Safeguarding Adult Review (SAR) - Procedure

The Essex Safeguarding Adult Board

Version 1 (March 17)

Essex Safeguarding Adults Board

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TABLE OF CONTENTS

1. Introduction, Purpose and Context 4

introduction 4

2. Criteria for Conducting a Safeguarding Adults Review 7

3. Referral to the Safeguarding Adults Review Sub-COMMITTEE 8

Links with other reviews 8

decision making flowchart for dhr referrals 9

4. The Decision to Conduct a Safeguarding Adults Review 10

Decision-making Process 10

additional sar sub-committee responsibilities 10

5 Information 10

Information sharing 10

Freedom of Information Act [FOIA] 11

6. Safeguarding Adults Review Reports and Action Plans 11

7. Embedding Learning 12

Appendix 2 – SAR Decision making process 16

Appendix 3 Partnership Learning Review 19

Appendix 4 - Six key principles underpin all adult safeguarding work (Department Of Health) 30

Appendix 5 – Independent advocacy 31

Identifying substantial difficulty in engaging 31

Mental Capacity Act 32

An appropriate individual to facilitate the person's involvement 32

Who can act as an advocate? 33

The role of the independent advocate 34

Appendix 6 - SAR Report Quality Assurance 35

1. INTRODUCTION, PURPOSE AND CONTEXT

INTRODUCTION

1.1 This procedure sets out the arrangements by which Essex Safeguarding Adults Board (ESAB) will conduct its Safeguarding Adult Reviews (SARs). It highlights its statutory duties, overall process for running a SAR and how ESAB will commission such work.

1.2 Section 44 of the Care Act 2014 requires that the Essex Safeguarding Adults Board must arrange for there to be a review of cases involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.3 Reviews **must** also be arranged if an adult in its area has not died, but it is known or suspected that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. ESABs can also arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

1.4 The Safeguarding Adults Review Sub-committee (SAR Sub-subcommittee) of the Essex Safeguarding Adults Board (ESAB) is responsible for recommending the commissioning of Safeguarding Adults Reviews, managing the process and assuring ESAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

1.5 This document sets out ESAB's criteria for conducting a Safeguarding Adults Review and the procedure for conducting those reviews in accordance with the Care Act 2014[1] and its associated statutory guidance[2]. The associated procedure and templates are designed to ensure governance of the process and to provide a process for achieving a complex and challenging task more effectively.

1.6 SAR's should seek to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm from occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for this purpose, including criminal proceedings, coroners enquiries, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

[1] Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect

[2] Care and Support Statutory Guidance Issued under the Care Act 2014, (Department of Health 2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

1.7 ESAB will include findings from any SAR's in its Annual Report and what actions it has taken, or intends to take in relations to those findings. Where ESAB decides not to implement an action it will state the reason for that decision in the Annual Report. All documentation ESAB receives from registered providers which is relevant to the Care Quality Commission's (CQC) regulatory functions will be given to the CQC on their request.

1.8 SAR reports should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- Be written in plain English ; and
- Contain findings of practical value to organisations and professionals

1.9 Agencies will have their own internal procedures to review practice and raise standards, such as complaints, audits and serious incident investigations; a Safeguarding Adults Review is not intended to duplicate those processes, or to investigate allegations of abuse or neglect. Rather, the focus is on multi-agency learning through consideration of how agencies worked together, with the intention of improving how they do so in the future.

1.10 SAR's will reflect the six safeguarding principles[3] (Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability). ESAB will agree Terms of Reference for any SAR they arrange and these should be published and openly available. When undertaking SARs, final reports and other published materials will either be anonymised through redaction or consent will be sought from the family and participating agencies to identifiable information being used.

1.11 The following principles will be applied by ESAB and its partner agencies to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith, and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

[3] Care and Support Statutory Guidance Issued under the Care Act 2014, (Department of Health) Updated December 2016 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

See appendix 12

1.12 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

1.13 The process for undertaking SARs will be determined according to the circumstances of the case The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The core process that ESAB will utilise for all Safeguarding Adult Reviews is set out in the Partnership Learning Review document set out at Appendix 3. The SAR sub-committee will however have discretion to deviate from the process if it will assist in achieving the outcomes of the review.

1.14 ESAB will ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. It is also important that discussions take place at an early stage with the adult, family and friends to agree how they will be involved. In some cases it may be helpful to communicate with the person who caused the abuse or neglect

1.15 The Care Act requires that each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. Further information can be found at Appendix 13.

1.16 It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others;
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- collaborative problem solving experience and knowledge of participative approaches;
- good analytic skills and ability to manage qualitative data;
- safeguarding knowledge;
- inclination to promote an open, reflective learning culture.

1.17 ESAB will aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings.

1.18 Every effort will be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

2. CRITERIA FOR CONDUCTING A SAFEGUARDING ADULTS REVIEW

2.1 Section 44 of the Care Act sets out that:

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

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and .

(b) condition 1 or 2 is met. .

(2) Condition 1 is met if— .

(a) the adult has died, and .

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). .

(3) Condition 2 is met if— .

(a) the adult is still alive, and .

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

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

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— .

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

(b) applying those lessons to future cases.

2.2 Additionally the 14.133 – 14.135 of the Care Act Statutory guidance[4] summarises this legislation and provides some additional guidance around criteria for safeguarding reviews in setting out:

[4] Care and Support Statutory Guidance issued under the Care Act 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

14.133 a SAB **must** arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.134 Reviews **must** also be arranged if an adult in its area has not died, but the safeguarding board knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. ESAB can also arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

14.135 ESAB should be primarily concerned with weighing up what type of `review` process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases

3. REFERRAL TO THE SAFEGUARDING ADULTS REVIEW SUB-COMMITTEE

3.1 The referrer will complete a referral form (form SAR 1) which sets out the areas of potential learning and indicates the issues that indicate the case requires a review. This form requires referrers to set out how the criteria for a Safeguarding Adults Review are met and to focus on the potential learning for ESAB. Professional staff who refer must have senior management endorsement of their referral.

3.2 The referral form is held on the Essex Safeguarding Adults Board website (http://www.Essexsab.org.uk).

3.3 The referral for a Safeguarding Adults Review should be sent from a secure email address to: essexsafeguarding.adultsboard@essex.gcsx.gov.uk. Where the referrer does not have a secure email address, they should telephone the Safeguarding Adults Board Team (03330 131019) and discuss how best to send the form.

