Cheshire West and Chester
Local Safeguarding Adults Board (LSAB)

Safeguarding Adult Reviews (SARs)

Procedure

April 2019

Local Safeguarding Adults Board

Cheshire West & Chester LSAB
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Contents

Page

Cheshire West & Chester LSAB
Local Safeguarding Adults Board

Cheshire West and Chester Safeguarding Adults Review (SAR) Procedure

1. Introduction

1.1 The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in section 1 of the 2014 Care Act (implemented in April 2015). It is a statutory requirement of Adult Safeguarding Boards to carry this function out.

1.2 Cheshire West and Chester (CWaC) Local Safeguarding Adults Board (LSAB) oversees and leads adult safeguarding across the locality and has a range of statutory duties that contribute to the prevention of abuse and neglect. This includes the duty to conduct any SARs in accordance with section 44 of the Care Act. SARs are reviews that examine the way agencies and individuals have acted when they have been involved with an 'adult at risk'. The purpose of the SAR is to identify learning that will bring about improvements so that the likelihood of harm to adults at risk is minimised.

1.3 This procedure specifies the statutory requirements and the working arrangements of Cheshire West and Chester LSAB in respect of SARs.

1.4 SARs are not to reinvestigate or apportion blame. The purpose is not to make an enquiry into who is culpable or how the person met their death – these matters are for the Coroners Court, Criminal Courts and employment procedures as appropriate.

2. Statutory Duty under Section 44, 2014 Care Act

2.1 There are three broad circumstances under which the Care Act statutory guidance considers a SAR may take place. The guidance makes a distinction between those circumstances where the LSAB ***must*** and ***may*** arrange a SAR:

2.2 The LSAB ***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:

1) there is reasonable cause for concern about how the LSAB, members of it or other persons with relevant functions worked together to safeguard the adult; and;

2) EITHER

a) the adult has died, and the LSAB 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).

OR

b) the adult is still alive, and the LSAB knows or suspects that the adult has experienced serious abuse or neglect (serious may be defined as life changing injury/condition).

2.3 A LSAB ***may*** also 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). SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. In cases where there is learning but the case does not meet the thresholds for a full SAR the independent chair may recommend a step-down review.

2.4 Each member of the LSAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

3. SAR Criteria

3.1 The first criterion for determining whether a SAR should be conducted is in establishing whether the adult was in need of care and support services (whether or not the local authority was meeting any of those needs).

3.1.1 The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014 (the 'Eligibility Regulations'). The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

3.1.2 In considering whether an adult has eligible needs for care and support, local authorities must consider whether:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes (which are described in the Care Act guidance sections 6.105 to 6.112)
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

3.1.3 Significant impact is not defined and should be understood to have its everyday meaning.

3.2 The second criterion to be met is establishing a cause for concern about how the LSAB, its member organisations, or other persons with relevant functions, worked together to safeguard the adult. A particular emphasis is the extent that they could have worked more effectively to protect the adult from the resultant outcome and therefore the potential for learning.

3.3 The third criterion involves an examination of the link between the death or serious harm (what constitutes serious harm is detailed in 3.4) and suspected abuse or neglect.

3.4 In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of the abuse or neglect.

3.5 **Timescales** – any learning from a review should be current or recent, therefore any request for an SAR should be within 12 months of the alleged abuse/incident occurring.

3.6 All three criteria must be met in order for the panel to say that a SAR must be carried out.

4. Purpose and Principles of a Safeguarding Adults Review (SAR)

4.1 The purpose of a SAR is to promote effective learning and improvement action, through identifying 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 investigation.

4.2 The SAR's purpose is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

4.3 A SAR should highlight any lessons that can be learned from the case and through a clear set of recommendations; ensure that relevant actions are taken in order to help prevent future deaths or serious harm. This helps to improve both single and multi-agency working to better safeguard and promote the wellbeing of adults at risk.

