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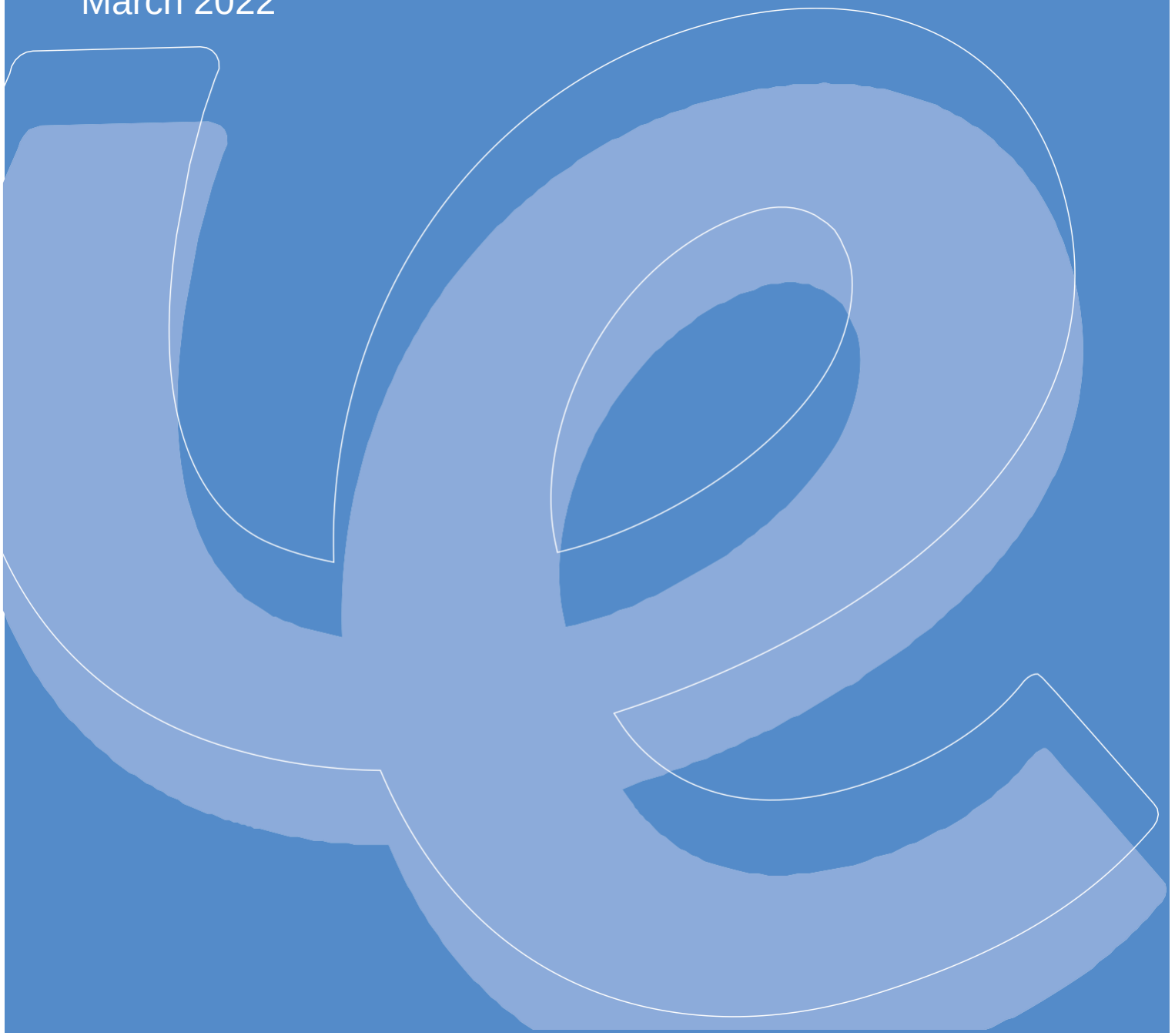
Safeguarding Adult Review Quality Markers

Comprehensive checklist tool

March 2022



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About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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First published in Great Britain in April 2022 by the Social Care Institute for Excellence

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Introduction: a new cycle of development of the Safeguarding Adult Review (SAR) Quality Markers

SCIE is pleased to relaunch the Safeguarding Adult Review (SAR) Quality Markers. First published in 2018, they have now been refreshed and updated.

The revisions have drawn on:

- feedback from some Safeguarding Adult Boards (SABs) and regional SAR Quality Champions since the first iteration
- key messages from the national analysis of SARs 2017-2019 (**https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019**)
- the evidence base and innovations related to effective incident reviews, sometimes referred to as 'safety science'
- good practice related to enabling change and development in organisations
- common methods and tools for evaluating impact.
- input from a workshop held to share SAB experiences of SAR publication and dissemination, improvement action and evaluating impact.

With their launch, we start a six-month schedule for feedback and review.

The work is supported by a Reference Group made up of representatives of the key networks: SAB Chairs, SAB Business Manager and SAR Quality Champions, as well as from the CHIP Programme. Reference group members bring a cross-section of regional representation and include reviewers. Members will play a key role in helping:

- facilitate engagement of the relevant networks in the process
- negotiate an agreed consensus on any amendments and additions.

Over the coming months, as the refreshed SAR QMs are used, SCIE will be seeking feedback via relevant networks.

What they are

SAR Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs.

The Quality Markers are based on statutory requirements, established principles of effective reviews and incident investigations, as well as practice experience and ethical considerations.

The SAR Quality Markers assume the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountable). These principles therefore permeate the Quality Markers explicitly and implicitly.

How they can be used

The SAR Quality Markers can be used flexibly and in a variety of different ways. They are not a burdensome imposition; they can be used them according to your needs. For example:

- Is there a particular area of SAR activity that as a SAR subgroup or a reviewer, you feel less confident about? Find the relevant Quality Marker and use it to update your understanding of what good looks like and the issues involved.
- Have you had your fingers burned before, due to misunderstandings of expectations between SAB commissioner and independent reviewer commissionee? Use the whole suite of SAR Quality Markers to inform the scoping process and make sure everyone is on the same page.
- As a SAB Chair, SAB and Subgroup members, do you find yourselves stuck in a one-size-fits-all approach to SARs? Use the SAR Quality Markers on commissioning to build confidence in designing SARs that are proportionate in order to gain maximum value from each SAR.
- Are you a new SAB Chair or new reviewer? Use the SAR Quality Markers as part of your induction, to make sure you are working to the best available evidence base.
- Are your SAB quality assurance processes for SARs working effectively? Use relevant SAR Quality Markers to check you are prioritising the right things.
- Is your role to support the practical planning of the SAR? Use the Quality Markers to check that you have anticipated all the relevant needs.

