Safeguarding Adults Review Policy and Procedure

June 2023

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1. Introduction

The Knowsley Safeguarding Adults Board (KSAB) is the statutory body that sets the strategic direction for safeguarding and is responsible for protecting adults who are at risk of abuse or neglect in Knowsley.

The Care Act 2014 outlines the circumstances in which Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR). The Care Act further placed a duty on all Board members to contribute to the undertaking of such reviews.

The purpose of undertaking a SAR is to determine what relevant agencies and individuals involved who are or have been involved with the individual have done differently that could have prevented harm or death.

This is so that lessons can be learned, and those lessons applied to future practice and procedure to prevent similar harm occurring again. The Care Act 2014 also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

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

2. Purpose

The purpose of this policy is to outline the principles and definitions that support the commissioning and undertaking of Safeguarding Adults Reviews and to describe the statutory duties set out under Section 44 of the Care Act 2014. Section 44 Care Act 2014
This policy is underpinned by the KSAB Multi-Agency Adult Safeguarding Procedures.

Knowsley-Safeguarding-Adults-Procedures-V1-Final

3. Scope

The safeguarding duties apply to any adult who:

a. has needs for care and support (whether or not the local authority is meeting any of those needs)
b. is experiencing, or at risk of, abuse or neglect
c. as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

This definition of adults at risk of abuse or neglect includes:

- Those who are at a greater risk of suffering abuse or neglect because of physical, mental, sensory, learning, or cognitive illnesses or disabilities; and substance misuse or brain injury

- Those who purchase their care through personal budgets, those whose care is funded by local authorities and/or health services and those who fund their own care

- Informal carers, family and friends who provide care on an unpaid basis.

4. Policy Statement

The Knowsley Safeguarding Adults Board is committed to protecting an adult's right to live in safety, free from abuse and neglect.

It further seeks to examine lessons learned as a result of SARs undertaken both locally and nationally. These lessons will be used to help improve the approach taken in Knowsley to better protect adults from abuse or neglect.

5. SAR Criteria – Legal Framework

The Care Act 2014, Section 44 Section 44 Care Act 2014 requires that Safeguarding Adults Boards must (mandatory SAR) arrange a Safeguarding Adults Review when:

- an adult in its area dies (including suicide) either as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

or

- if an adult has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect

The Act further defines that something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The Care Act also states that SABs are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support:

- when it is clear there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future

This policy has been developed within the context of the law and guidance that seeks to protect adults including (but not exhaustive):

- The Care Act 2014 Care Act 2014
- Care Act 2014 Statutory Guidance Care Act 2014 Guidance
- The Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards) MCA 2005
- The Human Rights Act 1998 Human Rights Act 1988
- The Equality Act 2010 Equality Act 2010
- Mental Health Act 1983 and the Code of Practice 2015 MHA 1983 - Code of Practice
- Serious Crime Act 2015 Serious Crime Act 2015
- Modern Slavery Act 2015 Modern Slavery Act 2015
- Criminal Justice and Courts Act 2015 Criminal Justice and Courts Act 2015
- Statutory Guidance on Female Genital Mutilation Statutory guidance of female genital mutilation

6. Information Sharing

The Care Act 2014, Section 45 creates a legal duty for any agency or person to share what they know with the Safeguarding Adults Board (SAB). The test is that the information requested by the SAB must be for the purpose of enabling or assisting it to perform its functions, including that of undertaking Safeguarding Adults Review. This means that if a SAB requests information from an organisation or individual who is likely to have information, which is relevant to the SAB's functions, they must share what they know with the SAB.

7. Who this Policy applies to

This policy applies to all partners of the Knowsley SAB who have collective responsibility for ensuring that the Board can meet its statutory duties.

8. Principles

This policy reflects the six safeguarding principles described in the Statutory Guidance that underpin all safeguarding adult work, and which applies to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. These principles are as follows:

Accountability - Accountability and transparency in delivering safeguarding.

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.

In addition, the Statutory Guidance outlines a number of principles to be followed by Safeguarding Adults Boards and their partner organisations when undertaking Safeguarding Adults Reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the well-being and empowerment of adults, identifying opportunities to draw on what works and promote good practice

- The approach taken to reviews should be proportionate according to the level of complexity of the issues being examined

- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

- Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith

- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

9. Key Roles and Responsibilities

The Independent Chair of the Knowsley Safeguarding Adults Board

The Independent Chair has responsibility for:

- Ensuring that the SAB meets its statutory responsibilities and ensuring there is reporting on the discharge of these functions (including ongoing cases) at every Board meeting

- Making a decision in response to any recommendation for a Safeguarding Adults Review

- Appointing suitable independent individuals to lead the SAR where appropriate, who should have the required level of objectivity to ensure openness and transparency

