Northamptonshire Safeguarding Adults Board

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

A Local Protocol for Requesting and Conducting a Safeguarding Adult Review in accordance with Section 44 Care Act 2014

Version 2.6 last reviewed	January 2017
Version 3 re-draft - reviewed by SAR Sub Group	6th November 2018
Version 3.1 reviewed at SAR Sub Group	5th February 2019
Version 3.1.2 updated following discussion at Extraordinary SAR Sub Group	13th March 2019
Version 3.1.2 revised and approved by SAR Sub Group	4th June 2019
Version 3.1.2 ratified by Board	4th July/24th July 2019
Next Review	January 2021

CONTENTS

Acknowledgements, context and local references

This protocol has been extensively revised since the Board's initial Safeguarding Adults Review protocol was first published in 2015 which was based on the existing SCR policy first published in 2009.

It should be read in conjunction with both the Northamptonshire Safeguarding Procedures
http://www3.northamptonshire.gov.uk/councilservices/adult-social-care/safeguarding/Documents/NSAB%20Inter-Agency%20Policy%20V2%200.pdf

Northamptonshire Safeguarding Adults Board (NSAB) would like to acknowledge the assistance given by protocols from the London Boroughs of Camden; Richmond, Tower Hamlets and Wandsworth.

1. INTRODUCTION

1.1 Section 44 of The Care Act 2014[1], requires that Safeguarding Adult Boards (SAB) are responsible for Safeguarding Adult Reviews (SAR). Paragraphs 14.162 to 14.179 of the Care and Support Statutory Guidance[2] sets out in more detail the principles, definitions and outlines a framework for when certain events happen.

1.2 The SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. The specific criteria are set out in paragraph 4.2 and on Form A - Appendix 1 of this document.

1.3 The NSAB is free to arrange for 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.

1.4 The adult who is the subject of the SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them. If they are able and chose to, they should be fully involved throughout the process (see Section 10 below).

1.5 This SAR Protocol has been developed by the Northamptonshire SAB to support the effective identification of and response to SARs within the County and to support the Board in discharging its statutory duty. The Protocol describes the process to follow, and is informed by the statutory text and complements the County's Safeguarding Policy.

1.6 It is important to stress that a SAR is not a 'second stage' safeguarding process and is usually reserved for the most significant of issues.

2. SAFEGUARDING ADULT REVIEW OPERATING FRAMEWORK AND GOVERNANCE

2.1 Northamptonshire Safeguarding Adults Board (SAB) has the lead responsibility for carrying out a Safeguarding Adult Review (SAR) based upon receipt of a referral (see below within the relevant section and within the appendices for supporting documentation).

2.2 NSAB has delegated management of this responsibility to one of its Sub Groups, the Safeguarding Adult Review Sub Group (hereafter referred to as the "Sub Group") chaired by an agreed[1] member of NSAB. The Sub Group membership is made up of the statutory members of the SAB (the Council, Police and Clinical Commissioning Group), with specific Terms of Reference that are annually reviewed. It reports to the SAB. The Chair of NSAB also attends.

2.3 The Sub Group meets on a planned basis throughout the year, but a meeting will be convened as soon as is practical upon receipt of a referral or an ongoing basis to act as a co-ordinating group to any SARs in progress.

1 http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse- or-neglect/enacted

2 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

3. PURPOSE OF A SAFEGUARDING ADULT REVIEW

3.1 The purpose of a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an enquiry into how an adult at risk died nor is it to apportion blame; but to learn from such situations, and that those lessons are applied to future cases to prevent similar harm occurring again.

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

3.3 It will be highly likely that a safeguarding process will have been followed in relation to the circumstances. The SAR is for consideration of the most serious issues, and will not be an alternative to a safeguarding enquiry, investigation or process.

3.4 The purpose of conducting a SAR is to:

- Establish whether there are lessons to be learnt from the circumstances of the case, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi- agency and those of individual organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- It is acknowledged that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these, but it does remains a statutory requirement in its own right and will be complemented by other such processes.
- Where there are possible grounds for other review processes to be activated (e.g. Domestic Homicide Review, Child Serious Case Review, Health Serious Incident) a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair, with a final joint report being taken to all the relevant review commissioning bodies. However it must be remembered a SAR is a statutory requirement and will be required to be undertaken as much as other processes.

4. CRITERIA FOR SAFEGUARDING ADULT REVIEW

4.1 In summary, the SAB has the lead responsibility for arranging and conducting a SAR and **must** do so 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.
- If the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

4.2 "*Serious abuse or neglect*" may include where:

- the individual would have been likely to have died but for an intervention.
- the individual suffered permanent harm as a result of abuse or neglect.
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect;
- the individual has sustained a potentially life threatening injury through abuse or neglect,

4.3 The SAB **<u>may</u>** also consider a SAR in other specific circumstances outside of the statutory requirement, including where, for example:

4.3.1 A case 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.

4.3.2 A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

4.4 Any agency or professional body, together with the Coroner, may refer such a case to the SAB seeking a SAR to establish if there are important lessons for inter-agency work to be learnt from any given case. (For how to make a referral see Appendix 1).

4.5 Specifically, Section 44 of the Care Act 2014 states:

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)."*

5. REQUESTING THAT A SAFEGUARDING ADULT REVIEW BE UNDERTAKEN (REFERRAL)

5.1 Any agency, individual or professional may consider that a case meets the criteria for a SAR and request that one be undertaken. This includes members of the public and family and friends of the individual. It is expected that any request by a professional is first considered by the agency or organisation for whom the professional works, and that the most senior manager or their SAB representative makes any formal referral. (The prospective referrer may find it helpful to discuss the issue with Council's Head of Safeguarding and Professional Standards, or Designated Nurse Adult Safeguarding in the first instance). In all cases, it is expected that the criteria in Section 4 is fully considered before making any referral.

5.2 It is important to note the NSAB will only consider cases *"in its area"* as per Section 44 of The Care Act. In practice this means it will consider cases that relate to people residing within the County Council area (which includes people who have been placed by other Local Authorities or Clinical Commissioning Groups in Northamptonshire). Should a person placed by a Northamptonshire Clinical Commissioning Group or Northamptonshire County Council in another area be the subject of circumstances that would be a SAR, then it would be for the SAB of that local area to carry out and oversee a SAR. In such circumstances, Northamptonshire agencies may have to make the relevant approach or referral to the SAB of the relevant area.

5.3 The formal referral to the SAB should be made using the Referral form in Appendix 1 to the Chair of the Sub Group. Details for submission are set out on the form in Appendix 1.

5.4 Upon receipt of a SAR referral the Chair of the Sub Group will review the information against the criteria and will agree to convene the Sub Group to consider the merits of the referral, and the appropriate methodology to follow.

5.5 In deciding whether a referral should progress to a SAR, the Sub Group will invite the referrer to the Sub Group meeting to present their completed referral, allowing the Sub Group to clarify matters as required.

5.6 If the issue under consideration is also the subject of a Police investigation or judicial process, then the SAR Sub Group will need to be advised or will seek to identify this before considering the next steps. Equally where an issue triggers a mandatory investigation or review within an organisation (e.g. NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. In all such cases, legal advice may be appropriate to guide the decision making.

6. DECIDING TO UNDERTAKE A SAFEGUARDING ADULT REVIEW

6.1 The SAR Sub Group remains responsible to the SAB. The Chair of the SAB has ultimate responsibility for deciding whether or not to conduct a SAR.

6.2 Once a referral is received, considered **and the Sub Group agrees** that a SAR should be instigated; the Chair of the Sub Group will notify the SAB Chair of the recommended actions that should then follow, including the proposed or recommended methodology (see Section 7). This decision to proceed (or not) will be made ideally within 14 days but no later than one month. In all situations the notice of the referral and the decisions that follow will be raised at the next SAB and recorded.

6.3 If the recommendation of the Sub Group is **not to proceed to a SAR**, the sub- group may consider whether to request an alternative review or a smaller-scale audit of agency involvement. In such cases, arrangements should be made for the agency to share relevant findings with the Sub Group or other appropriate body. The SAB Chair will be notified of the referral and sub group decision.

6.4 **If the Chair of SAB does not agree with the recommendation** of the SAR Sub Group (proceed or not proceed), a meeting should be convened with the Chair of the Sub Group to try to resolve the issue as a matter of urgency. If necessary, a special meeting of the full SAB should be convened to make a final decision.

6.5 Whatever the ultimate decision, the referrer should be notified by letter from the Chair of the Sub Group, within a reasonable time scale. If the SAR is not to proceed, then the letter should outline the reasons for the decision.

6.6 All such decisions and actions, including those that are taken by the Sub Group or a convened SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability – see Care Act Statutory Guidance and Multi-Agency Safeguarding Adults Policy and Procedures for more details).

