Safeguarding Adults Reviews Process and Best Practice Guidance

Solihull Safeguarding Adults Board
Protecting Adults Together

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1. Introduction

1.1. The Care Act 2014 requires Safeguarding Adult Boards (SAB) to arrange Safeguarding Adult Reviews (SARs), and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

1.2. The Solihull Safeguarding Adults Board (SSAB) Safeguarding Adult Review Panel is responsible for carrying out Safeguarding Adult Reviews and other Learning Reviews in order to learn lessons and make improvements to safeguarding systems to safeguard and promote the welfare of adults.

1.3. The purpose of a SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. It is not the function of a SAR to reinvestigate, apportion blame or hold any individual or organisation to account.

2. Criteria for a SAR

2.1. Criteria from s44 of the Care Act 2014 states that:

(1) An 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.

(2) 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 about or suspected the abuse or neglect before the adult died).

(3) 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.

(4) An SAB may arrange for there to be a review of any other 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).

2.2. The provision in Section 44(4) enables a SAB to commission a review of a case that has not met the criteria but it is clear that there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the

wellbeing of adults and their families, and to prevent abuse and neglect in the future.

This may include;

- Serious incidents not meeting the criteria for a SAR
- Cases featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises
- Cases featuring good practice in how agencies worked together to safeguarding and adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

2.3. On receipt of a referral the SAB Business Manager must ensure that it explicitly references which of the statutory criteria the case has met, and/or how the case features practice issues to be pro-actively reviewed before abuse or neglect has occurred in order to tackle them.

2.4. In making a decision about whether to undertake a SAR and of what kind, the SAB's SAR subcommittee must ensure that the decision is defensible paying attention to Care Act 2014 and Making Safeguarding Personal principles.

3. Principles for Conducting a Safeguarding Adult Review

Timely

3.1. The SAR must be timely. The SAR Panel should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it (locally agreed as at the point of the appointment of the Independent Overview Report Writer), unless there are exceptional circumstances for a longer period being required.

3.2. Every effort should be made whilst the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

3.3. There is a presumption that even when criminal proceedings are ongoing, the work of the SAR will go ahead in accordance with the timescales unless there are special circumstances which would require some compromise.

3.4. If there are clear reasons put forward by the Police or CPS in discussion with the SAR Independent Report Writer it may be possible to negotiate a delay in final completion of the SAR, or some restriction of its scope. If there is any question about whether the SAR could be carried out in parallel with a criminal investigation, the police Senior Investigating Officer should be consulted.

3.5. All decisions and actions will be recorded in order to enable an audit trail.

Share Learning

3.6. The aim of a SAR is not to place blame but to share learning that will improve the way agencies work individually and together.

Proportionality

3.7. Each case and SAR should be treated as unique.

3.8. The process should include the recommended elements however, it should be proportional to the case and it should utilise the appropriate methodology that will maximise the learning.

Open and Honest

3.9. Throughout the SAR Process all parties should communicate and voice their opinions and their views openly and honestly with an appropriate “tell it like it is” approach.

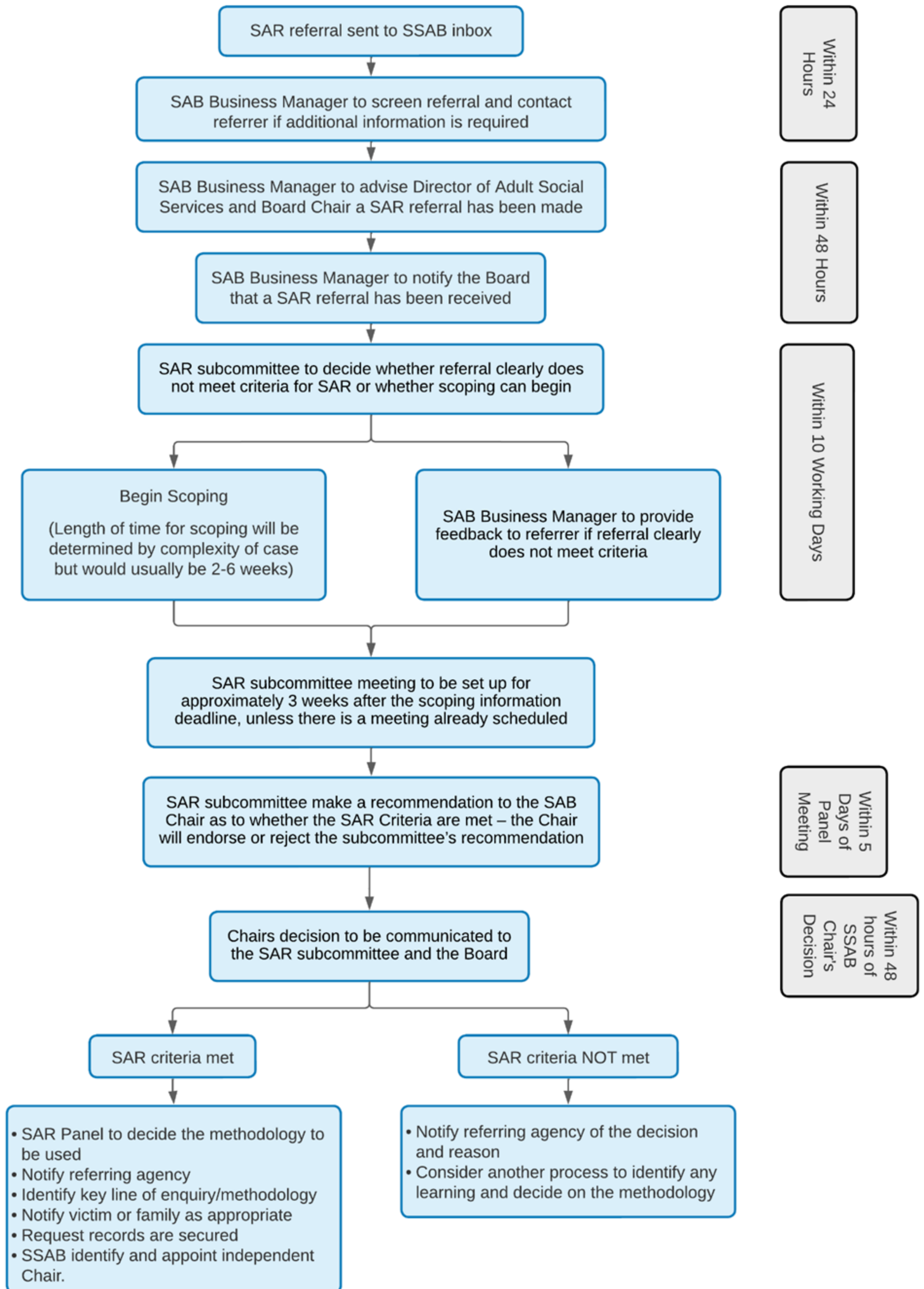
3.10. The circumstances of the case will require a level of sensitivity especially when the individual and/or their relatives are involved.

