Safeguarding Adult Review (SAR) Protocol

Bexley Safeguarding Adults Board

Written and created by:
Anita Eader and Alexandra Gregory, Bexley SAB Business Team

Signed-off by Bexley SAB: on 7th September 2022

Contents page:

1. Foreword
2. Introduction
3. Purpose
4. Conducting SAR's in Bexley
5. Embedding Learning and Assurance Framework
6. Appendices

1.Foreword

The Bexley Safeguarding Adults Board recognises and values the opportunity to ensure that the partnership learns, develops, and uses a reflective approach for all reviews.

This Protocol is designed to explicitly set out the ***statutory*** roles and responsibilities within Bexley for Safeguarding Adults Reviews and to clarify the governance arrangements relating to such reviews for the Bexley Safeguarding Adults Board.

Bexley have incorporated the requirements of the Care Act 2014, and are adopting the term, 'Safeguarding Adults Reviews' known as, SAR, for all safeguarding learning reviews regardless of which methodology is used to achieve learning. All Safeguarding Adults Reviews are of equal significance and value to the BSAB.

Safeguarding Adults Reviews are essential in helping the Board prevent abuse and neglect of adults at risk and learn from cases and situations that challenge us as a multi-agency partnership.

The Care Act 2014 makes safeguarding ***everyone's responsibility*** to safeguard adults at risk and together I am certain we can achieve better outcomes based on the learning we receive.

It is important to remember that ***anyone*** can make a SAR Notification to the BSAB regarding the ***death or serious incident*** of an adult (or group of adults) at risk residing in Bexley.

It is the BSAB's expectation that ***all partners and agencies working with adults*** in Bexley use this SAR Protocol and Toolkit to have consistency, governance and understanding of the SAR process and to embed the learning found through SAR.

It is my expectation as the Independent Chair, that all partners continue to give assurances to the Board by active participation in the review process and will continue to reflect, learn, and develop safeguarding practice in Bexley.

Andy Rabey

Independent Chair – Bexley Safeguarding Adults Board

July 2022

2. Introduction

2.1 The Care Act 2014 states that local boards must conduct any Safeguarding Adults Review (SAR) in accordance with Section 44 of the Act. Our local board is the Bexley Safeguarding Adults Board (BSAB).

It is important to understand that no single agency can refuse to make a SAR Notification as the final decision sits within the role of the Independent Chair.

All SAR Notifications should be made to the BSAB within 5-days of the incident and the Independent Chair will make a decision within the first 30-days in accordance with ***the statutory guidance expectations that all learning is embedded within 6 months of the incident.***

2.2 A SAR is an independently reviewed multi-agency process that considers whether or not serious harm was experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented and uses that consideration to develop learning that enables the safeguarding adult's partnership in Bexley to improve its services and prevent abuse and neglect in the future.

2.3 The Care Act 2014 states, ***SARs should reflect the six safeguarding principles***, these are: -

Empowerment – People being supported and encouraged to make their own decisions and informed consent

Prevention – It is better to act before harm occurs

Proportionality – The least intrusive response appropriate to the risk presented.

Protection – Support and representation for those in greatest need.

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.

Accountability – Accountability and transparency in delivering safeguarding.

The SARs in Bexley use these principles throughout the SAR process, including the learning and action plans after the SAR has concluded.

3. Purpose

3.1 The purpose of a SAR is to prevent serious harm or the risk of serious harm to adults at risk of abuse or neglect by learning from complex cases that agencies find challenging, which, on initial analysis, demonstrate areas of practice that could have been delivered more effectively and additionally, where there are clear concerns that agencies have not worked as well together as they might.

A SAR in Bexley may be any case review where the s.44, (4) duties have been agreed; including the use of already completed Reviews with learning. For example, LeDeR or Serious Incident Reviews and/or Coroner's Reports.

3.2 A SAR's purpose IS to:

- establish the facts, including those opinions and views of the family and carers close to the adult
- establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of the adult) work together to safeguard adults at risk
- review the effectiveness of procedures (both multi-agency and those of individual organisations)
- inform and improve local inter-agency practice and commissioning arrangements by acting on learning and developing best practice
- prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action

The SAR should consider National Learning Themes and any identified Quality Markers.

3.3 The BSAB recognises that on occasion there may be discrepancies between agencies or services where a SAR is agreed and findings are made, which is why the Terms of Reference (TOR) for all SAR's must be clear, concise and escalate when needed to ensure the SAR is about learning.

- A SAR is not - A SAR is explicitly ***not*** about blaming any agency, service or individual. However, it will be expected of all agencies to embed the learning and its findings with accountability to the Board. It should also be noted that this process is ***not*** intended to simply focus on the most dramatic and harmful cases, but on those that afford maximum learning in Bexley.

- In summary, they are not: -

    - to investigate or apportion blame.

    - to address professional negligence.
        - Should the review identify necessary disciplinary action this should be addressed through agencies' own Disciplinary Procedures and authors therefore need to be cognisant of their agency's disciplinary procedures. Where potential disciplinary or poor practice is highlighted, the BSAB may ask for further actions to be considered so that safeguarding assurances can be given.

    - an enquiry into how an adult at risk has died: that is a matter for the Coroner's Court.

    - an enquiry into who is culpable for the death of that adult at risk: that is a matter for the Criminal Courts.

    - a Judicial Inquiry: there is no oral evidence or cross-examination of that evidence. It is acknowledged that agencies may have their own internal/statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these but use these as part of the SAR process.
        - Additional reports and information may be asked to be submitted to the SAR

4. Conducting SAR's in Bexley

4.1 SAR Notifications: -

- The SAR Notification can be made to the BSAB by anyone, including family, friends, and carers.
- The BSAB contracts with QES, a Company that manages an online SAR/DHR platform for the UK. The BSAB Notification is an electronic form which is securely sent to the BSAB Business Team as an alert.
- The BSAB SAR e-Notification Form can be found here – www.safeguardingadultsinbexley.com (see Appendices).
- Once the SAR e-Notification Form is submitted, the BSAB Business Team will receive an email from QES which alerts them to the new notification. They will log into the secure website and send a pdf version to the following: -
  - SAR Subgroup members
  - BSAB Independent Chair
  - Deputy Director ASC
  - Head of Safeguarding Adults Team, ASC
  - Any other named agency relevant to the individual(s) being notified
- The SAR Notification acts as a Serious Incident Notification (SIN) to Head of Safeguarding Adults Deputy Director for the London Borough of Bexley's Adult Social Care Services. The SIN will allow the Local Authority to have oversight and give assurances that all other children, young people and/or adults are safe from harm.
- It is the expectation of all partners to complete a SAR Notification when any adult whether own to services or not has died unexpectedly in Bexley; this may include the public in and/or outside Bexley can notify the BSAB of a serious incident and/or death regarding one or more adults.
- All SAR Notifications will be added to the next rolling SAR Subgroup Agendas

4.2 The SAR Subgroup: -

- The SAR Subgroup meets every 6-7 weeks to decide whether or not the partners believe the SAR criterion, under the Care Act 2014. Sometimes the SAR Subgroup will need to make decision outside the meeting due to urgency of the concerns raised.

- The SAR Subgroup is Chaired by the Head of Safeguarding Adults and Principal Social Worker; Vice-Chair will cover when the Chair is unavailable; and where neither Chair nor Vice-Chair are able to fulfil the role, the BSAB Practice Review & Learning Manager will step in.

- The SAR Subgroup is made up of all statutory partners, allied and acute health and any other specialist area service that may be required to attend. Note: The SAR Subgroup must be quorate with LA, Police and Health, as they make up the SAB as outlined in statute for decision-making. The Independent Chair is also a member of this Subgroup for BSAB oversight and scrutiny.

- The SAR Subgroup will have set agenda items for each meeting, they are as follows:-

    - Introductions and Apologies; including any guest professionals linked to the cases on the agenda
    - New e-Notifications since previous meeting; each case will be introduced and where possible by the notifier.

        - The Decision-Making Form will be followed for each case prompting case discussions throughout.
        - The SAR Subgroup will make a collective recommendation using the Decision-Making Form (see Appendices) and submit that to the BSAB Independent Chair to make the final decision on whether or not a SAR will be commissioned.
        - The Decision-Making Form (DMF) has been designed to ensure consistency and clarity is kept when the SAR Subgroup have decided whether or not SAR criterion has been met.
        - Using the DMF will allow the SAR Subgroup and Independent Chair to identify early learning themes, ensure commissioned SARs are clearly procured, and link new SARs (including other reviews, such as: DHRs, SCRs and LeDeR) with existing through the BSAB Thematic Action Plan.

- The SAR Subgroup of the Bexley Safeguarding Adults Board (BSAB) is the ***only body in Bexley*** that is responsible for recommending the commissioning of Safeguarding Adults Reviews (SARs), managing the protocol, and giving assurance to the statutory partners the recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

    - **The rationale:** there are standardised decision-making processes in place. These processes ensure continuity, challenge (where appropriate) and assurances that Bexley SAB is operating within their duties of the Care Act 2014.

- All SAR Subgroup recommendations will go through to the BSAB Independent Chair. The Independent Chair will have 20 working days to scrutinise the decision to commission a SAR. ***The decision to commission a SAR is the BSAB SAR Subgroup and not any other body outside the SAR Subgroup of the BSAB.***

    - Other potential recommendations may include: -
        - Any urgent safeguarding actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review;
        - Working with relatives and/or the individual involved (where death has not occurred and when appropriate); and
        - And seek any information that will give the BSAB assurances that learning is being embedded in Bexley.