6.7 Once a confirmed decision has been made to instigate a SAR, the Care Quality Commission will be notified by the Chair of the Sub Group.

6.8 If the referrer (including family referrers) disagrees with the decision not to proceed they can ask the Chair of the SAB to review the decision. If a referrer is still unhappy with the outcome, the Chair of the NSAB can ask a Chair of another SAB in the regional group to review the decision made. There is no further appeal.

7. ELECTING THE MOST APPROPRIATE METHODOLOGY FOR THE CASE IN QUESTION

7.1 Once it has been agreed to commission a SAR, the most appropriate methodology to use should be considered. Different methodologies will suit different types of circumstances. These can range from facilitated learning events over a day or two, through to formal panel-led over-arching type of enquiries carried out over a period of time. The choice of methodology is therefore significant and must be appropriate and proportionate to the case under review. The Care and Support Statutory guidance indicates that, whichever methodology is employed, the following elements should feature:

a. **SAR Panel Chair/ Lead/ Facilitator,** that is independent of the case under review and of the organisations whose actions are being reviewed. They should have the appropriate skills, knowledge and experience, which will include:

- Strong leadership and ability to motivate others;
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics;
- Good analytical skills using qualitative data;
- A participative and collaborative approach to problem solving;
- Adult safeguarding knowledge and experience; and
- Commitment to/ promotion of open and reflective learning cultures.

b. **SAR Panel of relevant and nominated people** who will contribute to and scrutinise information submitted, in the form agreed. The panel size should be proportionate to the nature and complexity of the review.

c. **Clear Terms of Reference,** setting out what is the focus and scope of the SAR (and where appropriate, what is not within scope); times frame within which the SAR will focus; roles and expectations and outcomes required. (See Appendix 6).

d. **Early discussions with the adult and their family/ carers** to agree to what extent, how they wish to be involved and to manage expectations. This includes access to independent advocacy if required (See Section 10).

e. **Appropriate involvement of professionals and organisations who were working with the adult** so they can contribute their perspectives without fear of being blamed for actions they took in good faith (See Section 11).

f. **A final report and recommendations,** which effectively sets out the specific and wider learning considerations (See Appendix 7).

7.2 Whatever methodology is used it must be proportionate to the specific circumstances of the individual case. It should however, provide the most effective learning mechanism and best enable the involvement of key agencies and staff as well as those who are connected to the person (e.g. family etc.). It must however, be balanced against the cost, resources and length of time required to conduct the review and the subsequent outcome required.

7.3 Each methodology is valid in its own right and no approach should be perceived as more significant or holding more importance or value than another. In deciding upon a methodology, consideration should be given to the following key determinants:

- Is the case complex, involving multiple abuse types and/ or victims?
- Is significant public interest in the review anticipated?
- What level of staff/ family involvement is wanted/ appropriate?
- Are any criminal proceedings on going that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained lead reviewers available in-house or nationally for the method selected? Are resources available to train or commission a lead reviewer?
- Can value for money be demonstrated?
- Is the right person available to lead the type of preferred methodology
- How the right person to lead the SAR will be identified and agreed

8.1 DIFFERENT METHODOLOGY OPTIONS AND CONSIDERATIONS FOR A SAFEGUARDING ADULT REVIEW

8.1 The suggested different types of methodologies that could be utilised are set out below. This is not a prescriptive or exhaustive list but offers a range of options that could be matched to different presenting circumstances. Alternatives, based upon the collective experience of the Sub Group and SAB should also be considered as appropriate.

8.2 When a referral is considered by the Sub Group, they should also consider the most appropriate methodology and include this in any recommendation about the SAR's merits to the SAB Chair.

8.3 There are broad considerations prior to initiating a SAR. Some of these may feature in the initial decision making and some will feature in more detail in the actual carrying out of the SAR. These include, but are not limited to:

- The level of independence that is required of people who will be involved in the SAR (and who may be possible Panel Members and who may be involved in writing any reports or developing any agency analysis for the process);
- Level of independence required of the SAR Chair (e.g. representative from another agency, external consultant etc.);
- The broad Terms of Reference for the SAR (see Appendix 6 for a template) including timescales for completion and how learning from the SAR will be disseminated and embedded;
- The required output from the SAR; and
- Whether an independent author is required, and level of independence.

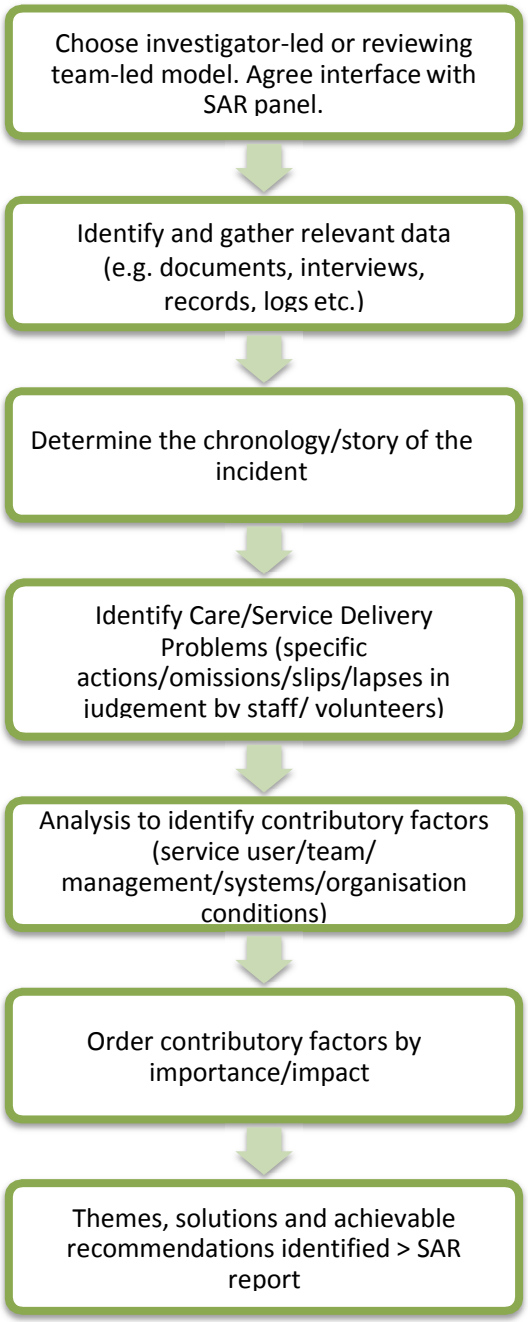
OPTION A: Traditional SCR Approach

Key features:

- ✓ Independent Chair/Author
- ✓ Formal panel
- ✓ Single agency Individual Management Reports (IMRs)
- ✓ Individual and Integrated chronology
- ✓ Staff/ adult/ family involved as agreed
- ✓ Provides analysis of what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
• More familiar to SAB/stakeholders, who may consider it more robust/objective; • Brings a strong level of independence and scrutiny; • Public/political confidence is more likely to be assured via a tried and testedapproach; • Particularly useful where there is multiple abuse, or high profile cases/serious incidents; • Methodology usually reflects that of Children SCRs/Domestic Homicide Reviews (DHR); and • Composite action plan offers clear governance of implementation of necessary practice and system changes.	• Perceived as overly bureaucratic; • Structured process may mean it's not light-touch; • Protracted-implementation of lessons learnt/recommendations may not be sufficiently responsive to time considerations; • Can be costly - costs may notjustify the outcomes; • Can be perceived punitive, attributing blame which is not the focus of a SAR; • Frontline staff often feel/are precluded, so disengagement from process and subsequent learning; and • Family involvement could be problematic unless thought through at the outset.