4.4 SARs will be undertaken in accordance with the following principles:

- There should be a multi-agency culture of continuous learning and improvement; identifying opportunities to draw on what works and promote good practice.
- The approach should be proportionate according to the scale and complexity of the issues and the potential for learning.
- SARs should be led by individuals who are independent of the case and of the organisations whose actions are being reviewed, with the skills and experience necessary to maximise learning.
- SARs should be trusted and safe experiences that encourage honesty, transparency and sharing of information. People, who are invited to contribute, should do so without fear of being blamed for actions they took in good faith.

- SARs should be underpinned by a culture of openness, transparency and candour. This should be reflected in the involvement of people affected by the case including the victims of abuse and their families.
- Recommendations and learning will be shared appropriately through local and regional safeguarding networks to ensure that good practice is made available to those who work closely with adults at risk and those who assist to influence and develop practice in this arena.

4.5 The LSAB should be primarily concerned with deciding what type of review process best enables this to happen. The level of the review will be determined by the Independent Chair of the LSAB following the SAR Panel's recommendation.

4.6 The findings from SARs will be anonymised and included in the LSAB's Annual Report along with relevant service improvements and actions and the reasons for any decisions not to implement actions.

5. Initiating a Safeguarding Adult's Review (SAR)

5.1 Only Cheshire West and Chester Local Safeguarding Adults Board can commission a Safeguarding Adults Review, however any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR.

5.2 Where an individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they may refer a case to the LSAB to establish if there are important lessons for multi-agency work to be learnt from a case. This includes any professional body, members of the public, councillors, MPs and the coroner. The Secretary of State also has authority under the Local Authority Social Services Act (1970) to cause an enquiry to be held where he/she considers it advisable.

5.3 LSAB member organisations will publicise within their own agencies the criteria and circumstances under which a SAR may be considered and the process under which a referral might be made. This information will also be publicly accessible.

5.4 A referral is made by completing the referral form and sent by secure email to the LSAB Board Manager. Referrals should be made as soon as it is apparent that the criteria may be met, subject to considerations in paragraphs 5.5 and 5.6 below. An unreasonable delay in raising an issue can impact both on the process and the key purpose in a number of ways.

5.5 The LSAB will not review cases that are more than twelve months old, unless there is significant information that has recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. The decision to take on cases that go outside the time limit, need to be referred to the LSAB Independent Chair for a final decision.

5.6 Prior to making a referral, professionals working with adults at risk, should consider the relevant guidance, and discuss with their organisations line manager, Safeguarding lead (if applicable) or LSAB representative.

5.7 By virtue of the criteria, in cases where a SAR may be indicated, a safeguarding concern and/or enquiry may already have been made. In this case a discussion with the relevant manager who was responsible for authorising the case should normally take place prior to making a referral for a SAR. Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to multi-agency safeguarding policy and procedures which consider any immediate protection required.

5.8 However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have committed suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

5.9 All agencies should have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning, and this protocol is not intended to duplicate or replace these.

6. Decision Making

6.1 On receipt of the SAR referral request, the Chair of the SAR Panel, supported by the Safeguarding Adults Board Manager, will discuss with members of the panel to consider whether the criteria are met.

6.2 The Chair of the SAR Panel may seek further information including clarity about parallel investigations that may be taking place such as a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

6.3 Agencies can be asked for additional information by the LSAB Board Manager to inform a decision as to whether a review should take place. After reviewing all the information available against the criteria and guidance, the SAR Panel will determine if they consider that the criteria for a SAR have or have not been met.

6.4 The Independent Chair of the Safeguarding Board is responsible for deciding whether to undertake a review or not, based on the recommendations of the SAR Panel.

6.5 The Chair of the SAR Panel will inform the referrer in writing of the decision. If the referrer does not agree with the decision, they may appeal to the Independent chair of the LSAB, whose decision is final.

6.6 If the decision is to undertake a SAR, the LSAB Board Manager will arrange to notify the individual, their family or carers (where appropriate), collaborative agencies of the Board, and if applicable to do so, the Care Quality Commission (CQC) which is the regulator of health and social care services.

