Somerset Safeguarding Adults Board

Learning & Improvement Policy

Version	Date	Amendments	Date agreed by SSAB
Draft v.2	05/11/2015		
Draft v.3	12/02/2016	Issued to SSAB Members for approval	
Final v.4			25/02/2016

1. Introduction

There are a number of processes that can be used by the Somerset Safeguarding Adults Board (SSAB) for the purpose of learning lessons from incidents and practice, and to use these findings to improve, impact upon and develop local practice and service delivery or design.

The range includes:

- Safeguarding Adults Reviews (SARs);
- Audits of multi-agency and single agency practice;
- Reviews of whole service safeguarding;
- Reviews of individual safeguarding.

Throughout all learning and dissemination activity, the statutory requirements of the Care Act 2014 should be observed. The six principles of Adult Safeguarding should inform all arrangements.

The purpose of a review is not to re-investigate an incident or incidents, nor is it to apportion blame. Its main function is to identify whether lessons can be learnt about the effectiveness of professionals and agencies working together to safeguard adults at risk.

2. Statutory requirements of the Care Act 2014

Safeguarding Adults Board **must** arrange a Safeguarding Adults Review (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 (s.14.133).

SABs **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. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support (s.14.134).

The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. 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.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is in order for lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

The purpose of a SAR is **not** to hold any individual or organisation to account. Other processes exist for this, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission (CQC), the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and organisations are fearful of SARs, their response will be defensive and their participation guarded and partial (s14.140).

3. Principles of the SSAB Learning and Improvement Framework

The 6 key principles of adult safeguarding should apply to SAR activity, namely:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability.

In undertaking SARs, Somerset's Safeguarding Adults Board will expect that:

- there is a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews will be proportionate according to the scale and level of the complexity of the issues being examined;
- reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals will be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- adults at risk will be involved in a SAR about their experience; if they have any significant difficulty in being involved, an independent advocate will be commissioned to support them to be involved as possible throughout the process;
- families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

4. Safeguarding Adult Reviews (SARs)

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. (Care Act statutory guidance 14.141)

4.1 Criteria for a SAR

SARs are concerned with the abuse or neglect of adults with care and support needs, who are not able to protect themselves because of those care and support needs. The adult does not have to be in receipt of care and support.

SABs **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 (s14.133).

SABs **must** arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs may arrange for a SAR in any other situation involving an adult in its area with needs for care and support where it believes there is value in doing so.

Cases for a SAR not involving death or serious abuse or neglect may be selected by the SAB because they allow the SAB to proactively address issues of concern, for example:

- a case will provide useful insights into the way organisations work together to prevent and reduce abuse and neglect of adults;
- examples of good practice can be explored via appreciative inquiry where lessons can be identified and applied to future cases.

4.2 Decision-making Process

4.2.1. A SAR can be requested by any partner agency, the Coroner or the Secretary of State. All requests for the SAB to consider a case for a SAR are to be made by formally writing to the Chair of the Safeguarding Adults Board - ***see Appendix 1 for referral form (page 10)***

The decision must be made within 1 month of receipt of the request.

The final decision rests with the SAB Chair; however, the Chair will be advised by the SAR subgroup who will consider the request and make recommendations to the Chair. If necessary, the Chair may also consider peer challenge from another SAB Chair.

4.2.2. The SAR subgroup will assess whether the criteria for a SAR have been met and the potential methodology before making a recommendation to the SAB Chair.

4.2.3. Agencies immediately involved in the case who are part of the SSAB Subgroup will need to be represented by someone independent of the case in question.

4.3 Type of review
The SAB SAR subgroup will consider a SAR approach proportionate to the complexity of the issues to be considered.

In considering the approach, the SSAB will consider:

- how best to promote effective learning and improvement actions to prevent death or serious harm;
- how to avoid a hindsight bias which may obscure analysis of complex situations;
- how to promote a broad organisational learning approach and reflect current practice realities.