NB Where other statutory reviews, such as a child SCRs or Domestic Homicide Reviews (DHR) overlap with an adult safeguarding review, consideration should be given to the most appropriate methodology to achieve joint outcomes and avoid duplications of process



OPTION B: Systems Analysis

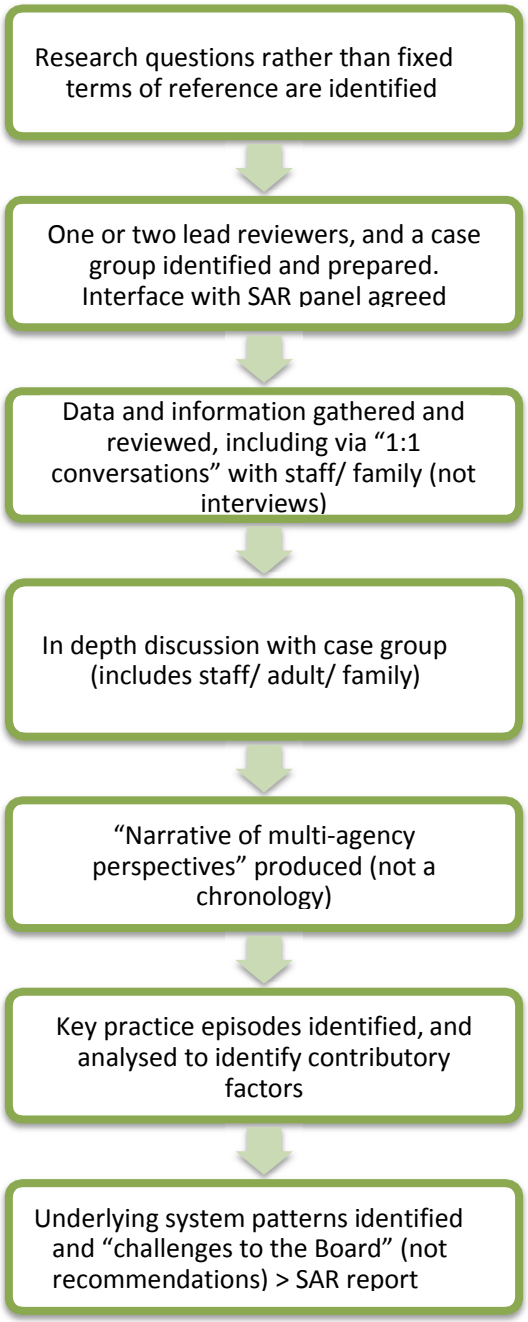
Key features:

- ✓ Team/ investigator led
- ✓ Staff/ adult/ family involved via interviews
- ✓ No single agency management reports
- ✓ Integrated chronology
- ✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
• Structured process of reflection; • Reduced burden on individual agencies to produce management reports; • Analysis from a team of reviewers may provide more balanced view; • Managed approach to staff involvement may fit well where criminal proceedings are ongoing; • Enables identification of multiple causes/ contributory factors and multiple causes; • Range of pre-existing analysis tools available; • Focusses on areas with greatest potential to cause future incidents; • Based on thorough academic research and review; and • RCA tried and tested in healthcare and familiar to health sector SAB members.	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions; • Staff/family involvement limited to contributing data, not to analysis; • Potential for data inconsistency/ conflict, with no formal channel for clarification; • Unfamiliar process to most SAB members; • Trained reviewers not widely available; • Structured process may mean it's not light-touch; and • RCA may be more suited to single events/ incidents and not complex multi-agency issues.

Available models:

Vincent et. al. (2003) Systems analysis of clinical incidents: the London Protocol Woloshynowych et. al. (2005) Investigation and analysis of critical incidents NHS National Patient Safety Agency (NPSA) Root Cause Analysis



OPTION C: Learning Together

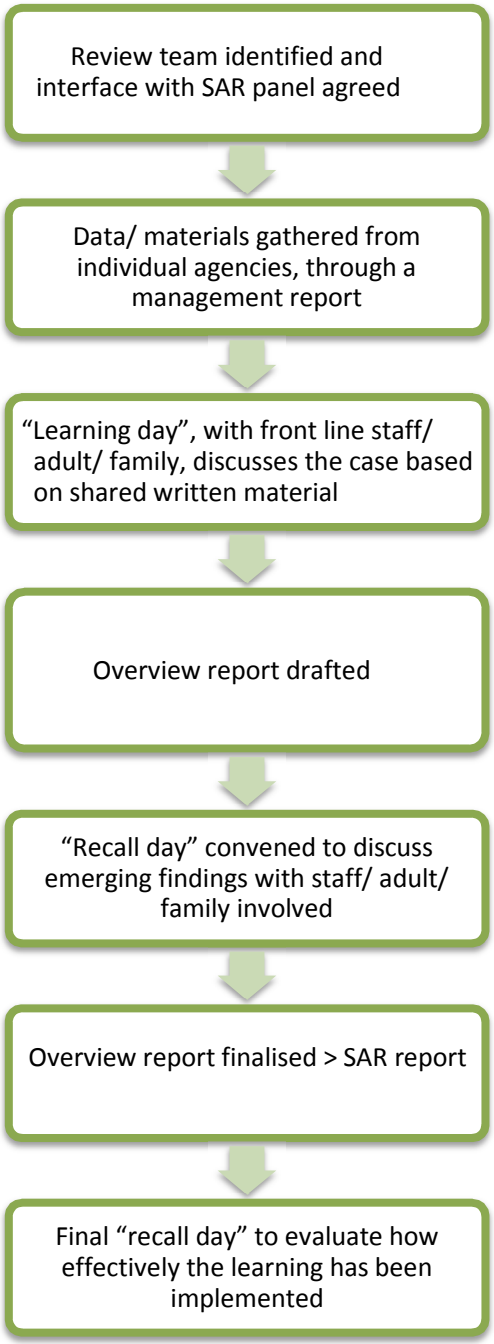
Key features:

- ✓ Lead reviewer led, with case group
- ✓ Staff/ adult/ family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; no chronology
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages	Disadvantages
• Structured process of reflection; • Reduced burden on individual agencies to produce management reports; • Analysis from a team of reviewers and case group may provide more balanced view; • Staff and volunteers participate fully in case group to provide information and test findings; • Enables identification of multiple causes/ contributory factors and multiple causes; • Tried and tested in children's safeguarding; • Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity; and • Range of pre-existing analysis tools available.	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions; • Challenge of managing the process with large numbers of professionals/ family involved; • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses; • Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR; • Opportunity costs of professionals spending large amounts of time in meetings; • Unfamiliar process to most SAB members; and • Structured process may mean it's not light-touch.

Available models:

SCIE, Learning Together



OPTION D: Significant Incident Learning Process

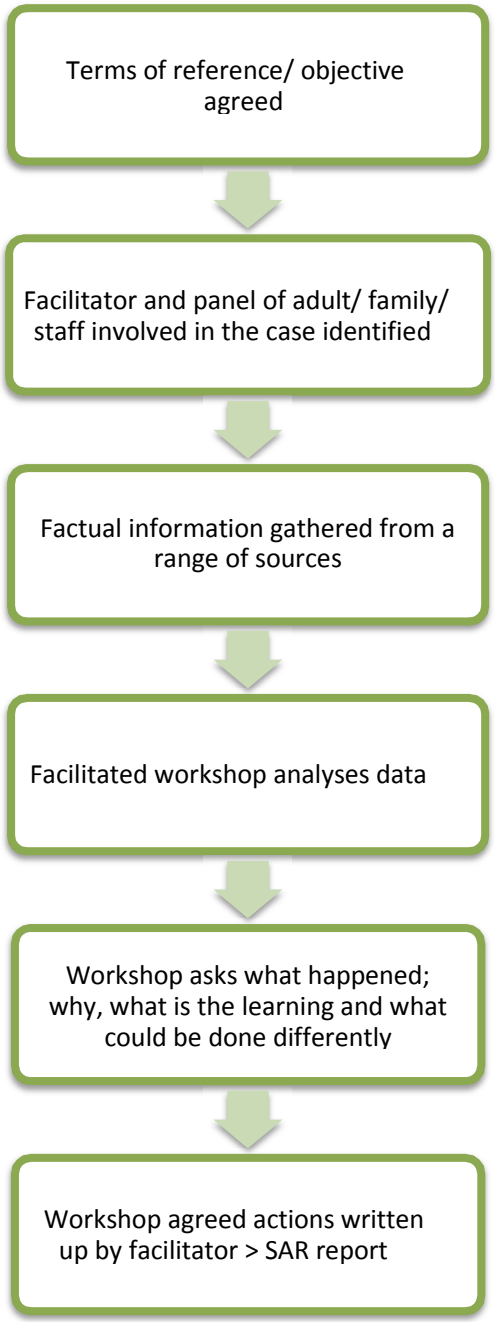
Key features:

- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

Advantages	Disadvantages
• Flexible process of reflection – may offer more scope for taking a light-touch approach; • Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants; • Has similarities to traditional SCR approach, so more familiar to most SAB members; • Agency management reports may better support single agency ownership of learning/actions; and • Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity.	• Burden on individual agencies to produce management reports; • Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR; • Opportunity costs of professionals spending large amounts of time in learning days; • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses; and • Not been widely tried or tested, nor gone through thorough academic research/review.