    - Independent Chair will scrutinise the following on each case: -
        - what initial themes have been identified;
        - whether those themes are within the last 12-months and can be linked to completed Bexley SARs;
        - what type of SAR they are commissioning using the BSAB SAR Methodology Tree (see Appendices); and
        - what type of Reviewer they want to commission, some options are: –
            - Commission an Independent Reviewer and Scrutineer; or
            - Commission a Local Reviewer and an independent Scrutineer; or
            - Commission a Local Reviewer with them as the Independent Scrutineer; or
            - Commission themselves as the Independent Reviewer and Scrutineer.

- Once the Independent Chair scrutinises the decision to commission a SAR, the BSAB Business Team will be tasked with the following:-
  - Informing statutory partners of the decision where partners will nominate a mandated person to be the representative at the meeting.
    - This should be someone who has capacity within their workload to take on this task, be senior enough to make decisions and lead change and give constructive engagement to the SAR process for learning.
  - Sourcing a SAR Reviewer – there is no set way to source a Reviewer. Unlike Children's and Domestic Homicide Reviews, there is not an overarching body to allocate the Reviews to a Reviewer.
    - In Bexley, the BSAB Business Team will ask for the National SAB Network to share the SAR Reviewer characteristics out for scoping of a Reviewer. Once shortlisting is completed, the Reviewer is sent a BSAB SAR Reviewer Contract (see Appendices) which gives details for the legal aspects of the SAR; including the ownership rights, Data Protection and Expectations for completion timetable.

  - Once the contract is signed, an agreement is made with the Reviewer and the BSAB Business team and together they plan the SAR panel meetings (see Appendices).
  - The BSAB Business Team will Chair the initial Terms of Reference Meeting prior to the Reviewer meeting the Panel, covering the following items:-
    - Background & Context
    - Meeting the SAB duty to conduct a Safeguarding Adults Review
    - The Purpose of a SAR
    - SAR Management
    - SAR Methodology (see BSAB Methodology Tree)
    - Agencies who will/have been asked to submit reports
    - Action to be taken if there is a failure by agencies to co-operate with a SAR request
    - Specific Issues to be Addressed

- ❑ Information sharing and confidentiality
- ❑ Previous Safeguarding Adult Reviews
- ❑ Issues relating to ethnicity, disability, sexual orientation, or faith
- ❑ Known research that may contribute
- ❑ Participation of the Family
- ❑ SAR Governance
- ❑ Period the Safeguarding Adults Review will cover and report completion
- ❑ Parallel Proceses
- ❑ Media Strategy (see Appendices)
- ❑ Legal Advice

- The BSAB Business Team will share the learning and findings with SAB partners once the SAR is completed for sign-off; and organise learning events to share the findings according to the BSAB Review Learning Pathway (see Appendices).

4.3. Additional factors to consider:

- SAR's in Bexley should be conducted in accordance with the following SCIE/National SAB Quality Markers (see Appendices): -

  - **Positive reflection**: the intention of SAR's is to conduct learning exercises and improve services; these are not to be conducted with the view of blame towards any individual or specific agency and reviews will highlight positive and innovative practice as well as that which could have been different.

  - **Timeliness:** priority will be given to ensuring that timescales set out are adhered to and reviews are undertaken in timely manner. This will be considered at the point of commissioning, or those partners involved in the process will need to prioritise this work.

  - **Impartiality:** the review will be conducted fairly and impartially with evidence of balance and objectivity in all reports.

  - **Thoroughness:** the review process is robust and committed to exploring each of the terms of reference.

  - **Openness and Accountability:** the review and its outcomes will be shared appropriately, and the process will be conducted in accordance with the BSAB and member agencies' governance arrangements.

  - **Sensitivity:** SAR's will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).

  - **Confidentiality:** all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

4.4 Concluding the SAR: -

- When the SAR is coming to conclusion the following governance arrangements must take place: -
    - The SAR Panel Members with the Reviewer will receive a Draft Final Report; including the statutory partners of the Bexley SAB and the Independent Chair.
    - The SAR Panel Members will be required to recommend actions using the National Thematic Report; they may make recommendations for agencies that are specific to that agency and not a theme depending on the Review findings.
    - The BSAB Business Team will share and manage the Draft Report and Action Plan, known in Bexley as the BSAB Review Delivery Plan, to the Bexley SAB (statutory partners and IC only) will opportunity for comments, scrutiny, and challenge; they will have 5 working days.
        - The BSAB Business Team will feedback to the Reviewer and SAR Panel Members any core changes needed before sign-off.
        - The BSAB Business Team will re-share the Final Report with the Bexley SAB (statutory partners and IC only) for sign-off – they will have 5 working days.
        - Once signed-off, the BSAB Business Team will send to the LB of Bexley Corporate Leadership Team (CLT) to share the findings and actions needed for the Review. There may be additional scrutiny here, if so, then the Bexley SAB will consider the challenge and make a decision on next steps, an example may be:-
            - Send the Report back to SAR Panel Members and Reviewer to answer unclear or unconcise statements or findings.
            - If this happens, the Bexley SAB will have to re-sign off on the updates and re-present to CLT before sharing the learning.

        - The 'signing-off of the Review(s)' implies that they will take the lead to ensure the learning is shared, embedding and will be held accountable to Bexley SAB for assurances through the BSAB Embedding Learning and Assurances Framework (Section 6), which is published in the Bexley SAB Annual Report.

- Once the SAR Report is signed off at CLT, the BSAB Business Team will use the BSAB Embedding Learning and Assurances Framework, to share across the following: -
    - Full BSAB
    - SAR Subgroup Members
    - SAR Panel Members
    - Director Leadership Team (DLT), LB of Bexley
    - Corporate Leadership Team (CLT), LB of Bexley
    - BSAB website
    - BSAB Learning & Development Programme
    - Heads of and Managers Meeting, LB of Bexley
    - Multi-Agency Learning Forum (MALF)
    - Provider Forums
    - Safeguarding GP Leads
    - National and Regional Networks
    - Any other identified forum

- The expectation from s.44 of the Care Act is that the Bexley SAB and agencies involved in the SAR must embed the learning. Statutory guidance says within 6-months of the incident or death.

- The Bexley SAR Subgroup will oversee and monitor all completed Reviews by using the BSAB Review Delivery Plan (see Appendices).

    - The BSAB uses a Thematic Action plan called Learning from Reviews Delivery Plan – all SARs will have an identified key theme; the individual SARs will not have bespoke action plans unless otherwise specified.
    - Any failure to complete actions will be escalated to the Independent Chair of the Board with the knowledge of the relevant BSAB Board member. Where this relates to organisation that is commissioned by the BSAB member, this will also be raised with the commissioner and regulator.
    - All SARs completed by the Bexley SAB are reported against in the BSAB's statutory Annual Report; all agencies will be asked to give assurances on how they have embedded the findings and acted on the BSAB Review Delivery Plan.

5. BSAB Embedding Learning and Assurances Framework

BSAB Review and Learning Protocol - Embedding Learning & Assurances Framework

A. Independent Chair's Expectations

B. What does the Care Act say you must do?

C. The Review(s) are completed, now what?

D. What is a Learning Pathway?

E. Key Performance Indicators (KPIs)

F. How will the Bexley SAB Offer support professionals to achieve learning?

G. How will Bexley SAB monitor the KPIs?

A. Independent Chair's Expectations: -

I am pleased to introduce this review and revised approach to learning for the SAR process. The Care Act 2014 is clear about my responsibility for the delivery of an effective and timely SAR process. However, the purpose of a SAR is for agencies to learn and improve processes and practice. It is this responsibility for learning that needs to be at the heart of every SAR. Families and friends who contribute to the review process often state their reason is to help others learn from the tragic events that led to the loss of a loved family member or friend. It is my intention throughout my tenure as the Independent Chair of the Bexley SAB to ensure that the SAR process is built around learning and improved outcomes. The measure of our success will be measured throughout this process and my promise to you is that I will share the positive outcomes that will emerge because of our collective efforts.

B. What does the Care Act say you must do?

The Care Act 2014 s.43 - stipulates the following as statutory core duties for all SAB's: -

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute; **and**
- publish an annual report detailing how effective their work has been**; and**
- ***commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.***

The Care Act 2014, s.44 - covers what all **SABs must** do with regards to meeting the commissioning of SARs. See Sections 4-6 of the Review & Learning Protocol. Your duties for participating, learning, and applying the learning is specified in s.44 (5) below: -

44 Safeguarding Adults Reviews -

(1) A 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) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB 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

C. The Review(s) are completed, now what?

Now that the Review(s) has completed what happens next with all the learning?

All Review(s) will have Themes and Actions added to the BSAB Learning from Reviews Delivery Plan found in section 7 of this document and will have a Key Performance Indicator(s) (see parts E and F of this section) added to it for assurances.

What this means in practice - we have allocated actions against the themes instead of each SAR having specific action plans. However, in the event, the SAR Panel and Reviewer has identified an agency to have a specific action to be held accountable then this will be recorded separately.

- All SAR Panel Members will be responsible for taking the findings back to their services, teams, and other relevant areas; including where needed commissioning, HR, and performance.
- All professionals identified with learning from Review(s) will be required to show evidence on an ongoing basis back to the Bexley SAB that they have embedded the learning.

- This will be monitored by the SAR Subgroup (see section H, BSAB Assurance Monitoring of this document).
- The Bexley SAB has defined Learning Pathways, Key Performance Indicators and Support to professionals to give evidence of embedding the learning.
- The Delivery Plan Actions will not be signed-off as completed until the KPIs are submitted from the named partner(s) assigned the action. These will be reported in the BSAB Annual Report, as required under s. 43, Care Act 2014.

D. What is a Learning Pathway? –

The Bexley SAB wants professionals to understand what a Review learning pathway is, how to use it and where to go for support.

A Learning Pathway is designed to cover: -

- How to move past the emotions of the findings to ensure learning
- Sometimes the learning can bring professionals to feel like ‘failures’ or ‘inadequate’ the learning events will promote positive learning outcomes, not blame.
- Professionals must be encouraged to put their own biases, experiences, and past knowledge aside to adapt to new learning and development themes and actions.
- Managers must support their staff by leading on this with themselves as well as promoting within their teams.

