Northamptonshire
Safeguarding Adults Board

Northamptonshire Safeguarding Adults Board (NSAB)

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

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

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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. This was based on Northamptonshire's pre-existing Serious Case Review policy first published in 2009.

It should be read in conjunction with the Northamptonshire Inter-Agency Policy and Procedures and other safeguarding policies and guidance available on the NSAB website.

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 (SABs) undertake Safeguarding Adult Reviews (SARs) in certain circumstances. The specific criteria are set out in paragraph 4.2 and on Form A - Appendix 1 of the supporting guidance. In addition, the Care and Support Statutory Guidance [2] provides more detail relating to SARs and outlines a framework for when certain events happen.

1.2 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, the adult or their family should be fully involved throughout the process (see Section 11 below).

1.3 This SAR Protocol has been developed by Northamptonshire Safeguarding Adults Board (NSAB) 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 relevant statutory provisions and complements the Northamptonshire Inter-Agency Safeguarding Policy.

2. SAFEGUARDING ADULT REVIEW OPERATING FRAMEWORK AND GOVERNANCE

2.1 NSAB has the lead responsibility for carrying out a SAR based upon receipt of a referral (see below within the relevant section and within the appendices of the supporting guidance).

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 member of NSAB. The Sub Group membership is made up of the statutory members of the SAB (who are the local authorities, police and the clinical commissioning group), with specific terms of reference that are annually reviewed. The Sub Group reports to NSAB.

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 and/or when otherwise required to act as a co-ordinating group to any SARs in progress.

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 or suffered harm and nor is it to apportion blame.

3.2 The purpose of a SAR is not to hold any individual or organisation to account. There are a range of other processes which have this function such as criminal proceedings and professional regulation[3].

3.3 The purpose of conducting a SAR is to:

a. 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.
b. Review the effectiveness of procedures and their application (both multi- agency and those of individual organisations).
c. 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.
d. 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.

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[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

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

[3] https://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

3.4 The SAR is for consideration of the most serious issues and will not be an alternative to a safeguarding enquiry, investigation or process.

3.5 It is acknowledged that all statutory 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 remain a statutory requirement in its own right and will be complemented by other such processes.

3.6 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 any other processes.

4. CRITERIA FOR A SAFEGUARDING ADULT REVIEW

4.1 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).*

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

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

4.3 Examples of when a SAB may carry out a discretionary SAR under section 44 (4) of the Care Act 2014, including the following:

- a. 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.
- b. A case featuring 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.

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 (to make a referral see Appendix 1). Examples of who may make a referral includes a Coroner, members of the public, family and friends of the individual. The prospective referrer may find it helpful to discuss the issue with the senior officer for safeguarding, or designated nurse for adult safeguarding from the relevant organisation, in the first instance. 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 NSAB representative makes a formal referral. In all cases, it is expected that the criteria in section 4 of this protocol is fully considered before making a referral.

5.2 It is important to note the NSAB will only consider cases *"in its area"* in line with section 44 of the Care Act 2014. In practice, this means it will consider cases that relate to people residing within Northamptonshire (regardless of where the commissioning local authority or Clinical Commissioning Group is based). If a person placed by North or West Northamptonshire Councils, or NHS Northamptonshire Clinical Commissioning Group outside of Northamptonshire is the subject of circumstances that would give rise to a SAR, then it would be for the SAB of that local area to carry out and oversee a SAR following a referral. In such circumstances, Northamptonshire commissioning bodies could make the relevant referral to the SAB of the relevant area.

5.3 The formal referral to the NSAB should be made to the Chair of the Sub Group via the NSAB Business Manager using the Referral form in Appendix 1 of the supporting guidance.

5.4 Upon receipt of a SAR referral, the Chair of the Sub Group will review the information against the statutory criteria set out in the Care Act 2014 and will convene the Sub Group to consider the merits of the referral, and if approved, discuss the appropriate methodology to follow. Members will take into consideration the findings in the Analysis of Local Government Association (LGA) Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 – Findings for sector led improvement[4].

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 if required.

5.6 If the issue under consideration is also the subject of a police investigation or judicial process, then the Sub Group will need to consider the next steps in light of this. In addition, 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 as soon as practicable. Internal governance processes and multi-agency reviews are not mutually exclusive and legal advice may be appropriate to guide decision making.