Encourage Excellence

3.11. The act of sharing the learning within and across agencies involved is to promote and encourage excellence within safeguarding.

3.12. Appendix C outlines key aspects and best practice when conducting a SAR.

4. SAR Process – Referral and Panel Decision



4.1. The decision making Panel will be chaired by the SAR Subcommittee Chair unless there are concerns about potential conflicts of interest. Where this is the case, the Vice Chair will take on this role. Further panel meetings will be chaired by the SAR Author.

4.2. SAR Referrals must be made to the Safeguarding Adults Board (ssab@solihull.gov.uk) using the West Midlands Safeguarding Adult Review Referral Form and Decision Record and completing with enough information to inform the screening process.

4.3. Potential referrals can be discussed at the SAR Subcommittee prior to a referral being made. Discussion and decisions reached must be recorded in the minutes.

4.4. It is expected that a referral will only be made by an organisation, once a conversation has been held with the appropriate senior lead for safeguarding within that organisation.

4.5. Cases should be referred for consideration if they appear to meet the criteria set out in Section 2.1 of this document.

4.6. The SSAB Business Manager will review all referrals at the point they are received and will contact the referrer if it is identified that further information is required.

4.7. At this stage, if the referral information does not suggest that the eligibility criteria would be met, following consultation with the subcommittee members, a decision may be reached not to undertake scoping and take the case to a decision making panel. Where this is agreed the referrer and the Independent Chair will be informed of the rationale for not scoping the case by the SSAB Business Manager.

4.8. If it is considered that there is a more appropriate route or process to which the case should be referred such as for a safeguarding enquiry, or an investigation under a different framework, the referrer will be advised of this.

4.9. If the subcommittee considers that the referral information suggests that the eligibility criteria for a SAR would be met, all partner agencies will be asked to complete the SAR Scoping Template and a chronology which details contact with the adult, significant incidents and information that would support the Subcommittee to understand what has happened.

4.10. Agencies that have not had involvement with the adult should submit a nil return.

4.11. The SAR Subcommittee will review the records held by each agency to;

- Establish the facts of the case;
- Review the effectiveness of procedures, both multi-agency and those of individual organisations;
- Highlight good practice identified;
- Establish if there are lessons to be learnt from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of adults;

- Establish whether criteria for a SAR is met and or any other type of review;
- Agree a recommendation to the SSAB Independent Chair; and
- Consider the findings of the various agency reports and challenge or seek assurance where required. This may include making recommendations for single agency actions outside of the SAR Process.

4.12. The recommendation of the SAR Subcommittee should be made to the SSAB Independent Chair within five working days. The Business Manager will communicate this by completing Section 2 of the West Midlands SAR Referral Form and sharing with the Chair.

4.13. The three recommendations noted below are the expected outcomes of the Subcommittee Decision panel.

Recommendation 1:	Criteria is met – Safeguarding Adult Review Required
Recommendation 2:	No evidence criteria is met – Alternative Multi-Agency Review Required
Recommendation 3:	No evidence criteria is met & no requirement for alternative review

Within these recommendations, even where the SAR criteria has been met, the Subcommittee can include variations and combinations of these recommendations. As an example, the scoping work may have been enough to identify the learning and make recommendations which will remove the need for further review.

Arrangements for a review should be proportionate to the circumstances of the case.

4.14. The subcommittee may also agree:

- Which agencies should be invited to attend future meetings of the Panel
- Type and extent of review to be undertaken;
- The independent author, if relevant;
- To identify an individual to write an overview report where it is not deemed appropriate or proportionate to commission an independent author. For example, when there has already been other reviews, or reports from related processes;
- How far back enquiries should go;
- What consultation with the adult and/or their family is required.
- What other investigations should inform or arise from the review;

4.15. If the case does not meet the criteria, the SAR panel will consider and make a decision as to whether it is still appropriate to undertake a learning review. In considering whether there are sufficient lessons to be learned and value in undertaking a review, the group will use the checklist shown in Appendix A.

4.16. SSAB Independent Chair will review the SAR Referral Form and make the final decision about whether SSAB will undertake a Safeguarding Adult Review. The decision will then be communicated to the board and the referrer.

4.17. The SSAB Independent Chair and the SAR Decision Making Panel should give consideration to the points set out in **Quality Marker 2** of the SCIE Quality Markers 2022 which looks at Decision Making.

