Safeguarding Adults in Lambeth

Lambeth Safeguarding Adults Board

Safeguarding Adults Reviews (SAR)

POLICY AND PROCEDURES

APPENDICES AND TEMPLATES

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Appendix One: Safeguarding Adults Review Referral Form

STRICTLY CONFIDENTIAL

REQUEST TO THE LAMBETH SAFEGUARDING ADULTS BOARD (LSAB) FOR CONSIDERATION OF A CASE FOR A SAFEGUARDING ADULTS REVIEW

One form to be completed for each adult/care setting. Please complete form as fully as possible.

1. Referral Details	
Date of referral to LSAB	Click or tap here to enter text.
Name of referrer	Click or tap here to enter text.
Job title	Click or tap here to enter text.
Agency	Click or tap here to enter text.
Address	Click or tap here to enter text.
Tel. no.	Click or tap here to enter text.
Email	Click or tap here to enter text.
2. Adult's Details	
Adults full name	Click or tap here to enter text.
Any known aliases	Click or tap here to enter text.
Address	Click or tap here to enter text.
DOB	Click or tap here to enter text.
Guardians / Carers	Click or tap here to enter text.
Next of Kin	Click or tap here to enter text.
Names and date of birth of any dependents	Click or tap here to enter text.

3. Agencies known to be involved with the case

Adult Social Care ☐	Police ☐	London Fire Brigade ☐
Probation Services ☐	London Ambulance Service ☐	CQC ☐

GP ☐ Named practice if known: *Click or tap here to enter text.*	Dentist ☐ Named practice if known: *Click or tap here to enter text.*	Community Nursing ☐
Guys and St Thomas' NHSFT ☐	South London and Maudsley NHSFT ☐	Kings College Hospital NHFT ☐
Other health services ☐ Please specify: *Click or tap here to enter text.*	Care provider ☐ Please specify provider: *Click or tap here to enter text.*	Drug and alcohol service ☐
Housing Services ☐ Please specify (e.g. council or housing association): *Click or tap here to enter text.*	Other ☐ Please specify: *Click or tap here to enter text.*	

4. Reason for notification (more than one box may be ticked)

An Adult At Risk has died (including suicide) and abuse or neglect is known or suspected to be a factor and the case gives rise to concerns about how multiple services or organisations worked together to safeguarding Adult At Risks from harm ☐

An adult at risk has experienced serious abuse or neglect resulting in permanent harm and the case gives rise to concerns about how multiple services or organisations worked together to safeguarding Adult At Risks from harm. ☐

Any other reason relating to an adult with care and support needs. Give details: ☐

Click or tap here to enter text.

5. Characteristics of case

Domestic abuse ☐	Alcohol misuse ☐	Drug misuse ☐
Mental health ☐	Fabricated illness ☐	Serious illness ☐
Sexual abuse ☐	More than one Adult At Risks abused ☐	Self-neglect ☐
Emotional abuse ☐	Recent neglect ☐	Long standing neglect ☐
Physical abuse ☐	Organisational abuse ☐	Death in custody ☐
Suicide and abuse ☐	Other ☐	

Please specify: *Click or tap here to enter text.*

Is the Adult At Risk subject to a protection plan?	Yes ☐	No ☐	Previously ☐	Don't know ☐
Have criminal proceeding been instigated?	Yes ☐	No ☐	Don't know ☐	
Has there been a conviction?	Yes ☐	No ☐	Don't know ☐	

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6. Case Outline

(Please include any specific concerns about the case and inter-agency working)

Click or tap here to enter text.

7. Involvement

Is the person concerned or their family aware of this referral for a safeguarding adults review?

Click or tap here to enter text.

Please outline the communication that has taken place with the individual concerned, their family and/or friends regarding this referral and their views. Please give contact details of the people involved.

Click or tap here to enter text.

PLEASE RETURN THIS COMPLETED FORM TO:

LB Lambeth Quality and Safeguarding Adults Service

Email: LSABadmin@lambeth.gov.uk

Postal Address: PO Box 734 Winchester S023 5DG

PLEASE ENSURE THAT REFERRAL FORMS ARE SENT SECURELY.