4.4 Review methodology
No single model is prescribed for SARs.

The choice of approach for each SAR is significant as how a review is conducted will influence the learning and whether the process is constructive and educative for those involved (SCIE 2015).

4.4.1. The SCIE Learning Together model: *the Learning Together approach has been used in both safeguarding adults and safeguarding children's reviews. The model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture.*

Practitioners are part of the case review team, and their perspectives are used to inform all aspects of the Review, including lessons learned.

4.4.2. Significant Incident Learning Process (SILP): *this approach explores a broad base of involvement including families, frontline practitioners and first line managers' view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.*

4.4.3. Root Cause Analysis (RCA): *RCA has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systemic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.*

4.4.4. Appreciative Inquiry (AI): *This approach is rooted in action research and organisational development and is a strengths-based, collaborative approach for creating learning change. SARs conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded and shared honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements.*

4.5 Lead Reviewers/Chairs and panel membership

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

- strong leadership and the ability to motivate others;
- expert facilitation skills and the ability to handle multiple perspectives and potentially sensitive or complex group dynamics;
- collaborative problem-solving experience and knowledge of participative approaches;
- good analytical skills and the ability to manage qualitative data;
- safeguarding knowledge;
- inclined to promote an open, reflective learning culture (s14.143).

The lead reviewer/SAR Chair is responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the stages described and outlined within Appendix 2.

Each agency participating in the SAR needs to identify a representative who has:
- sufficient seniority and authority to represent the agency and commit it to actions agreed as part of the review;
- relevant professional experience to allow them to analyse information and acknowledge evidenced weaknesses in their agency's involvement.

It is essential that panel members have not had any direct involvement in the case being reviewed or have any other conflicts of interest which may impinge upon the work of the SAR. At the nomination stage each agency will be required to confirm this professional distance from the case in question and that the panel member will be available to participate fully in the review until its conclusion.

Responsibilities of SAR Panel Members
- to represent their agency in review discussions;

- to liaise closely with whoever is preparing their agency's Individual Management Report (IMR) to ensure that the report addresses all the relevant issues and is submitted according to agreed timescales;
- to clarify any information sharing issues;
- to seek legal advice on behalf of the agency if required;
- to ensure the report and IMR, and subsequent actions arising from the review, have received approval at the appropriate level;
- to arrange for a chronology of their agency's involvement in the case to be produced;
- to analyse and contribute to panel discussions about the various agency reports to assist the panel in reaching its conclusions;
- to identify who within their agency will be responsible for monitoring and reporting on the relevant sections of the action plan;
- to act as a critical friend to other panel members.

4.6 Timescales

4.6.1. A decision as to whether a referred case meets the threshold for a SAR will be communicated to the referrer within 1 month of receipt of the referral.

4.6.2. SABs are expected to complete a SAR in a 'reasonable period of time' and within 6 months of initiating the review. A longer period is permitted, for example, because of potential prejudice to related court proceedings (s14.144).

4.6.3. The SAB will complete each review within 6 months of the SAR initiation meeting, attended by the lead reviewer. If the SAR is not complete after 6 months, the reasons for this will be published with the SAR and referred to in the SAB annual report.

4.6.4. Every effort will be made while the SAR is in progress to capture points from the case about improvements needed, and to take immediate corrective action where possible.

4.7 Duty to cooperate

4.7.1. SAB partners will ensure there is appropriate involvement in the review process of professionals and organisations involved with the adult subject to the review. Agencies that are members of the Board are expected to fully cooperate with it in regards to any review that is initiated, whether it is a SAR or other learning review.

4.7.2. The SAB may decide as part of the SAR to ask each relevant organisation to provide information in writing about its involvement with the adult who is the subject of the review. The form in which such written material is provided will depend on the chosen review methodology.

4.7.3. The SAB will notify each organisation that is a partner of the SAB of the decision to initiate a SAR, and what is expected of each organisation as part of the review. This notification will be sent to the Chief Executive of the relevant organisation and also to the board representative of the organisation where applicable. This notification will request the senior manager to:
- ensure all agency records relating to the case are made secure;
- identify a senior representative to be a member of the review panel;
- confirm whether there are any other investigations/review processes taking place or proposed.