How to participate in learning:

- The professional should be willing to engage in the learning event, whether online or face-to-face; or individual or group-based, the professional must take responsibility to participate in the learning experience on offer.

How to promote professional learning:

- Allow professional curiosity to be at the heart of your practice.
- Model this curiosity in the workplace with your colleagues and the staff that you manage.
- Keep note of progress and reward positive change

Understanding what learning is

- A change in behaviour as a result of experience or practice; including gaining skills, knowledge and understanding new principles and concepts
- Ensuring you are able to explain the information learned to further embed knowledge, skills and understanding to others
- Applying the new information within the workplace to enhance performance
- Reveal to others how you have applied what you learned and what results you have achieved
- Nurture others by teaching them what was learned so that they too may begin to learn.

Understanding that not everyone learns the same way and that learning can be captured in many different ways: -

- Analysis
- Use of media
- Peer to peer challenge
- Group learning
- Individual learning

Understanding that change is the goal of all Bexley SAB learning -

- The Bexley SAB will promote learning through the Bexley SAB Learning & Development Programme. This programme will have workshops, events and key learning forums for professionals to have access to learning.
- The events of the Bexley Learning & Development Programme specifically note the learning outcomes and what is expected on each key learning theme shared.
- The expectation is the professional will take that learning back to their service area, team, and staff to influence change.

Examples of effective embedding is -

- Adopting the new learning principles by:
    - Sharing your own challenges and ways you will change back to your teams, service area.
    - Creating inclusive working environments to promote the new learning principles
    - Identifying any immediate ‘Easy Wins’ that can be achieved to embed the learning, i.e., systems and updates to recording and where does feedback go, what is done with it, what differences are made are all good examples.

- Leading on the new learning principles by:
    - Influencing the change within your services and teams
    - Create objectives, strategic priorities and workplans to gain evidence of the learning being embedded.
    - Feedback to Bexley SAB through the use of Key Performance Indicators (KPIs) which will give evidence on what embedding looks like to yourself, your team and your service areas.

E. Key Performance Indicators (KPIs): -

Two types of KPIs, they are -

- Quantitative indicators – show numbers for data.
- Qualitative indicators - show what cannot be just a number but a description.

How to set KPIs –

- Identify the learning principle and desired outcome – i.e. this plan may be a year to 3 years to implement change, but not taking action is a breach of the Care Act.
- Cover these core areas for each learning principle –
    - Awareness – basic sharing of each learning principle
    - Engagement – ensuring you and your teams are consistent with learning; i.e. ensuring you have capacity within your staffing structures to enable learning and change
    - Risks to not embedding the learning principle
    - Impact and Reality – how the demand for services, services commissioned and .42 conversion rates impact on safeguarding ad in Bexley

- What support is on offer for staff to achieve this new learning principle – i.e. will it be added to your mandatory list of internal training or be part of your induction process?
- Who else needs to know about the learning and implement any changes – i.e. HR, Payroll, Public, Providers?
- What do the residents of Bexley including service users, patients and other have to say about the learning principles? Do you need to do a consultation event?
- Consider commissioning new services or reviewing the ones in place – Do you need to revisit your service contracts? Do they need updating to include the new learning principle(s)?

The Bexley SAB has created the following Key Performance Indicators (KPIs) for Bexley professionals to use to show evidence of embedding Review(s) learning: -

- KPI 1: Evidence for Awareness -
  - Number of staff informed of the new learning principle – this should be recorded by managers; for example, managers recording which team members have been informed.
  - Number of staff booked onto events – this should increase when achieved
  - Where did managers share the new learning principle – this should be recorded by managers; for example, team meeting minutes or emails.
- KPI 2 – Evidence for Engagement –
  - Number of staff attending learning events should increase – not all booked attendees show up for the events this will capture booked vs attended data.

- KPI 3 – Evidence for risks identified and actions taken learning cannot be embedded:
    - Partners should report back to Bexley SAB any identified risks they have found if the learning principle is not able to be embedded; for example, not providing safeguarding adults training as a mandatory requirement due to lacking time to allow staff to attend training, risk result - staff may not understand basic statutory duties and not fulfil the Care Act 2014 responsibilities.
    - The Bexley SAB can assist with embedding of learning across the partnership and such escalations should be seen as a helpful discussion to assist in embedding learning;
        - The Risks Identified may contribute towards the Bexley SAB's Risk Register (for more information on this process ask BSAB Business Team at bsab@bexley.gov.uk).
- KPI 4 – Evidence to capture the support offered within your organisation to embed the learning principle(s):
    - Describe what support, learning and/or training events will you provide the staff?
    - Describe whether or not supervisions cover learning from Reviews and what that process looks like to embed the learning principle(s).
- KPI 5 – Evidence of Impact and Reality:
    - Number of service users in commissioned services
    - Number of service users in commissioned services with s.42
    - Number of Provider Concerns
    - Number of cases where risks remain
    - Case Examples on where risks to individuals have been reduced or eliminated

- KPI 6 – Evidence for capturing ‘Lived Experience’:
  - Have partners needed to amend policy and procedures? If so, which ones? How did you implement these changes?
  - Have partners needed to amend commissioning contracts or statements? If so, which ones? How did you implement these changes?
  - Did partners communicate the learning principle(s) with residents, service users, patients, or others about the learning principle(s)?

F. How will the Bexley SAB Offer support professionals to achieve learning? -

- The Bexley SAB produces an annual Learning & Development Programme for the entire year in advance; published each March extending until the following March.
- The Bexley SAB has a protected amount in the shared budget to ensure that learning events can take place across the partnership.
- The Bexley SAB has an independent website where all information from Reviews, Toolkits, and other resources can be found for partners, public and others.
- The Bexley SAB will continue to review and update its systems and processes to ensure concise, consistent, and innovative ways will be delivered.

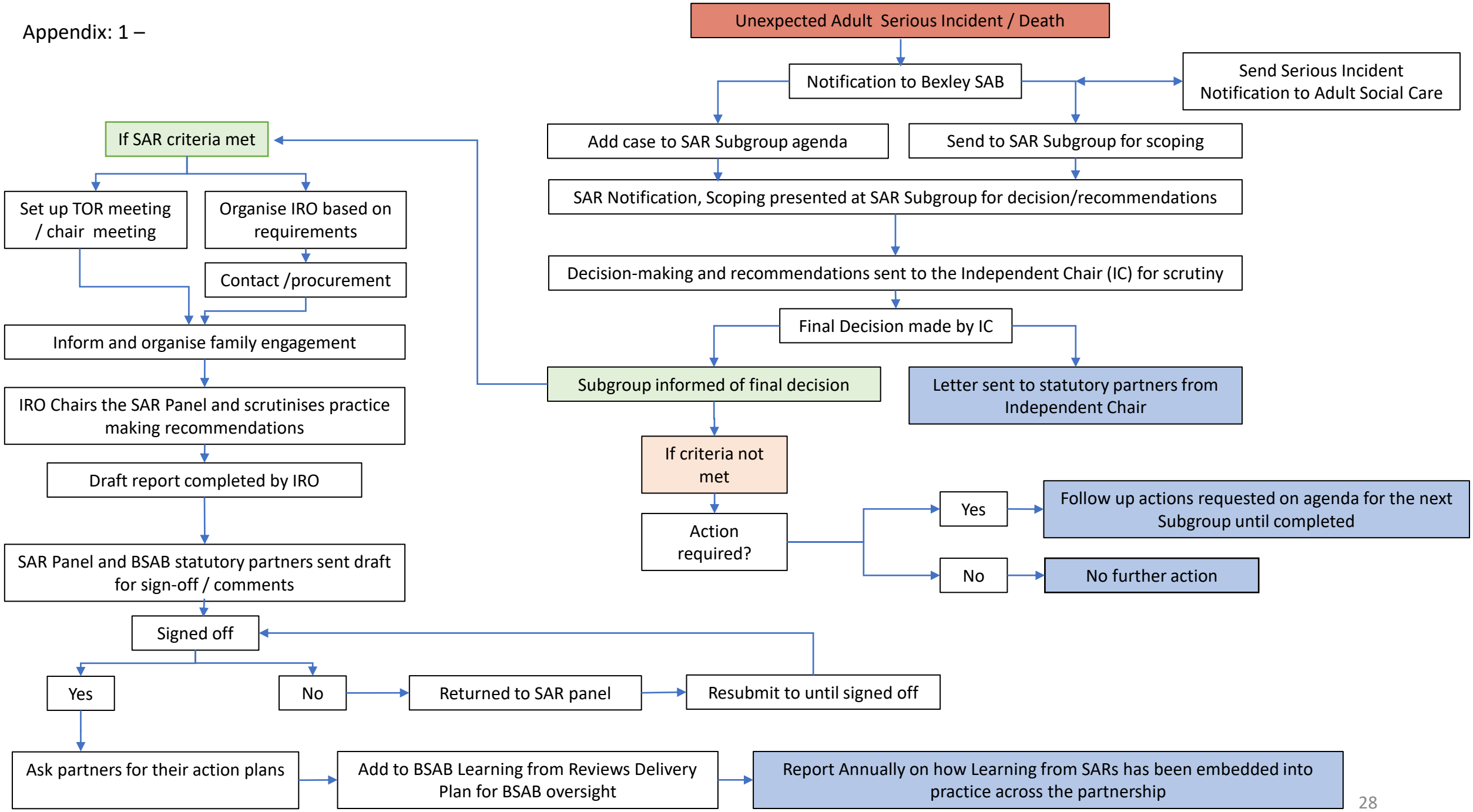
G. How will Bexley SAB monitor the KPIs?