- Considering whether an outside expert(s) should be consulted to help understand any specific aspects of the case

- Obtaining legal advice for any specific elements of the review as required

- Agreeing the scope, methodology and funding for the SAR and where the circumstances might be complex and / or challenging also agreeing the terms of reference

Knowsley Safeguarding Adults Board

The Knowsley Safeguarding Adults Board has responsibility for:

- Identifying appropriate individuals from their own agencies to be involved in the process

- Receiving/considering regular reports on progress from SARs via the Learning Partnership

- Considering and approving final review reports

- Agreeing the process for dissemination of the review

- Agreeing and ensuring that multi-agency action plans resulting from SARs and other forms of review are implemented

Merseyside Safeguarding Adults Review Group

Merseyside Safeguarding Adults Review Group (MSARG) has responsibility for:

- Considering all SAR referrals
- Making recommendations to the KSAB Independent Chair on the undertaking of SARs
- Making any recommendations on the appropriate type of review
- Making any recommendations about how the adult and/or their representative should be involved including whether or not they need an advocate
- Regularly reporting progress against the agreed action plans to the KSAB
- Working closely with other groups to ensure that any recommendations from a review are fully implemented
- Ensuring that any lessons learned from local, regional, and where appropriate, national SARs and other forms of review are disseminated throughout the KSAB partner agencies.

Safeguarding Adults Review Panel

The SAR Panel is a group that is set up to facilitate the delivery of a specific review. In most instances this will include the core membership of the Learning Partnership Sub-Group, although other partners/agencies and professionals may be approached to provide further expertise if/when required.

The Safeguarding Adults Review Panel has responsibility for:

- Undertaking the SAR in accordance with the agreed scope, terms of reference and methodology
- Considering how the interface between other reviews and parallel proceedings should be managed
- Ensuring that the SAR Panel has the necessary expertise to oversee and contribute to the review process based on the individual aspects of the case
- Ensuring appropriate involvement of professionals and organisations that were involved with the adult
- Taking account of the legal advice provided in relation to any aspect of the review
- Considering how best to liaise with and involve the adult and/or their representative

Staff Involvement

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

It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and practitioners involved in a SAR to “tell it like it is”, without fear of retribution, so that real learning and improvement can happen.

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

10. Involvement of the Adult, Family Members and Representatives

Discussion should take place at an early stage with the adult and/or their representative to agree if and how they wish to be involved in the process, using the principles of Making Safeguarding Personal (MSP). Where the adult has the mental capacity to engage with the review, the involvement of family or informal carers should be agreed with the adult. In any case where the adult does not have the necessary mental capacity at that time; family or informal carers must be consulted in accordance with the Mental Capacity Act 2005.

The Local Authority has a duty to involve an appropriate person, which could involve the use of Care Act Advocacy, Section 68 of the Care Act 2014 (Section 68 of Care Act 2014) to facilitate an adult's involvement in the process if it is deemed that they "would have substantial difficulty in participating themselves".

Advocacy

As part of the safeguarding adult procedure, consideration must be given as to whether the adult may benefit from the support of an independent advocate. Where the adult has substantial difficulty in participating in the safeguarding adult process (and there is no other appropriate person to assist them), the Local Authority must arrange that independent advocacy. Where an Independent advocate has already been arranged under (Section 68 of Care Act 2014 under the Mental Capacity Act 2005, the same advocate should be used unless for good reason, this is deemed to be inappropriate.

Reasonable and appropriate support and adjustments should be also made by KSAB as required to enable the adult(s), their family and/or representatives to participate in the SAR. This may include, but is not limited to:

- Easy read, large print and/or translated materials
- Access to an interpreter
- Support from a chosen chaperone or representative
- Longer meeting times
- Pre-meeting briefings and post-meeting de-briefs

11. Links to Other Reviews/Parallel Proceedings

When a SAR Notification potentially overlaps with another review e.g., Children Safeguarding Practice Review (CSPR) or a Domestic Homicide Review (DHR); then the Independent Chair work with the Chairs of the Knowsley Safeguarding Children Partnership or Community Safety Partnership to decide which process should take precedence.

Decisions on conducting SARs should also take into consideration how this may be affected by other parallel proceedings such as criminal investigations and court hearings, coroner's inquests and hearings or Independent Office for Police Conduct investigations (IOPC).
In such circumstances the KSAB Independent Chair should seek advice from the police and the Crown Prosecution Service if appropriate on if, and how, the Safeguarding Adults Review should take account of any criminal investigation or proceedings. They should establish if the Safeguarding Adults Review may have any prejudicial impact upon any such investigations or proceedings, and as such, if a SAR should not start until after the proceedings are completed, or if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings.