4.8 Links with other reviews

4.8.1. 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 Serious Case Review (SCR)

or Domestic Homicide Review (DHR), a criminal investigation or inquest. Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for the organisations involved. Where intelligence can be shared across reviews, there should be no organisational barriers to information sharing.

4.8.2. It will also be helpful if running a SAR, DHR or SCR 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.

4.8.3. Any SAR will need to take account of a coroner's inquiry and/or any criminal investigations related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay to the review process.

4.9 Findings from SARs

SAB SAR reports will:

- provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence wherever possible;
- be written in plain English;
- contain findings of practical value to organisations and professionals;
- be suitable for publication without needing to be amended or redacted;
- wherever possible, contain the response of the adult's family to the findings of the review.

The fact that the report will be published must be taken into consideration throughout the review process, with reports written in such a way that publication will not be likely to harm the welfare of any adults at risk or children involved in the case.

Consideration must be given on how best to manage the impact publication on those affected by the case. The anonymity of adults is not protected in law; this must be borne in mind when considering impact.

The SAB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders.

The SAB will include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take, in relation to those findings. If the SAB decides not to implement an action, it will state the reason for that decision in the Annual Report.

4.9.1. Agreeing Improvement Action: The SAB will oversee the process of agreeing with partners what action they need to take in light of the SAR findings.

On receipt of the final report, the Board will:

- formulate a response to the findings and issues raised into improvement action. Improvement actions must be clearly communicated and achievable within timescales considered.
- Agree arrangements to publish the report on the County Council's Safeguarding Adults webpage / SSAB website and notify partner agencies, the Care Quality Commission, and the Chair of the Health and Wellbeing Board.

All relevant findings and agreed SAB actions will be shared with the Learning Lessons subgroup who will ensure these form part of the agenda of its next meeting in order to consider how the findings will be implemented and any specific activity planned. As a minimum this should include:

- the review of training competency frameworks and recommended content;
- the production and dissemination of a SAB practice briefing note for all agencies to highlight key messages for use within individual supervision and team/staff meetings (with support of the Comms subgroup). The practice briefing note will also be disseminated to training providers to ensure the content is included within / informs safeguarding adults training.

4.9.2. Practitioners responsibilities: anyone who works with Adults at Risk in Somerset should actively engage with the learning opportunities provided by SARs. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- reading SAB SAR publications;
- reading SAB SAR briefing notes;
- attending appropriate single and inter-agency training;
- contributing to staff and team meetings / supervision;
- supporting colleagues and staff in other agencies in implementing the learning from SARs.

4.9.3. Serious Case Reviews from other SABs: other SABs will regularly publish SARs which may contain valuable learning for Somerset. The SAB's SAR subgroup will review select SARs for consideration. The findings from each will be discussed and, where it is considered that the findings merit further consideration, will be identified/referred to the SAB for action.

5. Audits of multi-agency and single agency practice

The SAB will determine audits to be carried out in the following areas:

- organisational self-audits undertaken on an annual basis;
- Board effectiveness surveys undertaken on an annual basis;
- Themed collaborative audits targeting practice, impact and experience based around the 6 key principles of adults safeguarding;
- audits of single agency and multi-agency practice.

Audits are conducted by / fed into the SAB's Quality Assurance subgroup and reported to the SAB and its Learning Lessons subgroup with analysis and recommendations for action.

6. Other lessons learned activity

The SAB's Learning Lessons subgroup will also undertake lessons learned activity related to whole service safeguarding and individual safeguarding adults practice.

7. Dissemination and embedding learning in practice

The SAB is committed to ensuring the findings and learning lessons activity are effectively disseminated and embedded across all agency members of the SAB. The purpose of lessons learned activity is to make improvements in practice, thereby improving the experiences of adults at risk and preventing harm wherever possible.