6. DECIDING TO UNDERTAKE A SAFEGUARDING ADULT REVIEW

6.1 NSAB is responsible for the SAR Sub Group and 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 commenced, the Chair of the Sub Group will notify the NSAB Chair of the recommendation to conduct a SAR and the actions that should follow, including the proposed or recommended methodology (see Section 7).

6.3 If the NSAB Chair agrees with the Sub Group's recommendation, they will write to the statutory NSAB members. The decision about whether to proceed or not will be made by all statutory members collectively and fed back to the NSAB Chair 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 NSAB meeting and recorded.

[4] Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

6.4 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 the agency involvement. In such cases, arrangements should be made for the particular agency to share relevant findings with the Sub Group or other appropriate body. The NSAB Chair will be notified of the referral and Sub Group decision, which will be raised at the next NSAB meeting and recorded.

6.5 **If NSAB does not agree with the recommendation** of the Sub Group (to proceed or not proceed), a meeting should be convened by the NSAB Chair with the Chair of the Sub Group to try to resolve the issue as a matter of urgency. If necessary, an extraordinary meeting of the full NSAB should be convened.

6.6 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.

6.7 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 the Inter-Agency Policy and Procedures for more details.

6.8 Once a decision has been made to conduct a SAR, the Care Quality Commission will be notified by the NSAB Business Manager.

6.9 If the referrer (including family referrers) disagrees with the decision not to proceed they can ask the Chair of NSAB to review the decision. If a referrer remains dissatisfied with the outcome, the Chair of NSAB can ask a Chair of another SAB in the regional group to review the decision made. Ideally, this should be within 14 working days of the decision being known by the referrer. There is no further opportunity to appeal.

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

7.1 Once a SAR has been agreed, the most appropriate methodology for undertaking the SAR should be considered. Different methodologies will suit different types of circumstances. These can range from facilitated learning events over 1-2 days, through to formal panel-led over-arching enquiries carried out over a period of time. In accordance with the Care and Support Statutory Guidance, a SAR should ideally be completed within six months[5]. 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.
- Commitment to/promotion of open and reflective learning cultures.

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

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); time frame within which the SAR will focus; roles and expectations and outcomes required. (See Appendix 6 of the supporting guidance).

d. **Early discussions with the adult and their family/carers** to agree to what extent they wish to be involved and to manage their expectations. This includes access to independent advocacy if required (See Section 11).

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 and be supported accordingly (See Section 12).

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

7.2 Whichever methodology is used it should 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 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:

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

8. METHODOLOGIES AND CONSIDERATIONS FOR A SAFEGUARDING ADULT REVIEW

8.1 The suggested 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 appropriate for different presenting circumstances. Alternatives based upon the collective experience of the Sub Group and NSAB should also be considered as appropriate.

8.2 When a referral is considered by the Sub Group, the suggested methodology should be included in the recommendation for a SAR in the letter from the Chair of the Sub Group to the NSAB Chair.

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

a. 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 reports or developing agency analysis for the process).
b. Level of independence required of the SAR Chair (e.g. representative from another agency, external consultant etc.).
c. The broad Terms of Reference for the SAR (see Appendix 6 in the supporting guidance for a template) including timescales for completion and how learning from the SAR will be disseminated and embedded.
d. The required output from the SAR.
e. Whether an independent author is required, and the level of independence.