Appendix Two: Need to Know – Initial Briefing

Name of Reporting Officer:	Click or tap here to enter text.		
Brief Description of Incident:	Click or tap here to enter text.		
Date and time of incident:	Click or tap here to enter text.	**Service area affected (if applicable please include detail of site / base affected)**	Click or tap here to enter text.
Other people notified / aware of incident:	Police ☐		Probation Services ☐
	CQC ☐		Lambeth CCG ☐
	London Fire Brigade ☐		Adult Social Care ☐
	Other (please state:		Click or tap here to enter text.
Type of Incident:	Death or serious injury – service user		☐
	Death or serious injury to employee		☐
	Serious safeguarding concerns or enquiries which concern Council employees		☐
	Provider service – incident which would be reportable to CQC		☐
	DCC required to give evidence to Coroner's Enquiry		☐
	DCC required to respond to application to Court of Protection or High Court by a third party		☐
	Serious incident of violence against staff		☐
	Allegation of Gross Misconduct – staff member		☐
	Major service failure e.g. imminent closure of service		☐
	Significant question of public interest and/or risk to Council's reputation		☐

Brief Details of the incident and action taken/proposed: - *continue on separate sheet if required.*	
Click or tap here to enter text.	
Lead Officer dealing with incident and their contact details:	Click or tap here to enter text.
Briefing sent to: *Please insert name of Assistant Director*	Click or tap here to enter text.
Assistant Director – Actions taken/proposed and timescales.	Click or tap here to enter text.
Follow-up actions taken	Click or tap here to enter text.
Outcome	Click or tap here to enter text.
	Send completed forms to: Quality and Safeguarding Adults Service Email: LSABAdmin@lambeth.gov.uk PLEASE ENSURE YOU USE A SECURE METHOD OF COMMUNICATION

Appendix Three: Individual Management Review Template

RESTRICTED

STRICTLY PRIVATE AND CONFIDENTIAL – NOT FOR DISCLOSURE

Scope and suggested format for Individual Management Reviews

Safeguarding Adults Review for Lambeth Safeguarding Adults Board

Report Details	
Name of Agency	
Name, agency and contact details of person completing chronology and individual management review (IMR):	
Date of Request for IMR:	
Date of Completion of IMR:	

Scope of Safeguarding Adults Review		
To review the involvement of agencies listed below, including the particular matters noted for individual agencies 1. 2. 3. With the people named below, during the period xx		
Person 1		Name: Date of birth: Date of death: Address:
Person 2 (delete/add as necessary)		Name: Date of birth: Date of death: Address:

FACTUAL/CONTEXTUAL SUMMARY: Provide a brief factual and contextual summary of your agency's involvement with the adult for the time period identified for this safeguarding adult review.

CHRONOLOGY OF AGENCY INVOLVEMENT: Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the relevant people over the period of time requested. Where abbreviations are used, please provide a glossary to explain them.

ANALYSIS OF INVOLVEMENT:

The report author is expected to rigorously analyse the involvement of their agency. Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. The Terms of Reference can be referred to as headings to analyse practice against. Facts should not be stated without their origin.

Areas to consider might include:

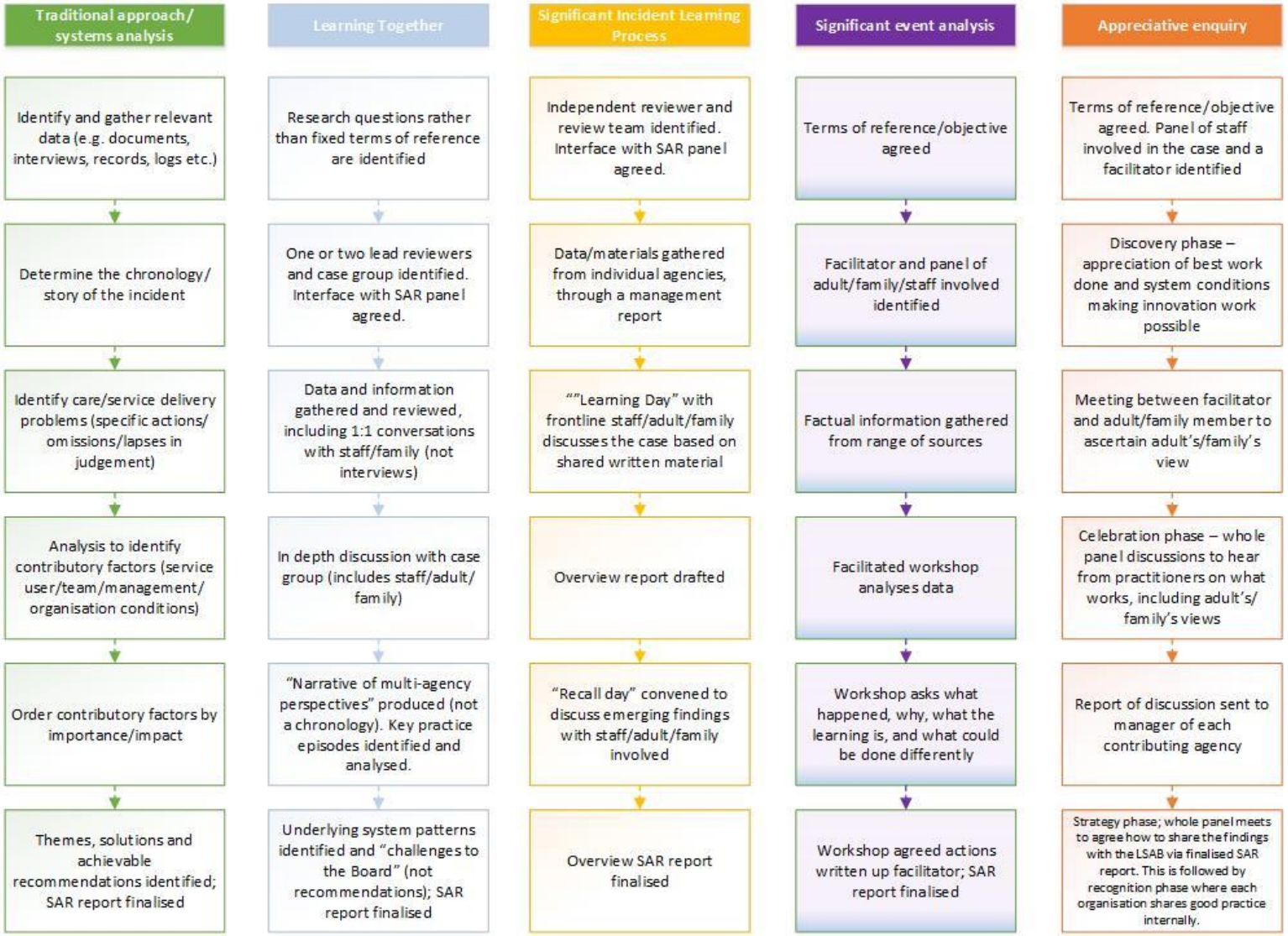
- Were practitioners sensitive to the needs of the adult at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a concern about an adult at risk?
- Did the agency have in place policies and procedures for safeguarding adults and acting on concerns about abuse or neglect?
- What were the key relevant points/opportunities for assessment and decision making in the case in relation to the adult? Do assessments and decisions appear to have been reached in an informed and professional way?
- 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 vulnerable adult?
- 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, and wider professional standards?
- Was mental capacity considered and any formal Mental Capacity Assessment recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult? Cite ethnicity and culture of the vulnerable adult and the relevance of this to provide an exploration.