7.1. Routes for dissemination of learning include:

- single and multi-agency training;
- SAB development days / annual conferences;
- local forums and networks
- SAB publications and briefings.

7.2. Activities to enable embedding learning into practice include:

- policy, procedure and practice guidance development;
- effective use of reflective practice and supervision;
- team/staff meetings.

7.3. Actions to be taken by all SAB partners:

- SAB partner agencies must ensure the content of training is regularly reviewed in order that it reflects and shares the learning from both local and other area SARs and lessons learned activity as disseminated via the SAB.
- SAB partner agencies will ensure that all training is consistent with the SAB competency framework and agreed content of training.
- SAB partner agencies will ensure they have undertaken activities to disseminate learning and assure that learning is embedded in practice.

Appendix 1

Safeguarding Adults Review (SAR)

Referral Form

The Somerset Safeguarding Adults Board SAR Subgroup will consider every referral on the basis of whether it meets the criteria for a Safeguarding Adults Review (see Section 4.1, SSAB Learning and Improvement Policy). The Subgroup needs as much information as possible to enable its members to make a proportionate decision as to how to respond to a case referral, ensuring, if the case is accepted for a review, that that maximum learning is achieved for the Safeguarding Adults Board. Please complete as much information on this form as possible and send for the attention of the Independent Chair of Somerset's Safeguarding Adults Board via: ssab@somerset.gov.uk

i. Referrer

Name:	
Title:	
Agency (where applicable):	
Address:	
Telephone number:	
Email address:	

ii. Senior Manager Authorisation (where applicable)

Name:	
Title:	
Telephone number:	
Address:	
Email address:	
Date referral authorised:	

iii. Adult at Risk and Person(s) Alleged Responsible to have Caused Harm or Neglect

Adult at Risk	
Name:	
Date of birth:	
Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
Agencies involved:	

Person(s) or Organisation(s) Alleged Responsible to have Caused Harm / Neglect	
Name:	
Date of birth:	
Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
Agencies involved:	

iv. Referral reason(s)

How does this case meet the criteria for a Safeguarding Adults Review? *(refer to the SSAB Learning and Improvement Policy, Section 4).* Please explain against each criterion.	
What learning do you think can be achieved through review of this case?	
Which agencies / services are / were involved in this case?	
Which agencies / services should particularly achieve this learning?	
What other learning / review processes have been followed? (please detail) What did they achieve? (please detail) How has that learning been disseminated? (please detail) What impact has it had? (please detail)	
Please detail any other relevant information that will enable the Safeguarding Adults Review Sub-group of the Somerset SAB reach a decision about how to respond to this referral.	

Appendix 2

SSAB Safeguarding Adults Review Process

This outline process is intended as a guide only, and follows a 'traditional' review process. The appointed Chair of the SAR can agree with the SAB Chair to vary this format where necessary.

Stage 1	**Initiating a SAR**	A SAR can be requested by any partner agency, the Coroner or the Secretary of State. All requests to be made in writing. Safeguarding Adults Review referral form completed and sent securely for the attention of the Independent Chair of the SSAB via ssab@somerset.gov.uk A threshold decision will be made within 1 month of receipt of the request by the SSAB Chair, with advice from the SAR Subgroup in assessing whether the criteria for a SAR have been met and the potential methodology to be utilised.
Stage 2	**Preparation for the SAR**	SSAB's SAR Subgroup to appoint a panel Chairperson and agencies involved in case to identify panel representatives. Standard SAR letter to be sent to Chief Executive or other nominated senior manager in all agencies/organisations who are to be invited to participate in the review. When the case under consideration involves a death, Coroner to be notified of SAR request and asked to confirm whether there is to be an inquest into the death. Where an inquest is planned, Coroner's advice to be sought re: appropriate timing of SAR. Agencies prepare an outline chronology of involvement (using Appendix 3 as a guide format for this process).
Stage 3	**1st Panel Meeting**	Primary purpose of first meeting is to establish in detail the Terms of Reference for the review, including key lines of enquiry for report writers. Agencies decide how to gather evidence.
Stage 4	**Preparation of agency reports (IMR)**	Report writers gather and evaluate evidence and prepare a report, using Appendix 4 as a guide format for this process. Panel representatives share reports with each other.
Stage 5	**2nd Panel Meeting**	Panel receives and discuss the report. Key findings identified and start to formulate recommendations.
Stage 6	**Preparing the Overview Report**	Panel Chair drafts overview report and recommendations. Agencies start to identify possible action points.
Stage 7	**3rd Panel Meeting**	Preparation of the final action plan.