4.18. Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with needs of care and support. If the SAB requests relevant information from a body or person (for example, in the context of a SAR) then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB. The test is that the information requested by the SAB must be for the purpose of enabling or assisting the Board to perform its functions, of which carrying out safeguarding adult reviews form part.

4.19. Where the SAR referral has implications for organisations in locations other than Solihull, the Business Manager will notify the Business Manager of the relevant Safeguarding Adults Board with opportunity to discuss further as required.

4.20. In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Practice Review (CSPR) or Domestic Homicide Review (DHR), a criminal investigation or an inquest. This should take place at the earliest opportunity possible.

4.21. It may be helpful when running a SAR and DHR or CSPR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. **SCIE Quality Marker 5** states that each review run in parallel should have their own Terms of Reference.

4.22. Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process to minimise avoidable duplication.

4.23. Consideration should be given to ensure that there is no prejudice to criminal trials, or unnecessary delay and confusion to all parties, including staff, the person and the relevant family members. Consideration should also be given to the retention of notes of interviews and meetings as well as copies of reports that might be relevant to the criminal proceedings. An index of materials generated by the SAR should be maintained so that it can be readily considered to see if it is disclosable. Additional information can be found on the CPS website.

5. SAR Process – Undertaking a SAR

5.1. The core group of the Panel requires a minimum of the 3 statutory agencies:

- Adult Social Care, Solihull Metropolitan Borough Council
- Birmingham and Solihull CCG
- West Midlands Police

5.2. SAR Panel members must not have had direct involvement in providing services to or been a direct line manager of professionals involved in the case. In most cases, representatives will be identified from the SAR Subcommittee to ensure consistency within the process and decision making.

5.3. Other agencies not involved in the case and specialist advisers may be invited to sit on the panel as 'critical friends' or to bring necessary knowledge or experience relevant to the case.

5.4. Panel members should also be invited from other relevant services that have had involvement in the case. If a SAR has implications for Children's Services then they should be invited onto the Panel.

5.5. Panel meetings will:

- Develop a Terms of Reference (Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management. *National SAR Analysis 2021 Recommendation 20*).
- Agree how far back enquiries should go (proportionality)
- Identify any parallel processes, ongoing or planned, and establish links as appropriate – **SCIE Quality Marker 8** on parallel processes should be referred to for best practice
- Consider how the adult, family members and/or advocates can be involved in the SAR – **SCIE SAR Quality Marker 3 and 11** should be referred to for best practice
- Consider findings and agree the key learning points of the SAR that are included in the SAR Report.
- Support the development of the report by the SAR Author by reviewing draft versions and shaping the final recommendations.
- Agree draft and final overview report (to be further approved by SAB)
- Endorse and adopt the action plan which should set out actions with named persons being responsible for their implementation within set timescales. The action plan should include by what means improvements in practice/systems will be monitored and reviewed;
- Clarify to whom the report, or any part of it, should be made available (including the adult and/or their family);
- Disseminate the report of key findings to interested parties as agreed;
- Make arrangements to provide feedback and de-briefing to staff, the adult and /or family members or carers of the adult and the media as appropriate; and
- Consider how to manage public and media interest in the case.

6. SAR Process – Commissioning an Author

6.1. The Safeguarding Adults Board Business Manager will support any recruitment arrangements for a SAR author ensuring that relevant recruitment procedures are followed.

6.2. If in the case of a competitive recruitment process, or for other reasons, there is a delay in the appointment of an author, a decision may be taken to initiate the early stages of the SAR in order that information can be gathered.

6.3. The Independent Chair, SAR Panel and SAB Business Manager should consider **SCIE SAR Quality Marker 5** which covers best practice around commissioning.

7. SAR Process – The SAR Panel and Chair

7.1. It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others;
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- collaborative problem-solving experience and knowledge of participative approaches;
- good analytic skills and ability to manage qualitative data;
- safeguarding knowledge;
- Inclined to promote an open, reflective learning culture.

7.2. The Chairperson is responsible for:

- Ensuring administration support is available to the Safeguarding Adult Review process and Panel meetings;
- Tasking the identified agencies to undertake scoping to present to the Panel Meeting where the request will be considered;
- Organising the Panel Meeting to consider the request, to take place within 28 working days of the request being made;
- Chairing all Safeguarding Adult Review Subcommittee meetings;
- Ensuring the minutes are an accurate reflection of the meeting;
- Challenging agencies and partners who are not engaging in the process;
- Ensure the quality of reports received; satisfy the requirements of the Panel;
- Making sure all information is received in a timely manner to enable timescales to be met;
- Making sure any immediate actions required (including the sharing of information) are acted upon; and
- Securely storing all papers relating to the Safeguarding Adults Review.

7.3. Participation in the SAR is a requirement of the Solihull Safeguarding Adults Board Panel members, who are required to:

- Give priority to participation in this process;
- Ensure their organisation complies fully with the Safeguarding Adult Review process, including providing detailed, high quality and professional reports;
- Identify relevant frontline practitioners with direct involvement who may need to contribute to the SAR
- Attend all Safeguarding Adult Review meetings; and
- Actively contribute to the process and meetings.

7.4. The SAR Panel and Chair/Author should consider SCIE SAR Quality Marker 6 on governance arrangements.

8. SAR Process – The SAR Report

8.1. The SAR Report brings together the learning and the themes identified during the SAR Process. It should provide analysis and comment on practice and the systems used to safeguard and promote the welfare of the adult. **SCIE SAR Quality Marker 12** covers best practice regarding analysis in the report.