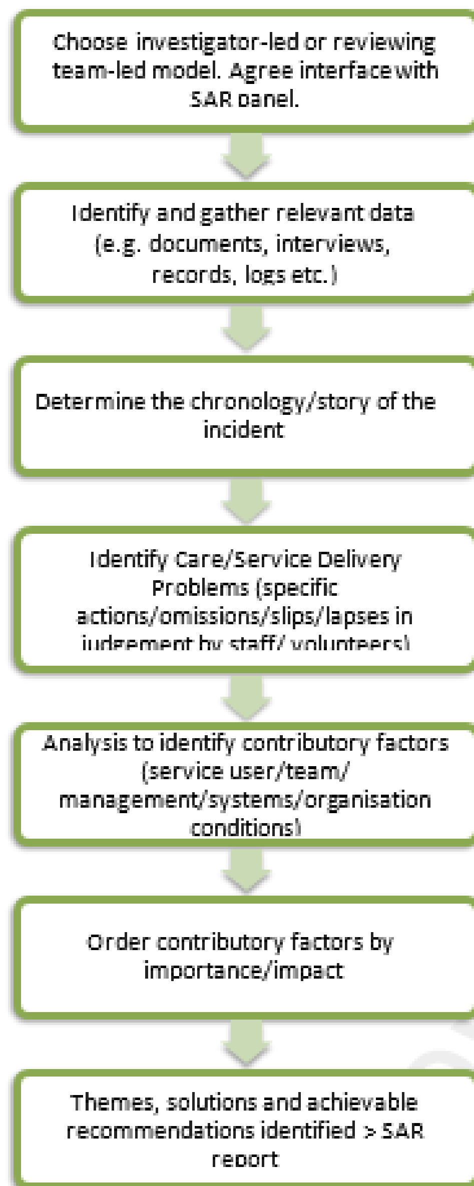
OPTION A - Traditional SCR Approach

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

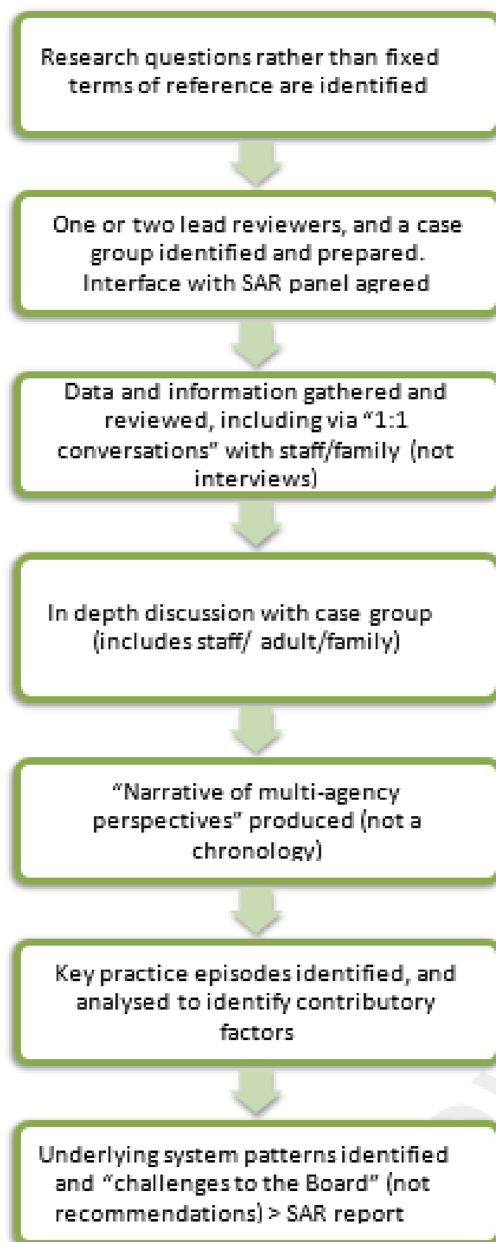
Key features:

- ✓ 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

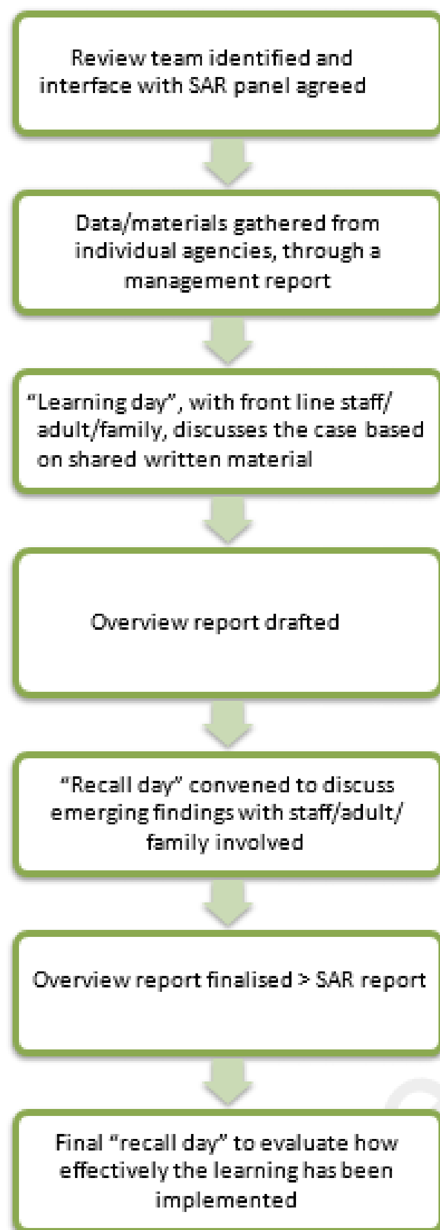
Key features:

- ✓ 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:

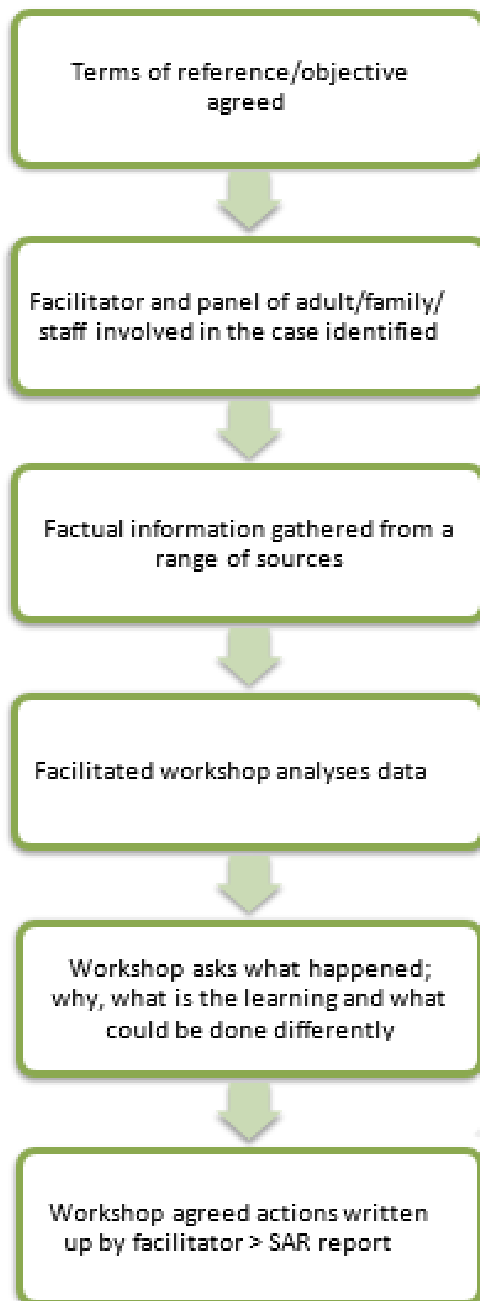
- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

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

Revised input



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

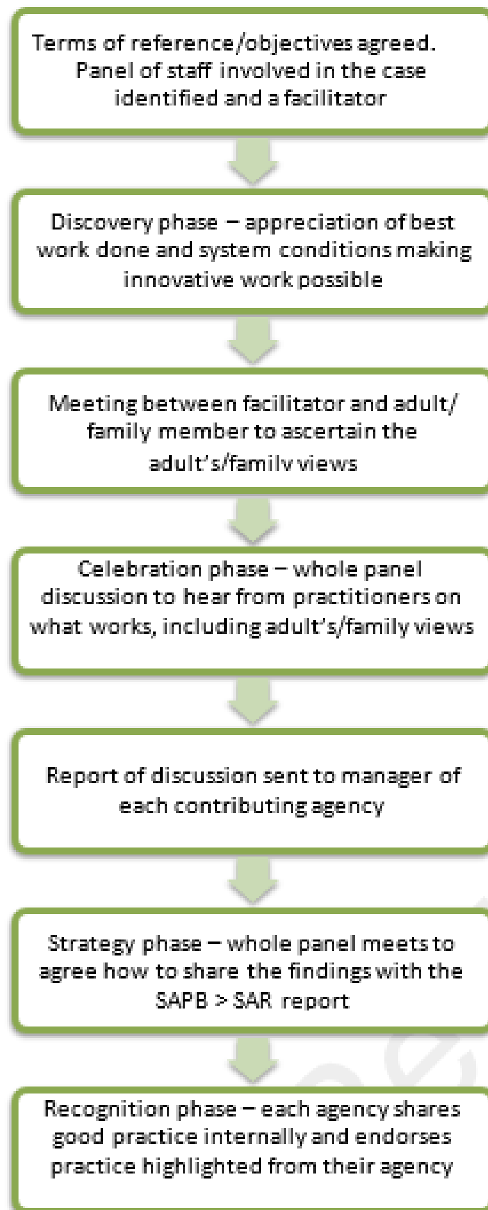
Advantages	Disadvantages
• Light-touch and cost-effective approach; • Yields learning quickly; • Full contribution of learning from staff involved in the case; • Shared ownership of learning; • Reduced burden on individual agencies to produce management reports; • May suit less complex or high-profile 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 consider which agencies or individuals 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 or individuals that should be approached and the process by which it will do so.