More broadly the KSAB Independent Chair should also take into account the advice of the Learning Partnership Subgroup and SAR Panel, including legal and other expert advice, before deciding if a review can commence or continue.

Safeguarding Children Practice Review (SCPR)

A SCPR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. A SCPR should take place if abuse or neglect is known, or suspected to have been involved and:

- A child has died, or a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child
- The child dies in custody
- A child died by suspected suicide

For more information: **https://Knowsleyscp.org.uk/scp/professionals-volunteers/case-reviews**

Domestic Homicide Review (DHR)

A Domestic Homicide Review incorporates a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself with a view to identifying the lessons to be learned from the death.

For more information: Statutory guidance for the conduct of domestic homicide reviews - GOV.UK (www.gov.uk)

12. Duty of Candour

Secondary Care Providers registered with the Care Quality Commission are subject to a statutory Duty of Candour when they are carrying on a regulated activity (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20). The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The Knowsley Safeguarding Adults Board is committed to supporting the principles outlined in the Duty of Candour when undertaking all safeguarding activity, and as such, the Board will work with partners and agencies engaged in SAR activity to comply with these regulations.

13. Timescales

The Knowsley Safeguarding Adults Board is committed to completing Safeguarding Adults Reviews in a timely manner and “in any event, within six months of initiating it unless there are good reasons for a longer period being required” (Statutory Guidance). This could include for example, the need to delay the process due to legal proceedings or to any relevant circumstances surrounding the adult.

14. Findings from Safeguarding Adults Reviews

In accordance with the Care and Support Statutory Guidance, all Safeguarding Adults Review Reports "should be written in plain and easy to understand language, provide a sound analysis of what happened and why; and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence" (Care Act 2014 Statutory Guidance).

All Safeguarding Adults Reviews conducted within the year must be referenced within the KSAB Annual Report, together with any actions that it has taken or intends to take in relation to implementing the lessons learned from SARs. The Annual Report must also include the reason for any decision where the KSAB decides not to implement an action.

The Knowsley Safeguarding Adults Board will consider publishing Safeguarding Adults Reviews on their website. The Board retains discretion over this including the timing of the publication, taking into account any mitigating factors e.g., ongoing criminal investigations.

The Knowsley Safeguarding Adults Board will retain the intellectual property rights in relation to all reviews undertaken.

15. For consideration of a SAR

Referrals should be made via the Knowsley Safeguarding Adults Board website.

Referral forms must be fully completed, include relevant and factual information, provide contact details for all agencies involved, and give a full description of how the case meets the criteria outlined on the form. Referrals should ideally be quality checked by the partner agencies designated Board member before submission.

Referrals from non-board member agencies should also be made using the online referral form, which can also be used by an adult or family member: Health and social care | Knowsley Council

The aim of Safeguarding Adults Review (SAR) is to determine what could have been done differently to prevent serious abuse, neglect, or a death.

A SAR is not undertaken to apportion blame. A review aims to promote and share learning to enable best practice and therefore prevent harm in the future.

Criteria for conducting a Safeguarding Adult Review:

Section 44 of the Care Act (2014) states that the Safeguarding Adult Board (SAB) must arrange a SAR when an adult with needs for care and support (whether the local authority has been meeting any of those needs) if:

- 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**
- the adult has died, **and**
- 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)

Or

- the adult is still alive, and the SAB knows or suspects that the adult has experienced **serious** abuse or neglect.

16. Consideration by the SAR Group (SARG)

The SAR Group meets regularly throughout the year to ensure that SARs are considered in a prompt manner. All relevant agencies will be invited to attend the relevant Sub-Group meeting to present and consider referrals, including the referrer wherever possible or applicable. Members of the Sub-Group will be sent all relevant paperwork in advance of these meetings for their consideration, which may include some initial chronology information when it is deemed necessary.

17. The KSAB Independent Chair

The KSAB Independent Chair should be advised of the date of the meetings, although it is not expected that the Independent Chair will attend these meetings unless it is deemed to be necessary.

18. Decision Making

The information contained on the referral should be considered by the SARG and a decision made using this Policy and Procedure, alongside the Statutory Guidance, as to whether:
a) The criteria for a mandatory SAR are met
b) There is sufficient merit to the notification that a discretionary SAR should be conducted
c) There is a need to gather more information to support the decision-making process
d) The criteria are not met but another type of non-statutory review would be appropriate
e) The criteria are not met, and no further action is to be taken.

The SARG should also take into account:

- Whether any other Statutory Review Processes are taking place
- Whether any other significant processes are taking place (Police Investigation, Coroner's Inquest)
- What potential impact a SAR may have upon such investigations or proceedings, including whether a SAR should not start until after the proceedings are completed, or if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings
- If there is a delay in the commencement of a SAR, then the SARG Chair will ensure that any learning at this stage of the process is identified and shared with relevant parties.