How they help

The SAR Quality Markers are intended to support commissioners and lead reviewers to commission and conduct high-quality reviews. They capture principles of good practice and pose questions to help commissioners and reviewers consider how they might best achieve them.

SCRs are a complex field of activity where simple rules rarely apply, so judgement is often needed. The Quality Markers are therefore designed to stimulate discussion and support informed judgements. They are not a ‘how to’ handbook because there are a variety of ways in which they can be achieved.

The quality markers do not presume or promote any particular model or approach for how to achieve them. They support variety, innovation and proportionality in approaches to case reviews.

The markers should not be treated as a process map, because while the three clusters in which they are structured are broadly sequential, the components within them are not.

This document

The SAR Quality Markers are going to take the form of a range of different forms and tools, in order to meet the needs and preferences of different audiences. This document is the complete ‘checklist’ version. SCIE is in the process of developing the SAR Quality Markers ‘handbook’. There will also be role-specific checklists.

How the Quality Markers are structured

The SAR Quality Markers are arranged in three sections:

- Setting up the review;
- Running the review; and
- Outputs and Impact.

The Quality Markers are numbered sequentially. Each has a quality statement, which is a summary description of the mark of quality. A list of questions are then provided to help people consider how they will know if they are on track to meet the marker. We have differentiated the questions per function, and colour-coded them accordingly. The aim is to allow people in different roles to readily identify the questions relevant to them.

Roles and functions

In different SABs, the SAR process and roles are arranged in a variety of different ways, and in different locations. In order to present the Quality Markers in a way that does not preference some arrangements over others, we have attempted to distinguish functions. The table below distinguishes seven different functions related to SARs. We give an indication of the possible role with responsibilities for that function, but there will be other ways that the functions are accomplished.

SAR roles and functions		
No.	Generic SAR function	Possible role
1	Who is 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	SAB Chair and Board
2	Who has delegated responsibility for managing the SAR? 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 • decide on publication • deciding/leading on immediate action in response to findings	SAB SAR sub-group

	• providing evidence of responses • monitoring the longer-term sustainability of changes and evaluating what difference, if any, has been made	
3	Who conducts the review and provides independent leadership? (This may be the same or different roles, depending on whether Panel and Panel Chair is used) • 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.	Reviewer(s) Independent Panel Chair
4	Who provides practical day-to-day support for the review? Including: • providing administrative support • project management support • means of access to data • links with staff • liaison with the Chair	SAB Business manager or Adult Safeguarding Lead

Setting up the review

Quality Marker 1: Referral

Quality statement: **The case is referred for consideration for a SAR with an appropriate rationale and in a timely manner.**

1.1 Those ultimately accountable

1.1.1 There are not currently any comments for this section.

1.2 Those with delegated responsibility

1.2.1 Does the referral state explicitly:

- what kind of abuse or neglect the person is known or suspected to have suffered
- whether the person has died, or experienced serious abuse and/or neglect and survived
  - and whether this happened in the SAB's area
- what concerns there are about how agencies worked together.

1.2.2 Alternatively, does the referral give a clear rationale for a discretionary review, whether:

a. to learn from good practice in the case
b. to review practice issues featured in the case before abuse or neglect has occurred, in order to pre-emptively tackle them
c. or for any other reason?

1.2.3 Does the referral document what is known about protected characteristics as codified by the Equality Act 2010, including race, culture and ethnicity?

1.2.4 Does the information provided evidence the rationale given for why the case is being referred for consideration for a SAR, and include relevant supporting information?

1.2.5 Are explanations provided for any delays in the referral?

1.3 Those conducting the review

1.3.1 There are currently no comments for this section.

1.4 Those providing practical support

1.4.1 Have details of ethnicity and other protected characteristics relevant to the SAR referral been appropriately recorded?

1.4.2 Where the person is alive, is enough known about their experience to explore the impact of the abuse and/or neglect in a person-centred way, which may include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness?

1.4.3 Is the identity of the referring agency or other source clear and recorded?

2 Quality Marker 2: Decision making – what kind of SAR, if any

Quality statement: **Factors related to the case and the local context inform decision making about whether a SAR is required and/or desired and initial thinking about its size and scope. The rationale for these decisions is clear, defensible and reached in a timely fashion.**

2.1 Those ultimately accountable

2.1.1 Is the rationale for the decision clear and defensible, paying close attention to the Care Act 2014 and Making Safeguarding Personal principles?

2.1.2 Has a clear legal mandate been established reflecting either a mandatory SAR [sections 44(1), (2) and (3) Care Act 2014] or discretionary SAR [section 44(4)]?

2.1.3 Is there transparency about any conflicts of interest and how they have been managed?

2.1.4 Is it evident how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 have been considered?

2.1.5 Has independent challenge to decision making been considered?

2.1.6 Have SAB member agencies had the opportunity to contribute to decision making process (whether or not the SAB has delegated decision making authority to the Independent Chair) through participating in a SAB subgroup or by other means?

2.1.7 Is there transparency for SAB members on the decision-making process and outcomes?

2.1.8 Has legal advice been sought, if appropriate, to check the lawfulness of the decision making?

2.1.9 Are explanations provided for any delays in decision making?

2.1.10 Is the clarity of purpose (QM 4) evident in decision making rationale?

2.2 Those with delegated responsibility

2.2.1 Has meaningful multi-agency discussion informed the recommendation to the Chair?

The case

2.2.2 Has there been appropriate challenge about how an adult with care and support needs is defined?

2.2.3 Have the kinds of abuse and/or neglect the person suffered been specified?

2.2.4 Have discussions about the abuse and neglect suffered by the person included self-neglect?

2.2.5 Where the person has survived, has there been adequate consideration of their experiences to support a person-centred assessment of whether the abuse and/or neglect experienced was serious?

2.2.6 Have discussions about any cause for concern about the quality of safeguarding practice, overtly referenced the principles of Making Safeguarding Personal?

2.2.7 Have discussions about any cause for concern about the quality of safeguarding practice overtly considered how race, culture, ethnicity and other protected characteristics, as codified by the Equality Act 2010, may have impacted on case management, including recognition of unconscious bias?

2.2.8 Have discussions about any cause for concern about working together to safeguard, included consideration of all parts of the system - provider and commissioner, direct practice and oversight?

2.2.9 Has the right balance been struck between timely decision making and the amount of time it is going to take to determine whether a SAR is mandatory in this particular instance?

2.2.10 Have the benefits of using the discretionary power of Section 44 (4) of the Care Act 2014 in order to proactively learn from practice in the case, been considered in tandem with identifying whether the circumstances meet the criteria for a mandatory SAR?

2.2.11 Is there evidence of sufficient good practice in the case that may allow learning about supportive system conditions which can be shared across the partnership?

2.2.12 Have alternative statutory review pathways or a single agency review been considered?

Local context

2.2.13 Do other quality assurance and feedback sources (e.g. audits/complaints) suggest the kind of practice issues in the case and/or their systemic causes are new, complex or repetitive?