3.4 This will be acknowledged within five working days and the Safeguarding Adults Board Team will contact the referrer to discuss the referral. The Safeguarding Adults Board Team may advise the referrer of a more appropriate route for gaining their required outcome.

3.5 The Safeguarding Adults Board Team are responsible for ensuring the referrer is kept informed of the sub-committee's response.

LINKS WITH OTHER REVIEWS

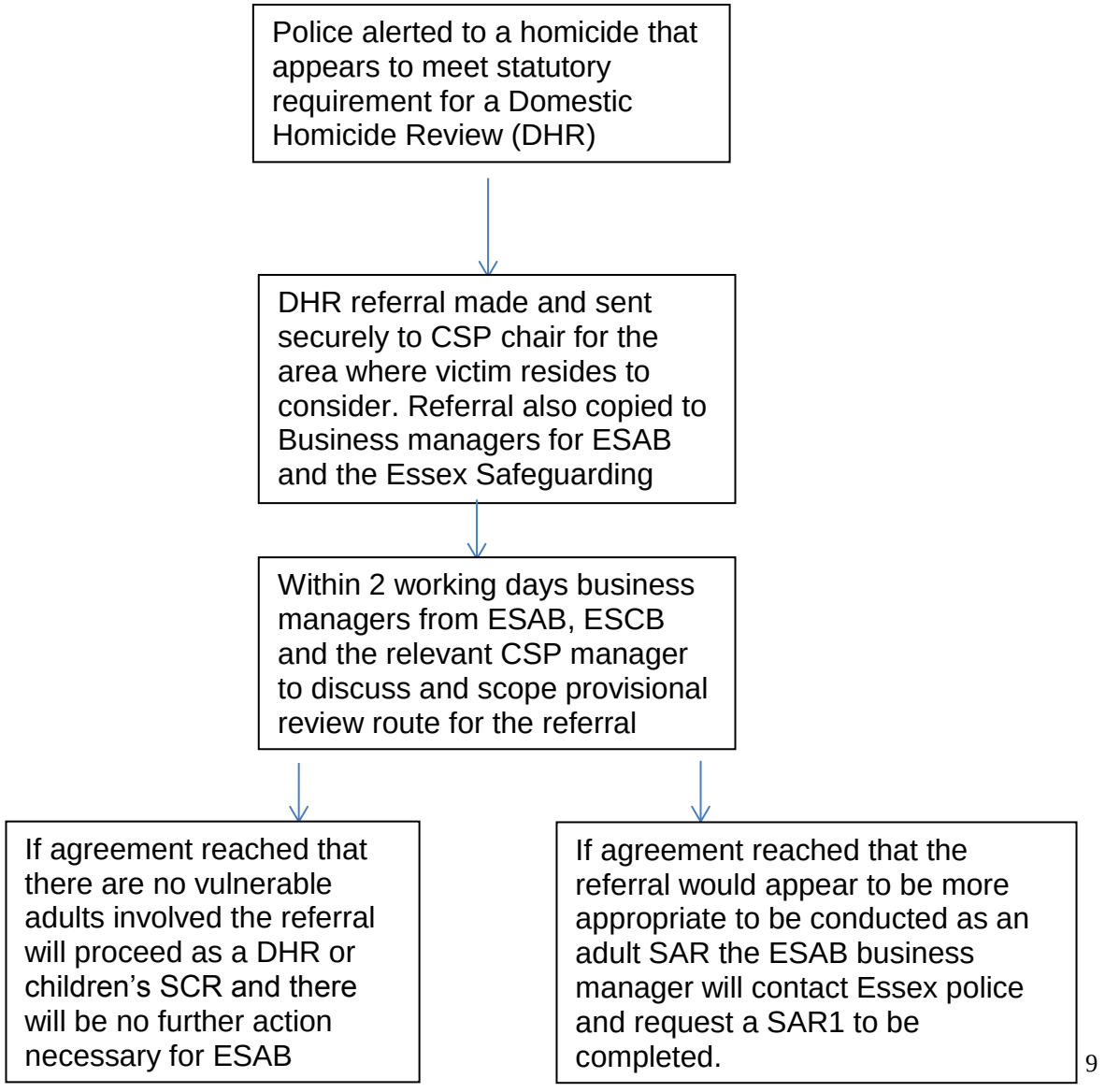
3.6 It is probable that in some circumstances statutory requirements to undertake reviews will overlap, particularly Domestic Homicide Reviews (DHRs') and to a lesser extent children's SCRs.

3.7 Where such reviews may be relevant to a SAR (for example the victim may be an adult in need of care and support), consideration should be given to which is the most appropriate statutory review for the circumstances under consideration. The flowchart below sets out a process for making such decisions with regard to DHR's.

3.8 There will be occasions where it is necessary for an SAR and DHR to run in parallel. In these circumstances it is important that it is done in the most effective manner possible so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

3.9 When running reviews in parallel it will be important at the outset to establish all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroners enquiry, and, or, and criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the ESAB support team to ensure contact is made with the chair of any parallel process in order to minimise avoidable duplication

DECISION MAKING FLOWCHART FOR DHR REFERRALS



4. THE DECISION TO CONDUCT A SAFEGUARDING ADULTS REVIEW

DECISION-MAKING PROCESS

4.1 The SAR Sub-Committee is made up of representatives from ESAB partner agencies. There is an expectation that all Sub-Committee members will ensure that they attend the meeting to share initial information and to assist in the shared decision making. The sub-committee must receive legal advice from the Board's legal adviser.

4.2 It is the responsibility of the SAR Sub-Committee to decide whether the presenting information meets the criteria for a SAR review and to make a recommendation to the ESAB Independent chair as to whether with the criteria set out within the Care Act 2014 have been met.

4.3 The final decision on whether to conduct an SAR has been formally delegated by the Essex Safeguarding Adults Board to its Independent Chair.

ADDITIONAL SAR SUB-COMMITTEE RESPONSIBILITIES

4.4 The SAR Sub-Committee will also be expected to quality assure the work of the Review team as the review progresses and will ratify the final report before presentation to the safeguarding board.

4.5 All Safeguarding Adults Reviews will be conducted through the Safeguarding Adults Review Sub-committee. Quoracy for the sub-committee must always include representation from Adult Social Care, Police and a Clinical Commissioning Group to recommend a Safeguarding Adults Review.

