

AN ESSENTIAL GUIDE FOR SAFEGUARDING ADULT BOARD CHAIRS

Fiona Bateman and Siân Walker-McAllister

May 2025

Essential Guide for Safeguarding Adult Board Chairs

Table of Contents

Part 1: Purpose of this guide _____ 2

Part 2: Status of the SAB _____ 3

Part 3: Governance of Core Functions_____ 4

Part 4: Members accountability according to roles and responsibilities_____ 7

Part 5: Undertaking functions: commissioning work and decision making_____ 11

Part 6: Evidencing Impact of SAB activity through audit and quality assurance _____ 18

Part 1: Purpose of this guide

The Care Act 2014[1] made the establishment of a Safeguarding Adults Board (SAB) a requirement; however, in the intervening years how each Board carries out their statutory functions has been a matter for local decision making. The guide is intended to support SAB Chairs to undertake their leadership role in a way that advances opportunities for transformative system change and practice improvement. It offers guidance on tackling some of the legal complexities that arise in this area. It is not intended to provide formal legal advice, but in drafting, it has considered the Care and Support Statutory Guidance and legal advice made available to the National Safeguarding Adult Chair's Network [NSCN].

As the nature of a Safeguarding Adults Board is collaborative, SAB Chairs may wish to share this with their partners and with those who have delegated responsibility for undertaking some tasks linked to SAB functions. This document is not intended to bind decisions made by any Chair or SAB, simply to aid discussions and encourage consistency within decision making that supports accountability and transparency. Therefore, it would be prudent to secure agreement from key statutory partners and, wherever possible, more widely across the partnership to the positions set out in this document.

We have included 'Top Tips' for SAB Chairs, Scrutineers and reviewers to consider throughout the document. There are also links to other resources or websites for further skill and knowledge development. Whilst every effort has been made within this guide to summarise current best practice, drawing on the experience of Chairs across the NSCN, please bear in mind that developments in case law, policy and best practice may supersede this advice as reviewed in March 2025.

Originally, the first version of this guide, was intended to consider some of the complexities arising from the commissioning and publication of Safeguarding Adults Reviews [SARs]. However, following discussions at the NSCN it has grown into a summary of several legal issues, quality assurance and impact analysis of a SAB's activities.

It also reflects the issues and concerns raised by experts by experience and families involved in SARs and identifies issues that Chairs and SABs should consider for maintaining transparency for decision making and when championing accountability for practice improvement. Version 2 of this guide is commissioned through the National SAB Chairs Network. The LGA/ ADASS PCH programme will suggest that this is included in any newly appointed SAB Chair's induction materials.

[1] https://www.legislation.gov.uk/ukpga/2014/23/schedule/2/enacted

Part 2: Status of the SAB

Local authorities are required by the Care Act 2014 to 'establish a SAB'; they have powers to do so as:

- a sub-committee of the Council, or
- A Company (probably a Community Interest Company)
- A Limited Liability Partnership
- An unincorporated partnership or association - i.e. an organisation set up through an agreement between a group of people who come together for a common purpose other than to make a profit. In a SAB's case this is to '*help and protect adults in its area in cases … by co-ordinating and ensuring the effectiveness of what each of its members does*.'
- Some other legal entity (e.g., a Co-op or mutual)

Schedule 2 Care Act and the Care and Support Statutory Guidance[2] defines the powers that are required for SABs but does not specify the legal status that must be chosen. The legal nature of each SAB should be set out within the governing documents (usually a Constitution, Memoranda of Understanding or Terms of Reference) and care should be taken to ensure the status chosen provides the relevant authority for the SAB to undertake its functions.

SABs have three statutory core duties, namely:

- in cooperation with its community, publish a strategic plan for each financial year,
- conduct any safeguarding adult reviews in accordance with s44 Care Act
- publish an annual report detailing how the SAB has achieved its strategic priorities and what each member has done to implement the strategy and findings for any safeguarding adults reviews.

The Governing documents should set out clearly how these statutory functions will be delivered, including clarifying any substructure and reporting requirements of the SAB. The Care and Support Statutory guidance is explicit that each member of a SAB has a responsibility to ensure their own organisation is informed of the work of Board and detail each year what actions have been taken to improve practice[3]; to be clear about how they will contribute the financial and human resources of their organisation to both preventing and responding to abuse and neglect; and highlight through their organisation's governance arrangements, any risks associated with that organisation not meeting its statutory responsibility in relation to safeguarding adults. As such, SAB governing documents should specify the processes for monitoring SAB activity, demonstrating robustly the impact of the SAB and identifying mitigation action (and by whom) if there are risks that core tasks cannot be completed within available resource. This is addressed in more detail within Part 3.

