Yorkshire Safeguarding Adults Board - Strategic outcomes – 2015 to 2018

AWARENESS AND EMPOWERMENT

Local people, staff, volunteers and people with care and support needs

- know what abuse is and how to protect themselves
- know how to raise safeguarding concerns
- are confident that they will get an appropriate response that takes account of their wishes
- influence the Board's priorities and can see a difference

PREVENTION

Care and support is safe personalised and of high quality, where people are treated with dignity and respect so that the likelihood of abuse occurring is minimised.

As a partnership we make communities safe and take actions to reduce risk and prevent further abuse occurring.

Carers understand safeguarding, how to get help and information, and are supported to enable them to continue caring and minimise the likelihood of causing intentional or unintentional harm or neglect to the person they support.

PROTECTION AND PROPORTIONALITY

People with care and support needs or their representative are involved in deciding the right level of protection for them.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards are implemented in such a way that people are safeguarded from abuse and neglect.

Any intervention is proportionate to a person's situation and their ability to make appropriate decisions to keep themselves safe.

Concerns about risks of abuse posed by staff, volunteers and students are co-ordinated by Designated Adult Safeguarding Managers (DASMs) and inform the work of the Board.

Making Safeguarding Personal, the MCA and safeguarding policy and procedures are high priorities for training staff and volunteers. Staff are confident of their roles and responsibilities.

PARTNERSHIP EFFECTIVENESS AND ACCOUNTABILITY

People of North Yorkshire have told us that they see GPs as a first point of call, so we will strengthen their contribution to safeguarding adults.

Information is shared appropriately across agencies and is effectively acted upon.

The Board will have a shared approach to challenges such as domestic abuse, self-neglect, modern slavery, exploitation, hate crime, mate crime and radicalisation.

We will put in place a systematic approach to learning from experiences in North Yorkshire and in other areas, and ensure this learning is embedded in practice.

We will strengthen the contribution of District Councils, in particular in developing a shared safeguarding response to self-neglect.

Continue to improve the Board's understanding of how safe North Yorkshire is for people with care and support needs, and if safeguarding reflects people's views and needs. The Board will show how well it is doing by benchmarking itself against national improvement tools.

3. Learning and Improvement Exercise

A learning and improvement exercise is any activity outlined in the NYSAB Learning and Improvement in Practice Framework with the aim of learning about safeguarding adult practice and improving outcomes for adults at risk of abuse or neglect in North Yorkshire. Once a learning and improvement exercise is undertaken, the findings will be analysed by the Learning and Improvement Group. This analysis will lead to identifying the key learning and improvement issues for NYSAB to consider. A report will be produced detailing the findings and issues for NYSAB, and where appropriate it will be presented to NYSAB or the relevant sub-group.

4. NYSAB as a Learning Partnership

The NYSAB Constitution outlines the purpose, aims and objectives of the Board and the function of each sub-group, with the Board itself having overall responsibility for all aspects of learning and improvement in practice within the structure. Reporting arrangements between the Board and sub-groups are also set out in the Constitution. NYSAB acknowledges the importance and participation of all sub-groups to take forward learning, and support the work of the Learning and Improvement Sub-Group.

All sub-groups of the Board, and the Board itself, are responsible for implementation of the NYSAB Learning and Improvement in Practice Framework.

Partner agencies who work with adults at risk are asked by NYSAB to endorse this framework and embed it in their internal governance processes and workforce development policies.

5. Principles for Learning and Improvement in Practice

Safeguarding Adult Reviews (SAR) are not only a way to address safeguarding failings, but also provide a platform in which to identify improvements that are needed within the County, and to champion and consolidate good practice. The Board and its partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and prevention of death, serious injury or harm to adults.

The Learning and Improvement in Practice Framework covers the full range of reviews and audits which are aimed at driving improvement to safeguard and promote the welfare of adults across North Yorkshire.

6. Governance Arrangements

NYSAB acts as an independent voice in respect of monitoring the quality of adult safeguarding arrangements within North Yorkshire. It is therefore within the remit of NYSAB to monitor and scrutinise the safeguarding arrangements of all responsible organisations and bodies within the North Yorkshire to ensure best practice and promote a culture of learning and improvement.