2.2.14 Are any of the issues and the system conditions indicated in this case, relevant to the SAB strategic plan and/or current and future priorities?

2.2.15 Has it been confirmed whether similar cases and/or circumstances have been subject of an earlier SAR locally, or the target of recent improvement activity, with implications for decision making about the size and scope of the potential review?

- For example, are there any different features in this case that may generate new insights?
- For example, does the focus need to be moved to understanding the extent to which change has been achieved since the previous SAR and why?

2.2.16 Has it been confirmed whether any similar cases or circumstances have been considered recently for a SAR, that suggest a local learning need in this practice area?

2.2.17 Has the recommendation to the SAB or Chair about whether a SAR is needed given an indication of the appropriate size/scope given the case and context?

2.3 Those conducting the review

2.3.1 There are not currently any comments for this section.

2.4 Those providing practical support

2.4.1 Have all key agencies provided information about their involvement?

2.4.2 Have neighbouring SABs been asked for information, if the person lived outside the SAB area?

2.4.3 Has intelligence from other quality assurance and feedback sources, that is relevant to practice in this case, been gathered E.g. audits/benchmarking, complaints and previous SARs?

2.4.4 Are you clear whether the s42 is completed (where relevant)?

2.4.5 Have other parallel processes been identified?

2.4.6 Is the decision-making rationale clearly documented on all records?

3 Quality Marker 3: Informing the person, members of their family and social network

Quality statement: **The person, relevant family members, friends and network are told what the Safeguarding Adult Review is for, how it will work and the parameters, and are treated with respect.**

3.1 Those ultimately accountable

3.1.1 Have you overtly championed the importance of prompt clear, accessible, compassionate and respectful correspondence with the person and relevant family or network, on accepting the recommendation to proceed or not with a SAR? Have you noticed and praised its completion?

3.1.2 Has there been overt encouragement and support from all partners for honest communication to address legitimate questions posed by the person, relevant family members, or other important network?

3.1.3 Have you addressed any apparent reticence from partners to progress initial engagement with person and/or family members?

3.2 Those with delegated responsibility

3.2.1 Has the person subject of the SAR, relevant family members, friends and members of their social network been informed at the earliest stage possible?

3.2.2 Have the purpose, process and parameters of the SAR been communicated in the most appropriate setting or method to ensure that these can both be understood and convey respect to those involved?

3.2.3 Are opportunities being offered to discuss any queries or clarifications about the SAR purpose, and do they give the individuals a realistic chance of doing so?

3.2.4 Has advice and support been sought from partners who might be more experienced in involving family members in incident reviews, such as NHS roles related to Mental Health Homicide Reviews and/or Domestic Homicide Reviews?

3.3 Those conducting the review

3.3.1 There are not currently any comments for this section.

3.4 Those providing practical support

3.4.1 Has information been gathered from agencies previously in touch with the person and/or family member, about their preferences in terms of communication with professionals and any support requirements?

3.4.2 Is the standard SAB correspondence available for use with family members in this SAR about the purpose, process and parameters of the SAR and is it adequately clear, accessible and kind?

3.4.3 Has discussion between the reviewer(s) and those with delegated responsibility created clarity and agreement about the parameters of the review (QM5) to be communicated to the family?

4 Quality Marker 4: Clarity of purpose

Quality statement: **The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory learning-focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities. Any factors that may complicate this goal are openly acknowledged.**

4.1 Those ultimately accountable

4.1.1 Have you demonstrated strong overt leadership about the practical value of the SAR in surfacing learning about the causes of strengths and difficulties in safeguarding practice and furthering improvement activity?

4.1.2 Have you demonstrated clear expectations that people use the escalation pathway to you, if there is any non-engagement by providers, commissioners or other agencies involved in the SAR?

4.1.3 Have any complicating factors been honestly acknowledged?

4.1.4 Has consultation with legal departments been sought if appropriate?

4.2 Those with delegated responsibility

4.2.1 Have you communicated with all the relevant parties (SAB members, involved agencies/provider/commissioner, leaders, legal advisors, as well as practitioners) a positive message about the statutory nature of the SAR, and restated its practical purpose of surfacing learning about the causes of strengths and difficulties in safeguarding practice and furthering improvement activity?

4.2.2 Have you clarified the kind of 'learning' that this SAR is intended to generate, or how it is going to progress improvement activity in order to minimise misunderstandings?

4.2.3 Is what you are saying underpinned by an agreed organisational accident or incident causation model (such as James Reason's 'swiss cheese' model and variations thereof) to aid clarity and provide suitable vocabulary?

4.2.4 Has there been a multi-agency discussion regarding any possible tensions and complications, so that they can be to be recognised and managed as best as possible?

4.3 Those conducting the review

4.3.1 Are you confident that all parties are on the same page regarding the purpose of the SAR?

4.3.2 Have you initiated overt discussion about any areas of potential disagreement?

4.4 Those providing practical support

4.4.1 There are not currently any comments for this section.

5 Quality Marker 5: Commissioning

Quality statement: **Strategic commissioning of the Safeguarding Adult Review takes into account a range of case and wider contextual factors in order to determine the right approach to identifying learning about what is facilitating or obstructing good practice and/or the progress of related improvement activities. Decisions are made by those with delegated responsibility in conjunction with the reviewers, and balance methodological rigour with the need to be proportionate.**

5.1 Those ultimately accountable

5.1.1 Is the precise form and focus that has been agreed for this SAR best suited to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities (see QM4) to the benefit of adults and their families?

5.1.2 Have you explicitly endorsed those with delegated responsibility to identify an approach to the SAR that is fit for purpose for this case and current context, and moves away from a one-size-fits all approach that assumes a set process and long report?

5.1.3 Is there adequate clarity in the commissioning specification about the proposed approach agreed, to allow confidence in the methodology being used and similar confidence in the analysis and conclusions?

5.1.4 Are there any issues regarding the capacity of practitioners, SAB and member agencies, and experienced / qualified reviewers that may impact on the feasibility and/or quality of this SAR?

5.2 Those with delegated responsibility

5.2.1 Have multi-agency partners with delegated responsibility been involved in discussions with the reviewers about the precise form, focus and approach, as opposed to delegating these decisions to the Business Manager or equivalent?

5.2.2 Have you agreed how learning from the SARs of other SABs, as well as research evidence, will be synthesized, in order that it can be used to develop a proportionate approach to the SAR that builds on the evidence base about what good looks like, barriers and enablers, rather than starting afresh?

5.2.3 Has detail from any parallel processes or statutory reviews been utilized to avoid unnecessary duplication and agree joint-commissioning where appropriate (while not losing focus of SAR Care Act requirements of the process)?