6.7 Where the SAR Panel agrees that a referral does not meet the criteria for a SAR but agencies will benefit from a review of actions, other methodologies can be considered. This might be the case where for instance, there is a safeguarding element and lessons to be learnt regarding the conduct of an agency, but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.

Options could include:

- **Serious Incident Review**: Organisations should use their own procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations
- **Single Agency Review**: A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue or a smaller scale audit of agency involvement.
- **Reflective Practice Session**: The original participants in the case may review identified aspects of the case as part of reflective practice session chaired by the Safeguarding Lead or other such suitable person, including an independent facilitator.

6.8 All referrals will be recorded and noted at the SAR Panel.

7. The SAR Panel

7.1 Core membership of the SAR Panel comprises of:
Cheshire West and Chester Senior Adult Social Care Manager
LSAB Board Manager
Cheshire Constabulary
NHS West Cheshire Clinical Commissioning Group

And any other local or national agency, which had or may have been involved with the victim, perpetrator or their families and households, should also be invited to contribute to and attend the SAR Panel meeting.

7.2 The SAR Panel will recommend:

- Which agencies should be asked to participate in the SAR
- Whether the agencies concerned are required to secure their files
- Which methodology should be used to facilitate learning in the case
- The Terms of Reference for the SAR
- The required output from the SAR (for example a report)
- The timescales for completion of the SAR. This should be within 6 months if possible.
- Recommendations relating to an independent facilitator/chair
- Recommendations relating to an independent author.

7.3 The SAR Panel will be provided with the referral plus any written reports the Chair has requested from the key agencies involved. Representatives from agencies may also be asked to attend during the first part of the panel meeting, to help clarify the circumstances of the case. It is important for the panel to have sufficient information before discussion begins.

7.4 However, the panel is not investigating the circumstances of the incident, and is not conducting the SAR themselves, so the consideration of issues should be proportionate.

8. Commissioning a SAR

8.1 The Care Act guidance states that the LSAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it unless there are good reasons for a longer period being required.

8.2 It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues, which emerge from the review and need to be considered immediately, should be brought to the attention of the Board.

8.3 On receipt of the LSAB Chair's decision to undertake a SAR, the SAR Panel Chair and the LSAB Board Manager will liaise in order to make the necessary arrangements. This will include:

- Notifying the referring agency, LSAB members and other interested parties (including CQC and the coroner).
- Identifying an appropriately qualified Independent Chair/Author and securing the necessary administrative support and budgetary requirements.
- Notifying the adult and/or their family/advocate as appropriate.
- Considering an initial scope and timescales.
- Initiating any information requests that are required.
- Considering media and communication strategies.

8.4 Once the decision has been communicated, each agency will be responsible for taking appropriate actions that may be necessary in relation to the security of their records. No member agency should comment publicly upon the case without express agreement of both their senior management and the Independent Chair of the LSAB.

9. Appointment and Role for the Review Panel Chair/Author

9.1 The Review Panel Chair/Author should be an experienced individual who is not directly associated with any of the agencies involved in the Review. The Review Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the

Individual Management Reviews (IMRs) and any other evidence the SAR Panel decides is relevant.

9.2 Consideration should be given to the skills and expertise required to effectively Chair a SAR. The Review Panel Chair/Author should have the appropriate core skills including:

- Strong leadership and ability to motivate others;
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- Collaborative problem-solving experience and knowledge of participative approaches;
- Ability to find and evaluate best practice;
- Good analytic skills and ability to manage quantitative and qualitative data;
- Knowledge of safeguarding adults;
- Ability to write for a wide audience and
- An understanding of the complexity of the health and social care system

9.3 The Review Panel Chair/Author is responsible for the final decision on the suitability of the SAR Terms of Reference and they are to be agreed at the first meeting of the Panel.

9.4 The Terms of Reference may, however, need to be revisited as the Review progresses and as new information is identified. The Review Panel Chair/Author will agree any amendments to the Terms of Reference with the SAR Panel.

9.5 The Review Panel Chair/Author will establish an agreed timetable of SAR Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of Individual Management Reviews.