Available models:

Tudor, Significant Incident Learning Process



OPTION E: Significant Event Analysis

Key features:

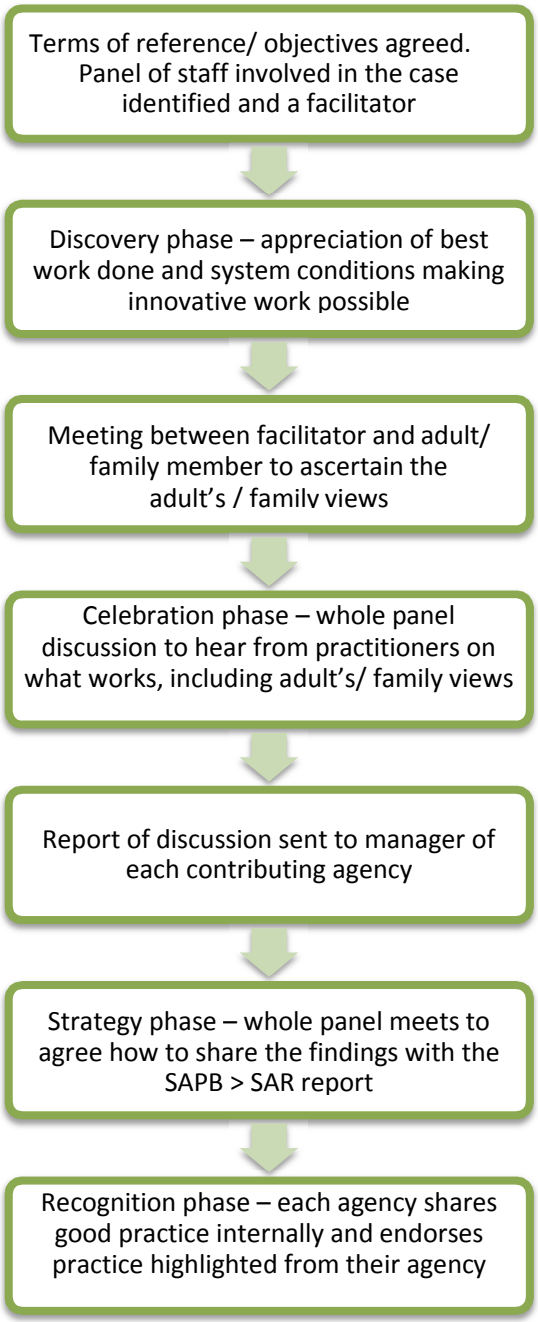
- ✓ Group led (via panel), with facilitator
- ✓ Staff/ adult/ family involved via panel
- ✓ No chronology
- ✓ No single agency management reports
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourage reflection and change

Advantages	Disadvantages
• Light-touch and cost-effective approach; • Yields learning quickly; • Full contribution of learning from staff involved in the case; • Shared ownership of learning; • Reduced burden on individual agencies to produce management reports; • May suit less complex or high-profile cases; • Trained reviewers not required; and • Familiar to health colleagues.	• Not designed to cope with complex cases; • Lack of independent review team may undermine transparency/ legitimacy; • Speed of review may reduce opportunities for consideration; • Not designed to involve the family; and • Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.

Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis Care Quality Commission, Significant Event Analysis

Royal College of General Practitioners, Significant Event Audit



OPTION F: Appreciative Enquiry

Key features:

- ✓ Panel led, with facilitator
- ✓ Staff involved via panel
- ✓ Adult/ family involved via meeting
- ✓ No chronology/ management reports

- ✓ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Advantages	Disadvantages
• Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days; • Staff who worked on the case are fully involved; • Shared ownership of learning; • Effective model for good practice cases; • Some trained facilitators available; • Well-researched and reviewed academic model; and • Model understood fairly widely.	• Not designed to cope with 'poor' practice/ systems 'failure' cases; • Adult/ family only involved via a meeting; • Speed of review may reduce opportunities for consideration; and • Model not well developed or tested in safeguarding. Minimal guidance available

Available models:

Julie Barnes, A new model for learning from serious case reviews

Newcastle Safeguarding Children's Board, Appreciative Inquiry Champions Group

9. INITIATING AND CONDUCTING A SAFEGUARDING ADULT REVIEW

9.1 As soon as it has been established and agreed **that a SAR should take place** the Sub Group will need to consider which agencies should be involved, especially as some may not be immediately obvious. In doing so the Sub Group will use its best endeavours to identify the agencies that should be approached and the process by which it will do so.

In instigating the SAR process, the Chair of the Sub Group, will, on behalf of the SAB:

9.1.1 Write to the Senior Accountable Officer[3] of each statutory partner involved (copying in their SAB representative/Safeguarding Adult lead) advising them that a SAR is being undertaken and the agency's SAR Sub Group member will be asked to be a representative for the SAR Panel. However, if the Sub Group member has direct involvement in the case, they will be asked to nominate a colleague for Panel who has had no direct involvement.

9.1.2 Confirm any specific actions required of the agency in preparation for the SAR (depending on which methodology is being followed) such as the need to prepare for any Individual Management Review (IMR) using Letter A (see Appendix 5). The templates for completing the chronology and the analysis components of the Individual Management Review (see Appendix 3) will conveyed to the agency.

9.2 As part of the considerations for commencing a SAR, the Sub Group will take the lead responsibility for identifying and appointing an appropriate Independent Chair of the SAR Panel with sufficient standing and expertise, ensuring there is no conflict of Interest.

9.3 Depending on the methodology being used, the Chair could be a SAB Member, or an appropriate senior manager from a partner organisation who will have oversight of the SAR process. If a full SAR methodology with IMRs is being instigated, it is likely the Chair will be specifically appointed for this purpose.

9.4 The Independent Chair, in conjunction with the Sub Group will:

- Draft the Terms of Reference for the SAR, including the period for which the SAR will focus;
- Confirm which partner agencies should be part of the SAR Panel;
- Consider how the adult at risk (where he or she has survived) will be supported and involved in the SAR process;
- Confirm how relatives, family or friends will be involved in the SAR and who will act as liaison and support to them;
- Confirm arrangements for any on-going support (e.g. legal support);
- Agree the outline communication plan that will be necessary during the SAR process and at the conclusion of the SAR, ensuring that a communication strategy is in place, with clear leadership and co-ordination;
- Agree the final product that will be produced and how it will be presented to the SAB;
- Propose how any learning from the SAR should be implemented;
- Propose how the SAR should be published, taking account of factors that may emerge throughout the process; and
- Agreeing how the Independent Chair raises any issues that arise as part of the process and with who.

3 The "Senior Accountable Officer" is an organisation's most senior manager (e.g. Chief Executive and/or Board representative)

9.5 All agencies represented on the SAB, must be aware of the criteria for implementing a SAR as set out above. The SAB members commit to their agency being involved in any SAR if their professional role can add value to the process. Safeguarding arrangements as required under the Care Act do require agencies to co-operate.

10. INVOLVING THE PERSON, THEIR FAMILY AND/OR RELATIVES

10.1 Involving the adult at risk (if they have survived) and/or their family are significant to the SAR process, whichever methodology is used. The purpose of a SAR and the process it follows will be unfamiliar for the 'adult at risk' and/or their family, adding to their distress and inevitable concerns. It will be a very sensitive time for everyone and consideration should be given at an early stage as to how this will be done; the ongoing identified support to those involved (how and who will provide it) with timely discussions taking place with the family or adult at risk, as to how the process will work, how they want to be involved and the type of outcomes that are likely from a SAR in general.

10.2 If the relative(s) to be involved is considered an 'adult at risk', consideration must be given to the support they require in terms of a representative or advocate.

10.3 Specific consideration should be given as to how to involve the 'adult at risk' (if they have survived) so they are as involved in the process as far as they want to be, involving advocates as appropriate. If the 'adult at risk' has capacity to consent, and allows for family (or friends) to be involved in the SAR, they will be invited to contribute their views. However, they should be made aware that a SAR is not about apportioning blame but is a review of agency functioning through which people are encouraged to reflect critically about their practice which translates into change and improved practice and working.

10.4 The 'adult at risk' may need a worker and/or advocate supporting them through the process; where relevant, appropriate communication with the worker and/or advocate will need to be considered. This will include informing them of the SAR and, if they are not SAR Panel members, sharing the outcomes in a way they wish for them to share.

10.5 The involvement and engagement of the family, relatives or the person who is the focus of the SAR should be central to the writing of the report. They may wish to be involved, for example, in shaping the Terms of Reference, how the person who is subject of the SAR is referred to in the report, and to review the final report prior to publication. In order to make this happen in a clear and open way, the family will be kept updated with the progress of the SAR, and will be invited to a meeting(s) with the Independent Author and/ or the NSAB Board Business Manager or NSAB SAR Sub Group Chair to review a paper copy of the final report. To ensure clarity around the final version of the report, it will be shared electronically with the family on publication.

10.6 Throughout the whole process due diligence, compassion and appropriate support must be provided and the Council's relevant community/locality team will provide this or an alternative should be arranged if that is more appropriate.