5.2.4 Have discussions about the precise form and focus of the SAR built on initial information gathering about case and local context (QM 2), drawing on the right range of information including:

- Evidence of impact on adults with care and support needs and their families, including of any serious public concern and/or potential media interest
- Other quality assurance and feedback sources e.g. audits/complaints
- Relevance to SAB strategic, current and/or future priorities
- Previous SARs locally, regionally and nationally (as relevant).

Agreeing the right approach

5.2.5 Where it has been agreed that the review will focus on surfacing learning about what is facilitating or obstructing good practice in the case, have you made it clear whether or not you expect the SAR to:

- establish whether what obstructed or facilitated good practice in the case, was more widespread at the time and/or
- assess the current relevance of past practice barriers/facilitators identified in the case being reviewed?

5.2.6 Where a similar case has been subject of an earlier SAR and/or the target of recent improvement activity, has there been adequate consideration of what a proportionate approach would look like?

- For example, beginning with the previous learning identified about barriers and enablers to good practice, and improvement actions proposed, and commissioning the new SAR to focus on where good practice has been facilitated, where barriers to good practice still need to be confronted and what has obstructed change, or whether the barriers have changed since the original SAR.
- For example, targeting the SAR only on practice areas / issues that appear to be new in comparison with the case previously reviewed.

5.2.7 If consideration of the case and wider intelligence has identified an urgency to identifying and tackling the barriers to good practice in particular areas, have approaches that allow a speedy turn-around of learning been considered?

- For example, the SAR In Rapid Time model.

5.2.8 Where similar cases or circumstances have been considered recently for a SAR, that suggest a local learning need in this practice area, has consideration been given to a themed SAR?

Methodological rigour

5.2.9 Has there been adequate expertise in research methods and/or quality improvement to inform agreement of the detail of the methodology proposed?

5.2.10 Does the approach proposed strike the right balance between methodological rigour and proportionate use of resources/capacity relative to the learning and impact expected?

5.3 Those conducting the review

5.3.1 Have you been allowed adequate influence on the scope, nature and approach for the review?

5.3.2 Has the scoping process covered all areas and issues covered by the SAR Quality Markers?

5.3.3 Have agreements been captured with suitable clarity and specificity?

5.3.4 Are there any disagreements or conflicts of interest that need to be escalated at the start?

5.4 Those providing practical support

5.4.1 Have you made available a standard scoping document anchored in the SAR Quality Markers to support decision making about the form, focus and approach for this SAR?

5.4.2 Have decisions about the precise form and focus of the SAR to be commissioned been captured in a Terms of Reference that is published at the start of the SAR?

5.4.3 Has the Terms of Reference consideration, as standard, of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management, including recognition of unconscious bias.

5.4.4 Is there agreement about what level and precision of detail is required to be captured about the case characteristics and where this will be logged, e.g. in the report or in a database managed by the SAB?

Running the review

6 Quality Marker 6: Governance

Quality statement: **Safeguarding Adult Board (SAB) governance arrangements for the Safeguarding Adult Review (SAR) are sound, enabling defensible decision making, reliable over-sight and accountability regarding the SAR process, outputs and impact. The SAR achieves the requirement for independence and ownership of the findings by the SAB and member agencies and enables public accountability for learning and improvement.**

6.1 Those ultimately accountable

6.1.1 Are you assured that you have adequate line of sight on the progress of the SAR including:

i. Has decision-making distinguished between mandatory and discretionary SARs, recognising that all SARs are statutory?
ii. Has decision-making on referrals been timely?
iii. What types of abuse and/or neglect are the main and secondary concerns?
iv. What methodology has been chosen and why?
v. What methods for gathering/exploring information have been chosen and why?
vi. What positive/negative reasons for delay have impacted on the process?
vii. Have services and agencies cooperated as required?
viii. What approach has been taken to subject and family involvement?
ix. Do annual reports provide required information: SARs, findings and actions taken in response?
x. How has SAR quality been assured?
xi. How has the SAB captured the outcomes of action taken?
xii. Have reasons for decisions at all stages of the process been recorded?[1]

6.1.2 Are you confident that everyone has clarity about when and how issues should be escalated?

6.1.3 In a review involving other SABs, have you achieved clarity and agreement from the outset about who leads the SAR (e.g. area for whom most learning is likely to emerge) and governance arrangements?

6.1.4 Have you demonstrated strong, overt leadership about the significant degree of objectivity combined with sufficient understanding of context and organisational arrangements, that is required for rigorous SAR analysis and conclusions?

6.1.5 Have you demonstrated clear expectations that if a consensus view cannot be reached in any aspect of this SAR related to the analysis and findings, the differing positions will be articulated in the final report?

[1] These 12 questions were identified from the findings of the national analysis of SARs study 'Analysis of Safeguarding Adults Reviews April 2017-March 2019' (November 2020). See Briefing for SAB chairs and business managers: **https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards/chairs-and-business-managers**

6.2 Those with delegated responsibility

6.2.1 Are there clear governance arrangements for this particular SAR in place from the outset of the process?

6.2.2 Has the system for quality assurance of the process and sign-off of the report been set out clearly from the start?

6.2.3 Do the agreed quality assurance mechanisms manage the tension in a fair and balanced way, between the independence of reviewer(s) and local involvement, and avoided agency defensiveness and inappropriate pressure?

6.2.4 Are senior managers being kept up to date in order to cultivate ownership of the conclusions, and avoid any surprises about the learning being identified?

6.2.5 Are there mechanisms in place to allow challenge to the information and analysis of the review, so that the findings/ recommendations have been thoroughly considered before the report is finalized and taken to the SAB?

6.3 Those conducting the review

6.3.1 Are you clear from the start about who is responsible for what, how and when to expect quality assurance and oversight, and what the routes for escalation will be?

6.3.2 Have people of the right level of seniority been identified to be involved, given the specifics of this particular SAR?

6.4 Those providing practical support

6.4.1 Have all decisions been recorded with appropriate detail and including the rationale?

6.4.2 Have reasons for any delay or departure from statutory guidance all been recorded?

6.4.3 Are mechanisms in place to inform the SAB Chair of any delays or other delivery issues in this SAR and reasons for them?

7 Quality Marker 7: Management of the process

Quality statement: **The Safeguarding Adult Review (SAR) is effectively and considerately managed. It runs smoothly, is concluded in a timely manner and within available resources. The welfare of all participants is attended to. The process strives to help bring resolution to any tensions or conflicts between individuals or agencies as well as questions of families.**

7.1 Those ultimately accountable

7.1.1 Have you made yourself available to provide leadership in addressing any challenges that arise during the SAR?

7.1.2 Has there been clear messaging from senior leads of statutory partners that how the SAR is conducted is important, with an expectation that people are cared for and relationships fostered through the process?