The Review Report will usually be shared with the person concerned or family members involved. Is there anything in this report that cannot be shared with the person concerned or family members involved? Click or tap here to enter text.

Please return completed summary to [insert Independent Reviewers contact details] or LSABadmin@lambeth.gov.uk (Please ensure this is done securely).

Appendix Four: SAR Methodology Processes

The below summarises the key features, processes and advantages and disadvantages of selected methodologies. SAR Sub-group members may direct reviewers to use a combination of these methodologies and draft a process accordingly.



A.	Traditional approach

This broadly follows a traditional model, with the appointment of a SAR panel, including chair/independent reviewer and core membership which oversees progress. Combined IMRs and chronologies can reveal patterns, missed opportunities, information-sharing, working together This methodology is more likely to be applicable where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

⊕ Tried and tested process which is familiar to people, giving confidence in the approach ⊕ Useful where multi-agency involvement has been long-term ⊕ Works well for complex and serious incidents or high-profile cases	⊖ Overly bureaucratic and protracted, there is potential that lessons learnt will not be responsive to time considerations. Does it get beyond description to answering why things happened the way they did? ⊖ Costs may not justify the outcome ⊖ Can preclude direct contact with the frontline practitioners; contact with those involved in the case may be done on a single agency basis, missing opportunities to maximise learning ⊖ Can be perceived as punitive

B.	Systemic approach – learning together

This approach looks for patterns and for factors that promote good practice or create unsafe working environments. There is a focus on structured reflection with those involved rather than management reports. This approach aims to create an integrated narrative with no chronology.
Available models: SCIE Learning Together

⊕ Less distance between the reviewers and the reviewed ⊕ Less dependent on a single reviewer and reduced burden on individual agencies to produce management reviews ⊕ Analysis from a team reviewers and case group may provide more balanced view ⊕ Staff and volunteers participate full to provide information and test findings	⊖ Approach may result in reduced single agency ownership of learning/actions. ⊖ Challenge of managing the process with large numbers of professionals/family involved ⊖ Cost involved to train in-house reviewers or commission SCIE reviewers ⊖ Demanding of professionals' time, who have may have to spend a lot of time in meetings ⊖ Very structured

C.	Significant Incident Learning Process (SILP)

This approach has a focus on structured reflection around key themes drawn from management reports, with learning events used to explore people's perspectives of events, and analyses what happened and why.
Available models: Tudor, Significant Incident Learning Process