9.2 In commencing the SAR process, the Chair of the Sub Group will do the following on behalf of NSAB:

a. Write to the Senior Accountable Officer[6] who is believed to have been involved (copying in their SAB representative/Safeguarding Adult lead) advising them that a SAR is being undertaken, and request a representative from their agency for the SAR Panel. The SAR Panel representative should not have had direct involvement in the case.

b. 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), a detailed questionnaire and/or a chronology. The templates for completing the chronology and the analysis components of the Individual Management Review (see Appendix 3 in the supporting guidance) will be conveyed to the agency.

c. If appropriate, advise the Coroner's office that a SAR is commencing.

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

9.4 Depending on the methodology being used, the Chair could be a NSAB 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 appointed independently for this purpose.

9.5 The SAR Sub Group, will discuss the SAR at the Sub Group meeting, and include:

a. Commission/consider and agree the most appropriate Independent Author and whether an Independent Chair is required.

b. Confirm which partner agencies should be part of the SAR Panel.

c. Confirm arrangements for any on-going legal support.

d. 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.

e. Agree the draft and final report(s) and how they will be presented to NSAB.

f. Propose how any learning from the SAR should be implemented.

g. Propose how the SAR should be published (where appropriate), taking into account factors that may emerge throughout the process.

9.6 Agencies and individuals have a duty under the Care Act 2014 to cooperate in the SAR process and provide all appropriate information within a specified timescale as requested by NSAB[7].

10. COMMISSIONING AND APPOINTING AN INDEPENDENT AUTHOR/CHAIR

10.1 Conducting a SAR requires a diverse range of expertise. The Care and Support Statutory Guidance states SARs should be led by individuals who are independent of the case under review and of those organisations whose actions are being reviewed. Consideration will be given to identify individuals from among salaried professionals in the local safeguarding network, or NSAB will commission an independent author.

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

[7] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 – section 14.180 – 14.186

10.2 The NSAB Business Manager will seek recommendations for an Independent Author via the national network of Safeguarding Adult Board Business Managers.

10.3 The Independent Author may also act as Chair of the SAR. However, where the Sub Group deem it necessary, an Independent Chair may also be commissioned.

10.4 Details of the recommended authors will be reviewed by Sub Group members and a decision made based on the skills and experience needed for the review in line with the Care and Support Statutory Guidance– see 7.1 a. above.

10.5 Once a decision has been agreed by the Sub Group, the Business Manager will write to confirm the appointment of the Independent Author and send a contract.

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

11.1 Involving the adult at risk (if they are alive) and/or their family are significant to the SAR process. A SAR may be unfamiliar for the 'adult at risk' and/or their family, potentially adding to their distress and concerns. It is very likely to be a very sensitive time for everyone involved and consideration should be given at an early stage as to how this will be sensitively communicated. The following should be considered by the SAR Panel:

a. How the family want to be involved and the type of outcomes that are likely from the SAR.
b. If the relative(s) is considered an 'adult at risk', specific consideration should be given to the support they require in terms of a representative or advocate.
c. If the 'adult at risk' has capacity to consent, and allows for family (and/or friends) to be involved in the SAR, they will also be invited to contribute their views. This will include informing them of the SAR and sharing the outcomes with them in an appropriate way, taking in to account their preferences.

11.2 It's important to set an appropriate expectation of the SAR with the family. The 'adult at risk' and the family/friends 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.

11.3 The involvement and engagement of the family/friends 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/friends will be kept updated with the progress of the SAR, and will be invited to a relevant meeting(s) with the Independent Author, and to review a paper copy of the final report ahead of publication. To ensure clarity around the final version of the report, it will only be shared electronically with the 'adult at risk' or their family on publication.

11.4 Throughout the whole process, due diligence, compassion and appropriate support must be provided and the commissioner of the care will provide this or an alternative should be arranged if that is more appropriate.

11.5 Should a family member or friend be an 'adult at risk' and/or also the alleged perpetrator of the abuse, the SAR Panel will need to consider the involvement of the individual in the SAR process.

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

12.1 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 to what 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.