9.6 As part of the Terms of Reference, the Review Panel Chair/Author should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the Review in conjunction with Cheshire West and Chester's Council's Communications Team.

9.7 The Review Panel Chair/Author should as far as possible, ensure that the Review process is a learning exercise in itself for all those involved in the case.

9.8 The Review Panel Chair/Author will maintain contact with the LSAB Board Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

9.10 The Review Panel Chair/Author should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

9.11 Where there is an on-going criminal investigation the Review Panel Chair/Author will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes.

This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

10. Methodology

10.1 SARs can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies, led by an independent overview report author. With this method, individual agencies are asked to review the practice within their organisation through Individual Management Reviews (IMR) and Chronologies, which then form part of an Overview Report.

10.2 Other methods considered are:

- Action Learning Approach
- Peer review approach
- Thematic Reviews
- Single Agency Review

See **Appendix 3** for further information on SAR Methodologies and tools

11. Links with other reviews and investigations

11.1 There are a number of types of review and investigation that may interface with a SAR and it is important to identify any other processes which may be running in parallel or being considered. These include a Child Serious Case Review (SCR), Domestic Homicide Review (DHR), safeguarding and serious incident investigations, criminal justice processes and Coroner inquests. The criteria for a serious incident in the NHS are described in 12.5 below.

11.2 In setting up a SAR, the LSAB must consider how the SAR will dovetail with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning; and minimising the impact on those affected by the case.

11.3 Where there are possible grounds for both a SAR and a Child SCR or a DHR then a decision should be made at the outset by the respective decision-making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and

overseen, or one Board leading, with the same or different reports being taken to each commissioning body.

11.4 Any SAR will need to take account of a coroner's enquiry and, or any criminal investigation including disclosure issues, which may impact on timescales. It will be the SAR lead's role – usually the Chair of the SAR Panel - to ensure the necessary contacts are maintained with appropriate people.

11.5 Serious Incidents in the NHS include: (Serious Incident Framework NHSE 2015)

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm;

11.6 Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare is not taking appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.

11.7 This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), a Safeguarding Adult Review (SAR), a Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident. In the event of the aforementioned occurring the incident would necessitate in completion of serious incident reporting and investigation

12. Involvement of Family Members, Friends, and other Support Networks

12.1 Family members and friends can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the SAR Panel have opportunities to listen to family and friends experiences and perspectives and that these contribute meaningfully to the final report. Family members and friends can include:

- Siblings
- Parents
- Carers
- Grandparents
- Other significant family members

- Friends

12.2 As a minimum, family members and friends should:

- Be notified of the review process, what that means for them and how they can access support – including impact of media coverage
- Agree the level and frequency of contact with family members to ensure they are kept informed
- Supported to contribute to the review process – either in writing, by meeting with the review panel, sharing views via a third party or by other means identified by the SAR Panel
- Included in feedback about the learning identified by the SAR Panel
- Informed and prepared for the publication of the report in a timely manner – again including any likelihood of media interest
- Provided with a read only copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version. A 'hard' copy of the report should not be provided until the report is in the public domain.
- Agree about anonymising the person and identify a pseudonym name to use in the report.

12.3 Reflecting the principles of openness, transparency and candour; the LSAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care Act, where an adult has "substantial difficulty" in participating, this should involve representation and support from an independent advocate (who could be a family member).

12.4 Staff involved in the SAR need to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how a known abuser might have some input to the review process.

12.5 Normally, individuals should be notified that the SAR Panel is taking place. Involvement may be by formal notification only, or by inviting them to share their views in a way that suits them.

12.6 The timing of such notification is crucial particularly where there are criminal justice processes running parallel and decisions will need to be taken in consultation with relevant others.

12.7 If a decision is taken not to involve the adult at risk, or their family, the reasons should be informed by legal advice and recorded.

12.8 If the adult at risk/or their family has been affected by an NHS notifiable patient safety incident, the Duty of Candour will apply to the NHS body. Under the Duty of Candour an NHS body must:

- Communicate honestly and openly about any care and treatment that has been provided.
- Offer an apology.
- Advise the relevant person what further enquiries it believes are appropriate as a result of the patient safety incident and provide updates.