⊕ Useful where key episodes can be identified ⊕ Flexible process of reflection; may offer scope for taking a light-touch approach ⊕ Facilitates staff and family participation in a structured way; easier to manage large numbers of participants ⊕ Agency management reports may better support single agency ownership of learning/actions	⊖ Cost involved to train in-house reviewers or commission SILP reviewers ⊖ Demanding of professionals' time, who have may have to spend a lot of time in meetings ⊖ Has not been widely tried or tested, nor gone through thorough academic research/review

D.	Significant Event Analysis

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. Significant Event Analysis has been used for many years in the health service to analyse a significant event *'in a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements.'*
The approach begins with information gathering, collating as much information as possible from a broad range of sources, in order to inform a facilitate workshop to analyse the event.
Available models:
NHS Education for Scotland and NPSA Significant Event Analysis

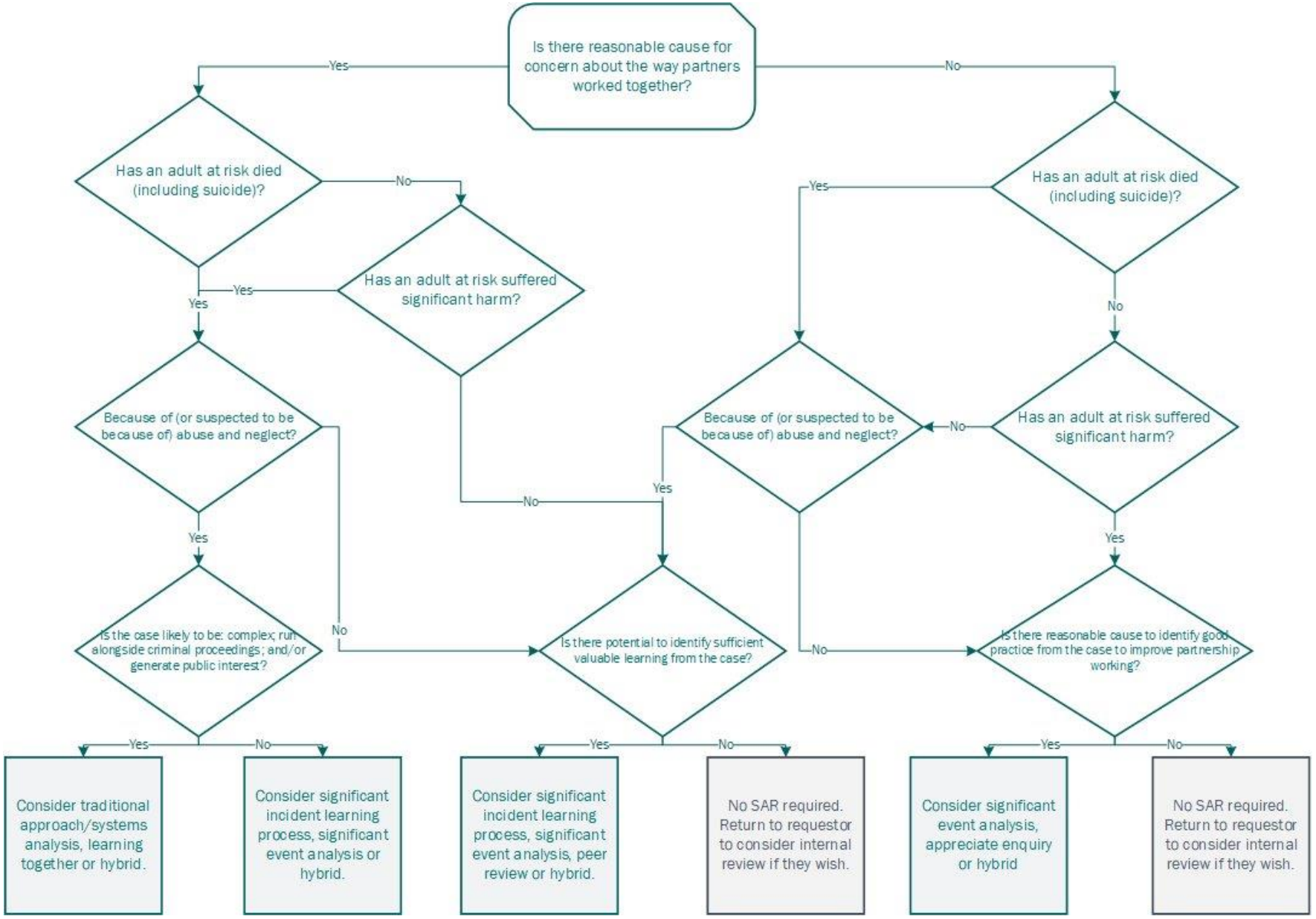
⊕ Light-touch and cost-effective approach; one workshop ⊕ Yields quick learning ⊕ Full contribution of learning from staff involved in the case, with shared ownership of learning ⊕ Trained reviewers not required ⊕ May suit less complex cases – useful for single episodes	⊖ Lack of independent review team may undermine transparency/legitimacy ⊖ Speed of review may reduce opportunities for full consideration of the case ⊖ Not designed to involve the family