12.2 To enable staff who have been involved in a case subject to a SAR to share their views, it may be necessary to provide them with additional support. It is key to organisational involvement that relevant information is gathered from officers who were involved in supporting the adult subject to the review to determine the situation and circumstances of the case in question. This allows a much richer review of the agency's involvement and ensures staff feel involved and supported and able to implement recommendations and actions that subsequently follow from the SAR.

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

12.4 Agencies are responsible for ensuring their own staff, volunteers and others are provided with a safe environment to discuss their feelings and are 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 this needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, but the team, organisation and wider workplace.

12.5 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 any 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 applies equally to the agency who may not have been directly involved but where disseminated learning is still required.

13. PRACTICE OR PROFESSIONAL CONDUCT ISSUES

13.1 This section must be read in conjunction with the Northamptonshire Inter-Agency Policy and Procedures.

13.2 Issues of concern relating to an individual's practice or professional conduct may become apparent during a SAR, but it is not within the remit of the SAR review process to deal with these.

13.3 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 take any necessary and appropriate action.

14. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

14.1 Each SAR will produce a final report with recommendations arising from the review, irrespective of the methodology used. The complexity and proportionality of the report will be matched to the issues in question.

14.2 The SAR Panel Author/Chair must ensure that there is sufficient broad analysis, scrutiny and evaluation of evidence by the panel throughout the review process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the panel should form the basis of the report(s), produced by the nominated author.

14.3 The final report(s) should always be produced as soon as is practical at the conclusion of the SAR process. The panel should receive and agree the draft report(s) before presentation to the SAR Sub Group so that members are satisfied that the panel's analysis and conclusions have been fully and fairly represented. However, it should be understood the SAR Panel has final editorial oversight before it is presented to the SAR Sub Group and then to NSAB. If there are issues arising that cannot be resolved by the panel and full agreement of the final report(s) cannot be achieved, then the Chair of the SAR Sub Group should seek to find an appropriate way forward.

14.4 Final reports will be presented to the SAR Sub Group ahead of any NSAB meeting to consider the findings and the resulting recommendations and to seek clarification on any issues with the SAR Panel. Any outstanding issues or resolution will be agreed before presenting the agreed final report(s) to NSAB. The agreed final report(s), will then be presented at the next scheduled NSAB meeting or consideration will be given to convening an extraordinary meeting of NSAB.

14.5 The SAR reports remain the property of NSAB.

14.6 A sample report template is provided in Appendix 7 in the supporting guidance.

15. PUBLISHING REPORTS

15.1 NSAB recognises the importance of collective responsibility, open and transparent governance and the need for evolved learning when undertaking a SAR. In line with the Care Act 2014, the overriding consideration to publish the findings should be in line with the legal parameters about confidentiality.

15.2 Where appropriate, the SAR Sub Group will take the wishes and feelings of family members into consideration or indeed any national learning arising from the case that might affect decisions as to how and if the report is published. NSAB 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 may include publication of the overview report, executive summary or a redacted summary via the NSAB website.

15.3 If the report(s) is published, the Business Office will share the website link to NSAB and the agencies involved in the SAR to enable members to prepare their own communication to share the learning.

15.4 NSAB will make appropriate arrangements for the SAR report(s) 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 relevant Information Sharing Agreements, the Data Protection Act 2018 and General Data Protection Regulation, Information Governance arrangement and other legal requirements.

15.5 The Care Act 2014 requires the SAB to publish the findings of any SAR in its annual report.

15.6 Any reports 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 anonymisation. It may be that the person's name is not anonymised if this is appropriate in all of the circumstances mentioned.

15.7 Where appropriate, NSAB will consider seeking legal advice before the publication of a SAR.

16. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

16.1 The importance 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, and that multi-agency safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

16.1 Once a report and its recommendations have been confirmed by NSAB, the SAR Sub Group will be responsible for ensuring the development of a Composite Action Plan (see Appendix 8 in the supporting guidance) to ensure identified report recommendations are fully set out, prior to presentation to NSAB.

16.2 Agencies directly involved in the SAR, must take full ownership of the relevant recommendations and ensure their actions are implemented in a timely manner. They are also responsible for ensuring that learning and service changes, where appropriate, are embedded and evidenced within their organisation.

16.3 The Business Office will request regular progress updates from agencies involved in the review and amend the Composite Action Plan accordingly. The Sub Group will retain oversight of the implementation of the recommendations in the plan, providing updates to NSAB as necessary.

