



## **Hampshire Safeguarding Adults Board**

# **Multi-Agency Learning and Review Framework**

**Learning from Experience to Improve Practice**

**February 2015**

The Hampshire Safeguarding Adult Board believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice. This Framework is designed to support these processes.

| <b>Item</b> | <b>Contents</b>                                       | <b>Page<br/>No.</b> |
|-------------|---|---------------------|
| 1.          | <b>Introduction</b>                                   | 2                   |
| 2.          | <b>Legal and Policy Context</b>                       | 3                   |
| 3.          | <b>Roles and Responsibilities</b>                     | 4                   |
| 4.          | <b>Activities to Support Learning from Experience</b> | 5                   |
|             | Safeguarding Adults Reviews                           |                     |
|             | Multi-agency Partnership Reviews                      |                     |
|             | Multi-agency Reflective Workshops                     |                     |
|             | Multi-agency Themed Audits                            |                     |
| 5.          | <b>Learning into Practice</b>                         | 12                  |
| 6.          | <b>Monitoring and Review</b>                          | 14                  |
| 7.          | <b>Appendices</b>                                     |                     |

## I. INTRODUCTION

The 4 Local Safeguarding Adults Board are committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working to safeguard adults at risk. The 4 Local Safeguarding Adults Boards has developed this multi-agency Learning and Review Framework to support this approach. It has been developed for use by all partner agencies and local organisations which work with adults at risk across the Hampshire Local Safeguarding Board area. The LSABS is confident that the approaches outlined in the Learning and Review Framework will drive improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

### Overview

The Learning and Review Framework recognises that LSABS member agencies and organisations have their own internal governance and learning structures. This Framework therefore, seeks to complement and build on single agency arrangements by adding a multi-agency approach to 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 Learning and Review Framework is designed to support decision making regarding the use of multi-agency review processes and outlines the pathway for commissioning reviews and the governance arrangements underpinning these arrangements.

### Guiding Principles

The review and audit processes referenced in this Learning and Review Framework are underpinned by the following principles:

- ❖ Learning and review activities should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.
- ❖ Adults at risk and their families should always be offered the opportunity to contribute to the learning review and receive feedback on the learning outcomes achieved.
- ❖ Professionals from the range of agencies involved in the case should be fully engaged in the learning review and be invited to contribute their perspectives.
- ❖ 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 be fair and balanced and not used to allocate blame. It 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.
- ❖ The Care Act 2014 provides a statutory basis for undertaking the learning and review processes described in this Framework.
- ❖ 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.
- ❖ Where the LSABS are 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.
- ❖ Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a multi-agency review.

## **2. LEGAL AND POLICY CONTEXT**

The Care Act 2014 comes into force in April 2015 and creates a new legal framework for Adult Safeguarding. Section 44 of the Act requires Safeguarding Adults Boards (SAB) to undertake a safeguarding adult review (SAR) in specific circumstances and places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt. The law requires Local SABs to arrange a safeguarding adult review when an adult in its area 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 person at risk. The SAB must also arrange a safeguarding adult review when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. A separate Safeguarding Adult Review Policy has been produced which outlines the process to be followed in these cases.

However, the Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example. This Framework highlights a number of other review processes that could be used in these circumstances.

This Learning and Review Framework reflects and builds on the six safeguarding principles outlined in the Government's Statement on Adult Safeguarding published May 2013. These

not only should be the basis upon which judgements are made about events and practice but also are the principles underpinning the review process itself. These principles are:

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

### 3. ROLES AND RESPONSIBILITIES

The LSABS believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice.

Individual organisations will have their own internal governance systems and statutory or contracting requirements in respect of investigating or reviewing incidents. This Learning and Review Framework is not intended to duplicate or replace these but seeks to enhance and complement these arrangements. In relation to current single agency governance arrangements, the NHS is required to undertake Serious Incidents that Require Investigation Reviews (SIRIs) when specific criteria are met.

In addition to the safeguarding adult review process, the Learning and Review Framework also provides other tools to enable partner agencies to reflect on and learn from cases which may not meet the criteria for a safeguarding adult review but nonetheless have the potential for providing important learning with which to improve practice and partnership working.