⊕ Does not depend on independent reviewers	

E.	Appreciative enquiry
This approach is panel led with a facilitator and aims to find out what went right and what works in the system. This allows the panel to identify changes to make so that this happens more often. Available models: Julie Barnes A new model for learning from serious case reviews	
⊕ Timely, light-touch and cost-effective. Process can be completed in 2-3 days ⊕ Useful to focus on good practice and what is working well ⊕ Shared ownership of learning ⊕ Staff who worked on the case are fully involved. ⊕ Well researched and reviewed academic model.	⊖ Not designed to cope with 'poor' practice/systems 'failure' cases ⊖ Adult/family only involved via a meeting ⊖ Model not well developed or tested in safeguarding. Minimal guidance available. ⊖ Speed of review may impact on level of reflection

F.	Peer Review
This approach encompasses a review by one or more people who know the area of business. It accords with self-regulation and sector-led reviews of practice. This can either be peers from within the same partnership or outside the partnership but within a specified region (e.g. Greater London). Peer review methods are used to maintain standards of quality, improve performance and provide credibility.	
⊕ Objective, independent perspective but with some local knowledge ⊕ Trusted sources sharing common experiences ⊕ Very cost effective ⊕ Arrangements can be reciprocal	⊖ Capacity issues may affect availability and responsiveness ⊖ Potential to view peer reviews from other LSAB Members as not sufficiently independent, especially in high profile cases ⊖ Potential skills and experience issues

Process for helping SAR Subgroup identify most appropriate methodology: Use this flowchart to help you identify the best methodologies for the case being considered. Remember - this is only a guide and a flexible approach to methodologies should be considered.



Appendix Five: SAR Terms of Reference and Confidentiality template

Lambeth LSAB Safeguarding Adults Review: code/ initials

Terms of Reference

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All Lambeth Safeguarding Adult Board (LSAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Legislation

Section 44 of the Care Act 2014 places a statutory requirement on the LSAB to commission and learn from SARs in specific circumstances, as laid out below, and confers the LSAB the power to commission a SAR into any other case:

'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 SA(P)B, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) the adult had died, and the SA(P)B knows or suspects that the death resulted from abuse or neglect…, or
c) the adult is still alive, and the SA (P)B knows or suspects that the adult has experienced serious abuse or neglect.

…Each member of the SA (P)B 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.

Governance and accountability

This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures (London ADASS 2019); and
- LSAB SAR sub-group Policy and Procedure (2020)

As the accountable body responsible for its commissioning, the LSAB will receive updates on progress of this SAR at Board meetings or via offline written briefings as required.

SAR subjects *(redact before publishing)*
The summary of details of the subjects of this SAR are:

Name	DOB	DOD	Age	Ethnicity	Known and previous addresses

(*adult at risk)*

(source of risk)

Brief summary of concerns that triggered this SAR

SAR methodology

has been selected as the methodology for conducting this SAR. This methodology was selected because .

Specific areas of enquiry
The SAR panel (and by extension all contributors) will consider and reflect on the following:

1.
2.
3.
4.
5.

The SAR should cover the time period dd/mm/yyyy to dd/mm/yyyy.

Timescales for completion
This SAR will commence on dd/mm/yyyy and should complete within six months. However this may be affected by any criminal proceedings and the review may be suspended pending any court case and resumed when any trial is concluded. Everyone involved in the SAR process must be mindful of not jeopardising any criminal proceedings.

Evidence and submissions to the SAR
It has been agreed that the following organisations are to submit evidence to the SAR:

Organisation	Nature of the evidence to be submitted	Deadline

SAR report and publication

has been appointed to author the SAR report, the content of which is to be in line with Section 11 of the LSAB SAR Policy and Procedure and the London Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of full SAR report or the executive summary will be published on LSAB Website and submitted to the SCIE SAR Library unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to LSAB how to publish the report, setting out clear reasons for the recommendation.

Timings for publication may be affected by any criminal proceedings and court case, and the SAR report may be held for publication until such time as the proceedings/ case has concluded it can be published. In the meantime, any lessons learned can be taken forward immediately.

Involving and supporting the adult and family/ friends/ carers *(redact before publishing)*
The review will seek to involve the adult at risk and family/ friends/ carers *(delete/ adapt as applicable)* in this SAR. The SAR chair has agreed with the adult at risk and family/ friends/ carers *(delete/ adapt as applicable)* that they would/ would not like to be involved.

Name	Connection to the adult	Nature/ timing of involvement	Support agreed

The adult at risk and family/ friends/ carers *(delete/ adapt as applicable)* has indicated they would/ would not *(delete as applicable)* like to be kept informed of progress to extent.