12.9 If an adult affected by a notifiable patient safety incident, has died or experienced serious abuse or neglect then a conversation with the family/adult should be considered prior to a referral for a SAR. If a SAR is commissioned subsequently then they should be kept updated on developments from the investigation into the patient safety incident and the SAR.

13. Considerations for Disclosure in a Safeguarding Adults Review

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005.
- Consideration of relevant articles of the European Convention of Human Rights, as incorporated into the Human Rights Act (1998)
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act (1998) & Children Act (1989) (updated 2004).
- Information sharing between LSAB's and the Coroner is not defined in statute however case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the LSAB has commissioned a SAR, information sharing in relation to SAR documents should be considered on a case by case basis.

13.2 On receipt of a request for documents relating to a SAR, from the Coroner, the LSAB will seek legal advice in order to consider Public Interests Immunity arguments.

13.3 Chapter 14 of the Care Act Guidance sets out expectations in relation to information sharing between agencies and LSABs in relation to SARs including an expectation that information must be shared to enable a LSAB to do its job.

14. The Final Overview Report

14.1 The SAR overview report brings together the learning, themes identified from the review and will analyse and comment on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the adult.

14.2 The Review Panel Chair/Author has responsibility for collating the report and the report should:

- Provide a summary of the circumstances that led to the review.
- Briefly outline the review process and methodology, including how the views and participation of key stakeholders as achieved.
- Be written in a succinct and focused manner with the emphasis on recognising and sustaining good practice as well as identifying how and where practice can be improved in the future.
- Identify action that agencies or services have already undertaken in response to learning.
- Form a conclusion as to the effectiveness of local practice to safeguard and promote the welfare of the adult.

14.3 The SAR overview report should firstly be presented to the SAR Panel. This provides an opportunity to quality assure the document, reference the identified learning and to ensure an opportunity for the findings to be challenged where necessary.

14.4 Once agreed the Review Panel Chair/Author should present the report to the LSAB supported by the SAR Panel Chair.

14.5 It will be the responsibility of the LSAB to identify and agree how practice challenges or recommendations from the SAR Report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

15. Action plans

15.1 A clear SAR action plan should be developed by the LSAB with a focus on improving outcomes for adults at risk. The following should be included in the Action Plan as standard:

- A timeline for publication of the report should be developed and where possible a date identified.
- Action is taken by the LSAB to share the findings of the report with the practitioners who contributed to the Learning Event and with family members.
- The LSAB will identify how it will share the lessons learned, and practice impact with the wider workforce in Cheshire West and Chester.

15.2 Once the SAR report and action plan have been agreed, the report will be endorsed and signed off by the LSAB and copies will be available on the LSAB website.

15.3 The action plan will be regularly reviewed and its impact evaluated through the Audit and Review Sub Group.

16. Findings from SARs

16.1 The findings from any SARs should be reported in the LSAB Annual Report and what actions it has taken or intends to take in relation to those findings. Where the LSAB decides not to implement an action, then the Annual Report must state the reason for that decision.

17. Media Strategy

17.1 The SAR Panel Chair in consultation with the Independent SAR Panel Chair/Author, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

17.2 Since the Local Authority is the lead agency, media and communication issues will usually be co-ordinated by the Council's Communications Team. This will be done in collaboration with the Communications Teams of the other agencies involved, alongside agreed representatives of the Board.

17.3 All SAR reports will be considered for publication on the LSAB website. In the case of publication, the LSAB Independent Chair will release a statement where appropriate.

18. Learning from SARs

18.1 The value of SARs is in the learning derived from them. As such much effort should be spent on acting on recommendations as on conducting the actual Review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timely.

18.2 The following should help to secure maximum benefit from the Review:

- Conduct the Review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a Review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with adults.
- Make sure staff and their representatives understand what can be expected in the event of a SAR.