Partner agencies and local organisations who work with adults at risk are invited by the LSABS to endorse this Framework and going forward, to embed it in their internal governance processes as well as workforce development policies.

The LSABS are supported by two of its subgroups in the implementation, management and oversight of the Learning and Review Framework and the activities linked to it. The Learning and Review Subgroup is responsible for determining whether or not a review should take place (and if so, the most appropriate type of review to commission). It will also oversee the review process and the development of the action plan and publication of the report. The Quality Assurance Subgroup is responsible for monitoring the implementation of any action plans arising from reviews and for ensuring that the impact of changes on the experiences and outcomes for service users are evaluated.

The LSABS has developed a Learning from Experience database which contains links to national and local serious case reviews, reports and inquiries (both historic and current) and aims to support the dissemination of the learning arising from these across Hampshire and in doing so promote evidence based practice. All the cases on the database include a

summary and professional learning points for each. Cases can be searched by local authority area, date or theme. The database can be accessed via this link: [LSABS Learning From Experience Database](#) As part of the Learning and Review Framework, LSABS will develop a programme of learning workshops and hold a cross area conference to explore a sample of cases in order to improve frontline practice and partnership working.

This framework covers a range of reviews and audits aimed at reducing future risk and driving improvements. The Framework provides a mechanism to check that learning from serious case reviews, domestic homicide reviews, CQC investigations, etc. have led to changes and improvement at service delivery level. Appendix A outlines roles and responsibilities in the implementation of the Framework.

## **4. ACTIVITIES TO SUPPORT LEARNING FROM EXPERIENCE**

- A. Safeguarding Adults Reviews
- B. Multi-agency partnership reviews
- C. Multi-agency reflective workshops
- D. Multi-agency themed audits

### **Referrals for a multi-agency review**

This section outlines the process for making a referral for a multi-agency review. Following a serious incident, active consideration should be made as to whether or not a referral for a multi-agency review under the Learning and Review Framework is necessary. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

However, it is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (e.g. SIRI), this should take place as a matter of priority. Internal governance processes and multi-agency reviews are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes. Key questions to consider as part of internal processes include:

- Was the incident reported internally?
- Has an internal investigation been carried out?
- Has the investigation highlighted concerns about any other organisations?
- Has any information come to light indicating abuse or neglect as a contributory factor?
- Based on findings, are criteria for making a referral met?

The following considerations should be made when deciding whether to make a referral for a multi-agency review:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.
- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

Some cases referred may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children’s serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

There may also be parallel processes in place such as a criminal investigation or coroner’s inquest, which whilst not preventing a referral being made, will need to be taken account of in terms of the timing and management of any subsequent multi agency review.

The family should be informed of the concerns and that a learning and review referral is planned and so providing an opportunity for them to give their view about the referral and to discuss how they might want to be involved.

If it is felt that the circumstances of the case may benefit from a multi-agency review, the organisation’s LSABS representative and/or Learning and Review Subgroup representative must be briefed on the case and notified of the intention to make a referral.

To make a referral for a multi-agency review, the referral form in Appendix B should be completed and submitted to the LSABS Learning and Review Subgroup via the following email address [psab@portsmouthcc.gov.uk](mailto:psab@portsmouthcc.gov.uk)

Each referral will be looked at the LSABS Learning and Review Subgroup. After consideration, the Subgroup may contact involved agencies to request completion of a scoping chronology to inform decision making about next steps. Appendix C outlines the referral pathway and timescales.

If the case meets the criteria for a safeguarding adult review, the LSABS Learning and Review Subgroup will commission this following the specific policy guidance written for such reviews. Click here to view the [LSABS Safeguarding Adult Review Policy](#).

A safeguarding adult review is a statutory process for cases meeting specific criteria. For cases not meeting these criteria, the LSABS Learning and Review Subgroup may consider commissioning another type of review. The following section provides guidance on the different types of review which may be considered.