Involving and supporting key staff and volunteers

The review will seek to hear the perspectives of all key staff and volunteers by .

The SAR panel member from each agency is responsible for identifying and notifying relevant staff and volunteers of this SAR and giving them the opportunity to share their views on the case.

The SAR panel member from each agency is responsible for ensuring relevant staff and volunteers are provided with a safe environment to discuss their feelings and offered emotional support where needed, including counselling or other therapeutic support.

Disclosure and confidentiality

Confidentiality should be maintained by all LSAB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All LSAB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, Lambeth SAB may use its powers under Section 45 of the Care Act to obtain the relevant information. The Chair of LAB and/or the SAR chair may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/ guidance, or meet with review participants.

Criminal proceedings may be running in parallel to this SAR, and in such cases all material received by the SAR panel must be disclosed to the police if and as requested.

The SAR author must consider with the family whether they would prefer anonymity for their relative within the SAR report and how they will be referred to.

Communications and media strategy

Communications advice will be provided to the Board in respect of a SAR and where appropriate the communications approach would be managed by Lambeth Council

communications department. All media queries will be referred to the Chair of The Board. For further detail please see Section 13 of the LSAB SAR Policy and Procedure.

Legal advice

Legal advice for the Board in respect of a SAR will be sought as required and if appropriate from the Lambeth Council legal department to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and coroner

There are no/ the following police or coroner's investigations ongoing linked to this case:

-

The SAR chair has agreed the following arrangements to link the review and ongoing investigations:

-
-
-

The SAR chair will be responsible for ensuring appropriate ongoing liaison with the Crown Prosecution Service, Coroner and the Police as required.

Links to parallel reviews

The SAR panel has identified that this review links to no other/ the following other ongoing statutory reviews:

-

The SAR chair has agreed the following arrangements for dovetailing the reviews and reducing duplication:

-
-
-

The SAR panel shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, children's Serious Case Reviews or a SAR being conducted by another LSAB.

Funding and resourcing

Funding of this SAR, arranged by the Board, will be sourced from the agencies which are involved.

Review of Terms of Reference

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of the LSAB.

Appendix Six: Confidentiality statement to be signed by independent SAR Reviewer

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The following confidentiality statement is to be read and signed at the point an Independent Reviewer is commissioned to carry out a SAR.

This SAR has been commissioned by the Lambeth Safeguarding Adults Board (LSAB). It remains the property of the Board and its Independent Chair and is not to be disclosed to anyone other than the Chair, officers working on the SAR and members of the SAR Sub-group. When complete, the Board will make decisions on publication and sharing the Review.

LSAB Safeguarding Adults Review: code/ initials

I, the undersigned, confirm my understanding and acceptance of the following confidentiality requirements in relation to this SAR:

- All sensitive, personal and other information and documentation will be shared in the strictest confidence. It is expected that the duty of confidence will be maintained in line with the requirements of Data Protection legislation and local protocols for the sharing of information, including Caldicott requirements within health and social care.

- All information received or given (including all documentation and notes, whether in electronic or hard copy form) must be held securely and safely. All material relating to the review must be kept together in one place. This includes information stored electronically which will normally be supplied in protected form.

- Electronic data may only be stored on agency systems. Memory sticks or other portable devices must not be used for this purpose.

- All documentation should be marked 'Confidential' and may not be disclosed to others without the prior written consent of the Chair of the SAR Panel or the Chair of LSAB.

- All information discussed at any meetings as part of this review is and remains strictly confidential. It may not be discussed, disclosed or in any other way made available to other parties without the prior written consent of the Chair of the SAR Panel or the Chair of LSAB.

- The unauthorised disclosure of information outside of meetings, beyond that which has been agreed and recorded within the minutes of any meetings as part of this review,

may have legal consequences. It would be considered as a breach of the data subject(s)'s confidentiality and a breach of the confidentiality requirements of the agencies involved.

- All information and documentation supplied as part of the review is the property of LSAB. It remains the confidential property of the Board even when stored within agency systems. All materials must be returned to the Chair of LSAB on request, at the end of meetings, or at the end of the review process. Confirmation of secure destruction will be provided.

Advice on these requirements is available from the Chair of LSAB and the Chair of the SAR sub-group.

Signed:

Name:

Role:

Organisation
(if applicable):

Date:

Appendix Seven: SAR report and action plan guidance and template

The SAR report must be delivered within timescales and according to the agreed terms of reference. The report must collate and analyse the information and evidence presented to the SAR process, highlight lessons learned and make practical recommendations on areas the safeguarding partnership should address to improve joint working and outcomes for adults and their families.