NYSAB are part of a consortium of Boards that have developed and adopted multi-agency Safeguarding Policy and Procedures. These provide the framework for safeguarding adults with care and support needs from abuse and neglect.

This Multi-Agency Safeguarding Adults Policy and Procedure seeks to promote strong partnerships arrangements by:

- Providing a framework for multi-agency working and partnership
- Providing a framework for recognising and taking action to prevent the abuse of adults at risk
- Defining the responsibilities of partner organisations in responding to safeguarding adult concerns/allegations
- Providing common values, principles and practice that underpin the safeguarding of adults at risk
- Identifying the different types of abuse, signs, symptoms and indicators
- Setting standards of practice that safeguard adults at risk.

Each West and North Yorkshire and York Safeguarding Adults Board has adopted this policy and procedure, ensuring consistency of approach across the region.

7. Scrutiny and Challenge

NYSAB is subject to internal scrutiny through an annual self-assessment, and external scrutiny through challenge from other partnerships, such as the Health and Wellbeing Board, Scrutiny Committees, Care Quality Commission (CQC) and the Coroner's Office. Further additional reviews may also be undertaken, such as Peer Challenges, as agreed by the Board.

8. Support for Partners

The Learning and Improvement in Practice Framework supports the work of NYSAB and its partners so that:

- Reviews/audits are conducted regularly, not only on cases which meet the statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of adults.
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings
- Action results in lasting improvements to services which safeguard and promote the welfare of adults at risk of abuse or neglect, examples of which can be shared across agencies
- There is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Safeguarding Adult Reviews (SARs) with the public
- Reviews can also be taken in cases that have been well-managed by multi-partnership agencies and where examples of best practice can be shared both county wide and regionally
- Quality assurance can be implemented
- Learning can be disseminated across agencies

9. Reviews and Audits

The Care Act 2014 provides a statutory basis for undertaking the learning and review processes described in this Framework. Within all reviews and audits there should be a culture of continuous learning and improvement, including identifying opportunities to draw on what works, with a particular focus on promoting good practice, in particular:

- Reviews/audits should be proportionate according to the scale and level of complexity of the issues being examined
- Safeguarding Adult Reviews (SARs) should be led by individuals who are independent of the case and organisation whose actions are being reviewed
- Families, including surviving adults at risk of abuse or neglect, should be invited to contribute to the reviews and receive feedback on the learning outcomes. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the adult at risk of abuse or neglect is at the centre of the process. The process should be transparent, including publishing final SAR reports and NYSAB's response
- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a multi-agency review.
- The impact of SARs and other reviews on improving services to adults at risk of abuse or neglect and their families/carers, and on reducing the incidence of deaths or serious harm to adults at risk of abuse or neglect must also be described in the NYSAB annual report and will inform inspections
- Professionals must be involved fully in reviews/audits without fear of being blamed for actions they took in good faith
- The central focus of any learning review will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working.
- The learning review should take account of what practitioners knew or could have reasonably have been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.
- Learning reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and allows for reflection.
- This Framework recognises that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and the importance of managing the interface between these.
- Improvement must be sustained through regular monitoring and review so findings from reviews make a real impact on improving outcomes for adults at risk of abuse or neglect in North Yorkshire.
- Where the NYSAB is satisfied that other review processes have adequately identified learning it may not be necessary to conduct a multi-agency review under this Framework in order to avoid duplication of activity.

10. Quality Assurance and on-going improvement

In order to support the recommendations made in the Care Act (2014) NYSAB employs a variety of review methods and audit tools to monitor and evaluate the way in which their policies, procedures and practices for the protection of adults at risk of abuse or neglect are working, as follows:

10.1 Safeguarding Adult Reviews

Safeguarding Adult Reviews (SARs) are multi-agency reviews of how professionals and organisations have worked together with an adult at risk of abuse or neglect and their family/carers when a serious incident has occurred. This serious incident can be the death of, or serious harm to, an adult at risk of abuse or neglect.

The Care Act (2014) requires all Safeguarding Adults Boards to arrange a review 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. A review must also be arranged if the same circumstances apply and the adult is still alive, but has experienced serious neglect or abuse. The final decision whether or not to conduct the SAR rests with the NYSAB Independent Chair. If a SAR is not required because the criteria given above are not met, the NYSAB may still decide to commission a SAR, or they may choose to commission an alternative form of case review.