5 INFORMATION

INFORMATION SHARING

5.1 A general duty to co-operate between agencies is created by section 6 and section 7 of the Care Act. This is reinforced by a specific requirement in relation to Safeguarding Adult Reviews sections 44 and 45 of the Act. In addition the guidance issued under the Act provides that local authorities must co-operate and collaborate with each of their relevant partners and those partners must also co-operate with the local authority in the exercise of their functions including those to protect adults. It follows that the provision of information to a Safeguarding Adult Review would fall into this category and that information, when requested, should be provided.

FREEDOM OF INFORMATION ACT [FOIA]

5.2 As a general rule agencies involved in an SAR will deal with requests to them under FOIA in accordance with their own procedures. Safeguarding Adults Boards are not deemed as public authorities under the Schedule to the Act and are therefore exempt from requests for disclosure of information under FOIA. Only information that is made public voluntarily or is accessible under other legislation [e.g. Data Protection Act] will be available to others.

6. SAFEGUARDING ADULTS REVIEW REPORTS AND ACTION PLANS

6.1 All reports of Safeguarding Adults Reviews are owned by ESAB and held securely by the Essex Safeguarding Adults Support Team. Reports and action plans are only final when accepted by the Independent Board Chair and ESAB.

6.2 Final Safeguarding Adults Review reports should:

- provide a sound analysis of what happened in the case including organisational context, and why, and what needs to happen in order to reduce the risk of recurrence (this will be reflected in the recommendations and action plan);
- contain findings of practical value to organisations and professionals
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

6.3 When compiling and preparing to publish reports ESAB will consider carefully how best to manage the impact of publication on all those affected by the case. ESAB will comply with the Data Protection Act 1998 when compiling or publishing the report, and will comply also with any other restrictions on publication of information, such as court orders.

6.4 In preparation for publication of the SAR the press and media offices of each participating organisation will be advised in advance of the proposed timetable for publication and given the opportunity to comment and contribute to a strategy to deal with the process of publication. A lead press/media office will be designated, usually that of the local authority and all press and media enquiries will be routed through this office.

6.5 Individual Agency Management Reviews and Reports produced for the process of the SAR are owned by the agency that authored them.

6.6 ESAB is responsible for approval of all Safeguarding Adults Review Reports and Action Plans. The Safeguarding Adults Review Sub-committee is responsible for monitoring and confirming completion of all Safeguarding Adults Review action plans.

6.7 All action plans will explicitly set out how agencies will evidence completion of an action and how the learning from the Safeguarding Adults Review will be embedded within the organisation.

6.8 Action plans will be monitored by the Safeguarding Adults Review Sub-committee. Any failure to complete actions will be escalated to the Independent Chair of the Board with the knowledge of the relevant ESAB Board member. Where this relates to an organisation that is commissioned by an ESAB member, this will also be raised with the commissioner and regulator.

6.9 When an action plan has been completed, this will be reported to ESAB prior to closure of the Safeguarding Adults Review. The Review can only be closed when ESAB is satisfied and has agreed that all actions have been completed.

7. EMBEDDING LEARNING

7.1 The purpose of a Safeguarding Adults Review is to learn and improve practice and services. It is essential therefore that the learning from Safeguarding Adults Reviews is widely disseminated.

7.2 All Safeguarding Adults Review action plans will have a specific action setting out how learning will be disseminated and embedded.

7.3 Learning from Safeguarding Adults Reviews can be disseminated in a number of ways:

- Via ESAB Bulletin
- Through regular Learning from Practice Events
- Through participation in ESAB Annual Conference
- At post-review learning dissemination workshops
- By publication on the Essex Safeguarding Adults Board Website
- Through an annual Safeguarding Adults Review report, which highlights learning themes in both local and national reviews
- By individual agencies taking responsibility to share learning internally.

Appendix 1 - Safeguarding Adults Review Referral Form

Form SAR 1
Referral Form

ESAB Safeguarding Adults Review Sub-committee considers every referral on the basis of whether it meets the criteria for a Safeguarding Adults Review (see Section 3, ESAB Safeguarding Adults Review Policy)

The Sub-committee needs as much information as possible to enable members to make a proportionate decision as to how to respond to a case referral, ensuring, if the case is accepted for a review, that maximum learning is achieved for ESAB. If you have any questions, please do not hesitate to contact the Safeguarding Adults Board team safeguarding.adults@Essex.gcsx.gov.uk

i. Referrer

Name:	
Title:	
Agency (where applicable):	
Address:	
Telephone number:	
Email address:	

ii. Senior Manager Authorisation (where applicable)

Name:	
Title:	
Telephone number:	
Address:	
Email address:	
Date referral authorised:	

iii. Adult at Risk and Person(s) Alleged Responsible to have Caused Harm or Neglect

Adult Subject to Referral:	
Name:	
Date of birth:	
Date of death (where applicable):	
Address:	

Health (physical):	
Health (mental):	
Agencies involved:	
Person(s) or Organisation(s) Alleged Responsible to have Caused Harm or Neglect	
Name:	
Address:	
Any additional information:	

iv. Referral reason(s)

Brief facts of the case/Chronology of events	
Was the subject of this referral in need of care support	
Did the subject of this referral die as a result of abuse or neglect (Known or suspected)	
Are there concerns that partner agencies could have worked more effectively to protect the adult in this referral	
What learning do you think can be achieved through review of this case?	
What other learning/review processes have been followed? (please detail) And if so: 1. What did they achieve 2. How has that learning been disseminated 3. What impact has it had? (please detail on all)	
Please detail any other relevant information that will enable the Safeguarding Adults Review Sub-	

committee of ESAB reach a decision about how to respond to this referral.	

V.

Signature:	
Date:	

These details need to be included/completed

APPENDIX 2 – SAR DECISION MAKING PROCESS

1 **Incident leading to referral**

The referral (Form SAR1) must clearly state why - in line with statutory guidance - a review is thought to be necessary and that the referral is fully supported by the agency concerned. The referral will be acknowledged and the ESAB Support Team will be in contact within 5 working days

NB: A short period of reflection is advised before submitting a referral to ensure that it is appropriate.