The report should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Include enough of the evidence, analysis and "working out" for the SAR subgroup and LSAB to scrutinise, critique and quality assure it;
- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

A template for the report and a LSAB action plan is provided overleaf. As with all such review reports the precise format that will be used depends on the features of the case and will be set in the terms of reference.

All contributing agencies or individuals will have the opportunity to ensure their information is fully and fairly represented in the report before it is presented to the Chair of LSAB for comment and then to the full Board for approval and action planning

The whole report or parts of it may be made available to partners and to CQC if appropriate. The overview report must contain an Executive Summary which will be made public on the LSAB website and the annual report .

The SAR subgroup may propose a multi-agency action plan to append to the report, for discussion by LSAB and which will be presented to each organisation for endorsement at senior level.

LAMBETH SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

REPORT

Adult at risk male/ female: code/ initials

Date of birth:

Date of death/ Age at time of incident:

Report author:

Date of report:

1. Introduction

Give a summary of the aims of the report and the individual who is the subject of the review.

Clarify that the SAR has been conducted as a statutory review under Section 44 of the Care Act, as agreed by the LSAB. Set out that this SAR has been undertaken in line with the London Multi-Agency Safeguarding Adults Policy and Procedures and with LSAB's SAR Policy and Procedure.

Clarify that the SAR is not intended to reinvestigate the case or apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimate improve the safeguarding and wellbeing of adults in the future.

2. The circumstances that led to a SAR being undertaken in this case.

Provide a brief and anonymous overview of the specific individual circumstances that led to a SAR being undertaken for this case.

Provide reasons for conducting the review and what SAR criteria were met (or if the criteria were not met the reason for conducting the review).

State decision and date to hold the SAR.

3. Terms of reference

State when the SAR commenced, details of the commissioner (usually independent chair of LSAB), SAR panel members, and the report author.

State the dates the SAR panel met and agreed terms of reference for the SAR (this can be added as an appendix).

List contributors to the review and the nature of their contributions (e.g. management report by social care, serious incident report from health agency, interview with staff members, etc.) Cite contribution of family members and any others. Include any communication with CQC or Government Office. Set out how the involvement of staff and the adult/ family/ friends/ carers was facilitated and supported (e.g. advocacy).

Identify the key issues within the SAR. Comment upon the quality of the evidence supplied and whether any action was required. Provide an explanation for any delay in completing the SAR in relation to the SAR framework and terms of reference.

4. Case summary: the facts

Provide a brief case summary including details of the incident, kind of maltreatment, who was believed responsible for the abuse. This should include:

- *A pictorial display of the adult at risk's relationship to family members, extended family and household and any care services provided. Details provided should be brief and anonymous (as appropriate).*
- *An integrated chronology or narrative of agency involvement with the adult at risk, family/ carer on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology/ narrative each occasion on which the adult at risk was seen and the adult at risk's views and wishes sought or expressed.*
- *An overview that summarises what relevant information was known to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult at risk.*

5. Analysis & Findings

Look at how and why events occurred, decisions were made and actions taken or not taken. Explain how events and conditions had looked to professionals at the time of the incident and in the period leading up to it. Explore the range of contributory factors and systems conditions that played a part in causing the abuse or neglect.

Consider whether different decisions or actions may have led to an alternative course of events. Consider how system conditions would have needed to be different to facilitate the different actions or decisions that would have been required.

Highlight any examples of good practice.

6. Conclusions and recommendations

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

Translate the lessons into recommendations for areas LSAB should address to improve partnership working and outcomes for adult at risk at their families.

Recommendations should be few in number, focused and specific, and capable of being translated into an achievable action plan (think SMART/CLEAR). Views on how the recommendations can be translated into action can be included. Consideration should be given to the resources required to implement the recommendations such as cost.

<u>Recommendations should be divided into:</u>

- *Review – practice that should already be happening*
- *New – actions that need to be introduced and implemented.*

Whilst focus should be on multi-agency learning, recommendations may also be made to individual organisations where this is appropriate.

If there are lessons for national, as well as local, policy and practice these should also be highlighted.

7. Proposed multi-agency action plan

The author and SAR panel may provide a proposed set of actions for discussion, adaption and approval by LSAB. The action plans should support the implementation of the recommendations identified in section 6 of the report. The actions identified should be multi-agency in nature: requiring the combined action of a number of partners in order to achieve them. Some single-agency actions may be identified where these are vital to the implementation of the recommendations. The action plan should conclude with a statement on how the plan will be reviewed to determine if the outcomes have been achieved.

A multi-agency action plan template is provided below.