In making a decision to recommend that a SAR is conducted the SARG Chair and group members should aim to generate a 'consensus', not a majority view. If the group cannot come to a consensus, the final decision will rest with the Chair of the Knowsley SAB after carefully considering the views of all panel members. The Chair may wish to seek peer challenge from another SAB Chair when considering this decision.

If the criteria are not met, but another type of case review is felt to be appropriate, the SARG should recommend which type of review would maximise learning. Other types of review may include a Lessons Learned Review, Management Review, Single Agency Review, or a Reflective Practice Session (this list is not exhaustive).

The referring agency/person will be informed of the decision in writing by the Independent Chair, and discussions should be held on how to inform the adult and/or their representative if there is to be a SAR which will be confirmed in writing. The adult and/or their representative will not to be informed if there is not going to be a SAR unless there are exceptional circumstances.

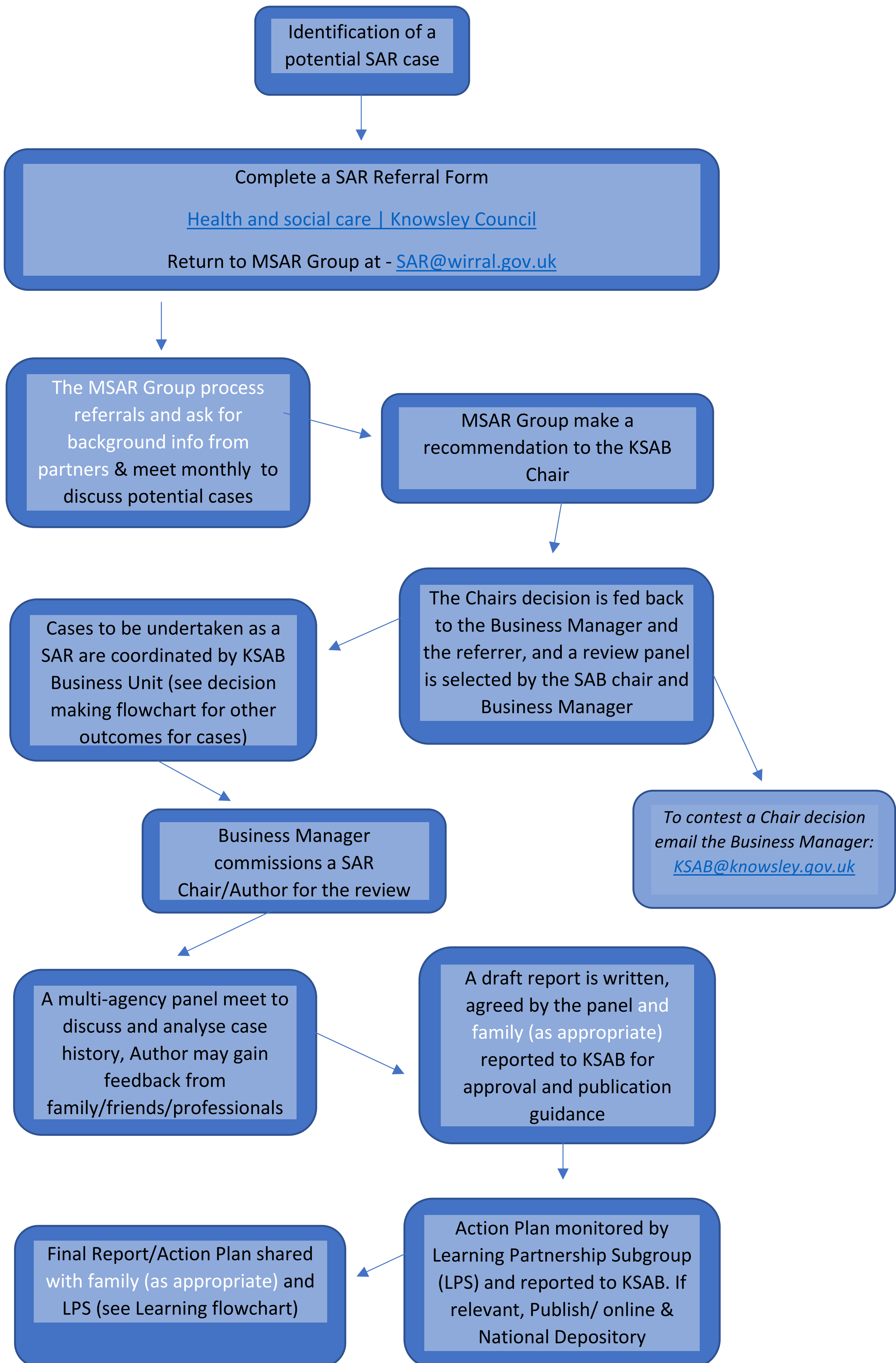
Where another type of review takes place the KSAB will receive a report on the findings and any recommendations made and will help to monitor the delivery of any action plan.