2. (Timescale 10 working days)

The ESAB Support team will collate additional information and compile a Consideration report to enable the ESAB Board Manager and the ECC Director of Adult Safeguarding to undertake an initial review

3.(Timescale 5 working)

Consideration report forwarded to ESAB Independent Chair who will agree whether appropriate for consideration by the SAR Review sub-committee

3(i) **If Yes:**

- **All agencies requested to provide written information held relating to the case**
- **Proceed to consideration discussion by the SAR Review**

3(ii) **If No:**

- **Letter to Referrer with full explanation of reason(s)**
- **Confirmation to SAR Sub Committee**

4. *(Timescale – 28 days)*

Convene SAR Review sub-committee and appoint Panel Chair, who should be independent of the services directly concerned with the case. Sub-committee should include representation from the ESAB's statutory partners.

Collated multi-agency information will be shared before the meeting

5.

At the consideration meeting the Panel Chair will make clear the purpose of the meeting and ensure that an overview of the case is outlined to all Panel Members based on the information available at that time

6.

The Board's legal adviser will remind Panel Members of the options available to them in considering the circumstances of the case, based on national guidelines and may comment on how they are likely to apply to the case

7.

Panel Chair will require all agencies present to give information known to them about the case and those directly involved. The Panel Chair will seek to ensure that information is clear and unambiguous.
Panel Chair will ensure that key information is carefully logged for future reference

8.

Panel Chair will ensure that the information given by agencies is discussed, questioned where necessary, and clearly understood by the Panel members

9.

Based on the information available related to the incident and the case, the Panel Chair will ask Members to explain whether or not they consider that learning may arise from further consideration of the case and whether it should be subject to review - clearly giving a rationale in support of their view (which must be recorded)
Members will be asked to vote based on the following:-

(i) The rationale for their view of whether the criteria set out in the Care Act 2014 and associated statutory guidance for review are met

(ii) Proportionality – the type of review undertaken and the learning expected based on the principles set out within the Care Act Statutory guidance and this document

10. *(Timescale – 7 days)*

Panel Chair will promptly write to the ESAB Independent Chair confirming the Panel's recommendation regarding the need for SAR or other review. This letter will make clear the key considerations and rationale of the Panel in reaching its conclusion and highlight any significant areas of disagreement if necessary. This recommendation must be clear and unambiguous to the Chair stating the reasoning behind the decision.

11. *(Timescale – 14 days)*

Independent Chair will promptly consider the recommendations of the Panel and seek clarification or additional information, if considered necessary. It should be clear that the Independent Chair will not automatically accept recommendations from the Panel and will reserve the right to challenge if considered necessary or appropriate. The basis of any challenge from the Independent Chair will be made clear.

The options open to the Independent Chair at this point are to accept or reject the recommendations of the Panel or to defer a decision pending receipt of further information. The Independent Chair will reserve the right to review this decision in light of any further information which may become available.

If the Independent Chair is minded to reject the recommendation of the panel, a further meeting will be convened to discuss the original recommendation and the reasons for it between the Panel and the Independent Chair before the Independent Chair makes a decision about whether to reject the recommendation.

12.

The Independent Chair will make a decision and confirm in writing to the Panel Chair and the Chair of the standing SAR Sub Committee.

13.

If SAR or other review to be commissioned the Independent Chair will request that a review panel be convened and a Lead Reviewer be appointed.

14.

Terms of reference and methodology to be discussed and agreed with the Lead Reviewer by the ESAB Manager/Lead for Safeguarding and then signed off by the Panel taking into account key issues arising from the consideration panel discussions

The terms of reference will need to make clear explicitly which organisations/agencies are expected to co-operate with the review and also the basis upon which they are required to contribute information to the review process

APPENDIX 3 PARTNERSHIP LEARNING REVIEW

Introduction

This document sets out a process to be used to conduct Safeguarding Adult Reviews and which is in keeping with the principles prescribed within the Care Act statutory guidance.

Paragraph 14.138 of the Care Act sets out the following principles that should be applied by Safeguarding Adult Boards and their partners to all reviews

- There should be a culture of continuous learning and improvement across organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith, and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

In a Partnership Learning Review (PLR), the key players are: -

Independent Lead Reviewer – This will need to be someone independent of ESAB. This person will manage the process, chair meetings of the Review Team, facilitate the professional's Partnership Learning Review events, and in most instances also be the author of the Overview Report.

Dependent on the complexity of the case, there may be a requirement for a second independent person whose main role will be to be the **Author of the Overview Report**. This person will work closely with the Independent Lead Reviewer to manage and lead the PLR event meetings with professionals.

The Review Team – which will be a small team (again dependent on the complexity of the case) but as a minimum would need senior managers who have multi-agency safeguarding experience and as a minimum would need a representative from ESAB's statutory partners i.e. ECC Adult's Social Care, Essex Police and a Clinical Commissioning Group representative. The panel should also include a person who is able to represent ESAB and keep the ESAB independent Chair informed of the progress of the PLR. Members of the Review Team will assist the Independent Lead in facilitating the Partnership Learning Review event and in providing local context and challenge as the analysis of professional practice and learning develops.

Individual Agency Representative (IAR) - Chronology author – Although this process does not necessarily require Individual Management Reviews to be completed, these persons will be responsible for the completion of the Individual Agency Chronology on behalf of their agency. This will be for the time period identified for the review, and the chronology template must include a column requiring objective comments, analysis and observations of practice taking place. The

IAR will also be requested to provide a summary of their "comments" at the end of the chronology, identifying any themes that may have emerged and of any potential learning for the agency. The IAR must have had no line management experience in the case but must be able to provide a reflection of organisational context , practice strengths and shortcomings , and in some cases organisational analysis. An additional summary chronology will need to be completed covering the same time period, but in respect of any organisational change, significant events, staffing issues etc. which the organisation has experienced. This will assist with later consideration of any contextual issues that might have impacted on the services provided to the adult. It must be made clear that this information will also be shared with other agencies as part of the Partnership Learning Review event.

Front Line Practitioners and Operational Managers directly involved in the case – will be invited to the Partnership Learning Review event/s set up in relation to the case and will be actively involved in a collaborative and analytical process, with their involvement intended to make a significant contribution to the eventual development of Learning and Development from the case.

Members of the Family – will be engaged in the process in a similar way to the more traditional SARs and will be asked to contribute via interviews with the Independent Lead/Overview Author. This would normally be done before the PLR event with the practitioners, so as the views of the family, if appropriate can be included within the discussions and analysis of professional practice. It is recognised that other arrangements may be necessary to meet the particular needs of family members.