NY SAB SAR policy

The NYSAB SAR policy can be read in full here:

10.2 Learning Lessons Review

A Learning Lessons Review (LLR) is a multi-agency discussion of events or a time period within a case that enables the individuals to reflect on their involvement in the case and identify good practice and areas for development.

The main purpose of the LLR and the role of the facilitator is to support reflection in a case which would include considering why work was undertaken, the reasons for the decisions that were made, the nature of the professional relationships, and the impact for staff so that lessons can be learned without apportioning blame. A case can be considered for LLR if there have been issues regarding the practice in the case, and any case referred to be considered for LLR must be agreed by the NYSAB. The process can only be undertaken when there is more than one agency involved in the work with the adult at risk of abuse or neglect.

10.3 Case File Audits

Multi-agency case file audits review the systems in place and the standard of co-operation and collaboration between the key agencies charged with responsibilities to safeguard adults at risk. The overall aim is to secure positive outcomes for adults at risk by highlighting good practice, identifying shortfalls in order that lessons can be learned from past successes and mistakes and reviewing how well a person-centred, outcomes approach was applied to the safeguarding process. In assessing the current systems, the quality of joint working and past practice, and NYSAB Safeguarding Adults Procedures will be used as benchmarks.

10.4 Audit of Multi-Agency Safeguarding Meetings

Audits of multi-agency safeguarding meetings are exercises where Board members and senior managers from partner agencies attend safeguarding meetings and analyse the quality of the practice including preparation and engagement of the adult at risk of abuse or neglect and their family/carers, application of thresholds, and the work of the core group etc. A report with identified areas for learning is produced and embedded as appropriate.

10.5 Other Audit Tools

Other audit tools, such as NYSAB self-assessment and thematic reviews (also known as deep dive reviews) may be employed to undertake a detailed analysis of the data available to the SSAB around a specific issue impacting on the safety and welfare of adults at risk in North Yorkshire.

10.6 Inspections

Partner agencies of the NYSAB will be inspected in respect of their safeguarding arrangements by organisations such as CQC and Healthwatch. Learning and areas for action will be identified as part of these inspections and the NYSAB will monitor implementation of the action plans and seek assurances that partners have robustly embedded the improvements within their multi-agency practice.

10.7 Communications and Engagement with Adults at Risk of Abuse or Neglect and their Families/Carers

The views of adults at risk of abuse or neglect and their families/carers will shape the work of NYSAB. Their views will be sought through a variety of forums (including complaints procedures), consultation work and community events, supported by the Equality and Engagement Officer. These consultations may be about specific subjects or more generic issues.

11. Performance data

The NYSAB data set is used to give Board members an understanding of the multi-agency performance in North Yorkshire around areas such as numbers of safeguarding alerts and referrals received, contact by outcome, gender/ethnicity/age of victims, categories of abuse etc. By studying the data, areas for improvement and further work are identified.

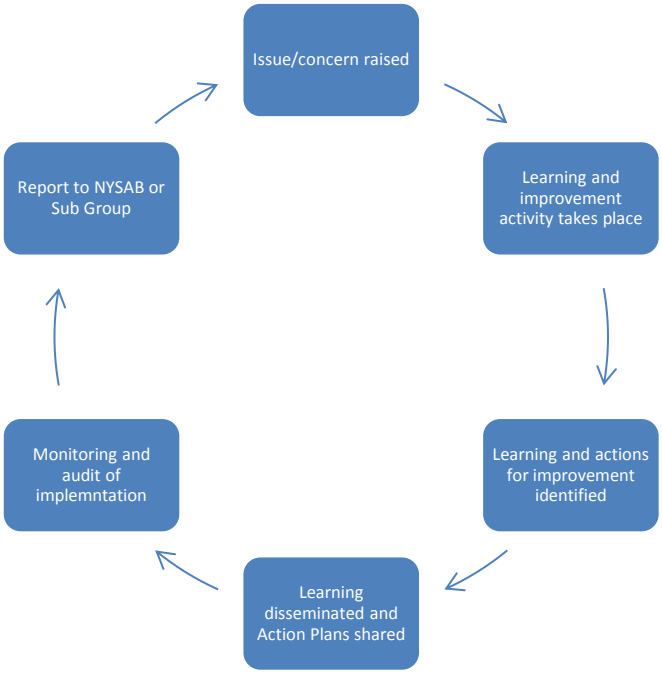
12. Training

In accordance with the Care Act (2014) the NYSAB ensures that relevant partners provide training to staff and volunteers on the policy, procedures and professional practices that are in place locally, and reflect their roles and responsibilities in safeguarding adults in the county.