SABs established as unincorporated associations should note that it may prove difficult for a SAB to enter into a contract (e.g. for insurance or to directly commission external expertise to provide training or conduct audits or reviews) as, technically, it is not a separate legal entity. The general view is that, where a SAB has been set up as an unincorporated association, the local authority (as lead agency under s43 Care Act) should facilitate the operational practice of the SAB. However, the Care and Support Statutory Guidance explicitly permits any member to assist. [14.142]

[2] The Care and Support Guidance was issued, in line with powers under s7 of the Local Authority Social Services Act 1970, as statutory guidance which means it is intended to guide professional practice and binds local authorities unless they can demonstrate cogent reasons for not following it.

[3] Pg 14.136 Care and Support Guidance

***Top tip**: Newly appointed SAB Chairs or scrutineers should familiarise themselves with the local governance arrangements as part of understanding the safeguarding landscape. Equally, it will be important to understand the geography and demographics of the local area, key issues and existing initiatives and strategic priorities for SAB member organisations to ensure the SAB has appropriate resource and skilled membership to fulfil the statutory functions. Therefore, any new Chair/ Scrutineer's induction should fund sufficient time for those taking on the role to meet with a wide group of stakeholders, including local Councillors, senior leaders across statutory, provider and third sector organisations and people with managerial responsibility for strategic and operational delivery of harm reduction, e.g. in the context of domestic abuse this would be the Chair of the local Community Safety Partnership, Children's Safeguarding Partnership Chair or Scrutineer, Violence against Women and Girls Board, Chair of MARAC and the provider of local Independent Domestic Abuse Advocacy.*

Part 3: Governance of Core Functions

Over time, as SABs have become more established, the focus of activity has developed reflecting the accumulation of data (quantitative and qualitative) for local population needs and national policy and practice development. However, the overarching purpose of a SAB remains directed to prevent abuse and neglect and to safeguard adults with care and support needs locally. It does this by:

- analysing data on safeguarding concerns to build up an understanding of prevalence of abuse and neglect locally
- reviewing local safeguarding arrangements and developing mechanisms to hold partners to account and gain assurance that systems are effective, including by carrying out Safeguarding Adults Reviews, multi-agency audits, surveys and reflective learning events
- working collaboratively to develop strategies to prevent abuse and neglect
- raising awareness, including through the publication of their annual report and strategic plan, of risks to adults with care and support needs in their area
- developing policies and guidance for protecting adults which are shaped by partners and including the views of adults with care and support needs, their families, advocates and carer representatives
- assuring itself that multi-agency training or policy development has improved safeguarding practice and is improving and enhancing the quality of life of adults in its area[4].

These functions require SAB members to collectively undertake and be accountable for tasks for which it must have sufficient resource. The SAB governing documents should detail the expectations of each member for ensuring SAB functions are met, but also how each member is supported in respect of liability for decisions, actions and inaction associated with those tasks.

Funding arrangements

The Care and Support Statutory guidance advocates for local decision regarding how SABs will be funded, specifying that all members of a SAB are expected to consider what assistance they can provide, including through payment as '*it is in all core partners' interests to have an effective SAB that is resourced adequately to carry out its functions*'.[5] The statutory duty for local authority, NHS integrated care board [ICB] and chief officer of the police to be represented on the SAB establishes the shared ownership across agencies'

[4] Summary of the core functions set out in pg14.139 Care and Support Guidance
[5] Pg 14.142 Care and Support Guidance

responsibility for health, criminal justice, social care, housing, public health and education services.

Given this parity of responsibility, the governing documents should equally specify how each statutory partner will resource activities. Likewise, the wider member organisations should, through the governing document, understand how they will be expected to contribute (including financially) to resource statutory tasks the SAB undertakes on behalf of its partners. Various arrangements exist across the country, but each SAB should submit a budget report within the SAB's Annual Report. Governing documents should also specify how decision making regarding the viability of existing resources will be reviewed. This should be considered, at the very least, at Executive level within the SAB on an annual basis to ensure there are sufficient resources to meet statutory duties. This will include activities identified by partners within the SAB's strategic plan as well as those required to implement the recommendations from local Safeguarding Adult Reviews [SARs]. Where there is insufficient funding to properly resource SAB activities, including covering the costs of SARs, separate funding arrangements to complete SAR activity should be made explicit in terms of the contribution requirement from partner agencies. There should also be mechanisms to report, as an organisational risk, inability to resource SAB statutory functions to all member organisations, but specifically to the three statutory core partners and agreement that any insufficient resource to meet statutory duties will be reported to the Local Authority Chief Executive and the NSCN. The Governing documents should empower the Chair to secure a response to such escalations from relevant Chief Officers within member organisations.