Stages of the Partnership Learning Review process

This is a Summary Checklist of the different stages of the PLR process with approximations of the timeframes within which they can be completed. This however will be dependent on the particular needs and complexities of the case. Greater detail of what the stages entail follows the Checklist**.**

Stage	Actions/Tasks	By whom	By when
1. Setting up the PLR	– Appoint Independent Reviewer in line with agreed ESAB Procedure – Establish time period for the Review and broad themes for Terms for Reference – Discuss with Police re family contact before contact is made by agencies completing chronology – Set timetable for PLR – SAR Sub Committee to identify the agencies required to take part in order for them to nominate the right Review	SAR Sub Committee	Week 3

	Team members.		
	- Involved agencies' Chief Officers requested to: (a) identify chronology authors and provide contact details. (b) submit the following:- (i) chronology on ChronoLator template supplied; (ii)summary of identified themes and potential learning; (iii)action plan to address any learning points. (c) identify practitioners with direct involvement in the case and provide contact details (d) ensure commitment to enable chronology authors and practitioners to fully participate in the process	ESAB Support Team; Lead Reviewer	Week 5
2. Information collection and collation	- Review chronologies and summary comments	Independent Lead/Overview Author; Review Team; Chronology Authors; ESAB Support Team	Week 8
3. Establishing Key Themes for Analysis	- Finalise Terms of Reference - Develop and agree Key Themes for Analysis - Agree when and how family will be involved	Review Team; Independent Lead/Overview Author; ESAB Support Team;	Week 8
4. Preparation for Partnership Learning Review Event	- Ensure appropriate participation of practitioners and first line managers (there is an expectation that practitioners / participants are offered some preparation time for these events). - Establish the structure and expected outcomes from the day	ESAB Support Team	Week 11

	- Agencies to ensure support in place for practitioners following the PLR Event - If further information is required Individual Management Reviews may be requested - composite chronology to be sent to all PLR participants - Guidance for Practitioners		
5. Partnership Learning Review Event	– Agree the facts of the case – Consider the adult's lived experience – Undertake the work on the Key Themes – Identify Key Lessons Learned	Practitioners and Line Managers; Independent Lead/Overview Author; ESAB Support Team	Week 12
Overview Report – Draft 1 completed	By Independent Lead/Overview Author		Week 15
6. Meeting 5 **Discuss Overview Report**	– Consider the analysis and findings in the Overview Report – Are particular actions required for individual agencies? – Agree the main lessons learned from the PLR and confirm the Key Learning Outcomes	Independent Lead/Overview Author; Review Team; ESAB Support Team	Week 16
Overview Report – Draft 2 completed	By Independent Lead/Overview Author		Week 18
7. Meeting 6 **PLR Event Practitioners feedback**	– Findings from Overview Report presented to practitioners and operational managers for comment and further development as necessary.	Practitioners and Line Managers; Independent Lead/Overview Author; ESAB Support Team	Week 20
8. Meeting 7 Finalising the Report	– Final agreement re the Overview Report – Overall findings to be developed into priority areas for Learning and Development for attention	Independent Lead/Overview Author; Review Team; ESAB Support Team	Week 22

	by ESAB – SAR Sub Committee for ratification – Feedback to family and publication		
9. Adoption by ESAB Board	- Presentation of key learning and themes to ESAB - Final sign off of Report	Independent Lead/Overview Author	Week 24
10. Lessons Learned and dissemination	- Feedback to family - Development of overall collated Action Plan - Dissemination of learning - Publication	SAR Sub Committee	Week 26

NB: This model is flexible and the number of meetings and level of information required will depend on the complexity of the case.

1. Setting up the PLR

1.1 Establishing that the criteria for a Safeguarding Adult Review has been met will be undertaken in line with the ESAB decision making referral guidelines (Appendix 2). The SAR sub-committee will also advise/agree with the ESAB Chair the detail of the Partnership Learning Review process by which the SAR will need to be conducted. This will be reflected by the perceived complexity of the case.

1.2 The SAR sub-committee will need to decide on the size and make-up of the Review Team with particular reference to whether there is any area of speciality or expertise that it would be useful to include in this team. Ideally however, this should be a small team who have broad interagency safeguarding experience at a senior level.

1.3 There will be the need to appoint at least one independent person as the Independent Safeguarding Lead. If the case will require input from a large number of agencies and professionals, and has complex areas of analysis across different facets of safeguarding practice, potentially across Safeguarding Adults Boards, then a separate independent Overview Report author will likely be needed.

1.4 Wherever possible, the time period to be covered by the review should reflect the potential learning that is to be achieved, for example identifying professional practice and procedures in the case that has since changed, will have little learning attached to it.

Additionally with this process actively involving practitioners and their managers, the review period needs to be as short and as recent as possible. This needs to be balanced however with the need for example to understand the chronicity of neglect and whether early help interventions could have been beneficial.

1.5 All those agencies who provided services to the adult/s for the time period to be covered by the PLR will need to be formally requested by the ESAB Chair, to appoint their Individual Agency Representative to complete a chronology of their agency's involvement, and of any organisational changes over the same period of time, which may have impacted on front line practice. A chronology template will be provided. Agencies will need to be advised that chronologies will be shared with other agency chronology authors, practitioners and the Review team.

1.6 Agencies will also be required to provide a summary of their comments made in the chronology identifying any themes that may have emerged and any potential learning for their agency, together with an action plan to address any learning points.

2. Information collection and collation

2.1 The work of the Review Team, chaired by the Independent Safeguarding Lead, begins once the chronologies have been completed and have been amalgamated. The team will need to be satisfied that the appropriate level of information has been provided by each agency and that the "comments" section of the chronology, and the summary of these, provides useful insight and commentary on organisational context during the period of the review as well as the actions undertaken by the agency and of possible learning for that agency.

2.2 If necessary, the Review Team may decide to either request more information from an individual agency, or ask the author of the chronology (the IAR) to attend a meeting if further clarity is needed about their agency's role.

3. Establishing the Themes for Analysis

3.1 By studying the chronologies and considering the commentaries provided within them, the Review Team will need to discuss the case in detail and develop what they consider will be the Key Themes for Analysis. These should be as few as practicable and ideally should not number more than six or seven. They should also not be set in stone as once the PLR event begins, these may well adapt and change. Nevertheless, these key themes will be an important foundation to the work of the PLR and do not need to pose specific questions, but raise issues of practice that have emerged within the case, but can be transposed into working with adults more generally and give insight into the systems which operate formally or informally within safeguarding practice.