- The Bexley SAB SAR Subgroup will oversee and monitor the KPIs and ensure that submissions are made on-time.
- The reports will be sent to the Bexley SAB Independent Chair (IC) along with the BSAB Business Team to analyse the information and address any immediate actions required.
- The Bexley SAB IC will report six-monthly to the Full Board the KPI analyse for information, discussion and agree any actions.
- The Bexley SAB will include the KPI analysis in the Bexley SAB Annual Report.
- The BSAB should see a difference to the overall SAR thinking and process. The BSAB will use the following (as developed by Professor Michael Preston-Shoot, Emeritus Professor of Social Work, University of Bedfordshire): -

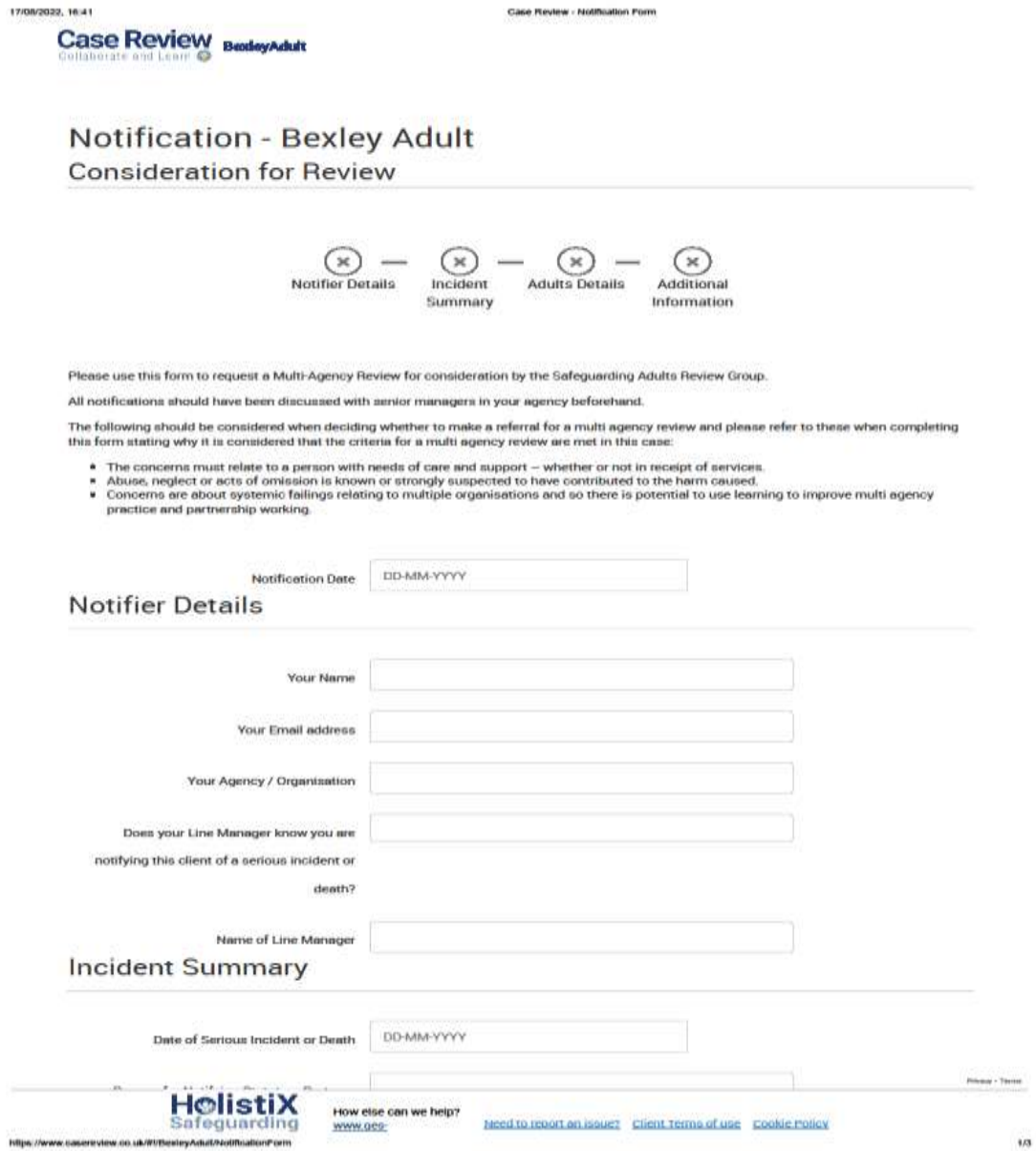
Partner reactions	•Views of their experience of working with the SAB and in adult safeguarding
Changing attitudes	•Perceptions of partnerships in adult safeguarding are modified
Knowledge and skill acquisition	•Developing understanding and application in practice of procedures regarding assessment, intervention, purchaser/provider roles in adult safeguarding
Changes in practice	•Implementing new learning about adult safeguarding by the workforce
Changes in organisational behaviour	•Implementing new learning in organisational culture and procedures
Benefit to service users and carers	•Improvements in wellbeing

Appendices

Appendix: 1 –


Unexpected Adult Serious Incident / Death
Notification to Bexley SAB
Send Serious Incident Notification to Adult Social Care
Add case to SAR Subgroup agenda
Send to SAR Subgroup for scoping
SAR Notification, Scoping presented at SAR Subgroup for decision/recommendations
Decision-making and recommendations sent to the Independent Chair (IC) for scrutiny
Final Decision made by IC
Subgroup informed of final decision
Letter sent to statutory partners from Independent Chair
If criteria not met
Action required?
Yes
Follow up actions requested on agenda for the next Subgroup until completed
No
No further action
If SAR criteria met
Set up TOR meeting / chair meeting
Organise IRO based on requirements
Contact /procurement
Inform and organise family engagement
IRO Chairs the SAR Panel and scrutinises practice making recommendations
Draft report completed by IRO
SAR Panel and BSAB statutory partners sent draft for sign-off / comments
Signed off
Yes
No
Returned to SAR panel
Resubmit to until signed off
Ask partners for their action plans
Add to BSAB Learning from Reviews Delivery Plan for BSAB oversight
Report Annually on how Learning from SARs has been embedded into practice across the partnership

Appendix: 2 –
Notification E Form



17/08/2022, 16:41 Case Review - Notification Form

Case Review
Collaborate and Learn
BexleyAdult

Notification - Bexley Adult

Consideration for Review

Notifier Details — Incident Summary — Adults Details — Additional Information

Please use this form to request a Multi-Agency Review for consideration by the Safeguarding Adults Review Group.

All notifications should have been discussed with senior managers in your agency beforehand.

The following should be considered when deciding whether to make a referral for a multi agency review and please refer to these when completing this form stating why it is considered that the criteria for a multi agency review are met in this case:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.
- Concerns are about systemic failings relating to multiple organisations and so there is potential to use learning to improve multi agency practice and partnership working.

Notification Date DD-MM-YYYY

Notifier Details

Your Name

Your Email address

Your Agency / Organisation

Does your Line Manager know you are notifying this client of a serious incident or death?

Name of Line Manager

Incident Summary

Date of Serious Incident or Death DD-MM-YYYY

HolistiX Safeguarding How else can we help? www.ges- Need to report an issue? Client Terms of use Cookie Policy

https://www.casereview.co.uk/#!/BexleyAdult/NotificationForm 1/3

Appendix: 3 –
SAR Decision Making Tool

Bexley Safeguarding Adults Board
Helping adults to live a life free from abuse or neglect

SAR SUBGROUP REVIEW DECISION-MAKING FORM

The BSAB via the SAR Subgroup will consider undertaking a Safeguarding Adults Review when it is known or suspected that:

Case Number:	
Date presented to SAR Subgroup:	
Summary of Final Recommendation by SAR Subgroup: (Circle one) **Date agreed:**	**YES** **NO**

Notification sent by:
Date:

Details from partners for scoping?

Question 1

Has there been any actions or omissions in several agencies involved in the provision of care, support or safeguarding of an adult, or group of adults, at risk of abuse or neglect have caused or are implicated in the death or serious harm of that individual or group of individuals?

- ❑ No – Go to question 2
- ❑ Yes - a recommendation for SAR to Independent Chair for decision-making.

Question 2

2.a. Did an adult or group of adults at risk die?

- ❑ Yes – What is the date of death?
- ❑ No – Go to next step

2.b. Did they experience serious harm?

- ❑ No – SAR criteria not met
- ❑ Yes – Go to Question 2.c
- ❑ Undecided – Go to Question 3

2.c. Are there are concerns about how agencies have ***worked together*** to ***prevent, identify, minimise, or address*** that harm and there are concerns about how this may ***place other adults at risk of serious harm?***

- ❑ Yes - Go to Question 2.d
- ❑ Undecided – Go to Question 3

❑ No - SAR criteria not met

2.d. Are there areas of early learning, practice improvements and/or service development that have the potential to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future?

❑ Yes - What are they?
❑ Undecided – Go to Question 3
❑ No - SAR criteria not met

Question 3

If it is still 'undecided,' the following questions should be considered; and a yes response to any of the below is likely to indicate that SAR criteria has been met:

3.a. Is there reasonable evidence of a risk of significant harm to an adult at risk that was:

a. not recognised by agencies or professionals in contact with the
    i. adult or perpetrator; OR
b. not shared with others, OR
c. not acted upon appropriately?

❑ YES – what is it?

❑ NO

3.b. Was the adult abused/neglected in an institutional setting?

❑ YES – where?

❑ NO

3.c. Was the adult abused/neglected while being supported by the Local Authority or a NHS Trust?

❑ YES – which one?

❑ NO

3.d. Does one or more agency or professional consider that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?

❑ YES – who?

❑ NO

3.e. Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?

❑ YES – what?

❑ NO

3.f. Does the case appear to have implications for a range of agencies and/or professionals?

❑ YES – who?