10.7 Should a family member be an adult at risk but also the perpetrator of the abuse, the SAR Panel will need to consider involvement of the individual in the SAR process.

11. SUPPORTING STAFF AND OTHERS INVOLVED IN THE SAFEGUARDING ADULT REVIEW PROCESS

11.1 As soon as a SAR has been agreed, staff and others that have had involvement in the case should be notified of this decision by their agency, as well as the role they wish their staff to play in the review. The nature, scope and timescale of the SAR should be made clear at the earliest possible stage to staff, others and their line managers. It should be made clear that the review process can be lengthy.

11.2 Enabling and supporting staff who have been involved in a case that is subject of a SAR and to encourage they share their views on the case as appropriate, is a key to the agency reviewing their organisational involvement and collating the required information. It enables the best way possible to determine information about the situation and circumstances of the case in question, enables a much richer review of the agency's involvement and ensures staff feel involved and therefore more able to implement recommendations and actions that subsequently follow.

11.3 All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so real learning and improvement can happen.

11.4 Agencies are responsible for ensuring their own staff, volunteers and others are provided with a safe environment to discuss their feelings and offered support where and as needed. The death or serious injury of an adult at risk will have an impact on staff and others and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

11.5 At the conclusion of the SAR, each agency should consider the best way to involve staff and others in disseminating learning that has been identified, and to ensure oversight of practice that subsequently changes. It is also important to note that staff who may not have been directly involved in an issue that becomes a SAR may well have learning to consolidate from a SAR's outcome. This equally applies to the agency who may not also not have been directly involved but where disseminated learning is still required.

12. PROFESSIONAL CONDUCT ISSUES

12.1 This section must be read in conjunction with the Northamptonshire Safeguarding Procedures.

12.2 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR panel to deal with these.

12.3 Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

13. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

13.1 There will always be a final report with recommendations arising from a SAR, irrespective of the methodology used to undertake the review. The complexity and proportionality of the report will be matched the issues in question.

13.2 The SAR Panel Chair must ensure that there is sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR panel should form the basis of any SAR report, to be produced by the nominated author.

13.3 The final report should always be produced as soon as is practical at the conclusion of the SAR process. The SAR panel should receive and agree the draft report before it is presented so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented. However, it should be understood the lead person for the SAR is the person that should have final editorial oversight. If there are issues arising that are contentious, and full agreement to the final report is an issue, then the Chair of the SAR Sub Group should be engaged to enable an appropriate way forward.

13.4 Final reports (including an Executive Summary, recommendations and any agency action plans) will be presented to the SAR Sub Group ahead of any SAB meeting, to consider the issues and resulting recommendations seeking clarification on any issues as required. Any outstanding issues or resolution will be confirmed. The final agreed report, with a resulting Composite Action (developed by the SAR Sub Group) will then be presented to the next SAB

13.5 A sample report template is provided in Appendix 7.

14. PUBLISHING REPORTS

14.1 The SAB recognises collective responsibility, open and transparent governance and the need for evolved learning. However, considerations of reputational risk or national learning arising from the case may affect decisions as to how the report is published. The SAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the SAB webpage, which at present is part of the Council's website. Agencies and SAB members can provide the relevant links as required. This will be kept under review.

14.2 The Chair of the SAB will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with prevailing Information Sharing Agreements, the Data Protection Act, GDPR, Information Governance arrangement and other legal requirements.

14.3 The Care Act requires the SAB to publish the findings of any SAR in its annual report, recognising the interests, transparency and disseminating learning but doing so within the legal parameters of confidentiality, setting out how learning will be implemented. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report[5].

14.4 Any reports to be published must be fully anonymised. However, in doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised nomenclature.

14.5 The SAB will consider seeking legal advice on a case by case basis before the publication of a SAR, particularly with regards a request from family not to publish.

15. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

15.1 The real value of a SAR is to ensure that the relevant lessons, specific or wider learning, are understood, the impact considered, addressed and consolidated into improved working arrangements within and across all services supporting adults at risk at risk and that multi-agency safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

15.2 The SAR Sub Group will be responsible for ensuring the development of a Composite Action Plan (see Appendix 8) to ensure identified report recommendations are fully set out, prior to presentation to the SAB.

15.3 Once a report and its recommendations have been confirmed by the SAB the Sub Group will retain oversight of implementation of the recommendations, with updates to the SAB as necessary. Agencies (either directly involved, or those who will benefit from the wider learning) will need to ensure actions are implemented updating the Sub Group on progress/achievement so the Composite Action Plan is effectively monitored.

15.4 In addition to SARs that are conducted by the NSAB, it will be as important to learn from SARs conducted by other SAB areas more generally, but especially where they relate to a Northamptonshire person whose services have been commissioned in another local authority area, or where any Northamptonshire provider or agency is involved. This is to ensure that the NSAB does everything possible to prevent similar issues occurring in its area.

[5] Section 14.177-14.179 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

16. SUPPORTING AND RESOURCING SAFEGUARDING ADULT REVIEWS

16.1 The SAB has to take a lead role in supporting the SAR process, supporting the setting up of the SAR Panel and supporting the SAR Sub Group in ensuring the right resources are made available to respond to this statutory requirement. This could include, but not limited to, budget to hire an independent chair or facilitator, additional capacity to facilitate all necessary actions, reports and writing of the report and support to relatives or people at the focus of the SAR in terms of advocacy or personal representatives.

16.2 A recommended amount will be suggested for SARs in each financial year and budgeted accordingly in the NSAB budget. Should additional funding be required for SARs, the statutory partners will agree the appropriate level of funding required.

16.3 Whilst recognising the challenges that all agencies are under in terms of resource constraints, this cannot impede the delivery of this statutory requirement.

17. SUMMARY OF GROUP RESPONSIBILITIES

Responsibilities of the Safeguarding Adult Review Panel

17.1 In addition to the more detailed issues set out within this Protocol, the SAR Panel will have specific responsibility for agreed activity and actions.

17.2 The SAR Panel, under the leadership of the Independent Panel Chair, will lead the review of the circumstances and issues surrounding the matter referred for SAR, using whatever methodology has agreed.

17.3 The SAR Panel is made up of a minimum of a nominated Chair, supported by the Safeguarding Board Co-ordinator (or agreed alternative) representing the SAR Sub Group and a dedicated Business Support Team Member along with key individuals who have been invited to be involved, depending upon the methodology being used. As a minimum statutory agencies such as the local authority, police and health commissioners (CCG) will be involved.

17.4 The SAR Panel will clearly set agreed terms of reference, clear process and direction for gathering information depending on methodology being used, as well as collate and review information.

17.5 The final product will be an Overview Report, including recommendations, accompanied by an Executive Summary as well as any specific action plans from contributory organisations.

17.6 Throughout this process the SAR Panel will consider communication matters and communication strategy, linking with the SAR Sub Group as required. Where legal opinion or guidance is required this should be provided by the Council's Legal Services, unless of course, there is a conflict of interest, and will be accessed via the linked representative of the Sub Group sitting on the SAR Panel.

17.7 The SAR Panel's work should be completed within 6 months of the initial decision to commission a SAR. Agency improvements should commence as soon as they have been identified (e.g. prior to or during the earlier stages of the Review).

Responsibilities of the Safeguarding Adult Review Sub Group

17.8 The SAR Sub Group has delegated responsibility from the SAB to have oversight of all SAR activity, policy and process. When a SAR has been commissioned, the SAR Sub Group, under the leadership of the Sub Group Chair (or nominated representative) acts as a liaison to the SAR panel and will arbitrate on any issues or decisions the SAR Panel and Independent Chair identify or raise.

17.9 The Sub Group acts as the intermediary between any SAR Panel and the SAB, and supports the work of the Panel in whatever way is appropriate either as a collective group or through delegated tasks to assigned members or assigned representatives.

17.10 The SAR Sub Group will work with the SAB and SAR Panel to identify any conflict of interests are identified and addressed (e.g. a SAR Sub Group agency representative may also be required to produce an IMR for the

Panel). Mitigating actions will be put in place and monitored so the best possible evidence is collated and review appropriately.

17.11 Throughout the process the Sub Group, via the Chair, should monitor the progress of the SAR via updates from the Independent Chair/report writer.

17.12 The Final Overview Report, Executive Summary and recommendations will be presented to the Sub Group to enable supportive presentation to the SAB. The Sub Group will ensure that there is a relevant Composite Action Plan, turning recommendations into actions and that this accompanies any documentation to be presented to the SAB.

17.13 The Sub Group will inform the SAB Chair that the review has been concluded and the report is available. Arrangements will be made for the Overview Report to be presented to a SAB meeting, so it can be ratified.