3.2 The Independent Lead will also need to produce a short "key events" document (2 sides maximum) taken from the amalgamated chronology, which will act as a reference

document throughout the work undertaken in the PLR event and provide information to the participants prior to their attendance. If desirable, the identified Key Themes for Analysis could also be shared prior to the meeting.

3.3 The Review Team will need to decide upon how and when the family will be contributing to the review. Ideally this should take place before the PLR event, so as the family's views can be included within the day so as it can add in the most appropriate way to the development of the understanding and analysis of professional practice.

4. Preparation for the Partnership Learning Review Event with practitioners.

4.1 The Review Team will need to be clear that they have a full list of appropriate professionals and line managers to invite for the PLR event. This will need to be obtained from the Individual Agency Representatives who compiled the chronologies. The criteria for the professionals to be invited will be that they would have had some form of direct operational involvement with the adult. It is particularly important that the most appropriate professionals attend. Requests for staff to attend who have not had direct involvement with the family should not normally be agreed, as this could unhelpfully impact on the dynamics of the group.

4.2 The letter of invitation should come from the ESAB Chair, give plenty of notice, explain the purpose of the event, format, feedback process and to give it the highest priority. Also in consultation with IARs, it may be valid for a member of the Review Team or the Independent Safeguarding Lead to have a pre-meeting with certain practitioners. This could be for a range of reasons but the purpose would be to enable the individual to contribute positively to the multi-agency work at the PLR event, and not be hampered by any concerns about a blame culture developing or that there would an inappropriate focus on individual practice. It is recognised that in cases where the adult has died, some professionals may feel vulnerable, upset or anxious and that a pre-meeting could help to allay those understandable fears and allow them to contribute fully at the PLR event.

4.3 Agencies should ensure that support is in place for practitioners following the PLR event.

4.4 If there are likely to be key absences from the PLR event, then steps should be taken by the Review Team to separately gain their contribution as soon after the PLR event as possible.

4.5 There may be occasions when the conduct of a review needs to take into account ongoing investigations (Police) and potential legal proceedings. Concerns in the ongoing conduct of a review and/or publication will be a matter for the Boards legal adviser to resolve with the Police and CPS in full consultation with the ESAB Independent Chair who will reserve the right to make the final decision which will be binding on all agencies.

5. The Partnership Learning Review - Event 1

5.1 The PLR event would normally be undertaken over one day, although a more complex case may require an additional half day or day. In summary the purpose of the PLR event is:

- For front line practitioners and operational managers to participate in the inter agency review of this case following a systems methodology, and in doing so;

- To discuss and agree the factual information compiled about the adult in terms of incidents and professional interventions, and to gain agreement or additions/changes to these,

- To work alongside the Review Team to undertake analysis of the professional practice from the key themes which have emerged in respect of the case

- To identify the key learning themes from the analysis and,

- Identify how the experiences of this case could be used to further develop local inter agency safeguarding practice

5.2 The structure of the PLR event must begin with establishing and agreeing the facts of the case. (See Appendix 2 for a proposed structure) Each participant will have had a copy of the Key Events summary and within the session it will be important to have the Integrated Chronology either displayed around the room or as a resource for reference within the meeting. (However this should be a copy of the chronology without the "comments" section, as this may unhelpfully direct views of participants before they have been able to provide objective input from their direct experiences with the family). It will then be for the participants, in multi-agency groups preferably, to share and discuss the content of the factual information and to add, question as necessary the information being presented. It may be that as a result of this exercise that some of the factual information will need to be changed, but ultimately there should be a common understanding among the participants of the range and detail of the professional interventions and key events that the adult had experienced.

5.3 With this knowledge, the group should then be encouraged to do some work looking at the "lived experience of the adult". This would help participants to view the "story" of what happened with the adult's perspective.

5.4 The next important part of the PLR event is for the participants to work with the Review Team to develop the analysis of the case based initially upon the "Key Themes for Analysis", with some specific questions posed to help with addressing these (as suggested in Appendix 2).The meeting will need to give priority to the experience and views of the practitioners and managers present in order to develop consensus views (where possible) about not only what happened but why interventions or the lack of them occurred in the way that they did. There will need to be a flexible approach to enable professionals to be able to contribute to the ley themes for analysis that are most applicable to them. Within this process it will be essential that all actions and decisions, or lack of them by professionals, are viewed within the context of the systems which surrounded them and to what extent they were supportive or otherwise of the work with the family. It will be important that the Independent Safeguarding Lead assists the group in avoiding hindsight bias in their consideration of what took place with the adult. In order to get to some of the detail about how and why certain aspects of professional practice took place in the way they did, it could be useful to identify which factors were impactful, and in particular whether they related to : -

- The family dynamics (e.g. difficulty in engaging the family, mobile family)
- Individual/Team practice (e.g. experience, knowledge and direction)
- Organisational/systems issues (e.g. staffing levels, procedural, culture of inter-agency working, organisational change, organisational expectations, management oversight and supervision)
- Community/environmental issues (e.g. local community strengths and weaknesses, local resources or lack of them, impact of racial and ethnic minority issues.),

  or probably the most likely,

- A mixture of some or all of the above

5.5 The meeting may also find it helpful to identify if there were any "reasonable alternative actions" which could have been undertaken by professional staff at particular stages of intervention, and if so, would they have taken the case in a different direction? The term "reasonable" is important so as to be sure that alternative actions are not only being identified with the benefit of hindsight.

5.6 The analysis of the extent that professional interventions were either: -

- Proactive (purposeful to address a problem and to generate change)
- Procedural (undertaken as part of a procedural requirement – e.g. statutory visit as part of a CP Plan, health development assessment)
- Reactive (in response to a request for help, referral, or to a crisis)
- Or to what extent they were a mixture of these three types of interventions….. will go some way to understanding the purpose and motivations for interventions which were carried out with the family. Once again these components of practice cannot be viewed without taking into account the wider systems which may have purposefully or inadvertently directed interventions to take place in a particular way.

5.7 The important issue is whether the mode of intervention reflected the needs of the adult at the time. Some agencies, such as the Ambulance Service and the Police will tend to only undertake reactive interventions, whereas others are more likely to be a mixture of all three. The ability to successfully intervene with adults who present different challenges, such as difficult to engage behaviours, will for example largely depend on the type of professional intervention and its consistency. The predominant type of intervention may reflect individual style of a practitioner or particular profession, but just as likely to reflect organisational/team aims or culture and the level of resources available to deliver services.