SAR multi-agency action plan:

Lambeth Safeguarding Adults Board

	Recommendation	Identified action(s)	Expected outcome	Evidence of completion	Barriers to implementation & mitigations	Lead person/ partner	Target date	Progress/next steps	RAG rating
1									
2									
3									
4									
5									

Key to RAG ratings:
Green: Objective completed or on target
Amber: Work in progress/further actions planned or required
Red: Objective not completed or target not met

Guidelines for completing safeguarding adult review action plans:

Identified actions should be focused and specific, and capable of being implemented. They can be actions that have or will be taken. Example actions may include: delivering training, developing new policies, introducing new standards, review working practices, etc.

Expected outcomes are the difference these changes will make to service users/ clients/ patients, and may include: referrals for safeguarding, quicker or better quality interventions, having to re-tell their story to fewer professionals, feeling safer etc.

Evidence of completion can be used to show LSAB how we will know whether actions are being undertaken or achieved, and may include: performance data, service user/patient feedback, minutes of meetings, new policies, training material, etc.

Barriers to implementation and mitigations is anything that may prevent/ hamper the partnership from taking the action forward, and what is being/ has been put in place to minimise the risk of the action not being progressed

Lead person – clearly state name (or initials) and role of the individual or partner who will lead on the action.

Target date – provide the date action was completed and/or provide a realistic timescale for the partnership to address the identified action.

Progress column provides space for the partnership to record, monitor and report on the implementation of the actions – state whether the action is 'complete', 'in progress' or 'delayed'. If 'delayed' provide an updated target date. This can also be used to identify next steps where appropriate. The partnership may use a RAG rating to monitor progress.

Appendix Eight: Communications protocol

On occasion the LSAB and/or its partners may receive direct approach from media outlets in relation to its work. Where this relates to the publication of a SAR, the following protocol should be followed.

1. General principles

1.1. The LSAB's communications will be open and honest in dealing with the media.
1.2. The LSAB's communication with the media will report any non-confidential decisions and outcomes of matters placed before the Board.
1.3. Where appropriate and relevant, Board partners will be involved in commenting and agreeing the content of any response to media enquiries, alongside communication leads within the relevant organisation.
1.4. The Independent Chair of the LSAB will approve all releases to the media.
1.5. Each organisation will identify a central point of contact which will be given in any communication to the media
1.6. Responses to queries from the media, in relation to Board matters, will be made by the Board office within requested deadlines where this can be delivered.

2. Statement/s

2.1. A reactive statement will be prepared in advance of the publication of any Safeguarding Adults Review and will be agreed by all agencies involved.
2.2. The joint statement will come from the Independent Chair of the LSAB and will be published at the same time as the review.
2.3. No joint statement/release will be issued without the approval and signoff of all agencies and the direct approval of the independent Chair.

3. Process for responding to media enquiries

3.1 Identifying agencies involved

3.1.1 When a SAR is published, the LSAB will take responsibility for ensuring that where appropriate, there is an agreement to jointly manage any subsequent media communications and that there will be one lead agency responsible for media contact. Where queries relate to partnership working, London Borough of Lambeth will be main point of contact (this will be led by LBL Communication in line with council policies supported by the Board office). Where there is an ongoing criminal investigation the police will be the lead agency.
3.1.2 No agency will speak on behalf of another and all requests for media responses to matters placed before the Board should be discussed with the Board office. In any case where an individual agency has had the key contact in the matter, their response should be discussed with the Board before media issue. Whilst media enquiries that are specific to actions taken by one of the organisations, may be responded to by the communications lead for that organisation, there should be discussion first with the Board office if the matter is one which is being considered by the LSAB.

3.2 Anticipating enquiries

3.2.1 When a SAR is published, key lines of enquiry that may result from the review publication will be identified by the Board office with the Independent Chair and relevant appropriate agencies. This, along with drafted responses/holding statements will be shared with all agencies

3.3 Maintaining communication with all partner agencies

3.3.1 It is important to ensure that all relevant partners are kept up to date regarding reactive media. There is an expectation that partner agencies will alert each other of any media enquiries, clearly setting out the media contact, deadline and proposed response prior to issuing an official response.

3.3.2 All responses, even where it relates to single agency, should be shared with others where appropriate via the Board office.

3.3.3 All agencies will alert the others to any emerging issues that could result in media attention even where no enquiries have been received. The LSAB process to be followed in such cases is the completion of the "Need to Know" Protocol

3.3.4 If any agency becomes aware of potentially damaging media interest which could have an adverse effect on the reputation of any of the partner organisations in respect of a safeguarding matter, the following action should be taken:

- The independent Chair of the LSAB to be alerted to the risk and the Board office will take the lead where this is a matter being considered by the LSAB
- All communication leads will be alerted to the risk by the Board Office
- Individual communication leads will cascade the information to identified spokespeople/key staff in their organisation, gathering information and sharing it where required to the Board Office
- Responses will be drafted, and final copy will be distributed for comment via the Board office
- The lead communication agency will keep all parties informed of the issue as it progresses.