If a request for a SAR is declined, and where the referrer is dissatisfied with this outcome, they should notify the Chair of the KSAB in writing (via the KSAB Business Manager). The Chair of the KSAB will discuss with the referrer and review the decision taking into account the concerns of the referrer.

If a decision not to hold a SAR is upheld, the requesting agency can choose to take no further action or to undertake an internal review using an appropriate methodology.

Safeguarding Adult Review Process

SAR Review Process



19. The relationship between Section 42 Enquiries and SAR'S

Section 42 Enquiries are undertaken when an adult with care and support needs has been identified as experiencing, or at risk of abuse and neglect. As a matter of law an enquiry under Section 42 cannot commence in relation to a person who has died. Where someone's death is suspected to be as a result of abuse or neglect and the statutory criteria appear to have been met under Section 44, then a SAR Referral should be submitted as outlined above.

If the circumstances of the death mean that there are reasons to be concerned about risks to 'other adults', Section 42 Enquiries may need to be made to decide whether action needs to be taken to protect them. For example, this will often be necessary following a death in an organisational setting where other adults are continuing to receive a service.

SAR Referrals can also be made in cases where someone is known or suspected to have suffered "serious abuse or neglect" (see Section 5, page 4).

The Statutory Guidance gives as examples of serious abuse or neglect cases where an adult "would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect". In this case, Section 42 Enquiries into what happened to that person may still need to take place in parallel, to ensure the person's immediate safety and the safety of any others who may be at risk. This enquiry should be limited to those purposes rather than duplicating what may take place through the process of a SAR.

20. Terms of Reference

The scope and terms of reference should be proportionate to the nature of the case and should identify what appear to be the most important issues to address in identifying the learning from the case.

The Terms of Reference (ToR) will:

- Determine the timeframe during which events in the adult's life will be reviewed, taking into account the circumstances of the case
- Clearly highlight the key questions that the review should aim to answer
- List the agencies and individuals who should be engaged in the review
- Illustrate which pieces of legislation, policies and strategies should be considered as part of the process
- Consider if there are any specific considerations around equality and diversity
- Outline the methodology to be used
- Reflect Data Protection Act requirements and outline the arrangements for storage and transfer of personal information
- Consider how the review process should take account of previous lessons learned both nationally and regionally, including reference to the national SAR Thematic Analysis
- Include a duty to report information to the Independent Chair if new information comes to light suggesting malpractice of individuals and/or organisations
- Consider how matters concerning family and friends, the public and media should be managed before, during and after the review
- Consider how to liaise with the adult and whether they require an advocate to support them
- Ensure that any learning identified at an early stage of the process is shared and acted upon

The process for undertaking SARs (the methodology) will be determined by the SARG who will consider this whilst the TOR is being drafted, and in consultation with the reviewer and panel.

No one model will be applicable in all cases, and a hybrid model may be the most appropriate method in the majority of cases. The “focus must be on what needs to happen to achieve understanding, remedial action and answers” (Statutory Guidance).

21. Outline of the Process

The process will be supported throughout by the Knowsley Safeguarding Adults Board Business Unit. The Business Manager will specifically act as the commissioning authority for the reviewer providing support and oversight to the contractual arrangements.

Some or all of the following actions/stages will be appropriate dependent on which methodology is being followed and will be determined by the Independent Reviewer and the SAR Panel:

1. Identify the evidence required from each agency
2. Produce Individual Management Reviews (IMRs) (see Appendix)
3. Produce a chronology of events
4. A review and analysis of the relevant evidence
5. Hold a practitioner event to consider what happened and why, areas of good practice, areas for improvement and lessons learned
6. Formulate a SAR Report with analysis of key issues, lessons learned and recommendations
7. Produce an action plan in response to the lessons learned
8. Agree how the learning will be disseminated, including providing feedback to staff and agencies involved in the case, and the delivery of a learning event
9. Publish the anonymous – lessons learnt via: SAR Report, briefings, case studies on KSAB and partner websites
10. Share presentations of anonymous learning at team meetings, spotlight sessions, training events and conferences

Liaison should take place with the adult, their advocate, relative or carers throughout the process and regarding the publication of the final report.

The SARG Chair should report regularly on progress to the Knowsley SAB.

Discussion will take place with the adult and/or their family regarding the use of pseudonyms within the report, or if the adults actual name should be used.

The Lead Reviewer should present the Final Report to the SARG.

The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the Knowsley SAB.