19. Complaints & Escalation procedure

19.1 Where a complaint is received about a LSAB process, for example a Safeguarding Adult Review, this will initially be responded to by the LSAB Board Manager in consultation with the relevant Head of Service, with a written response within 28 days of receipt.

19.2 If the complainant is unsatisfied with the response, they should contact the LSAB Board Manager who will arrange for their complaint to be considered by the LSAB Independent Chair.

19.3 The LSAB Independent Chair will provide a further written response within 28 days of the complainant contacting the LSAB Board Manager. All written complaint responses will include details of how to contact the Local Government Ombudsman.

19.4 The LSAB Board Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of the General Data Protection legislation.

Appendix 1 – A SAR review decision making process

Domestic Homicide

Notified by GMP to Head of the Safeguarding Unit

Case moves Straight to Review process

A safeguarding adult incident occurs

The Head of the Safeguarding Unit and the LSAB Board Manager to be notified within 1 working day

Safeguarding Investigation would refer to SAR Panel for consideration

Head of Safeguarding Unit consults with:

- Head of Adults Social Care
- Head of Commissioning

Consultation and agreement to take place within 2 working days of the incident

Does a SAR Consideration Panel meeting need to be convened?

A date for the SAR Consideration Panel meeting is arranged and all agencies are contacted and requested to complete an Agency Contact form and returned to the LSAB Board Manager within 15 working days of the request being made

The SAR Consideration Panel meeting takes place:
All agency information is reviewed and consideration is given as to whether the incident meets the criteria for a SAR

The SAR Consideration Panel meeting decision is referred to the LSAB Independent Chair for the final decision

	Decision to hold Practice Learning Review	Decision to hold SAR	No further action

Head of Adult Safeguarding Unit to inform CCG **within 14 days of decision being made**

Proceed to Review

Appendix 2 - Communication strategy in respect of a SAR publication

On completion of a SAR

- In the final SAR Panel meeting have a discussion with partners about communication issues and agree what information needs to be communicated and to whom.

In preparation for inquest

- Head of the Safeguarding Unit and/or the LSAB Board Manager will liaise with the Council's Communications Team re statements in relation to inquest - prepare statement in advance. Director of People will make a statement on behalf of Cheshire West and Chester Council as and when required.
- Head of the Safeguarding Unit and/or the LSAB Board Manager to write communication statement in co-operation with the Council's Communications Team and provide this to the SAR Panel members.
- The Council's Communications Team to provide statement to the Press on request.

In preparation for publication of SAR

- Agree a date for publication.
- Ensure SAR Panel have had final version of Overview report
- Send finalised report to SAR repository
- Agree publication style - pro-active press statements or publish on website.
- Liaise with Council's Communications Team about potential for press interest following the publication.
- Inform family by letter.
- Inform Independent SAR Panel Chair/Author
- Inform lead member and the Chief Executive. Consider if an elected members brief is required
- Notify Website team of intention to publish on LSAB's website.
- Liaise with SAR Panel members so that their Communication Teams can be alerted – SAR Panel members to provide communication lead from their respective organisation.
    - Final version of reports to be circulated to Communication representatives as required
    - Partners need to have their own statements ready and liaison should take place with Cheshire West and Chester Council's Communication Team about prepared statements.
    - If partners have media queries they **must** liaise with Cheshire West and Chester Council's Communication Teams named person before making a response so that the level of exposure and risk can be assessed.
- Inform LSAB Partners of intention to publish any reports and what information will be provided with the report. Usually this will be 7-minute briefing but it may include a summary of the changes that have taken place because of the SAR and an explanation about delays in publication.
- Report onto website - circulate link to partners

Appendix 3 SAR methodologies and tools

1. Traditional Model

This methodology, a traditional model, forms the basis of DHR and SCR in similar fields and historically in adult safeguarding. Typical features include:

- Appointment of a panel, including chair (usually independent) and core membership-which determines terms of reference and oversees process Independent report author, which can also be the chair.
- Combined chronology of events
- Involved agencies produce Individual Management Reviews, outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the commissioning board and monitoring implementation across partnerships

Individual Management Reviews (IMRs)

IMR's are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes, or individual and organisational practice could be enhanced. They are key learning tools used in several of the SAR methodologies and other similar reviews such as Domestic Homicide Reviews and Serious Case Reviews. They can be used in a multi or single agency environment.