Responding to risks, complaints, legal challenges, press and reputational risks.
Given the nature of safeguarding adults at risk and the functions of the SAB, careful thought should be given (within any governing document) to the role of the three statutory safeguarding partners and the SAB Chair in managing risks that the statutory functions are not met. Many SABs have risk management policies and registers so that there is a shared understanding across partners of issues and means to manage, mitigate and/or reduce risk.

SABs must also have policies and processes for resolving complaints about the SAB functions. We advise that the governing documents and the Independent SAB Chair's contract of engagement should be explicit that the Chair's role is confined to complaints, mediation of professional or inter-agency disputes and escalations which relate to SAB functions only. This should similarly be set out in any SAB's Complaints, Dispute Resolution and Escalation Policies. It is advisable to clearly state that if a complaint relates to how, operationally, a service or function was provided by a partner agency in line with their statutory obligations (e.g. how a s42 enquiry was conducted) that it would be for the relevant agency to respond through their own organisation's complaints process and thereafter to the relevant ombudsman or independent regulatory body (e.g. Local Government and Social Care Ombudsman (LGO), Parliamentary and Health Service Ombudsman or the Independent Office for Police Conduct).

Examples of SAB Risk registers and management policies and Complaints Policies are available to National SAB Chair Network Members on the NSCN Website.

Likewise, it is advised that the SAB governing document and Chair's contract of engagement specifies the Chair's role in resolving disputes or escalation of risk (between partners or between partners and members of the public) is as a mediator, is advisory only and that this applies only in relation to SAB functions. Any dispute resolution and escalation processes should take into account existing protocols and link in with pre-existing arrangements to protect against duplication or miscommunication.

SAB Chairs should ensure that there is clarity about the functions of the SAB, how someone can make a complaint, and who/ how any complaints about those functions will be investigated. From a public law perspective, those arrangements need to be in keeping with the law, reasonable (i.e. not so unreasonable that it might amount to an abuse of power) and fair. The LGSCO has confirmed that, as local authorities ultimately have lead responsibility for ensuring a SAB meets its statutory obligations, any complaints regarding SAB functions should be processed in accordance with the Local Authority Social Services and National Health Services Complaint (England) Regulations 2009. The LGSCO will investigate any unresolved complaint referred to them in line with their procedures. The LGSCO also publishes complaint investigation findings. It is therefore important for an Independent SAB Chair to be aware of the local authority processes, ensure close liaison with officers within the Local Authority's Complaints service and agree how the Independent SAB Chair will be involved in reviewing complaints made about SAB functions.

It will be important that any dispute or complaints protocol/ process acknowledges that adults who have experienced abuse or neglect, their families, representatives or other interested parties may be distressed by those experiences and may also require support to understand, weigh up or communicate effectively what the issues or concerns are. Consideration should be given, within any escalation or dispute resolution process or complaint policy to the availability of support for the adult at risk, including through advocacy or patient safety groups.

Case Example: Arun raised a complaint that the SAB did not complete a safeguarding adults review (under s44) following his father's death. He highlights that his father was in receipt of care and support and died whilst awaiting equipment that had been identified as necessary following an OT assessment. The equipment provider did not provide this in line with the expected timescales.

This complaint is relating to the SAB functions. The Chair will therefore need to enquire whether the matter had been considered in line with the statutory criteria and local protocols for decision making. This might include exploring if this was referred by the relevant member agency, whether the relevant organisations provided information in line with s45 Care Act to enable the SAB (or subgroup if this is delegated under the SAB's governing documents) to scope if the s44 criteria were met. As part of any process, all relevant parties (including Arun) should be consulted, informed of the outcome of the complaint and the next steps if they are dissatisfied with the outcome.

Access for SABs to appropriate legal and peer support:
The NSCN is a nationally recognised body representing SAB Chairs and Scrutineers; it holds the National SAR Library and a plethora of documents which will be supportive to SAB Chairs/ Scrutineers. The NSCN acts as a source of peer support, advice, guidance and induction support for SAB Chairs, individually and collectively about specific SAB related issues e.g. the interface with DWP, Coroners, working alongside strategic housing colleagues on the homlesssness prevention agenda; working with Prisons and in many other areas. It also coordinates Regional SAB Chairs' Networks. Active participation in the national and regional networks benefits local SABs by providing clarity on expected standards and access to best practice solutions. It also enables effective means to respond collectively to proposed legislative changes, promoting learning from SAB assurance and review activity.