A reason should be given for any decision where the Knowsley SAB decides not to implement a recommended action.

22. Publication of SAR reports

A SAR report will normally be drafted for all reviews unless there are exceptional circumstances preventing or precluding the need for this.

The requirement for this should be set out in the Terms of Reference as agreed by the Chair of the Knowsley SAB.

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

The Safeguarding Adults Board has a legal duty to coordinate SARs and it may be necessary to publish a report without the consent of the adult(s) and/or family if it would be in the publics best interest. However, the adult(s) and/or family should be given the opportunity to discuss the anonymised draft SAR report and conclusions, and their experience of the process.

The KSAB Business Manager and SAB Chair should receive and agree the draft report before it is presented to the Knowsley SAB membership, so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented.

The KSAB will decide to whom the SAR report, in whole or in part, should be made available, and the means by which this will be done.

Considerations of confidentiality, parallel proceedings or other legal reasons may affect decisions to publish. Any reports to be published must be fully anonymised. If the adult(s) and or family members, or their representatives, ask for the adult(s) first, last or both names to be used in the SAR report, the request will be referred to the KSAB Independent Chair who will make a decision about whether to publish.

Any request under the Freedom of Information Act (FOIA) 2000, related to information that has been created for the purposes of the work of the KSAB should be referred to the KSAB Business Unit in Knowsley Metropolitan Borough Council. The KSAB Business Unit will co-ordinate and respond to FOIs on behalf of the KSAB organisations. However, all Safeguarding Adults Reviews conducted within the year will be referenced within the Board's Annual Report to help satisfy FOI requests, which should include the reason for any decision where the KSAB decides not to implement an action.

When a Partner receives a Subject Access Request relating to information shared as part of this Agreement, they should advise KSAB firstly who will consult with the relevant Partners of the request.

The KSAB will also consider publishing Safeguarding Adults Reviews on its website.
KSAB website

SAR reports and other records collected or created as part of the SAR process will be held securely and confidentially for an appropriate period of time in line with KSAB's Information Sharing Agreement, the Data Protection Act and other legal requirements.

23. Quality Assurance

Quality assurance is embedded throughout the SAR process from developing the Terms of Reference, commissioning a reviewer, through to the SAB scrutiny of the report and the implementation of the recommendations.

The SAR report must provide a robust assessment and analysis of the evidence (working out) for the SAB to be able to check, scrutinise and critically analyse the content. In doing so, the SAB will gain assurance of the adequacy of the report and usefulness of the recommendations.

24. Learning from SARs

- When a Safeguarding Adults Review is completed the report's recommendations will identify improvements for professionals and organisations
- Not all reviews are statutory SARs, however the principles of sharing learning from SARs may be used to share learning from other reviews
- The recommendations are considered by the Knowsley Safeguarding Adults Board and are used to develop an action plan in order to promote change and improve approaches to safeguarding that will reduce the risk of repeat circumstances

SAR Action Plans

The Boards Learning Partnership Subgroup coordinates the completion of action plans, provides progress reports to the Board, and supports learning to be shared more widely (see below learning flowchart).

- Board members of the KSAB are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan
- Liaison to continue to take place with the adult and/or their representative as appropriate

What does a typical action plan include?

- Who is responsible for completing the actions
- The timescale within which the actions will be completed
- The intended outcome of the actions
- The means of monitoring and reviewing the intended improvements
- The way in which the report or key findings to relevant parties as agreed and provide feedback and debriefing to staff, family members and where appropriate the media.

Sharing learning from reviews

When sharing learning, methods must be sensitively tailored to meet different types of review and the needs and learning styles of different individuals and groups. A variety of approaches to sharing learning should be used. Volunteers from the Learning Partnership Subgroup may meet as a task and finish group to discuss ways to share learning from a review, including asking other relevant professionals or organisations to join the task and finish group as required.