## **A. Safeguarding Adult Review**

The Safeguarding Adults Board is the only body that can commission a safeguarding adult Review. Under section 44 of the Care Act 2014, the SAB must arrange a SAR when an adult in its area 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. The SAB 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. The adult who is the subject of any SAR need not have been in receipt of care and support services at the time.

### **Purpose**

The purpose of a safeguarding adult review is to:

- Determine what might have done differently that could have prevented harm or death.
- Identify lessons and apply these to future cases to prevent similar harm occurring again.
- Review the effectiveness of multi-agency safeguarding arrangements and procedures.
- Inform and improve future practice and partnership working.
- Improve practice by acting on learning (developing best practice).
- Highlight any good practice identified.

Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

### **Criteria for a safeguarding adult review**

The LSABS must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if:

- 1) The case involves an adult with care and support needs (whether or not the local authority was meeting those needs)
- 2) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

AND

- 3) The person died (including death by suicide) and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

- 4) The person is still alive but the SAB knows/suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.



## Process

- The Learning and Review Subgroup will be responsible for establishing an independently chaired Safeguarding Adult Review Panel to undertake the review and will maintain an oversight and co-ordination role throughout the process.
- The safeguarding adult review will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. A reviewer role profile has been developed to ensure appropriately experienced and skilled people undertake this role.
- The SAR will reflect the six safeguarding principles outlined on page 3.
- The LSABS Learning and Review Subgroup will agree terms of reference and these will be published and openly available
- If the SAB requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the SAB.
- When undertaking the SAR, the records will either be anonymised through redaction or consent should be sought.
- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a safeguarding adult review.
- Recommendations and action plans arising from the safeguarding adult review will be monitored by the LSABS Quality Assurance Subgroup.

## Reporting arrangements

The Learning and Review Subgroup will provide regular updates to LSABS on the progress of the review. The safeguarding adult review will report within six months of the SAR being established. Once completed, the report and recommendations will be presented to the LSABS for consideration. Once the report is approved, the Learning and Review Subgroup will produce a multi-agency action plan responding to any recommendations made. Monitoring of the implementation of the action plan will be undertaken by the LSABS Quality Assurance Subgroup. The norm will be to publish an anonymised version of the full report on the LSABS website. In exceptional circumstances however, this practice may vary. As a means of signing off the SAR process and its resulting action plan, involved agencies will be asked to complete an impact analysis report detailing the outcomes and difference made as a result of the actions undertaken. Collated findings from the review will be included in the LSABS Annual Report.

## **B. Multi-Agency Partnership Reviews**

A multi-agency partnership review will be commissioned by the LSABS Learning and Review Subgroup but will be led the organisations involved.

### **Purpose**

The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved.

### **Criteria**

Multi-agency reviews will be considered where an adult at risk has died unexpectedly or sustained serious injury or harm and/or where there were safeguarding concerns identified prior to the incident or as a result. This may include circumstances where self-neglect may have been a factor and also where an adult with needs of care and support has died as a result of fire and there may have been opportunities for the agencies involved to identify risk factors and to develop a risk management plan to manage these. This form of review can be used for cases falling short of SAR criteria and any of the following criteria can also be applied:

- The person was receiving services from more than one agency at the time of the incident
- The service user was under formal safeguarding procedures at the time of the incident
- Multi-agency concerns or learning has been identified
- The incident arose from or occurred during the delivery of care

### **Process**

Supportive partnership working should be maintained throughout the process.

- A review team will be set up consisting of representatives of the agencies involved.
- The lead, co-ordinating agency will be agreed who will be responsible for arranging and chairing meetings as well as drafting the review report. Terms of reference will be agreed jointly at an initial scoping meeting.
- Each review team member will review their practice against expected organisational standards by interviewing staff, reviewing records and referring to organisational policies and procedures.

- The review team will share their own organisational findings with each other and will produce a report jointly agreed by agency representatives, covering both single agency and multi-agency responsibilities.

### **Reporting arrangements**

Reporting will be via internal individual organisations usual governance arrangements. In addition, reporting will be through LSABS Learning and Review Subgroup who will include collated findings in an annual learning report to the LSABS.

## **C. Multi-Agency Reflective Workshops**

A multi-agency reflective workshop will be commissioned by the LSABS Learning and Review Subgroup but led by the organisations involved.