❑ NO

3.g. Does the case suggest that the SAB may need to change its local policy, protocols, or practice guidance, or that protocols and guidance are not adequately being disseminated, understood, or acted upon?

❑ YES – what?

❑ NO

Question 4

If the SAR criteria is not met, then the Safeguarding Adult Boards may also call for Safeguarding Adult Reviews if they have concerns that agencies are not working together in the best way to ensure safeguarding of adults, where there seem to be practice.

4.a. Have there been any parallel reviews to this case?

☐ No

☐ In Progress – type of Review(s) in progress:

☐ Yes – type of Review(s) completed:

4.b. Does this case require consideration to hold a special SAR even though the criteria is not met?

❑ Yes – why?

❑ No – recommendation to Independent Chair not to be a SAR

Question 5

5.a. SAR criteria is met. Are there any of the following themes identified as part of early learning; including other reviews completed? (Tick all that may apply):

❑ Domestic Abuse

❑ Making Safeguarding Personal - Reluctance to Engage

- ❑ Trauma-Informed Practice
- ❑ Mental Capacity in relation to Executive Capacity/Crisis/Duress/Inherent Jurisdiction
- ❑ Person-Centred Planning / Crisis Planning / Strengths-based
- ❑ SAB Governance / BSAB role in Improving Practice - Training & Awareness Raising / SAR Process
- ❑ Information Sharing / Inter-Intra Agency sharing / Information Recording Systems / Record Sharing / Information Flow / Record-keeping
- ❑ Record Keeping
- ❑ Suicide Awareness
- ❑ LA Oversight / Governance
- ❑ Think Family
- ❑ Safeguarding Literacy and Knowledge / Professional Curiosity, Professional Roles & Responsibility / Safeguarding Processes
- ❑ Assurances
- ❑ Risk Assessment / Visiting Individuals at Home where possible
- ❑ Organisational Policy/Procedures / Organisational Practice Silos / Information System Structure Silos
- ❑ Information to Regulator
- ❑ Homelessness/Housing Services/Impact on Individual and Family
- ❑ Assessing And Meeting Needs - Safeguarding Action – Referral & Response / Risk Awareness & Assessment; Working with Families And Significant Others / Responding to Characteristics of The Individual
- ❑ Practitioner Attributes - including Legal Literacy, Mental Capacity
- ❑ Case Co-Ordination / Failure to Engage a Multi-Agency Approach / Leadership / Use of Multidisciplinary Meetings And Complex Case Management Frameworks
- ❑ Lack / Shortage of Services - i.e. Housing stock, commissioned services
- ❑ Workload Pressures / Staffing / Supervision and Support / Management Oversight and Leadership
- ❑ Carer's Support and access to help as a Carer
- ❑ Parallel Processes / Reviews including LeDeR, DHR and CSCR; Cross SAR learning

5.b. Is there any additional learning to be considered?

- ❑ Yes – What? Put additional learning here (refer to Question 6 for Methodology) -
- ❑ No - Since SAR criteria is met, but no additional learning is to be considered - do the SAR subgroup members recommend to the BSAB Independent Chair, that a formal SAR is not required as themes identified are already in the Thematic Action Plan and agree that this case will be named SAR___ and added onto the Thematic Acton Plan immediately.

Question 6

6.a. What type of methodology are re recommending (refer to the Methodology Tree)

- ❑ Significant Event Analysis or Audit
- ❑ Systems Review
- ❑ Using Individual Management Reviews to Analyse Individual Agency Performance
- ❑ Multi-agency Combined Chronology

❑ Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel

6.b. What type of reviewer are we recommending?

❑ Independent Reviewer & Author – what skills do they need to have?

❑ Local Partnership Reviewer & Author – which agency to consider?

Question 7

Are there any other agencies to notify including other SAB's?

❑ *Yes – who?

❑ No – NFAR

Question 8

Is there any other salient information to be included with this recommendation?

❑ Yes – what?

❑ No

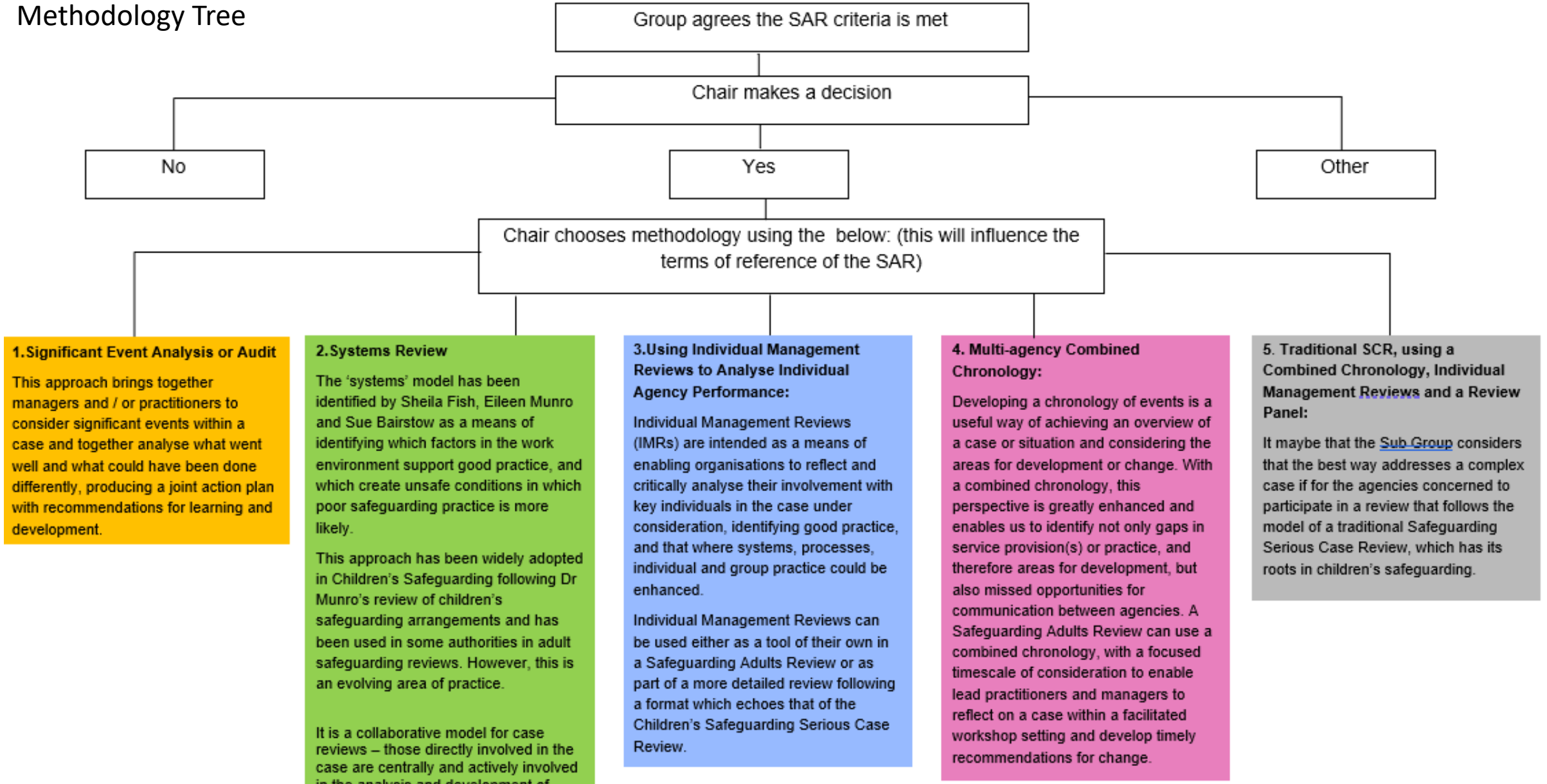
Next steps

1. Refer to BSAB Independent Chair for scrutiny and oversight Independent Chair makes a decision
   - what initial themes have been identified;
   - whether those themes are within the last 12-months and can be linked to completed Bexley SARs;
   - what type of SAR they are commissioning using the BSAB SAR Methodology Tree (see Appendices); and
   - what type of Reviewer they want to commission, some options are: –
     - Commission an Independent Reviewer and Scrutineer; or
     - Commission a Local Reviewer and an independent Scrutineer; or
     - Commission a Local Reviewer with them as the Independent Scrutineer; or
     - Commission themselves as the Independent Reviewer and Scrutineer.
   - Any urgent safeguarding actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review;
   - Working with relatives and/or the individual involved (where death has not occurred and when appropriate); and
   - And seek any information that will give the BSAB assurances that learning is being embedded in Bexley.

2. Independent Chair notifies the SAR Subgroup and Full SAB

3. Terms of reference meeting to be booked by BSAB Business Team
4. Anything else? (to be added in):

Appendix: 4 – SAR Methodology Tree



1. Significant Event Analysis or Audit
 	
This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.
	The process followed in a Significant Event Analysis or Audit is as follows:
	
	• Information Gathering – collation of as much factual information about the event as possible from a range of sources.
	• Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment.
	• Analysis of the Significant Event: The key questions that require answering in a Significant Event Analysis or Audit are:
	  o How could things have been different?
	  o What can be learned from what happened?
	  o What has been learned?
	  o What has been changed or actioned?