		Agreement of the overview report and an executive summary for publication.
Stage 8	**SAB Meeting to receive and approve report and action plan**	Chair of panel to formally present the work of the review and recommend its acceptance by the Board; Panel Chair to address any questions raised by SSAB members. SSAB to agree plan for publication and implementation, including plans for disseminating learning amongst their contacts as appropriate. SSAB members expected to have read and critically analysed the Overview Report and Action Plan.
Stage 9	**Publication of the report and action plan**	Published (in full or as an Executive Summary) on SCC / SSAB website with links on partner organisations websites. Copies sent by SSAB to Chief Executives of all agencies or organisations who participated in the review or are responsible for implementing parts of the action plan. Comms / Learning Lessons subgroups to produce SSAB Practice Briefing Note for all agencies to highlight key messages for use within team meetings/staff supervisions. Also to disseminate to training providers to ensure content informs safeguarding adults training.
Stage 10	**Implementation of the SAR Action Plan**	Once action plan accepted by the SSAB, responsibility for monitoring its implementation is handed to its Learning Lessons subgroup who will monitor agency progress reports at each subgroup meeting. Chair of the subgroup to alert SSAB Chair to any implementation delays or issues; SAB chair will decide how to address these. Learning Lessons subgroup to produce a summary of progress on the implementation of all SAR Action Plans to be included in the published annual report. *SSAB to include the findings of any SAR in its Annual Report and outline what actions it has taken/it intends to take, in relation to them.*

Appendix 3

SOMERSET SAFEGUARDING ADULTS BOARD

Agency Chronology Proforma

Agency/Organisation:
Completed by:
Relating to: XXX Safeguarding Adult Review

Date / time	Agency / Practitioner	Source of evidence / info	Contact with individual	Contact with family / carer	Communication or meeting within agency or to another agency	Actions taken / Decisions made

Appendix 4

Individual Management Report (IMR) for Safeguarding Adults Review

Guidance

Each agency will identify an appropriately skilled person to prepare the agency report according to the Terms of Reference agreed for the SAR.

The report writer will not have had any direct contact with the situation under review, not have had any line management or other responsibilities for any of the professionals involved.

As the effectiveness of the review depends upon agencies' willingness to be open, it is important that the report writer has sufficient authority to consult all relevant agency records and seek the views of all relevant professionals.

Guidance notes for agency report writers

The person identified to write an agency's SAR report must have an appropriate level of experience and authority. It will be the responsibility of the agency's panel representative to instruct and liaise with the report writer.

The report writer must not have had direct involvement in the management of the situation under consideration or be an immediate line manager of those agency employees who were involved.

The sources of information and methods used in preparing the agency report must be agreed by the agency representative on the SAR Panel. The report writer will need to be fully aware of the Terms of Reference and of any questions specific to their agency.

It is essential that a range of methods are employed by the report writer and reports based solely upon a review of agency records are unlikely to be considered acceptable by the SAR Panel. The agency report will need to draw conclusions about why events developed in the way they did and this will require contributions from those professionals most closely involved.

In completing the report, the writer may wish to utilise some of the following methods (not an exhaustive list):

- Interviews with key individuals and/or their line managers;
- Discussions with a group of staff or a team
- Review of formal agency records
- Review of policy and practice guidance documents relevant to the agency.

Any interviews/meetings should be formally minuted.

All evidence sources used in compiling the report to be listed.

The report writer will also prepare a chronology of the agency's involvement with the vulnerable person(s) during the relevant time period (see Appendix 3).