### **Purpose**

The purpose of this type of review is for agencies involved with an incident to meet together and share their perspectives as a self-assessment of the multi-agency safeguarding arrangements and practice and to identify improvements.

### **Criteria**

A reflective workshop should be undertaken in the event of an adult at risk experiencing harm and where there are limited concerns about how organisations or professionals worked together but where the outcome for the adult(s) involved was poor. The issue may have come to attention due to a complaint or a concern raised. These reviews should be commissioned where it is believed there is potential learning and the possibility of improvements in the system to be made.

### **Process**

The workshop will involve a one off facilitated event involving practitioners and managers directly involved in the case (or in some circumstances) other representatives such as those in policy or strategic roles who may be able to contribute to the learning process and/or in supporting implementation of learning into practice. The aim of the activity is to make a positive impact on frontline practice. The focus of the workshop will be to reflect on the adult's journey through the system to identify any opportunities for improved interface between agencies. The workshop will be facilitated by a people independent of the case or the organisations involved. To support this, a multi-agency pool of facilitators has been established to undertake reflective workshops.

### **Reporting arrangements**

As an outcome of the workshop a series of actions or recommendations will be agreed by the attendees. Delegates will be responsible for providing feedback on generic areas of learning and to their respective senior management teams to relevant operational teams.

These will also be shared with the LSABS Learning and Review Subgroup. Partner agencies' LSABS representatives should be involved in any action planning within their organisation around the recommendations highlighted (as relevant to their organisation). The agencies involved in the review will be asked to provide LSABS with an impact analysis report outlining actions taken by their organisation to improve practice and partnership working in response to the case. Thematic findings from the reviews will be collated on an annual basis and summary included in the LSABS Annual Report.

## **D. Multi-agency Themed Audits**

### **Purpose**

The purpose of multi-agency themed audits is to audit practice across agencies relating to a specific topics of interest. They yield qualitative information enabling the LSABS and partner agencies to test out the effectiveness of the system following changes in policy or guidance or it may be in order to understand why a particular group are more at risk or to evaluate the scale of an emerging problem area in order to seek to address it. These will be commissioned by the LSABS Learning and Review Subgroup but will be overseen by the LSABS Quality Assurance Group. Audit activities will form part of the LSABS Annual Audit Programme.

### **Criteria**

Multi-agency themed audits can be undertaken on any topic or themes where concerns are identified that suggest a particular group may be more at risk. Examples might include undertaking a multi-agency audit on responses to financial abuse to test out any blockages in the system or check how agencies are working together.

### **Process**

The programme will be agreed annually by the LSABS and will be co-ordinated and managed by the LSABS Quality Assurance Subgroup. The programme will be informed and influenced by an inter-play of five key factors:

- Issues and themes emerging from local safeguarding monitoring information
- Patterns and trends in local cases referred for learning and review
- Issues and themes emerging from Learning From Experience Database
- LSABS priorities
- Response to national developments and events

The audits will normally be undertaken by a multi-agency audit team working to agreed terms of reference. A report outlining findings and recommendations will be produced and a multi-agency action plan developed to address these. The Quality Assurance Subgroup will be responsible for monitoring implementation.

### **Reporting arrangements**

The audit report will be shared with the LSABS and more widely with partner agencies.

## 5. LEARNING INTO PRACTICE

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

### Embedding Learning

Embedding learning is achieved by disseminating learning and taking actions as a response to improve practice by:

### Dissemination of Learning

| What   | Responsibility  | Reporting to LSABS                   |
|--|---|--------------------------------------|
| Multi-Agency Training Programme                            | LSABS Workforce Development Subgroup<br>Partner agencies<br>Relevant organisations          | LSABS Workforce Development Subgroup |
| LSABS 'Learning Lessons' Workshops                         | LSABS Manager<br>Workforce Development Subgroup   | LSABS Workforce Development Subgroup |
| LSABS briefings and communication strategy                 | LSABS Manager<br>LSABS Communication Subgroup<br>Partner agencies<br>Relevant organisations | LSABS Communication Subgroup         |
| Publication and dissemination of SAR final reports         | LSABS<br>Partner agencies<br>Relevant organisations   | LSABS Learning and Review Subgroup   |
| Single agency training                                     | All agencies  | All agencies                         |
| Single agency briefings and other communication strategies | All agencies  | All agencies                         |
| Learning from Experience Database (LSABS Website)          | LSABS Manager<br>LSABS Learning and Review Subgroup   | LSABS Learning and Review Subgroup   |