7.2 Those with delegated responsibility

7.2.1 If there have been any changes in relation to key personnel, administrative support or reviewer capacity, has there been a reflection on how that may impact on the SAR and any action needed?

7.2.2 Does the provision of administrative support and reviewer capacity match expectations about the quality and timing of the SAR outputs?

7.2.3 Is there enough slack in the plan to allow for legitimate delays?

7.2.4 Is there sufficient feedback on the process to have oversight of the experience of those taking part?

7.3 Those conducting the review

7.3.1 Has best use been made of project management tools and approaches to support timely delivery of this SAR?

7.3.2 Have any known sensitivities, tensions or conflicts been shared with you in order that you can endeavour to address them appropriately?

7.4 Those providing practical support

7.4.1 Is there a clear plan with allocated roles and responsibilities for the transmission of information?

7.4.2 Are mechanisms in place to inform the SAB Chair of any delays and reasons for them?

8 Quality Marker 8: Parallel processes

Quality statement: **Where there are parallel processes taking place, the SAR is managed with the cooperation and communication required to avoid, as much as possible, duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.**

8.1 Those ultimately accountable

8.1.1 Have you supported, where necessary, efforts to communicate and cooperate with all relevant processes, to achieve the best fit for the circumstances?

8.2 Those with delegated responsibility

8.2.1 Has early contact been made with all those managing all relevant processes, to achieve the best fit between them for the circumstances, considering all key stages of respective processes?

8.2.2 Where necessary has there been early discussion with the police; Crown Prosecution Service (CPS); leads of any Domestic Homicide Review, Local Child Safeguarding Practice Review; Mental Health Homicide Review; and Coroner to consider any information relevant to criminal or other proceedings and the SAR. Have you considered whether a face-to-face meeting may be necessary?

8.2.3 Is it clear who owns documents generated through this SAR so that the relevant body can make judgements on their disclosure?

8.2.4 Have relationships that the SAB has established with the Crown Prosecution Service (CPS) and Coroner been used to support plans to protect the person's anonymity?

8.3 Those conducting the review

8.3.1 There are not currently any comments for this section.

8.4 Those providing practical support

8.4.1 Are note of interviews and meetings, and copies of reports that might be considered relevant to criminal proceedings, being retained?

8.4.2 Is an index being maintained of material generated by the SAR so it can be readily considered to see if it is disclosable?

9 Quality Marker 9: Assembling information

Quality statement: **The Safeguarding Adult Review (SAR) gains a sufficient range and quality of information and input, to determine the relevant objective facts, to 'stand in the shoes' and 'get inside the heads' of those involved and to grasp the way that single and multi-agency/professional practice is shaped both by work environments and conditions, and by social and organisational factors. The kinds of data assembled allows unique versus generalisable issues to be distinguished. The extent of, and methods for, data gathering are transparent and proportionate to the practical value of the SAR.**

9.1 Those ultimately accountable

9.1.1 Has the Board positively and clearly articulated the statutory duty on all agencies both to cooperate and contribute to this SAR and to provide information when the SAB exercises its power to request it (section 45 of Care Act 2014)?

9.1.2 Has there been consideration of whether non-compliance with section 45 of the Care Act 2014 is likely from particular agencies, and how best to address this as early as possible?

9.1.3 Have you demonstrated clear expectations that people use the escalation pathway to you, in respect of non- or partial engagement by participating agencies or individuals?

9.2 Those with delegated responsibility

9.2.1 Does the specification of information required and the level of detail needed, match with decision making about the precise form and focus, and approach agreed for the SAR commissioned (QM5)?

9.2.2 Has decision making about what data to seek from which sources been mindful of the need to be proportionate relative to the practical value of the SAR (QM4)?

9.2.3 Are all the ways proposed for gathering relevant information efficient, matching the proportionality agreed for the SAR, and minimizing demand on all participants?

9.2.4 Is everyone clear that any requests to extend information gathering needs to be considered in light of the precise form and focus of the SAR, and approach agreed?

9.2.5 Do you have adequate expertise in research methods and/or quality improvement to have oversight of plans and progress of information gathering for this SAR?

9.3 Those conducting the review

9.3.1 Will the types of information and input you are seeking allow the SAR to fulfil its purpose (QM4) of illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities?

9.3.2 Are you clear what kind of data you are seeking from the different sources of information, and from different contributors to the SAR?

9.3.3 Where others are supporting you, have you enabled them to understand what kind of information they are looking for from different sources, be it people or paperwork?

9.3.4 Have all avenues and sources of information and input been considered to cover the range of relevant positions and perspectives, including all parts of multi-agency configurations, both operational and strategic angles?

9.3.5 Is there sufficient clarity about the methodological purpose of any plans to gather practitioners together, specifically about the kind of data they are able to provide and by what means it is going to be sought during the meeting?

9.3.6 Is there clarity about what kind of input needs to be sought from the person, where it is possible, and others significant to them?

9.3.7 Have all requirements regarding the processing of personal data been fulfilled in accordance with the current UK Data Protection Legislation and associated regulations including: Data Protection Act 2018, UK General Data Protection Regulation (“UKGDPR”) and The Privacy and Electronic Communications (EC Directive) Regulations 2003?

9.4 Those providing practical support

9.4.1 Are you clear as to the range of information that needs to be assembled given the commission of this particular SAR and what arrangements are needed to support input from different individuals and groups of people?

9.4.2 Have the methods of gathering information in this SAR been documented?

9.4.3 Has guidance been provided to participating agencies and divisions about what information is requested at the beginning of the review, and the level of detail required, and why?

9.4.4 Where initial information gathering has taken place to support decision making about the referral, is there clarity about what additional information is needed to reflect the precise form and focus of the SAR (QM5)?

9.4.5 Has access been arranged for the reviewer(s) and relevant others to all the different sources of information and input deemed relevant?

10 Quality Marker 10: Practitioners' involvement

Quality statement: **The Safeguarding Adult Review (SAR) is informed by the experiences and perspectives of practitioners and managers, as relevant to the precise form and focus of the SAR commissioned. The process enables practitioners and managers to have a constructive experience of taking part in the review that helps cultivate an open learning culture.**

10.1 Those ultimately accountable

10.1.1 Have you communicated directly with practitioners invited to participate in the SAR, stressing the importance of their input, acknowledging their possible fears, clarifying the support that will be available, and the intention of creating a constructive and valuable experience for them?

10.1.2 Are you planning to attend any of the practitioner events in whole or part, to reiterate your messages about the value of an open learning culture and the importance of their being able to 'tell it like it is'?

10.1.3 Are there arrangements for the Chair to write to thank practitioners personally for their involvement once the SAR is completed?

10.2 Those with delegated responsibility

10.2.1 Have the right practitioners and managers been identified to contribute given the precise form, focus and approach that has been agreed for this SAR?