2. Systems Review The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice. It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.	**A systems approach to conducting a Safeguarding Adults Review involves:** • 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 the BSAB; 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 learned and recommendations • Event to consider first draft of the overview report and action plan • Final overview report presented to BSAB, agree dissemination of learning and monitoring of implementation • Follow up event to consider action plan recommendations • On-going monitoring via the BSAB.
3. Using Individual Management Reviews to Analyse Individual Agency Performance: Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced. Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.	Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model. Most popular methodology used – more information in Appendix 3 of the SAR Toolkit.
4. Multi-agency Combined Chronology: Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.	Chronologies are important tools that are particularly useful when combined across agencies using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.
5. Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel: It maybe that the Sub-Group considers that the best way addresses a complex case if for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding.	This method will provide a detailed analysis of agencies' work with an adult or group of adults and provide a familiar approach to learning; the SAR Sub-Group will give very careful consideration to any added value achieved through this approach. Safeguarding Adults Reviews are resource-intensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

Appendix: 5 – SAR
Terms of Reference

Safeguarding Adults Review – Case X
Terms of Reference

1.Background & Context -

2. Meeting the SAB duty to conduct a Safeguarding Adults Review

2.1 The BSAB will take the lead for conducting a SAR when:

- An adult at risk dies and abuse or neglect is known or suspected to be a factor in their death
- An adult at risk has sustained any of the following: a life threatening injury through abuse or neglect; serious sexual abuse; serious or permanent impairment of development through abuse or neglect

OR

- Where there are multiple victims
- Where the abuse occurred in an institutional setting
- A culture of abuse was identified as a factor in the Enquiry

AND

- The case has given rise to concerns about the way in which local professionals and services worked together to protect and safeguard the adult at risk

The Purpose of a SAR

In accordance to the Care Act 2014, and the associated statutory guidance, the purpose of this SAR is to:

a) establish lessons to be learned from the case of C, in terms of how professionals and organisations worked, both individually and together, to safeguard the adult at risk and prevent harm

b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems

c) deploy a mechanism for the BSAB to apply lessons learned to service responses for adults at risk across Bexley and to share these lessons at a national level

3. SAR Management

4. SAR Methodology

5.Agencies who will/have been be asked to submit IMR reports

6. Action to be taken if there is a failure by agencies to co-operate with a SAR request

7. Specific Issues to be Addressed

8 Information sharing and confidentiality

- 8.1 Previous Safeguarding Adult Reviews
- 8.2 Particular issues relating to ethnicity, disability, sexual orientation or faith
- 8.3 Known research that may contribute
- 8.4 Participation of the Family

9. SAR Governance

10. Period the Safeguarding Adults Review will cover and report completion

11. Parallel Processes

12. Media Strategy

13. Legal Advice

14. Attendance and Agreement

Appendix: 6 – SAR Letter To Family Template

Date

Dear

PRIVATE and CONFIDENTIAL

Safeguarding Adults Review -

Invitation to be involved in an Independent Safeguarding Adults Review

I am writing on behalf of the Bexley Safeguarding Adult Board as we were given your name(s) as the who sadly died, in . Please accept our belated condolences.

The purpose of my letter is to invite you to participate in an Independent Safeguarding Adult Review (SAR) commissioned by the Bexley Safeguarding Adults Board, which we are calling to keep anonymity. I have included the BSAB SAR Leaflet that explains the statutory duties of the board and how you can engage if you wish to do so.

In short, The Care Act 2014 requires local agencies to learn lessons from how they supported and during the review agencies will need to update the Reviewer that they have identified learning. On occasion, the Reviewer and the Review Panel (agencies involved) may highlight concerns, which will be highlighted to the appropriate teams to seek assurances that the welfare of any adult(s) or child(ren) are not at risk.

As part of this invitation, it is important for you to identify who the family of is and who the family will give permission or decline to engage in the review.

The Bexley Safeguarding Adults Board has appointed an Independent Reviewer, to lead this review. The independence of the Reviewer is to ensure that this Review is done both fairly and impartially according to government guidance.

Lucy would like to meet with some relevant staff who were involved in supporting Lorraine and if you choose to engage in the review, your identified family representative(s) to hear your point of view. You can have a friend or advocate with you when if you agree to meet with them. If you think any other family members would wish to talk with the Reviewer, please pass this invitation on to them.

It is our hope that you will meet with so that your views about how services worked with, so that we can also learn directly from you.

If you wish to contact Lucy, please email me at bsab@bexley.gov.uk, where I can assist in organising a suitable time and arrange to meet (under Covid we are holding most meetings online). Thank you for your time and we look forward to hearing from you.

Yours Sincerely,

Anita Eader, Practice Review & Learning Manager

Appendix: 7 – SAR
Media Template

Media Template

'IF ASKED' BSAB STATEMENT – OPTION 1

Safeguarding Adult Review (SAR) – DATE

We wish to express our deepest sympathy to the family and friends of SARX, who tragically died in YEAR.

Bexley's Safeguarding Adult's Board (BSAB) and the Safeguarding Adult Review (SAR) panel would like to thank SARX's family for their participation in the review, which has informed report that has been published DATE. Family engagement in the process is so important in helping statutory agencies to identify learning associated with SARs.

The SAR process, which brought together all relevant agencies, began in MONTH YEAR. It was chaired by an Independent Reviewer to help identify learning and write the final report.

There has been a range of learning from the review and a number of recommendations. These will be implemented and monitored through the SAR & Learning Subgroup with partner agencies, and reported back to the BSAB, with all agencies seeking to bring about preventative changes for adults in Bexley.

Anyone in need of support should contact CRUSE (bereavement services) freephone 0808 808 1677-The helpline is open Monday-Friday 9.30-5pm (excluding bank holidays), with extended hours on Tuesday, Wednesday and Thursday evenings, when we're open until 8pm, Friday.

ENDS

‘IF ASKED’ BSAB STATEMENT – OPTION 2

Bexley’s Safeguarding Adult’s Board wishes to express its sympathy to SARX family.

The safeguarding and protection of adults in Bexley is a priority for agencies involved in their welfare. It is a responsibility each agency takes very seriously.

As is standard practice when an unexpected death or serious injury of an adult occurs, a Safeguarding Adult Review (SAR) has taken place by the BSAB.

The SAR report provides a sound analysis of what happened in the case and makes recommendations for action and learning. The review findings have been actioned by the agencies involved and progress is closely monitored by the Bexley Safeguarding Adult’s Board.

The overview report has been published here/at www.safeguardingadultsinbexley.com

ENDS

BSAB 'HOLDING' STATEMENT – OPTION 1 - ISSUED BY LBB ON BEHALF OF THE BEXLEY SAFEGUARDING ADULT'S BOARD

Bexley's Safeguarding Adult's Board (BSAB) would like to express our sympathy to the family of SARX at this very difficult time.

The safeguarding and protection of adults at risk in Bexley is a priority for agencies involved in their welfare. It is a responsibility each agency takes very seriously.

As is standard practice when an unexpected death or serious injury of an adult occurs, a Safeguarding Adult Review (SAR) may take place by the BSAB.

In line with the government's Care Act 2015 regulations, the report provides a sound analysis of what happened in the case and looks at the actions and learning put in place by agencies in response to the review findings and the impact these actions have had on improving services.

We are unable to make any further comment at this stage.

ENDS

Notes for editors –

Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). This resource aims to help SABs in thinking about how they fulfil those responsibilities. It focuses on a selection of key issues. It is intended to supplement the policy development work already underway or completed by SABs.

The Care Act 2014 states that BSAB's must conduct any Safeguarding Adults Review (SAR) in accordance with Section 44 of the Act.

For more information on SARs, visit www.safeguardingadultsinbexley.com

Appendix 7: SAR Commissioning Contract Template : - Upon request only

Appendix 8: National SAR Themes:
https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

Appendix 9: SCIE SAR Quality Markers : https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/

Appendix: 10 – SAR Governance.
Partnership Roles and Responsibilities

No.	SAR Roles	Generic SAR Function	Responsibilities	Bexley Named individual
1	SAB Independent Chair	Ultimately accountable. Including: • decision to commission a SAR, • sign-off of the SAR • providing transparency and accountability via the SAB response and annual report • seeking assurance of effective responses by agencies and/or Board • challenging and highlighting areas for improvements when agencies are not embedding learning or evidencing safeguarding adults improvements.	The Independent Chair of the BSAB is responsible for deciding in response to the Safeguarding Adults Review Subgroup's recommendations for a Safeguarding Adults Review and its associated methodology etc. The Independent Chair of the BSAB is responsible for ensuring the Board receives regular updates in respect of progress of Safeguarding Adults Reviews.	Andrew Rabey Andrew.rabey@bexley.gov.uk
2	SAR Subgroup Chair and Vice-Chair	Delegated responsibility for managing the SAR recommendations. Including: • initial information gathering, • recommendation to proceed or not, scoping the review, • identifying and commissioning reviewers, • agreeing and publishing the Terms of Reference • agreeing the methodology / model to be used • providing quality assurance and challenge	The SAR Subgroup is responsible for recommending to the Independent Chair of the BSAB whether a referral for a Safeguarding Adults Review meets the criteria. The SAR Subgroup is responsible for monitoring and recommending to the BSAB completion of Safeguarding Adults Review action plans.	Sue Chandler Gina Tomlin SAR Statutory Partners are members of this group: - LB of Bexley, MPS, ICB
3	BSAB Business Team	Provides practical day-to-day support for the review. Including: • providing administrative support, • project management support, • means of access to data, • links with staff,	Ensuring all partners and agencies involved are keeping to the BSAB SAR Protocol and holding account those who are not. Escalating where immediate concerns arise in practice and learning.	BSAB PR&LM Anita Eader BSAB Coordinator Alexandra Gregory

		• commissioning and managing the SAR protocol, independent reviewers, • updating the SAR Delivery Plan • liaison with the Chair	Liaising directly with the BSAB Independent Chair, Statutory Partners, Chairs of the SAR Subgroup, and any other senior executive, as necessary. Managing the budget of the SAR process, contract, and invoice handling for the review. Ensuring all aspects of the SAR are recorded accurately, stored securely and action plans.	
4	Reviewer(s) / Independent Panel Chair	Individual(s) who conduct(s) the review and provides independent leadership. This may be the same or different roles depending on whether Panel and Panel Chair is used. Including: • providing independent challenge • ensuring individuals and families are included • ensuring the review is informed through • engagement with front line practitioners and • managers • ensuring an accessible report is produced • ensuring reviews are conducted in a timely • manner	Where an Independent Author is required in a Review will be appointed from the BSAB approved pool of authors to write an independent Safeguarding Adults Review Report on behalf of the BSAB where this is an agreed output of a Safeguarding Adults Review. The Independent Author will work with members of the Safeguarding Adults Review to address each of the Terms of Reference of the Review and produce an Overview Report. This Report will have recommendations that are agreed by the Safeguarding Adults Review Panel and then the SAB Executive. These will be SMART and will provide the BSAB with positive learning that will enable it to improve services and safeguarding in the borough.	Commissioned duty
5	SAB SAR Panel Members -	Manages the follow-up to a review. Including: • recommendations on publication • deciding/leading on immediate action in response to findings • providing evidence of responses	Members of a Safeguarding Adults Review panel will be nominated by their BSAB member and senior agency manager to work together in considering the issues within the Safeguarding Adults Review. Must be people with the ability and seniority to effect real change in their organisation and to influence others in the Review to effect change across the Partnership.	Safeguarding Adults Review Panel members will be senior managers without line management responsibility for the case and without previous involvement in the matter. Agencies nominated individual with mandatory powers.