## Actions to Improve Practice

| What   | Responsibility                   | Reporting to LSABS                                     |
|--|----------------------------------|--|
| Implementation of single and multi-agency action plans from themed audits, multi-agency partnership reviews and reflective workshops | Relevant agencies                | Relevant agencies via LSABS Quality Assurance Subgroup |
| Monitoring of single agency action plans   | LSABS Quality Assurance Subgroup | LSABS Quality Assurance Subgroup                       |
| Monitoring of action plans from SARs   | LSABS Quality Assurance Subgroup | LSABS Quality Assurance Subgroup                       |

## Evaluating Learning

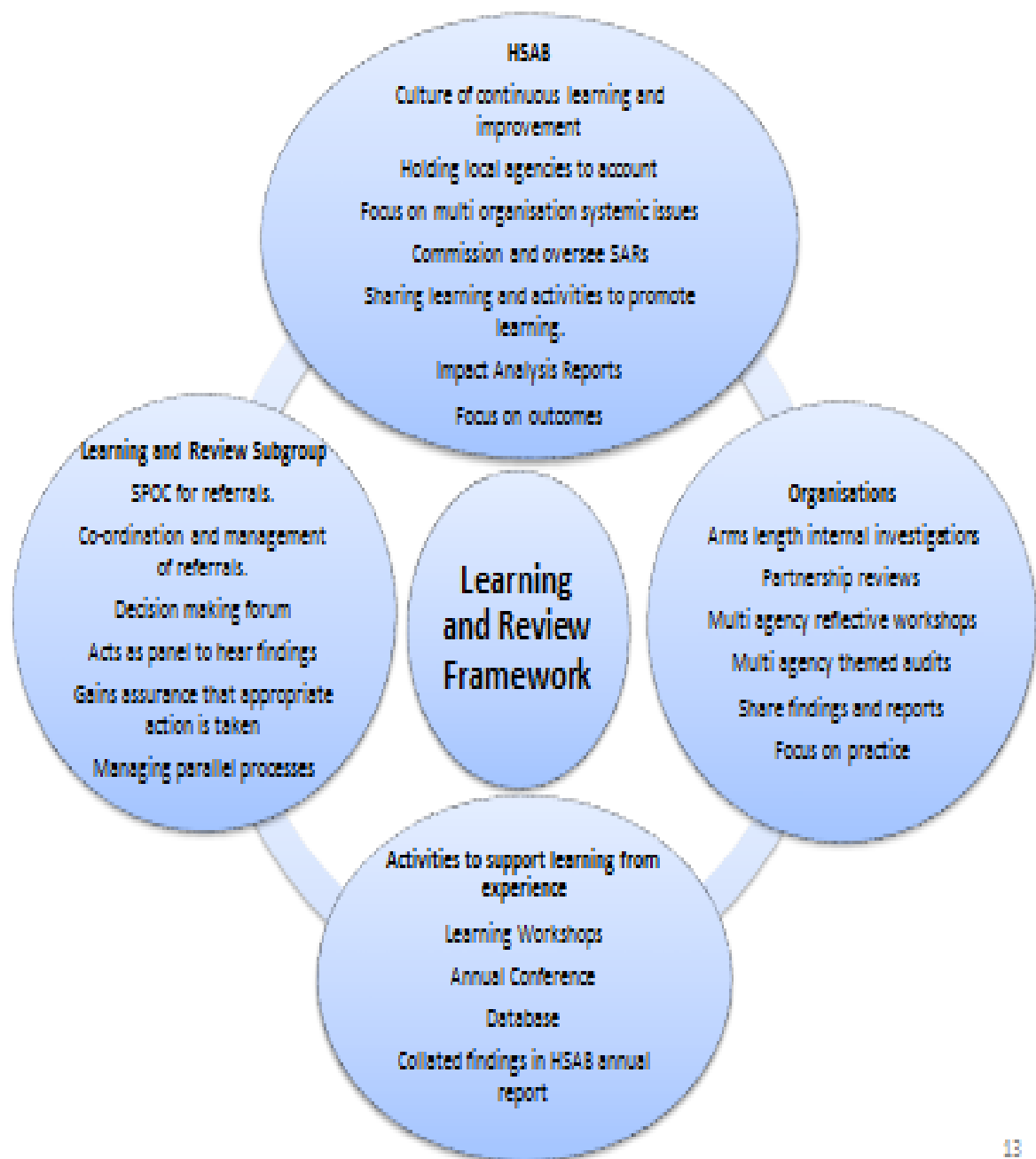
As part of its quality assurance activity LSABS evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