Responsibilities of the SAB

17.14 Ultimate responsibility for the completion of an agreed SAR, the related recommendations and their implementation remains with the SAB. They are also required to lead on communication issues and ultimate publishing arrangements. In practice the SAR Sub Group undertakes most of this as the delegated group, but accountability remains with the SAB.

17.15 The SAB will formally approve the Overview Report and formally accept the review findings and recommendations as appropriate. Any recommended final revisions should be referred back to the SAR Panel for their action.

17.16 The SAB will consider obtaining legal advice, in particular, when considering the remedial action to be taken in relation to the findings of the review to help prevent similar issues, and to ensure the statutory obligations under the Care Act 2014 as well as wider public law responsibilities.

17.17 An Executive Summary will be produced to share the learning from the SAR, and the SAB will need to confirm how and if the report is made public, the form of this and any following communication or media management.

18. RETENTION OF DOCUMENTATION

18.1 The Independent Author commissioned to undertake the SAR will not retain records beyond what is necessary for the purposes of the report as the information and records are likely to contain sensitive and personal data, and therefore subject to the provisions of the GDPR and the Data Protection Act 2018.

18.2 On completion of the SAR Overview Report, the Independent Author will return all information in their possession, including the completed report, and delete all information from their computer(s) and other electronic devices, as specified in the contract.

18.3 In line with GDPR 2018 and the Data Protection Act 2018, NSAB will retain documents relating to the SAR in line with the Local Authority's document retention and disposal schedule.

18.4 Individual organisations will take ownership regarding the retention of information such as Detailed Statements of Information and/or Individual Management Reviews.

18.5 Published Overview Reports and Executive Summaries will be made available on the NSAB website for one year following publication. Copies will also be available via the Social Care Institute for Excellence (SCIE) Safeguarding Adults Review Library.

Northamptonshire Safeguarding Adults Board

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

APPENDICES AND TOOLS

The following section includes a selection of sample tools to support the SAR Panel and are produced for simplicity to enable clarity of the relevant process

APPENDICES

APPENDIX 1

Making a Safeguarding Adult Review referral

Form A: Referral Notice

APPENDIX 2

Sample templates for completing any Individual Management Review and Chronology

Form B: IMR Summary Template and Identifying Information

Form C: IMR Chronology of Agency Involvement

APPENDIX 3

Guidance for Conducting Interviews

APPENDIX 4

Template Letter A – Initial Notice of SAR

Template Letter B – Initial Independent Chair Letter setting out the process (letter can be adapted)

APPENDIX 5

Roles & Responsibilities

APPENDIX 6

Safeguarding Adult Review – Considerations for Terms of Reference

APPENDIX 7

Template for Completing Overview Report

APPENDIX 8

Sample Composite Action Plan

APPENDIX 9

Useful information

APPENDIX 1:

Making a Safeguarding Adult Review referral and deciding if the referral should be subject to a Safeguarding Adult Review

The format for requesting a Safeguarding Adult Review is set out in **Form A.** The completed request must be sent in the first instance, under confidential cover to NSAB Business Manager.

Please do not copy and paste information from other forms, unless it is fully explained and all required detail completed.

Email to: **Suzanne Binley - NSAB@northamptonshire.gov.uk**

By Post to: **Suzanne Binley**
NSAB Business Manager
One Angel Square, Angel Street, Northampton NN1 1ED

All requests will be assessed by the SAB Safeguarding Adult Review Sub Group in accordance with NSAB Procedure/Guidance for conducting Safeguarding Adult Reviews.

Content of the request:

1. Name of the person submitting the request for a Safeguarding Adult Review;
2. Position/designation of person making the request;
3. Agency/organisation of the person making the request (if applicable);
4. Contact details, to include address, telephone number, fax and e-mail; and
5. Brief details of the issue to include:

- The name(s) and date of birth of the victim(s) (if known);
- Name of any service provider involved;
- Local authority involved in the safeguarding adults case;
- Name of the Safeguarding Adults Co-ordinating Manager and or the Chair of any strategy meeting or safeguarding adults case conference (if known); and
- Details of why, in the referrer's opinion, the case meets the Safeguarding Adult Review criteria and guidelines contained in paragraph 3 of the protocol, specifically linking the referred to the criteria.

Please note that Form A report should not exceed 3 sides of A4 paper.
If additional information is required you will be contacted by the Business Office.

Form A

REFERRAL FORM FOR CASE DISCUSSION BY SAFEGUARDING ADULT REVIEW SUB GROUP

This form should be completed when a vulnerable adult dies (including death by suicide) **and** where **substantial** abuse or neglect is known or suspected to be a factor in their death.

Before completion, the individual (if they are employed by an organisation that is part of the Board) should consult with their agency's representative to ensure that a referral has not already been made and that the grounds appear to be met.

1. Name of person referring:	**2. Agency name and address**
3. Telephone number:	**4. Email address:**
6. Name of service user involved (All information anonymised for confidentiality)	**7. Address of service user:**
8. Date of birth:	**9. Date of incident**
10. Describe the role of the referring person in the case:	
11. What criteria does the referring person believe are met in this case?	
11. Provide a brief description (under 200 words) of what happened and your concerns	
12. Any other information:	

13. Signed:	**14.**	**Date:**

Once completed, this form should be sent to NSAB Business Office for the attention of:
Suzanne Binley
NSAB Business Manager
One Angel Square, Angel Street, Northampton, NN1 1ED
Email: **nsab@northamptonshire.gov.uk**

APPENDIX 2:

Template forms for completing an Individual Management Review and Chronology

Introduction

The following (Forms B and C) are two templates that combined as a set form an Individual Management Review (IMR). This details an agency's involvement and sets out their relationship to the person(s) under consideration.

- These templates are to be fully completed by each agency who has been involved with the person(s) subject to the SAR, and who has been asked to do so by the SAR Panel. They record the decisions, actions taken and services provided to the person(s) who is subject of a Safeguarding Adult Review.

- The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

- Remember also, to keep the individual subject to the review at the centre of the IMR.

- The findings from the IMR report should be endorsed by the Senior Responsible Officer within the organisation who has commissioned the IMR and who will be responsible for ensuring that recommendations are acted upon.

- The IMR provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement with that agency

All Individual Management Reviews will be in **Calibri** and **Font 11.**

The completed IMR should be returned to:

NSAB@northamptonshire.gov.uk or to the address above

IMR TEMPLATE - Form B:

SAFEGUARDING ADULT REVIEW
INDIVIDUAL MANAGEMENT REVIEW

AGENCY	
AUTHOR	
AUTHOR'S SIGNATURE	
DATE	

SIGN OFF BY AGENCY MANAGER	
DATE	

DATE OF FIRST SUBMISSION TO SCR PANEL	

DATE OF REVISION	

DATE OF FINAL SUBMISSION	

IMR CONTENTS

Northamptonshire SAB: Safeguarding Adult Review (Appendices)

1. INTRODUCTION

This should comprise a short precis of the agency completing the report and of their involvement with the patient.

2. SAR PROCESS

The standing Safeguarding Adult Review (SAR) Sub Group met on xx.xx.xxxx and recommended that the threshold had been met to undertake a SAR in accordance with the Care Act 2014:

Quote to be added.

This recommendation was endorsed by the Independent Chair of Northamptonshire Safeguarding Adult's Board (NSAB) on date to be added.

Include name was appointed Independent Chair of the SAR Panel.

Include name was appointed as Lead Reviewer.

3. METHODOLOGY

The methodology used for this Safeguarding Adult Review has been a blended approach, taking elements of the process and coverage set out in *the Care Act 2014* and combining this with the focus on learning and public accountability encouraged in *the Care Act 2014*. This has been done to build on current arrangements and experience for producing IMRs and obtaining a secure chronology and robust individual analysis by each involved agency, but adding the greater involvement of practitioners and clinicians and encouraging reflection and learning from the circumstances and context of the case.

Each agency involved has been required to produce an Individual Management Review, but with the direction that this should have a clear focus on the issues and likely areas for learning set out in the Terms of Reference. Rather than interview staff in the traditional way, a SCIE systemic approach by the IMR author and the Lead Reviewer (if required) and were aimed at encouraging reflection on practice and performance. Another feature of the methodology was greater collaboration with practitioners: with a multi-agency briefing at the start of the process and a workshop later in the process to discuss emerging findings (see process chart, Appendix 1).

Role Of Individual	Agency/ Organisation Employing the Individual	Nature of Contact (meeting, interview, telephone call, e-mail, correspondence etc.	Date (s) of Consultations

4. SCOPE

The Terms of Reference and Scope for the Review are attached as Appendix 2. The timeframe for the Review is from xx.xx.xxxx to xx.xx.xxxx.

However, if there is any historic information prior to the start date that Authors consider relevant to this review, please include details.