Once complete, the agency report needs to be formally signed off by a relevant senior manager in the organisation. Once this has happened, the report will be shared with other agencies.

If information is gathered by means of an interview with staff members, they need to see and agree a set of notes from the interview prior to these being used in the report to ensure their information or views have been accurately recorded. However, individual staff **do not** have a right to challenge judgements made by the report writer. Staff interviewed should be made aware of the SAR process and how their information will be used. A copy of the guidance notes outlined in Appendix 5 should be given to them prior to any interview/formal discussion taking place. The

interviewer should ensure interviewees are able to contribute fully to the review, including their views about the lessons to be learned and improvements which could be made. They must also be made aware that if any information they provide indicates that a crime or registration branch/disciplinary offence may have been committed, this information will be forwarded to the appropriate agency to follow up.

It is the responsibility of the agency SAR panel representative and the report writer to present a full, open and honest analysis of their organisation's involvement with the vulnerable adult.

The reporting process must be conducted in a manner which encourages staff to be open, even when this involves criticism of their own or other organisations. This avoidance of defensiveness is essential if the Safeguarding Adults Review is to be effective in improving practice.

Format

Use the following headings when compiling your report unless you have a standard format for this type of report which covers the same areas.

Name of SAR

Name & address of Agency

Name of Agency Representative on SAR panel

Name of Report writer (if different)

Sources of evidence used in this report

Identify key findings and analysis of these using the questions from the terms of reference as headings

Any further issues to be considered by the SAR panel

Recommendations for the SAR panel to consider
Identify to which agencies these recommendations apply

Proposed actions to be taken by your agency
Please indicate if these are:

a) Changes to practice, procedure, or policy which do not need to await the end of the SAR i.e. which are specific to your agency and can be agreed by the relevant managers.

b) Changes to practice procedure or policy which will be co-ordinated with changes in other agencies.

Appendix 5

Guidance notes for staff being interviewed as part of a Safeguarding Adults Review

The purpose of a Safeguarding Adults Review (SAR) is to establish what can be learnt from a situation where a vulnerable adult has died or experienced significant abuse or neglect.

Safeguarding Adults Board must arrange a Safeguarding Adults Review (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 review will take place after any formal investigations have been completed.

Senior representatives of the organisations involved thoroughly examine the actions and decisions taken with a view to identifying areas for improvement and learning lessons.

To achieve this, it is essential that the views of those individuals most closely involved are understood.

Each organisation participating in the review is required to prepare a report about its involvement with the situation under consideration. The person chosen to prepare the report for your organisation has identified you as someone who can assist them in the learning process. They will have some specific questions to ask depending on the nature of the concerns, and you will have the opportunity to share your understanding about why events progressed in the way they did and whether you think anything could or should have been done differently.

For the review to be effective, it is important you feel able to be completely open and honest in sharing your opinions.

Any information and opinions you share with the report writer will be used in evaluating the effectiveness of your organisation's involvement. Before the report is finalised you will have an opportunity to check that what you have said has been recorded accurately. However, you will not be able to influence or veto any of the conclusions in the report. Any concerns about the content of the report should be discussed with the report writer in the first instance or with your line manager. You should do this without delay.

In order for learning form a SAR to result in positive change, organisations involved need to be publicly accountable. On completion of a SAR, the Safeguarding Adults Board publish a summary and action plan. Please be reassured that this is done in a fully anonymised way. No information identifying you personally will be available to the general public.

The report writer who interviews you should be able to answer any questions you may have about the SAR process or about your involvement in this specific review.

They will be aware of the anticipated timescale for the completion of the review.

Following the review your employer will make sure that you have a chance to see and discuss the outcomes.

Thank you for your cooperation with this process.

Appendix 6

SOMERSET SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review
Terms of Reference

Name of subject(s) of this review:

Name for this SAR:

Start date: *Date SAR agreed*

Target timescale for completion of SAR:

SAR request made by: *Agency name*

Date: *Today's date*

Summary of referral: *Referral reason*

Chairperson: *Name (agency / independent)*

Panel Members: *Name, Agency*

1.
2.
3.
4.
5.
6.