8.2. The SAR Report should;

- Provide an overview of the case, including a summary of the circumstances that led to the SAR being undertaken.
- Outline briefly the methodology and SAR Process including how the views and participation of stakeholders were taken into account.
- Identify how agencies worked with the adult, drawing out any common themes, significant failings and recognised good practice.
- Provide recommendations that are relevant on a multi-agency basis that are SMART (*Specific, Measurable, Achievable, Realistic and Time-specific*).
- Recommendations should be developed in consultation with the organisation that they relate to.

8.3. Where appropriate, the final draft of the report should be shared with the adult, family members and/ or advocates for comment and views on publication prior to submission to the Board. Where possible, this should be facilitated by a professional with an established relationship and consideration must be given to the support required to understand and respond to the report – **SCIE SAR Quality Marker 11** covers Involvement of the person, relevant family members and network

8.4. Progress of the SAR will be reported at the quarterly Board meetings to ensure that SSAB Members are sighted on the progress, arising issues and general themes of the review.

8.5. The Panel should agree the final draft of the report that is sent to SSAB Board for ratification.

9. SAR Process – SAR Ratification, Recommendations, and Accountability

9.1. Once the final draft of the report has been agreed by the SAR Panel, the draft report should be shared with the SSAB Members at Board for ratification. This should be presented by the SAR Author or an agreed representative of the SAR Panel.

9.2. The formal sign off at Board provides a further opportunity for wider comment and ratification. **SCIE Quality Marker 13** covers best practice expectations for the report.

9.3. At the point of ratification, SSAB Members take ownership of the findings of the report. SSAB Members are responsible for agreeing how the recommendations will be responded to and actions required (both as single agencies and from a multi-agency perspective). Where there are external agencies outside of the SSAB for whom recommendations are made, the SSAB Members must agree how to approach these actions and request a response from the relevant agency.

9.4. When the SSAB formally agrees the SAR report, consideration must be given as to whether any issue or learning from the SAR meets the criteria in the National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021 (See Appendix D). Criteria for referral of a SAR issue or learning: it concerns statutory guidance or national policy; and /or it involves a national organisation (e.g. CQC, NHSE), or sector (e.g. Police, emergency services).

10. SAR Process – SAR Report Publication

10.1. There is a statutory duty to publish the findings of SARs, however the method of publication and the extent of publication is decided by SSAB Members.

10.2. Decisions in relation to publication will consider the view of the SAR Panel, the adult, family members and/ or advocates and any potential impact on those involved in the case. Each organisation will be responsible for communicating with its employees who were involved in the case, that the report and key findings are to be published.

10.3. SAR Report publication may be impacted by other parallel processes such as criminal proceedings/ court cases, alongside data sensitivity issues that may impact on those who have been impacted by the case. Whilst publication of the report may be held, the lessons learnt and recommendations can be taken forward once the SSAB Members have agreed the report.

10.4. Regard should be given to **SCIE SAR Quality Marker 14** which covers best practice expectations on publication and dissemination.

10.5. General themes and outcomes of SARs will be reported in the SSAB Annual Report, with overviews and any resulting practice guidance/ resources for practitioners made available on the SSAB website.

11. SAR Process – Action Plans and Monitoring

11.1. Development of a multi-agency action plan against the recommendations will be commissioned by the Board through the SAR Subcommittee, with updates presented at Board.

11.2. Progress against the action plan, and exception reporting will be made to the Board by the chair of the SAR Subcommittee. The Board will also receive a report at the point that all actions have been signed off as completed.

11.3. The SAR Subcommittee will be responsible for developing a plan to evaluate impact of the completed action plan, and for compiling a summary report once the impact has been evaluated.

11.4. The Board and SAR Subcommittee should consider **SCIE SAR Quality Marker 15** which covers best practice around improvement action and evaluation of impact.

12. When an Adult is Placed Outside of Solihull

12.1. It is acknowledged that there will be cases where vulnerable adults have moved from their home area and may be placed and funded by an organisation that is outside Solihull.

12.2. If that is the case, a SAR should be carried out by the SAB for the location where the serious incident took place. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

13. Dispute Resolution during SAR Process

13.1. It is recognised that disputes may arise at any stage during the SAR process, including whether a SAR should be commissioned, how it is commissioned and any aspect of the outcome of the review, including the content of the report.

13.2. A dispute may arise because of a disagreement or complaint from anyone involved in the SAR process.

13.3. Where a dispute arises, it shall be dealt with as follows:

(a) Those responsible for the relevant part of the SAR process shall attempt to resolve the dispute, for example, the Decision Making Panel before a report is commissioned and the SAR panel and/or the report author during the carrying out of a review.

(b) The objecting party will provide written representation setting out their concerns to the Independent Report Writer within 7 working days of being advised that the final draft report will not be amended.

(c) The representations of the panel member and the Independent Report Writer will be considered by the Independent Chair. Where the Independent Chair is unable to resolve the dispute, they may recommend to SSAB that a reference to the dispute, and that is was not possible to resolve it, should be included as a footnote to the report.

Appendix A

Checklist for considering whether there are sufficient lessons to be learned and value in commissioning a SAR under Section 44(4).