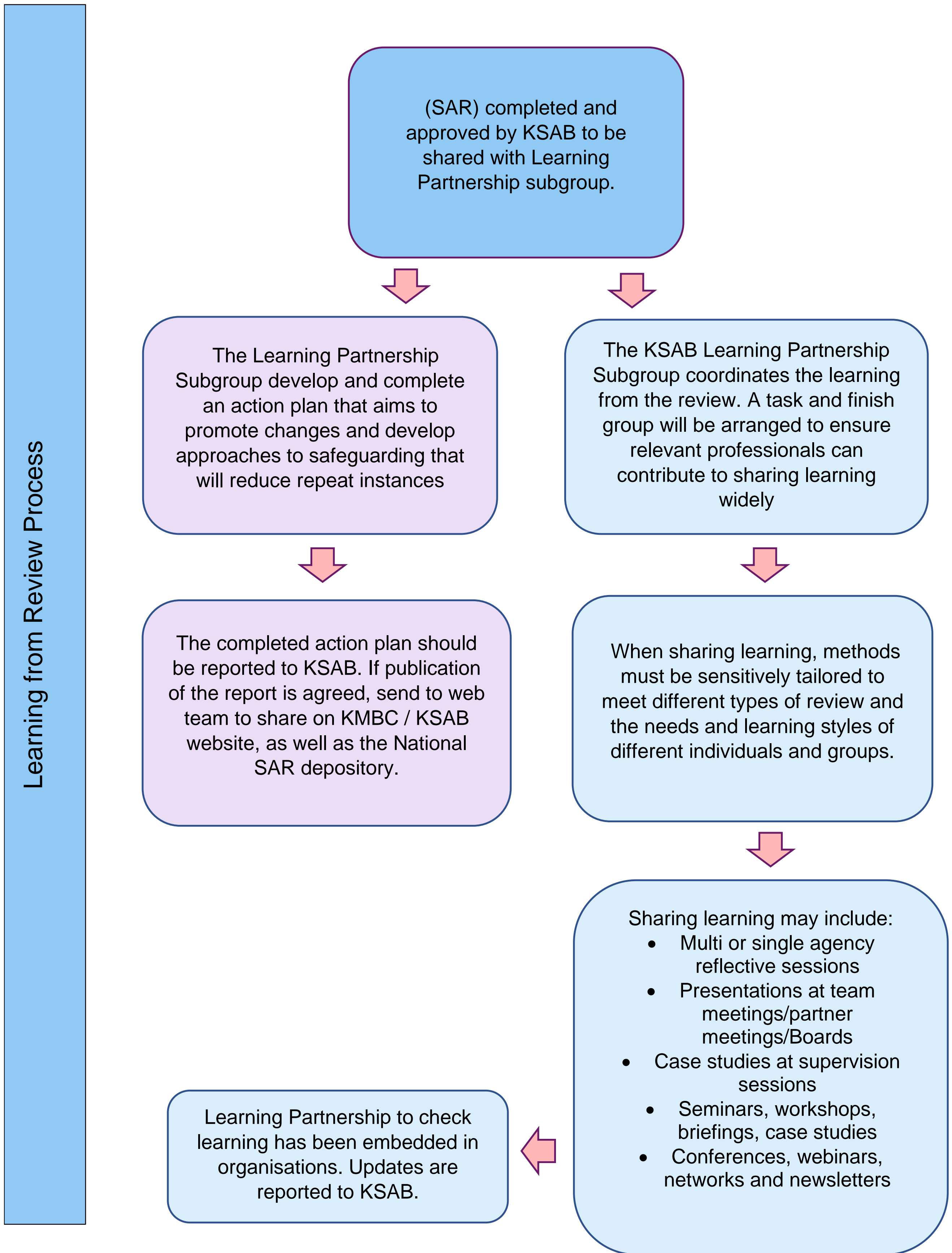
It is essential that learning is shared in a timely manner, is targeted at the right audience, and allows space for consideration of the implications for practice and systems and identifies what needs to happen to ensure the learning is applied.

It is anticipated that wherever possible learning from reviews should be shared at a regional and national level to help identify overarching themes for consideration and inform changes and the development of national policy. Sharing learning at a national level may include:

- KSAB Chair shares relevant learning at national meetings and forums
- Publishing SARs on websites (where appropriate)
- Sharing SARs with the National Depository (where appropriate)
- Presenting SAR Learning at regional meetings

Mechanisms should be developed to check that learning has been embedded in organisations. Learning updates should be reported to Board via quarterly briefings.

Knowsley SAR Learning Flowchart



25. Links to Other Websites

- Care Act 2014
- Safeguarding Adults Reviews (SARs) - SCIE
- National Analysis of Safeguarding Adult Reviews
- Knowsley Council website
- Link to KSAB website
- Ann Craft Trust
- Knowsley Safeguarding Children Partnership

Appendix 1: Guidance for Authors of Individual Management Reviews (IMRs)

Background

Each agency that has been involved in the case under review should, if requested, undertake an Individual Management Review (IMR) of its involvement with individuals/family.

What is an Individual Management Review?

Individual Management Reviews (IMR's) are a way of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. Every completed IMR should identify good practice alongside the identification of areas where systems, processes, or individual/organisational practice could be improved.

IMR's are used as one of the main sources of information for a Safeguarding Adults Review.

The IMR process is not designed for identifying gaps in the actions or activities of other organisations.

Principles

Individual Management Reviews should be:

Systemic– Considers the influence of systems - how services are set up and provided, rather than solely individual actions. **Proportionate** – Succinct and focused on the key lines of enquiry and relevant detail. **Independent** – Completed by someone who has not had prior involvement or case supervision responsibilities. **Transparent** – Open and honest in presenting and analysing the agencies involvement.