10.2.2 Have arrangements been made to secure the endorsement of leaders and managers in each agency and profession of their staffs' engagement, and to achieve the relevant support and protections for individuals contributing?

10.2.3 Has an adequate duty of care to all participants to be involved in this SAR been secured?

10.3 Those conducting the review

10.3.1 Is the purpose of practitioners' input clear, and understood by everyone, including that gained through interviews, conversations, meetings or events?

10.3.2 Are participants being provided with clear information about this SAR and their role in it?

10.3.3 Are agencies encouraging their staff to contribute their experiences and views to the SAR 'warts and all'?

10.3.4 Does the planning for the SAR include careful consideration of how to support all individual practitioners, including for example, those who played key roles in the

case, or those who are not part of core Safeguarding Adult Board (SAB) agencies, or are from agencies rarely involved in SARs?

10.3.5 Have you confirmed how all practitioners are being provided with adequate support and protections within their own organisations to take part in the SAR process?

10.3.6 In your planning of group events, how have you considered the support and protection of all involved practitioners?

10.3.7 Has there been adequate consideration of whether there are any implications of the review for people now in senior management positions and if anything needs to be done to support them?

10.4 Those providing practical support

10.4.1 Are participants being provided with clear information about the form and focus of this SAR and their role in it?

10.4.2 How will you gather feedback from participants about their involvement?

11 Quality Marker 11: Involvement of the person, relevant family members and network

Quality statement: **The Safeguarding Adult Review (SAR) is informed by the person, relevant members of their family and social network in terms of information they hold, their experiences and perspectives as relevant to the precise form and focus of the SAR commissioned. The process enables the individual and family to see how the SAR is designed to have impact and contribute to positive change.**

11.1 Those ultimately accountable

11.1.1 Has clear leadership been provided about the priority of enabling the person and relevant family and network members to contribute meaningfully to the SAR?

11.1.2 Is there a clearly documented and defensible decision process about who is invited to contribute to the SAR, how and the ways their input will inform the SAR, as well as a detailed rationale for anyone who has been excluded or declined?

11.1.3 Has the statutory requirement for early engagement with the individual, family and friends to agree how they wish to be involved, managing their expectations appropriately and sensitively, been sustained in this SAR regardless of its precise form and focus?

11.2 Those with delegated responsibility

11.2.1 Has there been discussion about which family members should be invited to contribute and why, linked to the purpose of the SAR and the precise form, focus and approach?

11.2.2 When two or more families are involved, is there a clear, feasible plan for how the process will be managed?

11.2.3 Has it been agreed who is best positioned to have early discussions with the individual, family and friends to understand how they wish to be involved, how this fits with the form and focus of the SAR, and agree how best to enable them to contribute in a way that is meaningful to the learning?

11.2.4 Is there clarity about how the person and/or their family and networks will be able to influence the focus of the review?

11.2.5 Is there clarity about what the family is going to be asked and why?

11.2.6 Has there been discussion about how the analysis will be informed by family members' information, experiences and perspectives relevant to the form and focus of this SAR?

11.2.7 Is there clarity and agreement about how the person and their relevant family and network, and their input, are to be represented in the final report?

11.2.8 What are the mechanisms to allow the person and/or their family to provide feedback on the report before it is completed?

11.2.9 Do arrangements to feedback on drafts for the report balance the need for assurance about confidentiality until the report is signed off by the Board, and the value of trust and partnership with the individual and their family members?

11.2.10 Is there clarity and agreement, including with the reviewer(s), on any limitations regarding how individuals can be involved and influence this SAR?

11.2.11 Who in the network has appropriate experience and expertise to communicate well with the person and family members at what may be an extremely difficult time, to best enable them to understand how to be involved, why it is important, to appreciate their expectations and manage any limits on their options clearly, kindly, sensitively and with respect?

11.2.12 Where there are criminal proceedings and family members are witnesses or suspects, has a discussion taken place with the police senior officer about the precise form and focus of the review, and the implications for when and how family members can be involved?

11.3 Those conducting the review

11.3.1 Is there clarity about why the person, family members and/or friends are being involved in the SAR in terms of statutory requirements, methodological data needs and the principles of Making Safeguarding Personal?

11.3.2 Is there absolute clarity about the role/ identity from which any family member or friend is contributing, and the implications, especially where the person is still alive, for what information can be shared with whom and where consent is required?

11.4 Those providing practical support

11.4.1 How is sufficient continuity of communication with the individual and family members going to be sustained? For example, who will be the specific point of contact with the person and/or family members?

11.4.2 Are there adequate arrangements to support the person and/or members of their family and network through the process, including providing advocacy or another specialist support service where needed?

11.4.3 Have arrangements adequately considered relevant accessibility issues and the need for any reasonable adjustments?

12 Quality Marker 12: Analysis

Quality statement: **The approach and methodology agreed for the SAR is used with optimum rigour within the size and scope of SAR commissioned. Analysis assumes a systems approach to safety and organisational reliability. It is anchored in relevant research and wider evidence base regarding effective clinical/professional practice and that of safety science. It draws on the full range of relevant information and input assembled, to evaluate and explain professional practice in the case(s) or the responses to earlier learning. Conclusions are of practical value, evidencing the wider learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date. There is transparency about any methodological limitations and the implications for the comprehensiveness or level of confidence in the analysis and findings.**

12.1 Those ultimately accountable

12.1.1 Are you championing the practical value of analysis that identifies what has led to and sustained the kind of practice problems or good practice that the case(s) reveals?

12.1.2 Are you building expectation at Board level of an analysis that seeks out causal factors and systems learning of relevance beyond the individual case or cases?

12.1.3 Are you managing expectations if the SAR is focused on exploring why progress had not been achieved against earlier learning, rather than a detailed analysis of the case referred for a SAR?

12.2 Those with delegated responsibility

Analysing practice in a case or cases

12.2.1 Is there adequate attention to detail and precision in presentation of the facts of the case and professional practice over the time period, to match the commission?

12.2.2 Has practice in the case been evaluated appropriately, identifying good practice and any shortfalls with reference to up-to-date research and the wider evidence base where this is helpful or necessary?

12.2.3 Does the assessment of practice in the case reflect the principles of Making Safeguarding Personal and the six core adult safeguarding principles?

12.2.4 Does the analysis explain why people did what they did in such a way that even incredible actions or inactions are comprehensible in the context of what people were trying to achieve, the challenges and constraints of their work

environment, as well as social and cultural aspects of single, multi-agency and multi-professional working?

12.2.5 Has the analysis of causal factors and efforts to untangle systemic risks been conducted with reference to up-to-date research and wider evidence base on safety science and 'human factors' that underpin a 'systems approach' to learning from practice and incidents?