QUESTION	YES	NO	COMMENT
Was there a "near miss"?			
Does the case indicate that there may be failings in how our adult safeguarding multiagency policies and procedures function, leading to serious concerns about how professionals/ services work together?			
Did the system not recognise/share evidence of risk of significant harm to an adult (or recognise/share it late)? Is there evidence that system conditions lead to poor multiagency working or communication?			
Does that case involve serious or systemic organisational abuse and multiple alleged perpetrators, from which learning could be transferred to other organisations to prevent such abuse or neglect in the future?			
Could the case potentially yield systems learning around how agencies work together to prevent and reduce abuse and neglect that would help us do things different in the future?			
Would a SAR enable SSAB to identify areas of practice to prevent serious abuse or neglect happening?			
Does intelligence from other quality assurance and feedback sources (e.g. audits/complaints) suggest			

that the kind of issue in this case is new/ complex/ repetitive and conducting a SAR would therefore be beneficial?			
Has this happened before in Solihull and was a SAR commissioned then? Has the learning from any previous SARs been implemented or is there new learning to be identified?			
Is there adverse media interest or serious public concern?			
Is there evidence of sufficient good practice that could be mainstreamed across the partnership to the benefit of adults and their families?			

Appendix B

Review Methodologies

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another. In determining the type of review and methodology to be used the statutory safeguarding principles should be applied. The focus will be on ensuring that there is an effective and proportionate means by which the SAB can identify key learning so that it can fulfil its statutory obligation to help protect adults in its area. *Please note this is not an exhaustive list.*

a) Rapid Reviews

This methodology is based on the Children's Safeguarding Practice Review process as set out in Working Together to Safeguard Children 2018.

The aim of the rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time;
- discuss whether there is any immediate action needed to ensure the adult's safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of the adult; and
- decide what steps they should take next, including whether or not to undertake a Safeguarding Adult Review.

Upon receipt of a notification which may meet the criteria for a Safeguarding Adult Review, a multi-agency rapid review meeting is called, within 15 working days, to consider the case. Scoping and analytical chronology requests are sent to all partners involved to gather facts about the case and determine the extent of agency involvement with the adult. Partners are asked to return information within 5-7 working days, this allows the business unit to review responses and consider key lines of enquiry prior to the rapid review meeting.

During the rapid review meeting the information gathered to date is considered and the case is reviewed against the SAR criteria, initial learning points are established and any further actions agreed. The partners then record a decision on whether there is further merit in progressing to a more detailed review or whether the learning has already been established.

If the rapid review is thorough, it can in some cases, obviate the need for further review and enable areas to move quickly to implement the learning across the system.

b) Traditional Serious Case Review Model

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

This model includes:

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning
- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

The benefits of this model are:

- it is likely to be familiar to partners
- possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- methodology stems from children's arena so process to adults is not so familiar
- resource intensive
- costly
- can sometimes be perceived as punitive and
- does not always facilitate frontline practitioner input.

c) Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)

- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- cost effective
- enhances partnership working and collaborative problem solving
- encompasses frontline staff involvement
- learning takes place through the process enhancing learning.

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

d) Individual Agency Review

This model would be relevant when a serious incident identifies just one agency involvement or one agency learning identified. There are no implications or concerns regarding involvement of other agencies and it is appropriate that lessons are learnt regarding the conduct of an agency and in the absence of the need for a multi-agency review.

Such reviews could be requested by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking an Individual Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships.

Circumstances when this model might be appropriate:

- Serious Incidents
- Implications relate to an individual agency but lessons could be shared, applied and learnt across the partnership
- Where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

The benefits of this model are:

- Provides an opportunity for learning from an individual agency
- Enables individual agency scrutiny into a specific area
- Assists a 'Duty of Candour'

The drawbacks of this model are:

- Can be seen as outside the SAR purpose of multi-agency learning
- Risks individual agency opposition.

e) Peer Review Approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasing used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- peers can be identified from constitute professionals/agencies from the Safeguarding Adults Board members or
- peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- increased learning and ownership if peers are from the SAB
- objective, independent perspective
- can be part of reciprocal arrangements across/between partnerships

- cost effective

The drawbacks of this model are:

- capacity issues within partner agencies may restrict availability and responsiveness
- skill and experience issues if SARs are infrequent potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

f) Significant Event Analysis/Audit (SEA)

SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it.

The benefits of this model are:

- It is not a new technique – doctors have long discussed cases for educational and professional purposes.
- NHS England has published Serious Incident Framework in March 2015.

The drawbacks of this model are:

- Seen as a model that relates only to Health.

g) Case File Audit (multi or single agency, table top or interactive)

Case file audit can be a powerful driver in improving the quality of front line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

- As a table-top exercise (therefore no input from practitioners)
- Interactive with partners and or practitioners.
- Interactive with the adult and or their family.
- Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- Flexible – in that they can be conducted in many different ways.
- Quicker learning can be achieved.

The drawbacks of this model are:

- Learning for some models will only come from written records without relevant context.

h) Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors - the Root Causes- of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes
- to be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence
- there is usually more than one potential root cause of a problem
- to be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS
- Focus is on the root cause and not on apportioning blame or fault
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

i) Thematic Reviews

A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or

investigation. Themes may also be identified by the Performance and Quality Assurance Subgroup. A thematic review considers an individual case as a starting point, but looks at issues raised generally, rather than the details specific to the case.

- Findings are collated from involved agencies or previous reviews
- The legal framework, risk and communication are considered
- An academic literature review is undertaken
- Policy documents are reviewed
- Interviews are held with practitioners
- Multi-agency response is considered

<u>The benefits of this model are:</u>

- Increased opportunity for wider learning
- Cost effective
- Engagement with staff and managers at different levels within organisations