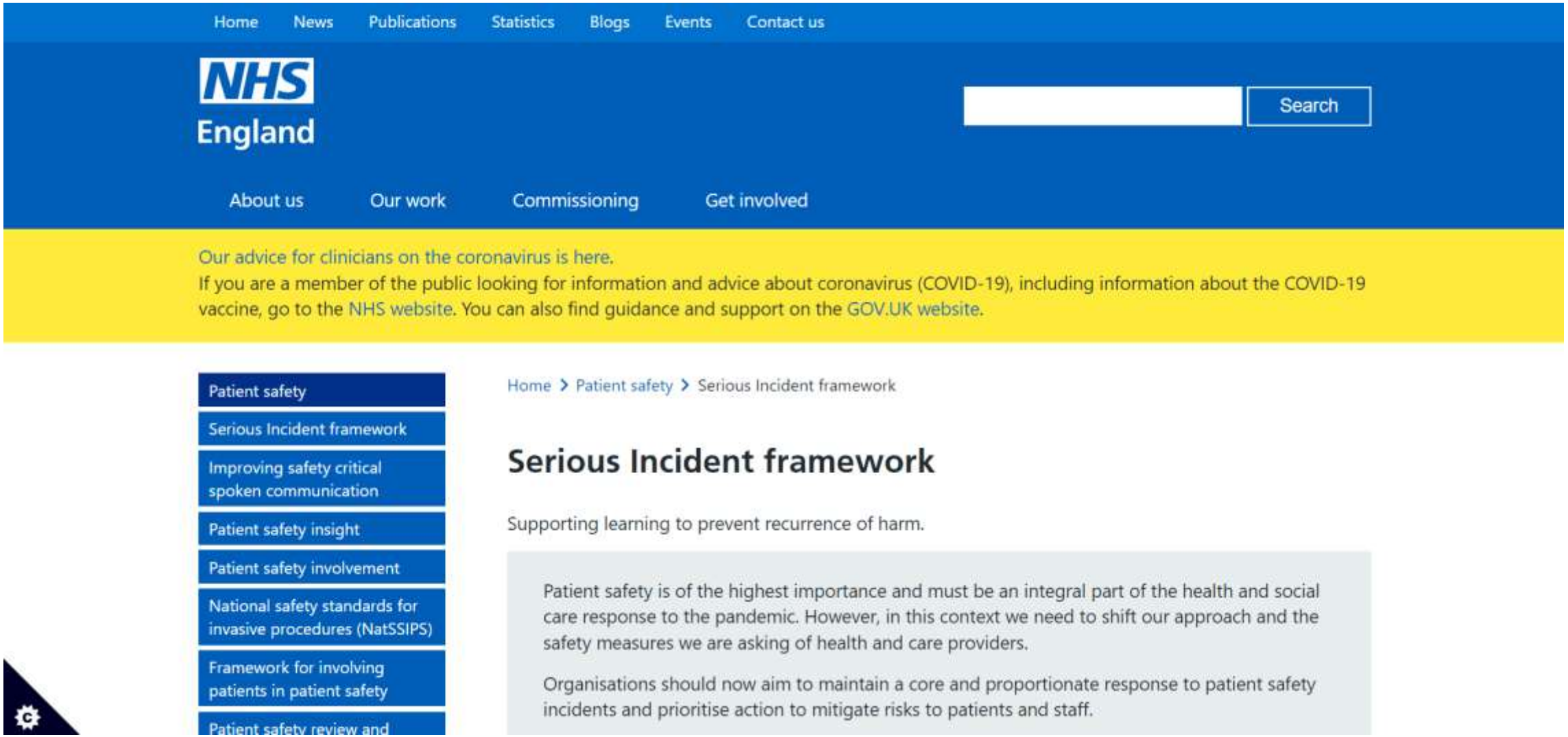
			Where this role has been delegated by the Safeguarding Adults Review Subgroup, the Review Panel will recommend the detail of the approach to the review, including, timescales, terms of reference, methodology etc. Members of the Safeguarding Adults Review Panel will feedback to their agency's BSAB member on progress and key issues emerging from the Review. Mandated Members of the Bexley Safeguarding Adults Board (BSAB) will nominate senior appropriately experienced and senior staff to participate in safeguarding adult's reviews in consultation with their agency's senior responsible manager. These members will be known as Panel Members. The BSAB has a Introduction to SARs in Bexley workshop for all new Panel Members to support the responsibilities for participating, acting and engaging at a senior level on behalf of their organisation.	
6	Adult(s) at Risk, Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and Significant Others	Individual / Service the Review is regarding.	The Adult(s) at Risk, Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and other people close to the Adult(s) at Risk have a valuable role in the Safeguarding Adults Review process and the BSAB values the importance of their views and also recognises that the process can be difficult. As such, the Safeguarding Adults Review Subgroup will offer to meet with those individuals, as agreed appropriate as soon as the decision has been made to proceed with a Safeguarding Adults Review in order to hear their views and explain the process, highlighting the purpose of the Review and signposting them to other routes if they wish would make a complaint. Similarly, it may be appropriate for the views of the Adult at Risk themselves, if	TBC each SAR

			possible and Person(s) or Organisation(s) Alleged Responsible to be fed into the Review. The Safeguarding Adults Review Subgroup will keep all relevant individuals regularly informed of progress through the review. At the end of the Safeguarding Adults Review, once relevant reports and plans have been accepted by the Independent Board Chair, the BSAB and the Director of Adult Social Services, the Independent Chair of the Board and the Chair of the Safeguarding Adults Review Subgroup will offer to meet with these people to explain the Review conclusions.	
7	Director of Adult Social Care (DASS)	Most responsible person from the Local Authority, Lead under the Care Act 2014.	The Independent Chair of the BSAB and the Chair of the Safeguarding Adults Review Subgroup will ensure the Director of Adult Social Services is advised of all Safeguarding Adults Review referrals and decisions. Where a Safeguarding Adults Review has a report of its findings, this will be approved by the Director of Adult Social Services, together in consultation with the Independent Chair of the BSAB and the Chair of the Safeguarding Adults Review Subgroup. The Director of Adult Social Services is ultimately responsible for approving the report. Where relevant, Bexley Council will be responsible for holding a joint BSAB press statement / release as necessary on behalf of the Board. The Director of Adult Social Services will meet with the Chair of the Safeguarding Adults Review Subgroup, the Independent Chair of the Board, Board, Practice Review & Learning Manager, and the Head Safeguarding Adults on an annual basis	Stuart Rowbotham

			to consider the learning from all Safeguarding Adults Reviews during that period. Where matters are outside the DASS's area of responsibility, the BSAB Independent Chair will lead on the SAR findings and accountabilities. For example, a DASS cannot and should not be responsible for holding LB of Bexley to account. This is the role of the BSAB Independent Chair.	Andrew Rabey

Appendix: 11 – Other Review Pathways

NHS England - The Serious Incident Management Process



Appendix: 12 – Other Review Pathways

DHR protocols

Parallel Statutory Reviews/Pathways - DHR: A SAR may be referred even if another statutory review has already been commissioned. The Independent Chair must decide on whether or not to proceed. The referral still needs to be made. It is not up to a single agency to decide what gets referred or not.

- Domestic Homicide Reviews (DHRs): Where a situation is being considered as a Domestic Homicide Review (DHR) and the case involves an adult at risk of abuse or neglect, the Community Safety Partnership will automatically refer the case to the BSAB for consideration as a SAR.
    - This will be referred to the SAR Subgroup, but that Subgroup will consider recommendation to the BSAB Chair:
        - a SAR led by the BSAB should be undertaken
        - a recommendation to the DHR with adult safeguarding involvement should be made OR
        - where a decision has already been made for a DHR, a joint review should be undertaken

Appendix: 13 – Other Review Pathways

Coroner's Court

The Coroner: Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody (including DOLS), which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk.

- These are likely to fall within one of the following categories where:
    - Obvious and serious failing by one or more organisations;
    - No obvious failings, but the actions taken by organisations require further exploration/explanation;
    - A death has occurred and there are concerns for others in the same household or other setting; **OR**
    - Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries/actions are identified by the Coroner or his or her officers.

NOTE: If HM Coroner contacts the BSAB and/or its partner(s) about any of these situations, the SAR Subgroup Chair must be informed through the Notification Form to the BSAB Working Team as per usual pathway for SAR consideration.