12.2.6 Has the analysis clarified whether practice issues were unique to the case(s) and context or emblematic of wider issues and whether the factors that influenced were anomalies or systemic?

12.2.7 Where required in the commission has the analysis detailed the current relevance of past practice issues and their systemic conditions?

12.2.8 Where reference is made to practice beyond the case, either at the time of the case or in the present, is it clear where the knowledge about the wider safeguarding system has come from?

12.2.9 Does the analysis have clear conclusions and show clearly how the conclusions relate to the case(s), as well as why they are relevant to wider safeguarding practice?

Progressing improvement activity

12.2.10 Does the analysis identify and evidence what has or has not changed in relation to earlier learning?

12.2.11 Is there a causal analysis of what facilitated or obstructed progress?

Rigour and reliability of analysis

12.2.12 Is there adequate detail and precision in the analysis relative to the size and scope of the SAR commissioned?

12.2.13 Is up-to-date research and the wider evidence-base about what constitutes good practice, being used in the analysis?

12.2.14 Is the causal analysis informed by, and referenced where appropriate, the evidence-base of safety science and human factors?

12.2.15 Is it clear what specific techniques have been used to minimise the bias of hindsight and knowledge of the outcome, on the analysis?

12.2.16 Does the presentation of the analysis show the working-out process adequately, allowing the interpretation to be critiqued and counter evidence to be brought to bear?

12.2.17 Does the lead reviewer(s) access supervision or peer challenge to support the quality of analysis undertaken?

12.3 Those conducting the review

12.3.1 Are the principles of Making Safeguarding Personal and the six core safeguarding principles reflected in your evaluation of safeguarding practice in the case(s)?

12.3.2 Are you sustaining a determined curiosity to take your analysis beyond commenting on compliance with relevant procedures, to providing explanations of professional behaviour that call on a range of social/cultural and organisational factors?

12.3.3 What approaches have you used to ward against only a partial use of information and input assembled for this SAR?

12.3.4 Is your analysis moving from the specific to the generalizable, identifying what professional activity in the case(s) reveals about how service delivery routinely worked at the time and why, and clarifying the nature of systemic risks that remain today?

12.3.5 In your analysis, are you balancing practice expertise with expertise in human factors and safety science to support a rigorous interrogation of causal factors?

12.3.6 Have you considered the full range of research evidence, practice knowledge, guidance and theory, statute, national policy, other SARs and inspection reports that might be referenced in order to articulate the underpinning knowledge base relevant to your analysis?

12.4 Those providing practical support

12.4.1 There are not currently any comments for this section.

Outputs, action and impact

13 Quality Marker 13: The Report

Quality statement: **The length and detail of the SAR report match the size and scope of what was commissioned. At minimum a minimum, it makes visible, in a clear, succinct manner, the systemic risks to the reliability of single and multi-agency safeguarding work that the SAR analysis has evidenced, in order to have practical value in directing improvement actions. It is written with a view to being published. Details of the person are included as judged necessary to illuminate the learning and/or in line with the wishes of the individual or their family.**

13.1 Those ultimately accountable

13.1.1 Has the report achieved the agreed commissioning specification?

13.1.2 Have you sought to manage expectations of all Board members regarding the proportionality of the SAR including the report?

13.1.3 Does it provide insights into factors that increase the risk that people will not be effectively safeguarded and/or illuminate conditions that are effective in enabling good safeguarding practice?

13.1.4 Are the findings that the SAB is asked to accept, and partners be responsible for acting on, presented clearly and succinctly?

13.1.5 Can you and partners readily use the contents of the report to inform work to enhance partnership working, improve outcomes for adults and families and improve the reliability of efforts to safeguard adults in the future?

13.1.6 Are you assured that individuals and agencies involved have been given the opportunity to comment on the factual accuracy of details contained in the report?

13.1.7 Are you assured that any disputes, in particular regarding inaccurate factual analysis, alleged breaches of personal information, negligent misstatements and defamation have been addressed in line with relevant SAB guidance and governance processes? (This issue is picked up again in QM 14 on Publication and dissemination.)

13.2 Those with delegated responsibility

13.2.1 Does the report get beyond description and foreground deeper analysis about social and organisational conditions that help or hinder effective, personalised safeguarding?

13.2.2 Does the structure of the report make it straightforward to distinguish any evaluation of the case from generalizable systemic issues deemed a priority for improvement?

13.2.3 Is there adequate transparency in how the conclusions have been reached?

13.2.4 Is the detail provided about barriers or enablers to good practice, and systemic risks specific enough to allow them to be shared and compared with findings from other SARs?

13.2.5 Has everyone involved, including the person and family had adequate opportunity to comment on the Final Draft Report and all comments, queries or disputes been addressed?

13.2.6 Does the report adequately manage accessibility and explaining complex professional and organisational issues?

13.2.7 Is the Report formatted clearly, in plain English, with any opinions or quotes attributed to their owners and referenced?

13.2.8 Is it clear in the report how views of the person and family members have been incorporated into the analysis, where appropriate?

13.2.9 Is the tone and choice of words appropriate to the review?

13.2.10 Does the amount of detail included about the person and the story of the case match what has been agreed, with input from the person and/or family themselves?

13.2.11 Has all the data to be routinely collected (administrative data; SAR characteristics; case characteristics) been detailed in the preferred format of the SAB and appropriate for this particular SAR, be that in the report or via a centralized SAB data base or spreadsheet?

13.2.12 Have you made it clear that the Final Draft Report is confidential, and not for distribution or public comment until the proposed publication date?

13.3 Those conducting the review

13.3.1 Are you focused on producing a report that is succinct, accessible and useful to supporting improvements?

13.3.2 Have you distinguished case findings and presented clearly your systems findings that explain particular practice problems which featured in the case and represent wider learning about enablers or barriers to good practice?

13.3.3 Have you evidenced the barriers or enablers to good practice as strongly and with as much specificity as possible, given the range of data available to you?

13.3.4 Have you avoided the temptation to articulate solutions to address the systems findings when these depend on factors and constraints outside the scope of the SAR?

13.3.5 Have you included details of the person and events of the case as agreed, in such a way that they do not detract from the systems learning in the report about causal factors that help or hinder practitioners doing their jobs to optimum effect?

13.3.6 Have you presented complex issues as straightforwardly as possible without over-simplifying them?

13.3.7 Are you assured that all administrative data, SAR and case characteristics have been documented, if they are not included in the report?