<u>The drawbacks of this model are:</u>

- Unfamiliar methodology
- Resource intensive

Appendix C

Solihull Safeguarding Adults Board
Protecting Adults Together

Safeguarding Adult Review Checklist

Section A
Criteria for a Safeguarding Adult Review The SSAB Safeguarding Adult Review Panel (SAR) has the lead responsibility for arranging and conducting a SAR and must do so when: • An adult with care and support needs (whether or not those needs are met by the Local Authority) in the safeguarding adult board's (SAB) area has died as a result of abuse or neglect, whether known or suspected **and** there is concern that partner agencies could have worked together more effectively to protect the adult. OR • An adult with care and support needs (whether or not those needs are met by the local authority) in the SAB's area has not died, but the SAB knows or suspects the adult has experienced serious* abuse or neglect and there is concern the partner agencies could have worked together more effectively to protect the individual. OR • The SAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice. * 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 had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Select from the options below	Selection
i. An adult with care and support needs (whether or not those needs are met by the Local Authority) in Solihull has died as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked together more effectively to protect the adult.	
ii. An adult with care and support needs (whether or not those needs are met by the local authority) in Solihull has not died, but the SAB knows or suspects the adult has experienced serious* abuse or neglect and there is concern the partner agencies could have worked together more effectively to protect the individual.	
iii. There are concerns and issues reoccurring and the SAB are looking to proactively review these in order tackle practice areas or issues before serious abuse or neglect arises. (Care Act S.44(4))	
iv. There is learning from good practice in interagency working which can be identified and applied to improve practice and outcomes for adults. (Care Act S.44(4))	

Section B	
Requesting a SAR to be undertaken (SCIE SAR QM 1)	Tick when complete
The requestor has reasonable grounds to believe that SAR criteria has been met	
The local SAR request form has been competed	
The SAR has been logged	
The Independent Chair has been notified	
The Business Manager has convened a panel to consider the SAR request	
Enough information has been submitted to make a decision as to whether the SAR criteria has been met *Note: if the board members have decided that the request does not meet the criteria for a SAR please go to section B.1*	
The Director for Adult Social Care has been notified	
The requestor has been notified	
The Panel and SAR Panel Chair have agreed the most appropriate/beneficial methodology to be employed	
The SAR has been commissioned	
Section B.1	
Process if the request has not met the criteria for commissioning a SAR (SCIE SAR QM 2)	Tick when complete
The SAR Panel have considered whether an alternative review/ learning event/ audit are in place	
The Independent Chair has been notified of the decision	
The referrer has been notified by letter from the Business Manager, within a reasonable time scale, outlining the reasons for the decision *Note: the requestor has the right to appeal the decision, if the appeal is upheld the SAR process will continue to from this point onwards however, if the SAR criteria has not been met and the requestor's appeal has not been upheld, the SAR log should be updated and the request should be closed. Refer to section B.2 below on the process to holding a learning event. Section B2 Learning event*	
Section B.1	
Learning Event A learning event can be organised when the decision has been made that the criteria does not meet the SAR threshold. Learning events are a way of having open and honest conversations using an action focussed approach. The approach will vary with each case. However, their benefit and value is not to be underestimated. Learning events can encourage excellence within an organisation and improve the way organisations and agencies work together.	Tick when complete
The agencies involved have been contacted and are willing to partake in a learning event	
A facilitator has been appointed	
The group have met and the discussions have led to an action plan with dates for completion	
The responsible person has ensured that the actions agreed have been completed in a timely manner and has logged the outcomes	

Section C	
Making decisions on the SAR Methodology The circumstance of the case will dictate the most appropriate methodology. Despite the methodology employed the following elements should feature in the SAR. The range and type of learning will be impacted by the type of methodology used.	Tick when complete
The Panel and Chair have appointed a SAR Chair, who is independent of the case under review and of the organisations involved. They have the appropriate skills, knowledge, and experience. They will be able to: • motivate others • handle multiple competing perspectives with strong leadership skills • analyse qualitative data • use their Adult safeguarding knowledge and experience to implement a collaborative approach to problem solving • This person could be drawn from a list of multiagency professionals in a senior role to promote transparency and independence	
A SAR Panel of relevant people responsible for scrutinising information submitted has been appointed. They will be responsible for appointing a reviewer with the relevant skills, experience and references. *Note: The size of the panel should be proportionate to the nature and complexity of the review*	
The Terms of Reference have been developed outlining roles, responsibilities, scope and focus. This does not include issues that are being resolved using other legislation.	
Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management. (National SAR Analysis).	
The independent SAR reviewer has been made aware of any other relevant local SARs.	
Discussions have been had with the family / individual involved as to the level of engagement and their expectations (See section E for more details)	
Professionals and organisations involved with the individual have been notified that they have the opportunity to contribute (See section F more details)	
The methodology includes a final report which set out recommendations and wider learning (See section H more details)	

Section D	
Methodology Options	Tick when complete
Rapid Review	
Traditional Serious Case Review Model	
Action Learning Approach	
Individual Agency Review	
Peer Review Approach	
Significant Event Analysis/Audit	
Case File Audit (single or multi)	
Root Cause Analysis	
Thematic Review	
All members of the SAR panel are aware of the methodology chosen and agree its suitability	

Section E	
Adult and family involvement (SCIE SAR QM 3 and 11)	Tick when complete
Support and advocacy has been considered and organised for the individual involved if they are to engage with the review	
Support and advocacy has been considered and organised for the relatives of the individual involved if they are to engage with the review	
Arrangements have been confirmed for any on-going support (e.g. legal support)	
The individual and their families have been made aware that the SAR is not to apportion blame but to use the learning to improve practice and working within and between the agencies involved	
There has been clear consideration given to the specific input of the individual and their family if they have survived	
Due diligence, compassion and appropriate support has been provided to the individual involved and /or their relatives	