5.8 The final part of the PLR event (or potentially carried over into a second meeting in more complex or detailed cases) will be the development of the Key Lessons Learned. From the analysis of interventions and of how systems were enacted or otherwise in respect of the work with this particular adult, then this will need to be transposed into areas of learning for professional practice in the future. It is essential that good practice is fully recognised so as this can be similarly developed for future learning. The outcome from

the meeting will therefore be a list of key areas of learning that this case has identified which could make a positive difference in future safeguarding practice.

5.9 All the information and outcomes obtained from the PLR event will provide the majority of the material to enable the Independent Safeguarding Lead/Author to complete the first draft of the Overview Report.

6. Overview Report (Draft 1)

6.1 With the information, analysis and lessons from the PLR event, then the Independent person can complete the first draft of the Overview Report, including any additional analysis that he/she may deem necessary, alongside references to research etc. It will be important includes sufficient analysis to identify, for example, context around the operational dynamics of organisations involved in the case. The report will then need to be presented to the Review Team to discuss at their next meeting and consider its findings with a particular focus on the Key Lessons Learned. There will also be the need for the Review Team to consider whether a request needs to be made to an individual agency to ensure appropriate action is taken to make improvements.

6.2 Arrangements will need to be finalised within the Review Team meeting for the 2nd PLR event.

6.3 Armed with the additional views and contributions from the Review Team, a revised Draft 2 Overview Report will be written.

7. Partnership Learning Review - Event 2

7.1 This will be the opportunity for those professionals from the first PLR event to return to hear from the Independent Safeguarding Lead/Overview Author of the findings and Key Lessons Learned as contained within the Draft 2 Report. This will need to be presented in summary form to the participants, not as a written document. The group can be asked to consider the Key Lessons Learned and from these identify how they can be transposed into practice on a day to day basis, the likely impact of their implementation, as well as the practicality of achieving them. It will be important however to acknowledge that a number of the lessons to emerge would not fall into the SMART categorisation of a recommendation, and will take much broader strategic developmental approach. For this reason the Review Team may consider it valid to seek additional attendance from key strategic managers to this second PLR event.

8. Finalising the Process

8.1 The final version of the Overview Report will be presented to the Review Team for their endorsement and will have finalised from the second PLR event, the main areas for learning and development that need to take place as a result. A main outcome from this

final meeting is to agree how these will be formulated to enable the ESAB to ensure that it obtains maximum learning and development from the process.

8.2 The Overview Report will be presented to the SAR Sub Committee for ratification.

9. Adoption by ESAB

9.1 Presentation of the outcome of the Review including key learning and themes from the case to the ESAB

9.2 ESAB to agree their response and actions as a result.

10. Lessons learned and dissemination

10.1 The SAR Sub Committee will develop an overall collated action plan.

10.2 The SAR Sub Committee will agree arrangements for publication in consultation with the Director of Adult Services and ESAB Independent Chair

10.3 Arrangements will need to be made to ensure that there is feedback to the family about the process and about the likely arrangements for publication.

10.4 Follow up with agencies carried out six months after the review to ensure that all actions, recommendations and learning has been carried out and that the impact of this has been measured.

APPENDIX 4 - SIX KEY PRINCIPLES UNDERPIN ALL ADULT SAFEGUARDING WORK (DEPARTMENT OF HEALTH)

Six key principles underpin all adult safeguarding work

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

  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

- Prevention – It is better to take action before harm occurs.

  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

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

  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

- Protection – Support and representation for those in greatest need.

  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

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

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

- Accountability – Accountability and transparency in delivering safeguarding.
  "I understand the role of everyone involved in my life and so do they."

APPENDIX 5 – INDEPENDENT ADVOCACY

1. Local authorities must arrange an independent advocate to facilitate the involvement of a person in a SARs if two conditions are met.
   - That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes and
   - there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer.

2. The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations as required for the safeguarding enquiry or SAR.

3. Local authorities must involve people in decisions made about them. Involvement requires the local authority helping people to understand how they can be involved, how they can contribute and take part and sometimes lead or direct the process. People should be active partners in the key care and support processes of assessment, care and support planning and review. No matter how complex a person's needs, local authorities are required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions.

4. The duty to involve applies in all settings, including for example, those people living in the community, in care homes or in prisons.

IDENTIFYING SUBSTANTIAL DIFFICULTY IN ENGAGING

5. Local authorities must form a judgement about whether a person has substantial difficulty in being involved with the SAR process. If it is thought that they do, and that there is no person who would be appropriate to support and represent them, then the local authority must arrange for an independent advocate to support and represent the person.

6. Local authorities must consider for each person, whether they would have substantial difficulty in engaging with the safeguarding process. The Care Act defines four areas where a substantial difficulty might be found, which are set out below.

7. The first area to consider is *'understanding relevant information'*. Many people can be supported to understand relevant information, if it is presented appropriately and if time is taken to explain it. Some people, however, will not be able to understand relevant information, for example if they have advanced dementia.

8. The second area to consider is 'retaining information'. If a person is unable to retain information long enough to be able to weigh up options and make decisions, then they are likely to have substantial difficulty in engaging.

9. The third area is *'using or weighing the information as part of engaging.'* A person must be able to weigh up information, in order to participate fully and express preferences for or choose between options. For example, they need to be able to

weigh up the advantages and disadvantages of moving into a care home. If they are unable to do this, they will have substantial difficulty in engaging.

10. The fourth area involves 'communicating their views, wishes and feelings'. A person must be able to communicate their views, wishes and feelings to aid the decision process and to make priorities clear. If they are unable to do this, they will have substantial difficulty in engaging.

11. For example, a person with advanced dementia, significant learning disabilities, a brain injury or mental ill health may be considered to have substantial difficulty in communicating their views, wishes and feelings. But equally a person with Asperger's may be so considered, as may a frail older person who does not have a diagnosis but is confused as a result of an infection, or a person who is near the end of their life and appears disengaged from involvement and decision-making.

MENTAL CAPACITY ACT

12. Some of the people who qualify for advocacy under the Care Act may also qualify for advocacy under the Mental Capacity Act 2005 where a specific decision is being made and specific criteria are met (see SET MCA Policy and Procedure). It is almost always in an individuals best interests to seek to ensure wherever possible that the same advocate provides support under both the Care Act and the Mental Capacity Act.