5. BRIEF FAMILY HISTORY

6. HISTORY OF PROFESSIONAL INVOLVEMENT

Please outline, with dates, the involvement of staff from your agency during the period under review.

7. ANALYSIS AND APPRAISAL OF PRACTICE

Please analyse and appraise the practice of staff involved during the period under review. Try to identify Key Practice Episodes and appraise the practice of the staff from this agency. This is not about blame, but it is necessary to appraise and analyse. Think of the WHY? Questions and contributory factors that may have influenced both good and less than good practice (list of contributory factors attached). Use your own headings to describe what issues or Key Practice Episodes you are analysing and appraising. There is a list of matters for consideration to help you in the scoping document (Appendix 1).

8. KEY LEARNING POINTS AND EMERGING ISSUES

Outline how the issue manifested itself in this case, and try and tease out whether this was a one-off, or whether it represents an underlying systemic pattern. If so, how widespread or prevalent is it? What are the implications for safeguarding practice?

9. CONCLUSIONS

Add the conclusions to your findings

10. FINDINGS AND RECOMMENDATIONS

APPENDIX 1: PROCESS CHART

To be added.

APPENDIX 2: SCOPE OF THE REVIEW

To be added

Northamptonshire Safeguarding Adults Board

CHRONOLOGY - FORM C

Chronology for Add Individual's Name

Date	Time	Agency	Communication within Agency	Communication external Agency	Response / Outcome	Comments
01.01.0001	00:00	In full				

APPENDIX 3

GUIDANCE FOR CONDUCTING INTERVIEWS

It may be helpful for the IMR writer/author to use the following format when conducting interviews in the process of compiling the IMR report:

Details of Contributor	
Full name:	
Qualifications:	
Designation:	
Time in post:	
Employing body:	
Employing address	
Home Address: (where appropriate)	
Previous employment:	
Employer Dates & Posts held:	
Description of role in relation to particular case:	

Matters to be covered in interviews

This is to be used in conjunction with the chronology of the case to check facts, discuss the interviewee's specific participation and the time scale of their involvement.

Explore with the interviewee:

a. Their knowledge of the history of the case and the adult at risk(s) prior to the interviewee's involvement;

b. Their specific involvement in the case;

c. Their knowledge of their employing agency's policy and procedures in relation to Social Care and Safeguarding Adults;

d. Their knowledge of identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon adults at risk, service user engagement techniques and their role in relation to Safeguarding Adults meetings;

e. The methods used to relate to and communicate with other professionals in the case;

f. The interviewee's record keeping;

g. The supervision received by the interviewee

h. The interviewee's feelings about the case, the adult at risk and/or the adult at risk's carer and how those feelings were dealt with in supervision;

i. The range of training both internal and external the interviewee has attended within the last 2 years;

   (a) Looking back, what the interviewee would do differently now;

   (b) What lessons the interviewee learnt from the case;

   (c) What the interviewee believes the agency could/should learn from the case.

APPENDIX 4

TEMPLATE LETTERS

Template Letter A – Initial Notice of SAR:

Dear [insert name]

NOTICE OF SAFEGUARDING ADULT REVIEW

Insert name of adult at risk

Date of Birth: **xx.xx.xxxx**

Date of Death: **xx.xx.xxxx**

A decision has been made that the above named person is to be made subject of a Safeguarding Adult Review.

On behalf of the Chair of the Northamptonshire Safeguarding Adults Board, I am writing to formally request that you take action to ensure that your agency files in respect of this person are immediately secured to guard against potential loss or interference, and to enable the Safeguarding Adult Review process to commence.

A Safeguarding Adult Review (SAR) Panel will be convened shortly to agree the Terms of Reference of the Safeguarding Adult Review and the focus of the Independent Management Review. Once these issues have been resolved we will communicate with you again on the next steps.

Please contact me by return with the name of the lead contact in your organisation with which the SAR Panel Independent Chair should make contact with.

If you have any further questions please contact Suzanne Binley, Business Manager on 01604 365681 or by email: Sbinley@northamptonsihre.gov.uk

Yours sincerely

Chair
Safeguarding Adult Review Sub Group
Northamptonshire Safeguarding Adults Board

Template Letter B – Initial Independent Chair Letter setting out the process (letter can be adapted):

Dear insert name

Re: Safeguarding Adult Review in relation to: xxxxxxxx xxxxxxx Date of Birth: xx.xx.xxxx

You were recently contacted by Northamptonshire Safeguarding Adults Board regarding a Safeguarding Adult Review relating to the above named person.

I have now been appointed as the Independent Chair of this Safeguarding Adult Review, and as such, I am writing to request that your agency participate in the SAR Panel that is being established. Your name has been given as the point of contact for your agency.

I would emphasise that the purpose of this Safeguarding Adult Review is not to apportion blame but to establish whether there are any issues in relation to inter-agency working under the Policy and Procedures for Safeguarding Adults at Risk, and to identify in the review process between agencies on the SAR Panel, any lessons to be learned. It is my intention to ensure that the SAR process is clearly focused encouraging a good exchange of information and a constructive dialogue and outcome.

My intention is that the initial SAR Panel will have its first meeting in the week beginning xx.xx.xxxx. At this meeting we will confirm the Terms of Reference of the Panel and agree the process for gathering Individual Management Reviews (IMRs). This will inform the final Overview Report which will be presented to the Safeguarding Adults Board together with a draft Action Plan to address any recommendations that the SAR Panel may make.

Do feel free to contact me by [insert contact details] f you would like to discuss this further. I look forward to working with you.

Yours sincerely

Independent Chair
Safeguarding Adult Review Panel

APPENDIX 5

ROLES & RESPONSIBILITIES

Chair of NSAB

- Retain strategic oversight of the SAR process;
- Support the SAB to fully consider the merits of a referral;
- Assist in arbitrating issues that are problematic; and
- Enable the SAB to understand the findings of the SAR.

Chair of NSAB SAR Sub Group

- Arrange Sub Group consideration;
- Refer to the SAB;
- Act as intermediary between SAR panel and the SAB;
- Senior point of reference for SAR panel oversight; and
- Strategic Composite Action Plan.

Head of Adult Safeguarding

- Enable practical delivery of the SAR Panel process;
- Practical point of reference;
- Address/respond to all issues directly only those by exception to SAR Sub Group Chair; and
- Deputise for SAR Sub Group Chair as appropriate.

Independent Chair SAR Panel

4. Lead overview of SAR review;

- Link to relevant agencies;
- Write SAR Overview report;
- Propose recommendations for the SAR Composite Action Plan; and
- Present to the SAB.

APPENDIX 6

SAFEGUARDING ADULT REVIEW – CONSIDERATIONS FOR TERMS OF REFERENCE

Any SAR is convened in accordance with the SAB's Procedure and Guidance for Conducting Safeguarding Adult Reviews, as it is deemed to the criteria. The Terms of Reference for a SAR will be specific to the circumstances of each individual case but should consider:

- The 6 Principles of Safeguarding (see paragraph para 14.4 *Care and Support Statutory Guidance (issued under the Care Act 2014);*
- The care arrangements in place for the individual;
- If any of the care or support contributed in any way whatsoever to the individuals' death or their significant harm;
- If all appropriate practices and professional standards were followed by staff assigned to the individual's care;
- If there was sufficient co-ordination amongst all agencies involved; and
- Any learning from this situation and make recommendations to improve future working practices.

APPENDIX 7

The following template is the suggested format to be used for the SAR Overview Report.

The prompts set out in bullet points are no more than ideas and issues to be covered, if appropriate, but are not exhaustive and additional information should be provided as required.

NORTHAMPTONSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS OVERVIEW REPORT

Name of adult at risk	
Date of birth	
Date of death	
Age at time of incident	

CONTENTS

Page No.

Overview Report Template Guidance for Independent Author

1. Introduction

a. Provide an overview and standalone summary of the circumstances that led to the review.
b. Clarify that the SAR has been conducted as either a statutory review under Section 44 of the Care Act, or as a non-statutory SAR or other type of review as agreed by the SAB.
c. Confirm the SAR has been undertaken in line with NSAB's SAR Protocol, reasons for conducting the review; the SAR criteria for undertaking, or, if the criteria were not met, the reason for conducting the review, and the date the decision was made to undertake a SAR.
d. Include Terms of reference for the review.
    i. State when the SAR commenced, details of the commissioner (usually Independent Chair of SAB), SAR panel members, and the report author).
    ii. State the dates the SAR panel met and the agreed terms of reference for the SAR.
    iii. List contributors to the review and the nature of their contributions (e.g. management report by social care, serious incident report from health agency, interview with staff members, etc.).
    iv. Cite contribution of family members and any others.
    v. Identify the key issues within the SAR.
    vi. Set out how the involvement of staff and the adult/family/ friends/ carers was facilitated and supported (e.g. advocacy).
    vii. Include any communication with CQC or Government Office.
    viii. Comment upon the quality of the evidence provided and whether any action was required.
    ix. Provide an explanation for any delay in completing the SAR in relation to the SAR framework and terms of reference.
e. Clarify that the SAR is not intended to reinvestigate the case or apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately improve the safeguarding and wellbeing of adults in the future. Also, state if there were any parallel investigations in place at the time of the review.