| How   | Who  | Reporting to LSABS                   |
|---|--|--------------------------------------|
| Follow up single and multi-agency case audits   | Partner agencies<br>Relevant organisations                             | LSABS Quality Assurance Subgroup     |
| Reporting on multi-agency and single agency action plans  | Partner agencies<br>Relevant organisations                             | LSABS Quality Assurance Subgroup     |
| Evaluation of training  | Workforce development course participants                              | LSABS Workforce Development Subgroup |
| Surveys and questionnaires  | Relevant agencies with oversight from LSABS Quality Assurance Subgroup | LSABS Quality Assurance Subgroup     |
| Impact evaluation reports of the difference made on service users experiences and outcomes                        | Relevant agencies  | Relevant agencies                    |
| Annual report of collated findings and analysis of the range of review activities undertaken throughout the year. | LSABS Manager  | LSABS Learning and Review Subgroup   |

## **6. MONITORING AND REVIEW**

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

## Appendix A: Roles and Responsibilities



13



## APPENDIX B:

# Local Safeguarding Adults Board

## Referral Form for a Multi-Agency Review

The following considerations should be made when deciding whether to make a referral for a multi-agency review and please refer to these when completing section 12 stating why it is considered that the criteria for a multi-agency review are met in this case:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.
- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

**Please provide the following information in full and send the form to:-**

[psab@portsmouthcc.gov.uk](mailto:psab@portsmouthcc.gov.uk)

| No. | Information required                    | Details |
|-----|---|---------|
| 1   | Name of Adult                           |         |
| 2   | Address                                 |         |
| 3   | Date of birth                           |         |
| 4   | Date and cause of death (if applicable) |         |
| 5   | GP contact details                      |         |
| 6   | Family contact details                  |         |
| 7   | Date of incident                        |         |
| No. | Information required                    | Details |

|    |   |  |
|----|---|--|
|    |   |  |
| 8  | Agencies involved with the person   |  |
| 9  | Brief details of the of the case  |  |
| 10 | Details of any internal review or investigation carried out                             |  |
| 11 | Details of any meetings held under safeguarding procedures                              |  |
| 12 | Please state why you consider criteria for a multi-agency review to be met in this case |  |
| 13 | Please provide any additional information which may be useful                           |  |