Section F	
Supporting staff and others in involved (SCIE SAR QM 10)	Tick when complete
The staff and agencies have been notified that they have been involved in a case that will be reviewed and they have considered how they would like to/ would like their staff to engage with the SAR	
The nature, scope and time scales have been communicated to the staff involved and their managers	
Staff have been encouraged to share their opinions and views in an open and honest way, as this will facilitate beneficial learning	
Agencies are aware that they have a responsibility to providing a safe environment for their staff to discuss their feeling and receive support	
Agencies have decided how they will share the learnings once the conclusions have been published	
Agencies have made it clear to their staff that they may need to engage in learning despite not being involved in the SAR themselves	

Section G	
Professional conduct	Tick when complete
The West Midlands Safeguarding Adults Policy and procedure has been reviewed in conjunction with this section	
It has been made clear to staff and all agencies that the SAR Panel are not to deal with issues of professional conduct that may become apparent during a SAR	
The SAR Panel Chair has fed back the individual conduct issues to the relevant agency as it is their responsibility to trigger any action in proportion with the concerns passed on by the SAR Panel	

Section H	
SAR reports and recommendations (SCIE SAR QM 12, 13, 14)	Tick when complete
The West Midlands Safeguarding Adults Policy and procedure has been reviewed in conjunction with this section	
The SAR panel chair has facilitated sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process.	
The SAR report has been based upon the systematic, practice and procedural issues and the key learnings have been identified	
The SAR panel have reviewed the report and are in agreement with the conclusions and recommendations proposed before it is presented to the SAB	
The individual involved and / or their relatives have been offered the opportunity to review the report	
The SAB have made a decision as to who the report will be made available to and to what extent i.e. full / part of the report. They have considered the reputational risk and national learning	
All agencies have been notified of publication and advised to let the staff involved know in the case of the publication. Individual Agencies are responsible for debriefing their staff.	
Consideration has been given to notifying other boards e.g. neighbouring SABs, LSCP etc.	
Consideration has been given to the potential for public and/or media interest	
The report has been anonymised	
The report has been stored according to legal requirement, the Data Protection Act and the local authorities information sharing agreement	

Section I	
Quality assurance of the SAR (SCIE SAR QM 6) Quality assurances are embedded throughout the SAR process from appointing an Independent Chair to lead the review, to giving the individual involved/ their families an opportunity to review the report. The first element of quality assurance is to demonstrate clear evidence that the SAR learning has been embedded. There are other arrangements that could be put in place which will allow for further assurance. You could ensure you have:	Tick when complete
Employed the most appropriate SAR methodology for the individual case	
Commissioned a suitably skilled, experienced and independent SAR reviewer to lead the review and analysis. They have the appropriate skills and training/shadowing experience	
Chosen independent SAR panel members with no conflict of interest	
Focussed on outlining the causal factors and systems learning	
Requirements have been written into the terms of reference for the SAR to take a broad learning approach	
The report provides a sound analysis of what happened, why and what action needs to be taken to prevent the same issues occurring again	
The report has enough information for the SAB to review and quality assure	
The report provides practical value to the individuals and organisations involved	

<table>
<tr><th colspan="2">Section J</th></tr>
<tr><td>Acting on the recommendations of the SAR (SCIE SAR QM 15)</td><td>Tick when complete</td></tr>
<tr><td>SAR Panel have translated the recommendations from the report to into a multiagency action plan

Note: The SAR will need to be published within the SSAB Annual Report even if they choose not to implement these actions.</td><td></td></tr>
<tr><td>The action plan includes:
• The actions that are needed.
• Who is responsible for specific actions
• Timescales for completion of actions are appropriate with specific end dates
• The intended outcomes: what will change as a result
• Mechanisms for monitoring and reviewing intended improvements.
• The plan for dissemination of the SAR report or its key findings.</td><td></td></tr>
<tr><td>The individual agencies have produced their own action plan where necessary as per internal governance processes</td><td></td></tr>
<tr><td>The Board partners aware that they are responsible for ensuring that the actions have been implemented from the multiagency action plan</td><td></td></tr>
<tr><td>The Learning and Improvement subcommittee are aware that they are responsible for disseminating the learning from the SAR.</td><td></td></tr>
<tr><td>The Performance and Audit Subcommittee are aware that they are responsible for audit of how effectively learning is embedded and impact on practice – this will usually be “one year on” from the Board sign-off of the completed action plan.</td><td></td></tr>
</table>

Appendix D

National Network of Safeguarding Adults Board Chairs

National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021

Context

The National Analysis of SARs April 2017-March2019 (2020)1 provided priorities for sector-led improvement, including priority No 27, which was: 'How SABs, regionally and nationally, should discuss the role of SARs in sharing learning with central government departments and national regulatory bodies and holding them to account when findings require a response that is beyond the scope of local SABs.'

Subsequent discussions with safeguarding policy leads at the Department of Health and Social Care clarified that a nationally agreed escalation protocol would be helpful to confirm a process for escalating issues that arise from local Safeguarding Adults Reviews, which require a national response. A proposal for escalation was discussed at SAB Chairs national and regional meetings during 2021, and the process was agreed at the Executive meeting of the National SAB Chairs Network on July 19th 2021.

Stage 1 - Regional Discussion

When the local SAB formally agrees a Safeguarding Adults Review (SAR) report (mandatory or discretionary), any issue or learning identified by the SAR author that meets the criteria, is taken forward by the SAB Chair to their regional network(s). This may include regional SAB Chairs, regional SAB Managers, Regional SAR groups.

The purpose of discussion at the regional level is to allow consideration as to whether the issue/learning affect the specific locality or affects other localities in the region; whether the issue/learning can be addressed or resolved regionally; to establish if the policy issue/learning is national in order to warrant escalation. Contact with the SAR author may be helpful for clarification of the recommendation/learning, and they should be made aware that the escalation process is being initiated.