2. Review Methodology

a. State the methodology adopted for the review (see pages 10-15 for further information) and confirm whether a practitioner's event was held.
b. Detail input from the individual management reports, panel discussion and the evaluation of evidence.
c. Include any involvement from family members.

3. The Person

- Provide sources of information and a pen portrait of the person(s) in question. Include a pictorial display of the adult's relationship to family members (if this adds benefit), extended family and household and any care services provided. Details provided should be brief and anonymous (as appropriate).

4. Case Chronology

a. Provide a timeline of key events and agency involvement indicating incidents or issues that affected the adult's life. Include the family/carer/relevant organisations/professionals and others who have contributed to the review process. Note specifically the occasions where the adult was seen and where their wishes were sought and expressed.

Northamptonshire SAB: Safeguarding Adult Review (Appendices)

5. Key Episodes

a. Detail key episodes that led to the incident/maltreatment and who was believed involved responsible for the abuse. This should include, where appropriate, care placement, deprivation of liberty, best interests meeting, factors leading to abuse or death:

- An overview that summarises what relevant information was known to the agencies and professionals involved about carers, any perpetrator and the home circumstances of the adult at risk.

6. Themed Analysis

a. Provide an introduction to your analysis.
b. Include mental capacity, mental health, inter-agency working and communication and safeguarding etc. in your analysis.

7. Conclusions

a. Introduction to the conclusions.
b. Include specific areas documented in the themed analysis. Show clearly how and why events occurred, decisions were made and actions were taken or not taken.
c. Explain how professionals were in events at the time of the incident(s) and in the period leading up to.
d. Explore the range of contributory factors, systems and conditions that played a part in causing the abuse, neglect or death.
e. Consider whether different decisions or actions may have led to an alternative course of events.
f. Consider how system/process conditions would have needed to be different to facilitate the different actions or decisions that would have been required.
g. Highlight examples of good practice.
h. Analysis of the collated information in general and specific.

8. Recommendations

a. Summarise, in the opinion of the SAR Panel, what the key themes and patterns were in the system arising from the SAR and what lessons can be drawn from the case.

b. Translate the lessons into recommendations where partners need to provide assurance to NSAB to improve practice, process, partnership working, outcomes and safeguarding to avoid similar incidents happening again.

c. Recommendations should be few in number and SMART - specific, measurable, achievable, relevant, and time-based. They should be capable of being translated into an achievable action plan. Views on how the recommendations can be translated into action can be included. Consideration should be given to the resources required to implement the recommendations, such as cost and resources.

d. Recommendations should be divided into:

i. **Review** – practice that should already be happening.

ii. **New –** actions that need to be introduced and implemented.

iii. **Local/National** - If there are lessons for national, as well as local policy and practice, these should also be highlighted.

Multi-agency Composite Action Plan

1. The Independent Author and SAR panel will provide a proposed set of recommended actions for discussion, adaption and approval by NSAB.
2. The composite action plan should support the implementation of the recommendations identified in Section 7 of the report.
3. The actions identified should be multi-agency in nature; requiring the combined action of a number of partners in order to achieve them.
4. Single-agency actions may be identified from the Independent Management Reviews where these are vital to the implementation of the recommendations.
5. The action plan should conclude with evidence as to how the plan has been reviewed to determine if the outcomes have been achieved.

APPENDIX 8

SAFEGUARDING ADULT REVIEW: COMPOSITE ACTION PLAN [INSERT NAME]

RECOMMENDATION	ACTION TO ADDRESS RECOMMENDATION	ASSIGNED LEAD AGENCY AND LEAD OFFICER	PROGRESS AND EVIDENCE COMMENTARY	RAG RATING/ DATE WHEN COMPLETED
Write the specific recommendation from the SAR Panel exactly as worded, adding further rows as required. **RECOMMENDATION 1:**	*Add any additional comments of points of clarification that enable the reader to be clear what is required.*		*This is the 'live' commentary and update of progress that shows the reader (and SAR Sub Group) progress against the recommendation.*	
RECOMMENDATION 2:				
RECOMMENDATION 3:				

APPENDIX 9

USEFUL INFORMATION

Safeguarding Adult Review [SARs] Checklist

Supporting dialogue about the principles of good practice.

This checklist aims to support commissioners and reviewers to commission and conduct high quality reviews. Covering the whole process, the list provides a consistent and robust approach to SARs. It is based predominately on established principles of effective reviews as well as SAR practice experience and expertise, and ethical considerations. It is also based on the Six Principles of Safeguarding that underpin all adult safeguarding work:

Empowerment - Prevention - Proportionate - Protection - Partnership - Accountable

Setting up the Review

1	**Referral**	The case is referred for a SAR consideration with an appropriate rationale and in a timely manner.
2	**Partnership Engagement in Commissioning a SAR**	Sufficient information is gathered on which to base a decision about whether to have a SAR and to determine the nature of the SAR that is required and whether it makes the criteria. The rationale for these decisions is clear, defensible and reached in a timely fashion. Reference to Care Act 2014 and Making Safeguarding Personal. There is transparency among SAB members about the decision making process and outcome.
3	**Engaging the relevant people to shape the review**	The person/relevant adults/family members/network are told what the SAR is for, how it will work, and the parameters, and are treated with respect. They will inform the Terms of Reference.
4	**Clarity of Scope and Partnership buy in**	The Board is clear and transparent, from the outset, that the purpose of the SAR is organisational learning and improvement and acknowledges any factors that complicate this goal. The scope needs to be clear and clarity around partnership buy in regarding, for example, in the submission of agency information, that all partners are aware they need sign off on their contribution to the process at Chief Officer level. Whatever the methodology selected, if the criteria are met then there is clarity that the review constitutes a SAR.
5	**Commissioning**	The decisions about the commissioning of the SAR take into account a range of relevant factors and are made with input from the SAB members and in conjunction with the SAB Chair. The methodology will be proportionate to the presenting circumstances.

Running the Review

6	**Management of the Process**	The SAR is effectively managed and achieves the requirements of independence and ownership of the findings by the Board. It runs smoothly, is concluded in a timely manner and with available resources.
7	**Parallel processes**	Where there are parallel processes the SAR is managed to avoid duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties. Any multi-borough review requires clarity on who leads and good governance arrangements agreed at the outset.
8	**Assembling information**	The SAR gains sufficient information to understand professional practice in the case, its context and relevance today. This includes chronologies from all involved organisations.
9	**Practitioners involvement**	The SAR enables practitioners and managers from relevant agencies and organisations to have a constructive experience of taking part in the review.
10	**Person/Family involvement**	The SAR is informed by the person/family knowledge and experience relevant to the period under review and drives the process appropriately (Integrating the Making Safeguarding Personal approach). To ensure person/family/network engagement.
11	**Analysis**	The SAR analysis is transparent and rigorous. It evaluates and explains professional practice in the case to illuminate routine challenges and constraints to practitioner efforts to safeguard adults.

Outputs, Outcomes and Impact from the Review

12	**The Report**	The report has the voice of the person throughout and their voice is heard. It reflects the six core safeguarding principles set out in the Care Act 2014. The report clearly identifies the analysis and findings of the SAR that are key to making improvement. Findings reflect the explanations for professional practice that the analysis has evidenced. The Board uses communication channels for cross boundary learning however, there may be boundaries other than geographical.
13	**Improvement action**	The Board enables robust discussion by agencies of what action should be taken in response to the SAR report. There is an opportunity for a review of the review process itself to capture anything that went particularly well or any learning for a future review.
14	**Board written response**	The Board agrees a written response ready for publication that explains, clearly and succinctly, what action should be taken in response to the SAR report and evaluating the impact on the SAB Strategic Plan. The SAR is reported in the SAB annual report.
15	**Publication**	The Board considers the impact of publishing the SAR report and response and decides how best this can be achieved.
16	**Learning**	There is learning from SARs within, between and outside of the SAB. How will the SAB be assured that the intended learning had taken place including the implementation and evaluation of impact? Consideration to be given to feed any learning into the ADASS online repository resource.

APPENDIX 10

FURTHER INFORMATION

Care and Support Statutory Guidance October 2016 (issued under the Care Act 2014)

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support- statutory-guidance

Learning Together (Social Care Institute of Excellence)

http://www.scie.org.uk/children/learningtogether/index.asp