### Referrer details

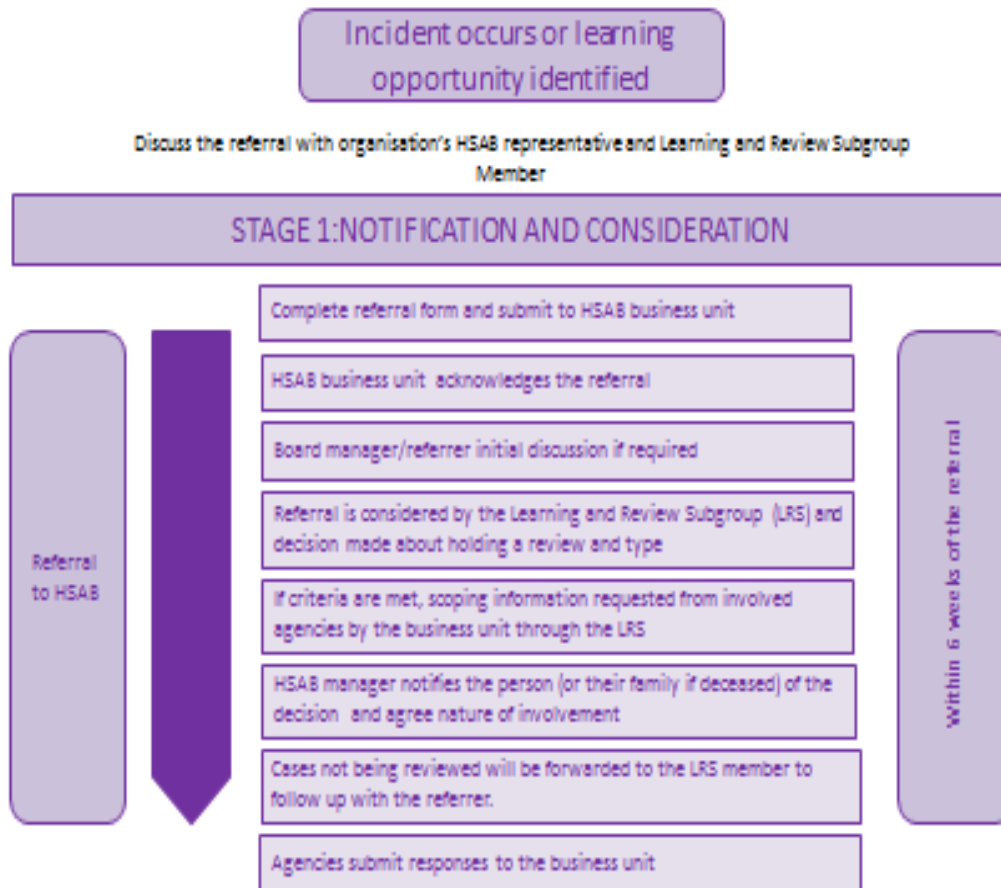
| Information required   | Details |
|--|---------|
| Referrer's name  |         |
| Job title  |         |
| Employed by  |         |
| Address  |         |
| Email  |         |
| Telephone  |         |
| If a commissioned service, please state if the commissioner been informed of this referral |         |
| Please state if your agency's LSABS representative has been made aware of this referral    |         |
| Please state if the adult's family are aware of this referral                              |         |

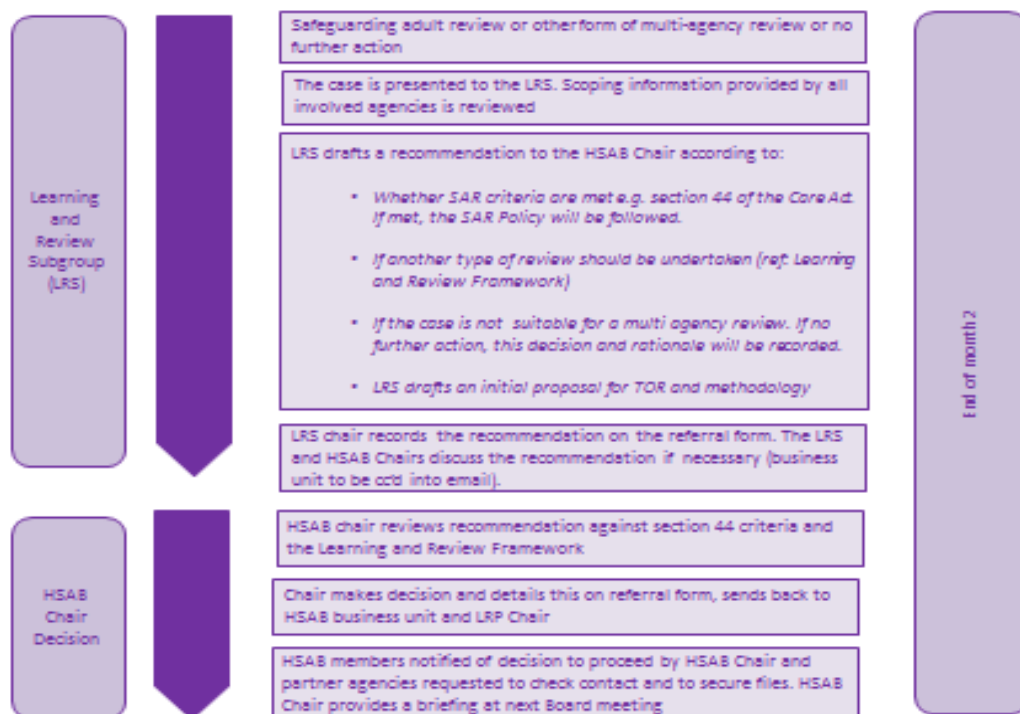
### For completion by LSABS Business Unit