Individual Management Review Process

When undertaking an IMR the following process should be followed:

- Collate information (reading records, interviews etc.)
- Analysis followed by identification of good practice and areas for improvement
- Identify findings and recommendations
- Write the IMR report
- IMR Approval within your organisation
- Submission to the KSAB Business Unit for use in the review

Collating Information

Explore a wide range of information from the sources available in order to carry out the analysis required.

Chronology

The Individual Management Review must be accompanied by a detailed chronology of contact with the adult for the time period identified for the Safeguarding Adults Review. A chronology of events is a useful way of achieving an overview of a case from information obtained from a number of organisations. This enables a review to identify gaps in service provision or practice, missed opportunities for communication and areas of good practice.

Also, identify key periods of the chronology where contact with the adult was felt to be significant to the care, support and treatment delivered, which could have affected the outcome of the case.

Content of Individual Management Review Reports

It is important that IMR authors do not assume that people who read their reports have any knowledge of the issues under examination. Consequently, it is important to ensure that the evidence, upon which conclusions and recommendations are drawn, is clearly stated. Try to get an understanding not only of "**what**" happened, but '**why**'. Never use abbreviations, jargon, or initials.

Professionals Involved in the Care and Support of the Adult

Please list all professionals involved in the care and support for the adult at risk from your agency.

Factual / Contextual Summary

Please provide a brief factual and contextual summary of your agency's involvement with the adult at risk for the time period identified for the Safeguarding Adult Review.

Analysis of Involvement

In this section the author must review the information in the comprehensive chronology and produce a critical analysis. The information included and the analysis should be appropriately evidenced. Your analysis should not consist of a rewording of the chronology. It is important to critically analyse your agency's involvement.

Author's Considerations

Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgements, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what occurred, but why.
Identify both good and poor practice, where performance exceeded or fell short of those standards expected in this type of case. Identify what underlying factors were significant and how they affected the practice and decisions in this case, also whether these were multi or single agency factors (e.g. workload, resources, staffing issues, training, management, recording systems and information sharing arrangements).

Consider alternative courses of action and what would have made a difference to the adult.

Questions are case specific, common IMR questions are:

- Were practitioners sensitive to the needs of the adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a Safeguarding Concern about an adult with care and support needs in these circumstances?
- Did the agency have in place policies and procedures for safeguarding adults at risk and acting on Safeguarding Concerns about abuse or neglect?
- What were the key relevant points/opportunities for assessment and decision making in the case in relation to these adults?
- Do assessments and decisions appear to have been reached in an informed and professional manner?
- Did action accord with assessments and decisions made?

 Were appropriate services offered/provided or relevant enquiries made in the light of assessments?
 Where relevant, were appropriate care plans in place, reviewing processes complied with, and how did they involve relevant risk assessment in protecting the adult at risk?
 Were more senior managers or other agencies and professionals involved at points they should have been?
 Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk of abuse and neglect, and wider professional standards?
 Was mental capacity considered and or any formal Mental Capacity Assessment conducted and recorded?
 Was practice sensitive to the racial, cultural, linguistic, and religious identity of the adult? If this was a relevant factor, was it cited and explored appropriately?
 Were relevant, appropriate safeguarding or care plans in place, and if so were these reviewed and complied with?
 Are there are any particular features of this case, or issues surrounding the death or injury of the adult(s), that you consider require further comment in respect of your agency's involvement?

Learning

 This section is where you will be able to explain what has been learned from the case.
 Is there good practice to highlight, as well as ways in which practice can be improved?
 Are there lessons from this case for the way in which this agency works to safeguard adults?
 Are there implications for ways of working?
 Are there implications for management and/or supervision?
 Are there implications for training (single or multi-agency)?

Recommendations for Action

In this section you will need to make recommendations on behalf of your agency.

Recommendations should be few in number, focused and specific, and capable of being implemented without delay. Consideration should be given to the resources required to implementing the recommendations such as cost. e.g.

 What action should be taken, by whom, and by when?
 What outcomes should these actions bring about?
 How will the agency review whether they have been achieved?

Quality Assuring Individual Management Reviews

Before the IMR report is provided to the safeguarding adults board it should be quality assured and agreed by a senior person within your organisation (preferably your organisations safeguarding adults board member) in line with your internal processes.

The purpose of quality assuring IMR reports is to promote consistency across organisation and ensure they are fit for challenge and scrutiny. The factors that an effective IMR will include are:

 A comprehensive chronology
 A clear history of our involvement
 Identification of strengths

- Critical analysis
- Well focused recommendations that are capable of being implemented without delay