13.4 Those providing practical support

13.4.1 Have editorial arrangements been agreed?

13.4.2 Have you reminded people to cross-reference the report with the commissioning specification?

13.4.3 Have adequate arrangements been made to enable the person and/or family to convey whether or how they want to feature in the report

14 Quality Marker 14: Publication and dissemination

Quality statement: **Publication and dissemination activities are timely and publicise the key systemic risks identified through the SAR, as well as features supporting high reliability of single and multi-agency working relevant to safeguarding. Compelling and engaging means of circulating the findings are used, adapted as necessary for different operational and strategic audiences. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and other families; professionals who participated are kept informed and supported as needed. Publication and dissemination foster active responsibility and public accountability for addressing barriers identified to good practice or progressing improvement work.**

14.1 Those ultimately accountable

14.1.1 Are genuine efforts being made to publish the SAR report as soon as possible and are any delays justified?

14.1.2 Have the wishes of and impact on the person, their family members and other families affected by the issues raised by this SAR been taken into account in all plans, and are they being supported well?

14.1.3 Are you satisfied that dissemination plans engage all the right audiences given the learning of this SAR, in compelling and engaging ways?

14.1.4 Do publication and dissemination plans reflect clearly and confidently the statutory functions and duties of the SAB?

14.1.5 Are you assured that any legal issues which may arise from publication have been identified and plans put in place to manage these?

14.1.6 Does the communications plan secure the right level of engagement from senior leaders of all relevant partners, regionally and nationally? Has active engagement with the media been considered?

14.2 Those with delegated responsibility

14.2.1 Is the report as anonymized as possible so that no individual can be identified through the contents, unless it has been explicitly agreed with the person themselves of their relevant family members to identify them?

14.2.2 Has the Final Draft Report been checked to identify any risk of legal challenge? For example, containing libellous content, conveying any civil or criminal liability, referencing law breaking or breach of professional standards which has not been already managed.

14.2.3 Have any potential points of disputes or litigation been identified? If so, have you alerted the accountable bodies and formulated a plan to manage this?

14.2.4 Do you need to alert the appropriate Legal departments?

14.2.5 Have you drawn up a media strategy and communications plan which considers the timing of publication, prepares press statements in advance and advises interested parties, including Chief Officers and Boards of organisations involved, of imminent publication?

14.2.6 Are the professionals directly involved being informed of the contents of the report, of the schedule for publication and being given appropriate support?

14.2.7 When will the family have the report and are they being given appropriate support regarding its publication?

14.2.8 Are all those who have a responsibility in addressing issues raised in the SAR, included in dissemination plans? Has adequate consideration been given to disseminating 'up' to strategic leads in relevant organisations locally, regionally and nationally?

14.2.9 Have the additional products and mediums and activities needed from this SAR for different audiences been discussed and agreed? Do they add up to a compelling and engaging means of circulating the findings?

14.2.10 Is the learning being made as accessible as possible to all relevant audiences through the range of products and extent of dissemination and engagement plans? How well are they designed to foster active responsibility for addressing systemic issues identified in the SAR?

14.3 Those conducting the review

14.3.1 Are you satisfied that any questions or concerns raised have been addressed and that there are no risks of legal challenge that have not yet been identified?

14.3.2 Are you satisfied that your report does not contain libellous material and that any third-party information has been verified or the third party been given a right to comment?

14.3.3 Where a living person is identified, have you given duties under the Data Protection Act (DPA) 2018 very careful consideration?

14.3.4 Have you had the opportunity to influence and/or comment on any additional products to check they accurately reflect the findings of the SAR report?

14.4 Those providing practical support

14.4.1 Is legal advice necessary to inform decisions about publication?

14.4.2 Have relevant champions, forums and/or networks been identified that can support dissemination to the range of different audiences?

15 Quality Marker 15: Improvement action and evaluation of impact

Quality statement: **Improvement actions agreed in response to the SAR set ambitious goals, seeking to align the motivations of different stakeholders, bringing partners together in new ways and foster collaborative working. Actions are integrated, where ever possible, with wider strategic improvement activity, plans and priorities, led locally, regionally or nationally. Evaluation of impact is designed from the start, supported by a logic model or similar, using measures that demonstrate whether the underlying causes of systemic risks identified have been addressed. The SAB maintains a public record of findings, actions and commentary to enable public accountability.**

15.1 Those ultimately accountable

15.1.1 Have you provided clear leadership about the need for an open and mutually challenging discussion about what is said in the report about the effectiveness of safeguarding arrangements and practice, or progress against earlier learning, and what needs to be done to address systemic risks identified or progress improvement work?

15.1.2 What part might the person and family subject of this SAR, and people with relevant lived experience and/or who draw on services more widely, have in this process of deciding actions and evaluation planning?

15.1.3 How can you bolster partners toward suitably ambitious goals?

15.1.4 Is specialist support or facilitation needed in the effort to align motivations and think beyond conventional responses and partnership arrangements?

15.1.5 Have discussions considered which findings may NOT be within the gift of partners locally to address, but instead need to be taken to national, regional or other forums for consideration of how best to address them?

15.1.6 Are proposed actions adequately integrated, where appropriate, into on-going or planned workstreams / priority areas of the SAB and/or partner agencies, regional or national bodies?

15.1.7 Are you assured that relevant agencies and sectors have the necessary mechanisms to link the SAR findings into improvement work as agreed and evaluation of impact and if not, what sources of support are available?

15.1.8 Has a logic model or similar technique been used to articulate to the SAB the intended impact and outcomes of proposed actions, for whom, in what timescales and by what mechanisms?

15.1.9 Are SAB expectations clear about plans for longer-term monitoring of improvement actions and follow up to evaluate impact?

15.1.10 Is there agreement about whether follow-up on impact best occurs locally or at a regional or sub-regional level?

15.1.11 Does reporting in the Board's Annual Report comply with statutory requirements and provide genuine transparency and accountability about whether improvement actions have taken place and whether they have made any difference?

15.2 Those with delegated responsibility

15.2.1 Do the proposed responses by agencies and the SAB genuinely tackle the systemic risks identified by the SAR and at the right levels of a system hierarchy, and avoid assuming that disseminating SAR outputs to operational staff is adequate?

15.2.2 Are you using a model for change management or 'organisational development' to help think wider than changes to procedures and training for staff?

15.2.3 Have you considered who is best placed to decide what an effective response to each of the findings would be, and how to engage them in these discussions?

15.2.4 Have any 'quick wins' been identified, and distinguished from causal factors and conditions that are less straightforward to address?

15.2.5 Is there a clear plan of how the SAB will monitor whether actions are on track?

15.2.6 Does the plan to evaluate impact match the theory of change for each finding?

15.2.7 Will a Task and Finish Group be needed to manage and monitor progress, particularly if there are numerous points to the Plan and if several organisations are involved and responsible for different aspects.

15.3 Those providing practical support

15.3.1 Can you help with making accessible intelligence from other sources that is relevant to findings in the report?

15.3.2 Has a clear, considered process been planned, to avoid a last-minute rush to agree responses?

15.3.3 Are any key players missing from this process and how can they best be engaged?

15.3.4 If developing an action plan is being left to you to create in isolation, have you escalated the issue?

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