13. Both Acts recognise the same areas of difficulty, and both require a person with these difficulties to be supported and represented, either by family or friends, or by an advocate in order to communicate their views, wishes and feelings.

AN APPROPRIATE INDIVIDUAL TO FACILITATE THE PERSON'S INVOLVEMENT

14. Local authorities must consider whether there is an appropriate individual (or individuals) who can facilitate a person's involvement in the SAR process, and this includes three specific considerations.

15. First, it cannot be someone who is already providing the person with care or treatment in a professional capacity or on a paid basis (regardless of who employs or pays for them). That means it cannot be, for example, a GP, or a nurse, a key worker or care and support worker.

16. Second, the person who is to be supported must agree to the particular individual supporting them, if the person has the capacity to make this decision. Where a person does not wish to be supported by a relative, then the local authority cannot consider the relative appropriate. The person's wish not to be supported by that individual should be respected regardless of whether the person is assessed to have or lack capacity. The person must agree to the appropriateness of the individual who is proposed to support them. If the person lacks the capacity to make a decision, then the local authority must be satisfied that it is in a person's best interests to be supported and represented by the individual.

17. Third, the appropriate individual is expected to support and represent the person and to facilitate their involvement in the processes. It is unlikely that some people will be able to fulfil this role easily, for instance a family member who lives at a distance and who only has occasional contact with the person, a spouse who also finds it difficult to

understand the SAR process, a friend who expresses strong opinions of her own prior to finding out those of the individual concerned, or a housebound elderly parent. It is not sufficient to know the person well or to love them deeply; the role of the advocate is to support the person's active involvement with the SAR processes.

18. If the local authority decides that they are required to appoint an independent advocate as the person does not have friends or family who can facilitate their involvement, the local authority should usually still consult with those friends or family members when appropriate.

19. It is the local authority's decision as to whether a family member or friend can act as an appropriate person to facilitate the individual's involvement. It is the local authority's responsibility to communicate this decision to the individual's friends and family where this may have been in question and whenever appropriate. The overall aim should be for people who need advocacy to be identified and when relevant, receive consistent support as early as possible and throughout the SAR process.

20. The local authority may be carrying out a SAR relating to two people in the same household. If both people agree to have the same advocate, and if the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent the two people. If any of the people involved in the review consider that it would be better to have different advocates, then separate advocates should be provided.

WHO CAN ACT AS AN ADVOCATE?

21. Advocates must have:

- a *suitable level of experience:* this may, for example, be in advocacy or in working with those groups of people who may have substantial difficulty in engaging with statutory processes.

- *appropriate training:* this may, for example, initially be training in advocacy or dementia, or working with people with learning disabilities. Once appointed, all independent advocates should be expected to work towards the National Qualification in Independent Advocacy (level 3) within a year of being appointed, and to achieve it in a reasonable amount of time.

- competency in the task: this will require the advocacy organisation assuring itself that the advocates who work for it are all competent and have regular training and assessments.
- integrity and good character: this might be assessed through: interview and selection processes; seeking and scrutinising references prior to employment and on-going DBS checks.

- the ability to work independently of the local authority: this would include the ability to make a judgement about what a person is communicating and what is in a person's best interests, as opposed to in a local authority's best interests, and to act accordingly to represent this.

- arrangements for regular supervision: this will require that the person meets regularly and sufficiently frequently with a person with a good understanding of independent advocacy who is able to guide their practice and develop their competence.

22. The advocate must not be working for the local authority, or for an organisation that is commissioned to carry out assessments, care and support plans or reviews for the local authority. Nor can an advocate be appointed if they are providing care or treatment to the individual in a professional or a paid capacity.

THE ROLE OF THE INDEPENDENT ADVOCATE

23. Advocates will decide the best way of supporting and representing the person they are advocating for, always with regard to the wellbeing and interest (including their views, beliefs and wishes) of the person concerned.

24. In addition, where practicable, they are expected to meet the person in private. Where a person has capacity, the advocate should ask their consent to look at their records and to talk to their family, friends, paid carers and others who can provide information about their needs and wishes, their beliefs and values. Where a person does not have capacity to decide whether an advocate should look at their notes or talk to their family and friends, then the Care Act requires the advocate to consult both the records and the family and others, but consulting the family and others only where the advocate considers this is appropriate and in the person's best interests. The Care Act allows advocates ability to access and to copy records where the person is unable to decide whether to give ability themselves. This mirrors the powers of an Independent Mental Capacity Advocate.

25. Acting as an advocate for a person who has substantial difficulty in engaging with a SAR is a responsible position. It includes:

    - Assisting a person to understand the SAR process. This requires advocates to understand the SAR policy and toolkit. It may involve advocates spending considerable time with the individual, considering their communications needs, their wishes and feelings and their life story, and using all this to assist the person to be involved and where possible to make decisions.

    - Assisting a person to communicate their views, wishes and feelings to those involved in the review.

APPENDIX 6 - SAR REPORT QUALITY ASSURANCE

1. The main function of a SAR report is to make accessible the SAR analysis, in order that it can support necessary improvement work. Descriptions of practice problems are not therefore sufficient. Instead the findings/recommendations need to reflect the explanations of professional practice that the analysis has identified, if learning and improvements are to result. These need to be easily identifiable to others can use them, Making the working out process transparent and helping in evidencing the findings so their validity does not need to be taken on trust.

Empowerment

- Family have been invited to contribute to the review
- Professionals have been fully involved in the review
- Adults in the case have been supported to participate in the review (including use of advocacy)

Prevention

- Recommendations/ actions are included that will assist in preventing a reoccurence
- The report does not include detail that is not relevant to the the learning

Proportionality

- The report provides recomendations and actions that are proportionate to the reviews findings
- The report adequately manages accessibility and explains complex professional and organisational issues

Protection

- The report balances the need for individual confidentiality with providing sufficient information to understand the rationale for recomendations/actions
- The report is adequately anonimised to ensure the protection of those involved

Partnership

- Contain findings of practical value to organisations and professionals
- Includes evidence of participation in review by all relevant partners involved with the case

Accountability

- The structure of the report makes it straightforward to identify relevant analysis and findings
- The repoirt is written inm plain English and in a way that can be easily understood by professionals and the public alike