Appendix: 14 – Other
Review Pathways

Safeguarding Practice Reviews

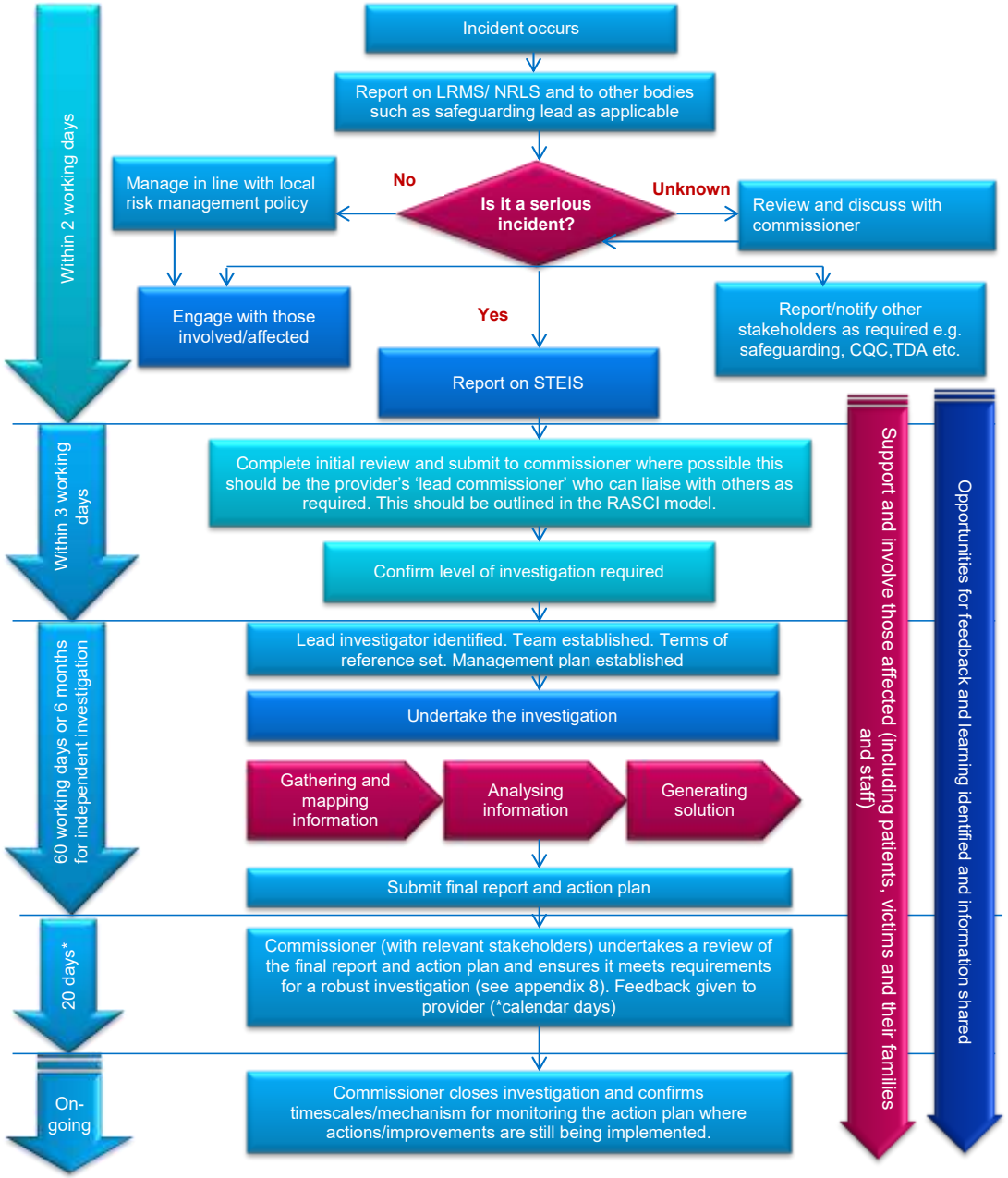
Children's Safeguarding Practice Reviews (previously known as: Serious Case Reviews (SCR)):

It may be that the Bexley Local Children's Safeguarding Partnership Board also conducts a review or is involved in the DHR and/or SAR a key partner to the BSAB or a jointly commissioned SAR may be decided on between Chairs of the LSCB and the BSAB and not in isolation nor by a single agency.

Appendix: 15 – BSAB Review Delivery Plan – Upon request only

Appendix: 16 – NHS England

The Serious Incident Management Process



Appendix: 17 – Domestic Homicide Review (DHR)

Setting up a review: the role of community safety partnerships (CSPs)

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

December 2016

Appendix: 18 – LeDeR

LeDeR

LeDeR is a service improvement programme for people with a learning disability and autistic people.

Established in 2017 and funded by NHS England and NHS Improvement, it's the first of its kind. LeDeR works to:

- improve care for people with a learning disability and autistic people
- reduce health inequalities for people with a learning disability and autistic people
- prevent people with a learning disability and autistic people from early deaths

LeDeR reviews

A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. We look for areas that need improvement and areas of good practice. We use these examples of good practice to share across the country. This helps reduce inequalities in care for people with a learning disability and autistic people. It reduces the number of people dying sooner than they should.
So far, we've completed over 9000 reviews. We have found out lots of information and learning on the best way to carry out these reviews. We use the data and evidence to make a real difference to health and social care services across the country.

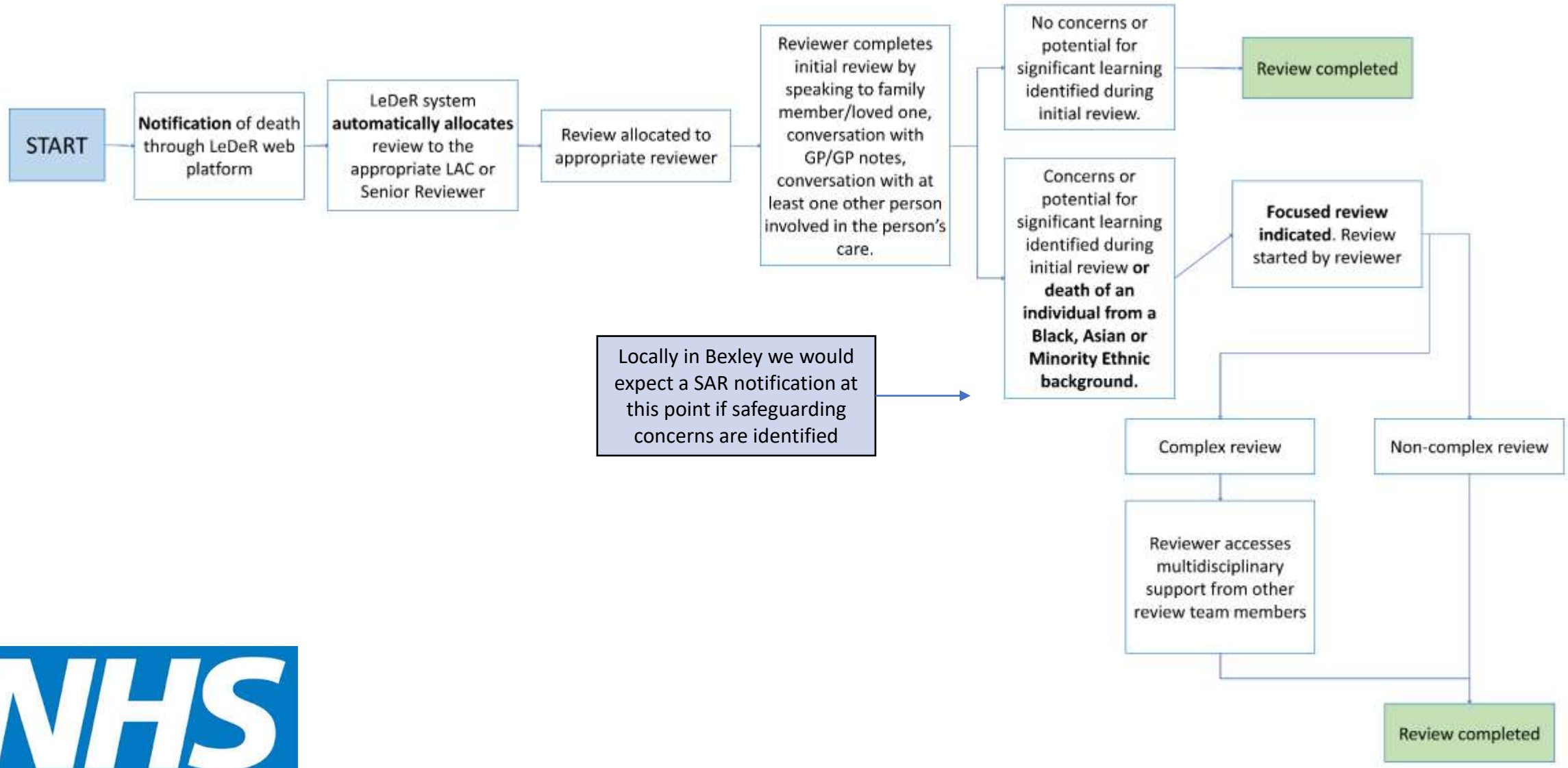
How LeDeR fits with existing local and national reviews of deaths

There are several different review processes for people who die. For example:

- child death review
- safeguarding adults' review
- review of deaths of people in hospitals

If this is the case, we will work together to try to avoid unnecessary duplication. Reviewers will make it clear to families where and how the LeDeR process links with other reviews or investigations.

LeDeR Review Process Overview



For more information contact: -

Bexley Safeguarding Adults Board

- Email: bsab@bexley.gov.uk
- Website: www.safeguardingadultsinbexley.com

Anita Eader, Bexley SAB Practice Review & Learning Manager

- Email: Anita.eader@bexley.gov.uk
- Phone: 0203 045 5315

Alexandra Gregory, Bexley SAB Partnership Officer

- Email: Alexandra.Gregory@bexley.gov.uk
- Phone: 0203 045 5386

Andy Rabey, Bexley SAB Independent Chair

- Andrew.rabey@bexley.gov.uk