The SAB Chair presenting the issue/learning should provide background information from the SAR and present the case for escalating the issue/learning to the regional meeting. This should include how it meets the criteria.

Criteria for referral of a SAR issue or learning: it concerns statutory guidance or national policy; and /or it involves a national organisation (e.g. CQC, NHSE), or sector (e.g. Police, emergency services)

Stage 2 - National Discussion

If the regional SAB Chairs group agree that the issue/learning warrants national escalation, the Chair of the regional group escalates the issue/learning and presents to a meeting of the National SAB Chairs Network, with the relevant SAB Chair presenting their SAR at the regional meeting, who can provide detailed knowledge and answer questions about the SAR.

The purpose of discussion at the national level is to allow consideration as to whether the issue/learning has a national impact; whether the issue/learning can be addressed or resolved through established national networks and connections; and to establish if the policy issue/learning warrants national escalation.

Stage 3 - Contact with DHSC Policy Leads and Others

The Chair of the National Network should email the DHSC safeguarding adults policy leads to consider how to take forward the policy issue/learning, summarising the outcome of discussion at Stage 2.

Depending on the issue/learning and the discussion, the DHSC policy leads would respond by email and advise on how to progress and address the issue/learning. The SAB Chair who presented the SAR would advise the Chair of the National Network and DHSC policy leads regarding the escalation of relevant issues arising from the SAR, alongside other SAB Chairs with evidence of the relevant issues.

In some circumstances a direct approach may be appropriate to a national body or organisation e.g. the Anti-Slavery Commissioner's Office. If appropriate the Chair of the National SAB Chairs Network, in consultation with the SAB Chair presenting the SAR, should agree how best to undertake any such approach. The Chair of the National Network and/or the SAB Chair presenting the SAR would contact Care Quality Commission, NHS(E), ADASS, LGA, Police, Emergency services or other national body (through their safeguarding adults leads) to consider how to take forward the policy issue/learning.

The email referral should:

- Demonstrate clearly that the issue raised is not a 'one off' and should provide the links to the relevant SARs.
- Summarise the problem/policy issue/learning clearly
- Suggest what could be done to address it, from the national perspective

There may be other further relevant considerations, such as joint reviews or parallel processes such as Children's safeguarding Case Reviews, Domestic Homicide Reviews, and this may affect the escalation process and the agencies involved.

Stage 4

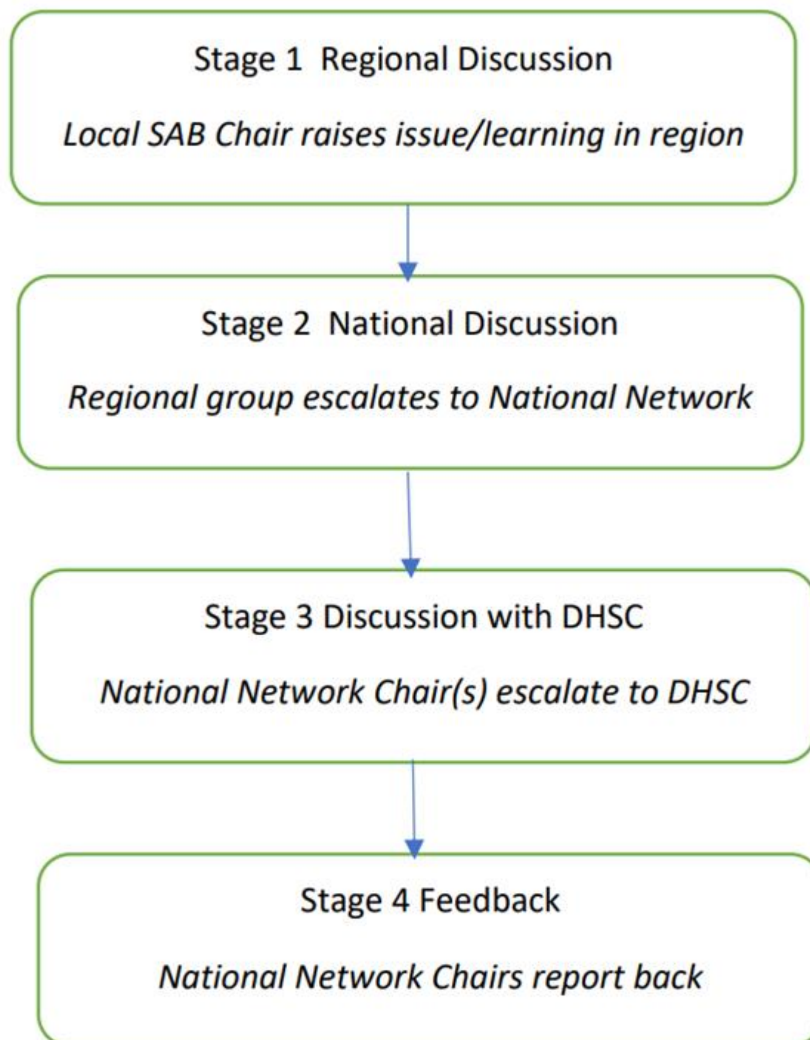
Feedback to the National SAB Chairs Network should be monitored to establish the outcomes of escalation of issues. The operation of the escalation protocol should be monitored on an ongoing basis by the Network. Feedback will be provided to the regions regarding progress, through the Executive meetings or emails.

Response Times

Every effort will be made to ensure that unnecessary delay is avoided, including the use of ad hoc meetings.

Any queries of comments regarding this protocol, please contact National Network of Safeguarding Adults Board Chairs or Adi Cooper, Care and Health Improvement Partnership [*Adi.Cooper@local.gov.uk*](mailto:Adi.Cooper@local.gov.uk)

Escalation Flow Chart



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