|  | <b>Decision</b> | <b>Date</b> |
|--|-----------------|-------------|
| Recommendation of the Learning and Review Subgroup |                 |             |
| Decision of the LSABS Chair                        |                 |             |

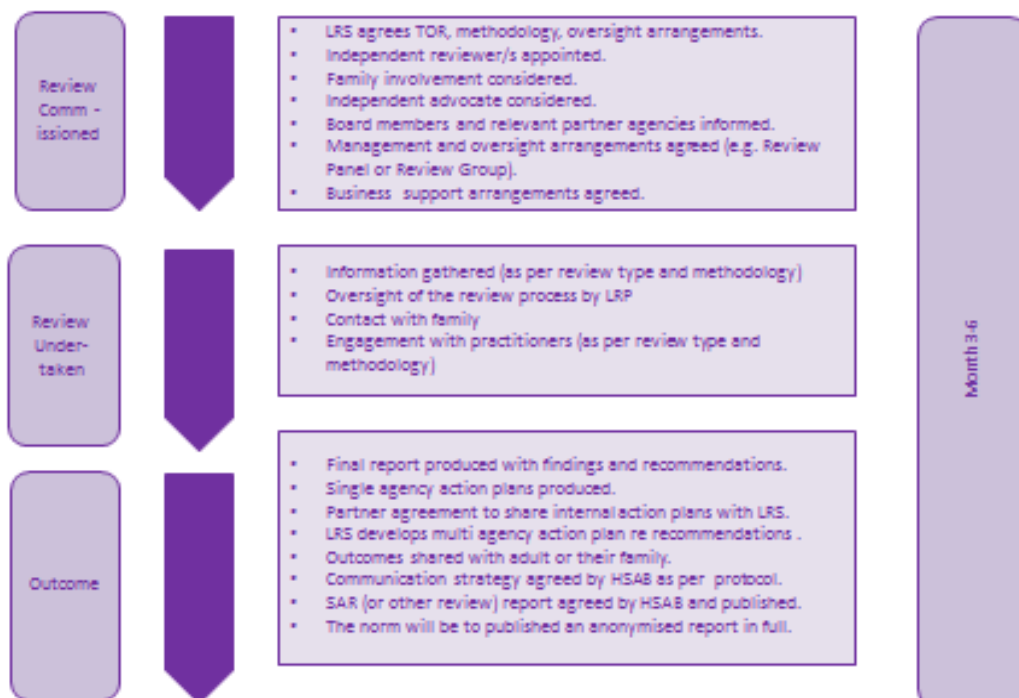
## APPENDIX C: Multi Agency Review Referral Pathway

### Multi Agency Learning and Review Process Flowchart





**STAGE 2: Review**  
(Safeguarding adult review or other form of multi-agency review)



STAGE 3: Learning and Improvement

Embed Learning



Partner agencies progress single agency and multi-agency action plans

Key messages are communicated as outlined in the communication strategy agreed by HSAB

Key messages feed into multi-agency and single agency training programmes

A case summary, professional learning points are added to the learning from Experience Database.

Month 6 - 9

Monitor and Evaluate



HSAB Quality Assurance Subgroup oversees progress against action plans

Regular updates on progress to HSAB

Workforce Subgroup commissions activities to support learning

Partner impact analysis reports presented to HSAB

Collected learning summary included in HSAB annual report

Month 9 - 12