13. Sharing and embedding Learning in North Yorkshire

In order to consistently improve safeguarding practice, learning identified from reviews and audits of practice must be considered operationally and strategically so that there is transparency and accountability, and changes to policy and practice can be taken forward.

Learning and improvements must be robustly shared and embedded as widely as possible across the multi-agency workforce and within communities as appropriate.



In some cases it will be incumbent on individual agencies to consider how these recommendations can best be implemented and in turn provide assurance to the NYSAB that this has been achieved effectively. The roles and responsibilities of individuals within this are set out in Appendix 1. In addition, responsibility within the SAB Governance structure includes the following:

NYSAB	Agreement, publication and dissemination of final reports. Holding of agencies to account SAB partner agencies will ensure they have undertaken activities to disseminate learning and assure that learning is embedded in practice.
Executive	To monitor and audit management action plans arising out of recommendations made in North Yorkshire SAR reports.
Learning & Improvement Group	Instruct relevant sub-groups of actions required, and monitor and report to NYSAB on progress on achieving these. Make recommendations to NYSAB on how to disseminate and embed learning from National SARs

	Seek assurance through additional audits that changes to practice have been embedded.
Quality & Performance Group	Provide performance data to contribute to audits and the monitoring of embedding of learning
Practice Development & Training Group	Consider implications of lessons learned on practice and multi-agency training programme, and amend/integrate within programme as required
MCA Forum	Dissemination and embedding of learning within practice under the Mental Capacity Act
Local Safeguarding Adults Groups	Dissemination of practice into localities

This framework will be monitored by the Learning and Improvement Group and will be reviewed in response to the delivery of this framework or changes in national policy or guidance. The Learning and Improvement Group will also produce an annual report for NYSAB of collated findings and analysis of the range of review activities undertaken throughout the year.

Appendix 1

Role of the NYSAB Independent Chair

On receipt of the learning and action required for improvement the NYSAB Independent Chair will:

- Ensure that the learning is disseminated fully across partner agencies
- Ensure robust arrangements are in place to implement the actions for improvement and audit the implementation
- Challenge NYSAB if improvements are not made as a result of learning

Role of NYSAB Members

On receipt of the learning and action required for improvement, Board members will:

- Share the learning and actions for improvement with all levels of staff throughout their organisation
- Ensure that learning is embedded within their agency and take steps to assure themselves that this is improving outcomes for adults at risk of abuse or neglect
- Provide regular updates on progress of how the learning is embedded to their own staff and to NYSAB
- Provide assurance to NYSAB that the learning and actions for improvement have been embedded
- Identifying any continuing concerns to NYSAB
- Support staff to attend any Learning and Improvement Workshops and relevant NYSAB training and workforce development activities

Role of Managers

On receipt of the findings, managers will:

- Read the SAR Overview Reports and attend Learning and Improvement Workshops as appropriate
- Read SAR briefing papers and apply the learning in practice
- Attend single-agency and multi-agency training
- Support staff to attend Learning and Improvement Workshops
- Discuss the learning and actions for improvement with teams
- Ensure learning is incorporated into frontline work as a means of evidence-based practice

Role of Individual Practitioners

On receipt of findings, practitioners will:

- Read SAR Overview Reports and attend Learning and Improvement Workshops as appropriate
- Read NYSAB briefing papers and apply the learning in practice
- Attend single-agency and multi-agency training
- Contribute to agency improvement through team meetings and supervision discussion
- Incorporate into assessments as a means of evidence-based practice

Role of the NYCC Safeguarding Adults Team

On receipt of the learning and the action required for improvements, the Safeguarding Adults Team will:

- Support the delivery of Learning and Improvement Workshops and disseminate learning as widely as possible
- Review and update NYCC training in partnership with Workforce Development, as appropriate
- Support the audit process used to evaluate the implementation of the actions for improvement
- Provide advice and guidance on the implementation of the actions for improvement as appropriate