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

17. SUPPORTING AND RESOURCING SAFEGUARDING ADULT REVIEWS

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

17.2 Expenditure will be allocated for SARs in each financial year in the NSAB budget. Should additional funding be required the statutory partners will agree the appropriate level of funding required.

17.3 Whilst recognising the challenges that all agencies are under in terms of resource constraints, this cannot impede the delivery of this statutory requirement and all partners should prioritise officers for this purpose.

18. SUMMARY OF RESPONSIBILITIES

Responsibilities of the Safeguarding Adult Review Panel

18.1 In addition to the more detailed issues set out within this Protocol, the SAR Panel will have specific responsibilities for agreed activities and actions including:

a. Setting the agreed terms of reference, and clear process and direction for gathering information depending on the methodology being used, as well as collating and reviewing all information.
b. Consideration as to how the ‘adult at risk’ (where they are alive) will be supported and involved in the SAR process.
c. Confirming how relatives, family/friends will be involved in the SAR and who will act as liaison and support to them, if necessary.
d. Under the leadership of the Independent Chair/Author, supporting the review into the circumstances surrounding the incident referred for SAR, using whatever methodology has been agreed.

18.2 The SAR Panel is made up of a minimum of a nominated Independent Chair/Author, Sub Group Chair and supported by the Safeguarding Board Business Manager (or agreed alternative), dedicated business support, along with key individuals who have been invited to be involved, depending upon the methodology being used. As a minimum, all statutory agencies will be involved in the SAR.

18.3 Throughout this process, the SAR Panel will consider a communication strategy, linking with the SAR Sub Group as required.

18.4 Where legal advice is required, the NSAB Business Manager will obtain this.

18.5 The SAR Panel should aim to complete the SAR within six 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 SAR). Any delays that have been incurred as part of the review will be documented within the report(s).

Responsibilities of the Safeguarding Adult Review Sub Group

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

18.7 The Sub Group acts as the intermediary between the SAR Panel and NSAB, 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 representatives.

18.8 The Sub Group will work with NSAB and the Panel to identify that any conflict of interests are identified and addressed (e.g. a SAR Sub Group member 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 reviewed appropriately, such as providing an alternative officer to complete the IMR.

18.9 Throughout the process, the Sub Group Chair will provide updates on the progress of the SAR at relevant meetings.

18.10 The final report(s) will be presented to the Sub Group before presentation to NSAB. The Sub Group will ensure that a Composite Action Plan is in place; turning recommendations into actions, which is presented to NSAB.

18.11 The Sub Group Chair will inform the Chair of NSAB that the review has been concluded and the report is available, subject to ratification by NSAB. If necessary, an extraordinary meeting of NSAB will be arranged.

Responsibilities of NSAB

18.12 Ultimate responsibility for the completion of the SAR, the related recommendations and their implementation remains with NSAB. They are also required to lead on all communication matters and any publishing arrangements. In practice, the SAR Sub Group undertakes most of this as the delegated group, but accountability remains with NSAB.

18.13 NSAB will formally approve the SAR report(s). Should NSAB not formally accept some or any of the recommendations, the points of contention will be referred back to the SAR Panel for their action and update. The amended final report will be represented to NSAB for formal approval.

18.14 NSAB may consider obtaining legal advice where appropriate.

18.15 An executive summary will be considered to share the learning from the SAR, and NSAB will need to confirm how and if the report is made public, together with any communication or media management.

19. RETENTION OF DOCUMENTATION

19.1 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 Data Protection Act 2018 and the General Data Protection Regulation.

19.2 On completion of the SAR, the Independent Author must securely destroy all materials pertaining to the review such as reports, chronologies, IMRs etc. and/or return any information in their possession to the NSAB Business Office. In addition, they will delete all information from their computer(s), laptop(s), mobile phone(s) and other electronic devices, as specified in the contract.

19.3 In line with the Data Protection Act 2018 and the General Data Protection Regulation, NSAB will retain documents relating to the SAR in line with the West Northamptonshire Council's retention and disposal schedule document.

19.4 Individual organisations will take ownership regarding the retention of information such as detailed Statements of Information, Individual Management Reviews, chronologies and questionnaires.

19.5 Published reports will be made available (where appropriate) on the NSAB website for three years following publication, or until all actions have been executed in the Composite Action Plan. A copy of the published report(s) will also be made available via the Social Care Institute for Excellence (SCIE) Safeguarding Adults Review Library, again, where appropriate.