The terms of reference are to be used by each agency in the preparation of their individual management report (see Appendix 4).

The time period to be considered by this review is: *enter time period*

All agencies will use the standard format for the production of involvement chronologies and agency review reports.

All SARs will need to address the following overarching questions:

- What were the relevant agency policies and procedural guidance for this situation at the time?
- Were these followed by the professionals involved?
- Were there significant weaknesses in or gaps between the agencies policies?
- Were all appropriate professionals involved?
- How effective was communication between the involved parties?
- To what extent were professionals aware of and influenced by the wishes of the vulnerable person and their carers?

This review will also address the following specific questions:
- *Add any additional questions to be addressed relevant to the SAR in question*

The meeting and reporting dates proposed for this review are as follows:

- 1st Panel Meeting *Add date*
- Submission of agency reports to Panel Chair *Add date*
- 2nd Panel Meeting *Add date*
- Distribution of draft Overview Report and recommendations *Add date*
- 3rd Panel Meeting *Add date*
- SAB Meeting for presentation *Add date*

SAB approval meeting

If the period from the date of decision to hold a SAR to the SAB approval meeting exceeds the 6 month target, please record the reason for this.

Any difficulties envisaged or encountered in meeting reporting timescales are to be discussed with the Panel Chair as soon as possible.

Communication Plan

The following communication arrangements have been agreed by the review panel:
(to include subject of a review/relatives/press enquiries/FOI requests etc)

Appendix 7

SAR Overview Report

The SAR overview report is written by the Panel chair.

Its purpose is to summarise the key issues from the referred case, identify the findings arising from the agency reviews and the subsequent discussion during the second panel meeting and to propose a set of recommendations from which the agencies will propose actions.

The report should include the following:
1) An executive summary which will be used for publication
2) A brief outline of the referred case
3) An analysis of the key themes arising from the panel discussions
4) A list of agreed findings of fact
5) A set of recommendations for action.

The report is considered in draft form during the third panel meeting and amended as needed. The agreed version of the report is then submitted to the SAB with the proposed action plan.

SAR Recommendations

- Effective recommendations need to result in achievable actions. Such actions need to contribute to enhancing the safety of vulnerable adults and therefore should be well targeted.

- The number of recommendations for changes in practice, procedures, guidance etc should be kept to a minimum in order to ensure their effectiveness.

- It is essential that all recommendations are proportionate to the findings upon which they are based.

- All recommendations proposed must be derived from and be explicitly linked to evidence accepted by the review as summarised in one or more of the findings.

- Not all findings need to result in a recommendation.

- Consideration needs to be given to the scope of any recommendations. Some will have only local e.g. single service implications. Others may require formal representation to national bodies to government.

- The framing of recommendations needs to bear in mind what the desired outcomes will be from effective implementation.

Appendix 8

SAR Action Plan

The action plan arising from the review will need to identify in clear and measurable terms:

1) What each agency proposes to do in response to each applicable recommendation
2) Who will be responsible for each action
3) A timescale for the completion of each action
4) The desired outcome from effective implementation of the actions
5) Each participating agency will identify how it plans to share learning among its own employees, with services it commissions and with the users of its direct services.

The SAB itself may wish to accept responsibility for some aspects of this dissemination of learning, via its Learning Lessons and Comms subgroups.

As part of its annual report, the SAB will need to comment upon how effectively learning from SCRs has been disseminated.

Monitoring of SCR action plans will be undertaken by the Learning Lessons sub-group on behalf of the SAB.

The sub-group will provide the Board with progress reports at agreed intervals and highlight any notable areas of progress or delay.

The monitoring of implementation will involve requesting reports from agencies about what progress they have made as well as conducting focused audit exercises.

One year after the completion of a SAR the sub-group will provide the Board with a report on the effectiveness of implementation. The Board will make this information public as part of its annual report.