It is important that individuals who are asked to undertake IMRs have the relevant skills and sufficient independence from the case being reviewed.

Where it is decided that IMRs are required:

- The SAR Panel should write to the Chief Officer of the organisations involved, providing the template for an IMR (see Appendix 3).
- Organisational reports should be prepared by a Senior Officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learnt and actions taken or to be taken.
- In the case of NHS organisations already completing a Serious Incident investigation the information produced such as a report, chronology, findings and an action plan should be transferred to the IMR document, within the scope of the terms of reference agreed.
- Individual Management Reviews must be signed off by the Chief Officer of each organisation.

Multi-Agency Chronology

Chronologies are important tools particularly when combined across organisations. This enables a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment.

Many of the methodologies outlined utilise chronologies within them, however they can be used in isolation to achieve an overview of a case fairly simply, that can assist in assuring or developing multi-agency working.

In this approach each agency produces a single chronology of involvement over the period that has been agreed as relevant to the investigation or review. They may also be asked to provide chronologies relating to more than one person of interest in the case.

The chronologies are then combined in a desk top exercise. This enables review by an individual, for example in determining whether there appears to be grounds for further investigation or potential for learning; or where this is the case, more detailed examination and discussion in a multi-agency workshop. This latter process will usually benefit from a facilitator.

Any identified learning points should be noted and translated into actions which are shared with the LSAB and implemented.

2. Action learning approach

This option is characterised by reflective/action learning approaches, which identify both areas of good practice and those for improvement and do not apportion blame. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

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

Further variance

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documents review, staff interviews and report production.
The table below is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the Safeguarding Adults Board in consideration of the best fit and individual preferences in the light of the case in question.
There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Health and Social Care Advisory Service (HASCAS)
- Paul Tudor-Significant Incident Learning Process
- Social Care Institute for Excellence (SCIE) - Learning Together Model

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

3. Peer review approach

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this SAR option regarding the balance of peer team to maximise identified expertise and increase viability. They can be developed as part of regional reciprocal arrangements which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning. Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the SAR.

The appointed peer team/panel should agree the Terms of Reference and specific methodology with the SAB.

4. Multi-agency practice learning reviews (PLRs)

This approach is suitable where several organisations have been involved in a case and it has been determined that there is the potential for learning and/or a need to refine or introduce policies and procedures to improve how they can work together in the future, to minimise a repeat of the incident concerned.

The methodology should be proportionate to the incident, however would normally involve the compilation of a multi-agency chronology, which is used to highlight critical areas for further examination within a facilitated workshop. The review should make best use of all available evidence including any single agency investigation reports and /or safeguarding investigations in order to maximise learning and reduce

administrative burden. Normally a suitably qualified chair from one of the SAB member organisations would lead and facilitate the review and a report author commissioned from within the SAB partners, who is suitably independent to the case produce a summary report and action plan.

Key priorities are ensuring the participation of all organisations in the coordination of information, participation in the workshop and in implementing the action plan.

5. Root Cause Analysis (RCA)

RCA is a technique which can be used to uncover the underlying causes of an incident. It looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events working back from the incident itself and identifies a range of factors which contributed to the incident.

This allows the real causes and contributory factors to be identified so that the relevant organisations can learn and put remedial actions in place.

6. Significant Event Analysis (SEA)

This method brings together managers and/or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently. Its focus is on learning which can lead to future improvements and it results in an action plan with recommendations for learning and development. Staff are brought together in a facilitated team approach.

This methodology has been used for many years in General Practice and in other areas of the NHS. The Adult at Risk is not involved in SEAs, however the findings may instigate further review or investigation which should involve them.

It will be for the SAR Panel Chair to decide which methodology suits the case best.