In addition to advocating active participation by the Chair or Scrutineer in the NSCN, the SAB governance document and contract with the Independent SAB Chair or Scrutineer should make provision for the SAB to have access to legal advice. In the main, it may be acceptable for the local authority or another partner agency to provide access to their legal

resources. It is advisable to plan for the SAB, through their Independent SAB Chair, to have access to independent legal advice where there is a risk of a conflict of interest between a lawyer employed by a partner agency and the SAB. The Solicitors' Code of Conduct permits solicitors to act where there is a risk of client conflict only if the clients have substantial common interests and the solicitor has explained the relevant issues to the client, all clients have understood and given their informed consent in writing and the solicitor is satisfied that the benefits of acting for both clients outweighs the risks. Ultimately this is for the solicitor to assess and not the LA Chief Executive, Director of Adult Social Services (DASS) or Independent SAB Chair, so this will need to be taken into account.

Some SABs cover cross border local authority arrangements e.g. Cornwall & Isles of Scilly, Richmond & Wandsworth or separate Boards but where they hold all meetings together such as Dorset & Bournemouth Christchurch and Poole. In such cases it is feasible for cross border local authority arrangements to be considered.

It should also be made clear that, where legal proceedings are anticipated, the local authority, as lead agency[6] will assume responsibility either as Applicant or Respondent in any proceedings. This is important because there is legal precedent for a Local Safeguarding Children Board having acted as Respondent, though it would appear that the legal status of the Board was not directly considered in *Deeqa Mohamed v Islington LSCB* [2015][7].

Chairs and Scrutineers' terms of engagement should make clear, if proceedings are initiated naming the Independent SAB Chair or Scrutineer as a Respondent, the Local Authority (or the partner agency who has commissioned them) will undertake to make arrangements and pay for any legal representation and/or costs associated with the legal action. A caveat to that may apply if the SAB Chair or Scrutineer has acted in breach of their contractual terms or the statutory functions of the SAB. Similarly, consideration should be given to including assurances to the SAB Chair or Scrutineer that, if as a result of the role, they experience threatening or abusive communications, legal advice and, where necessary, representation will be provided to secure proportionate, protective legal remedies.

Part 4: Members accountability according to roles and responsibilities

Currently the Care and Support Statutory guidance advocates for SABs to appoint an Independent Chair, though in some areas SAB partners have elected to have statutory partners chair the SAB and provide additional leadership or independent assurance by appointing a scrutineer.

Role of an Independent Chair

Where a SAB has appointed an Independent Chair, there is still an expectation for SAB members to deliver (for their own organisation) against their safeguarding responsibilities. Chairs are expected to work collaboratively with SAB members (across statutory, provider and third sector organisations), and partnerships as system leaders. This requires safeguarding leadership literacy[8] utilising their authority of position derived from their knowledge, skills and values.

The Chair is accountable to the Local Authority Chief Executive (as lead statutory agency) but should be appointed by statutory partners. The Chief Executive may delegate

[6] S.43 Care Act 2014

[7] *Deeqa Mohamed v Islington LSCB* [2015] available at: https://www.bailii.org/ew/cases/EWCA/Civ/2015/1162.html

[8] 'Adi Cooper & Michael Preston-Shoot, (2025) 'Independent Chairs of Safeguarding Adults Boards: system leadership in practice' in Robin Miller, Catherine Mangan, Helen Dickenson & Caroline Jackson, Eds. Research Handbook on Leadership in Social Care and Social Work, Elgar. Publication date September 2025. This lists a range of literacies, such as organisational, relational, ethical, historical, futures and legal literacy, acquired as a continuous process which enables transformational leadership.

accountability to another corporate director e.g. Director with responsibility for adult social care [DASS]. It is advisable for the SAB Chair to meet with the DASS, if this is the case, on a regular basis and provide assurance at a face-to-face meeting at least annually with the Chief Executive and Council Leader or lead member for adult safeguarding. The Chair should also have similar arrangements to meet with the ICB Chief Executive and Chief Constable and/or Crime and Policing Commissioner at least on an annual basis, given their status within the Care Act as statutory core safeguarding partners. This would also demonstrate partial adherence to the duty to submit the annual report (detailed at 14.160 of the Care and Support Guidance).

The SAB Chair '*has a critical role to lead collaboratively, give advice, support and encouragement but also to offer constructive challenge and hold main partner agencies to account and ensure that interfaces with other strategic functions are effective whilst also acting as a spokesperson for the SAB*.'[9] This includes providing critical challenge in respect of subgroup activities and decisions. To support their function to provide critical challenge, SAB chairs may find it beneficial to engage with the statutory monitoring officer's role[10] as part of any escalation protocol.

The Chair should also have clarity, within their contract, on statutory partners' expectations and time allocation to undertake tasks, including attending meetings with relevant national and locally bodies and partnerships (e.g. locally with Healthwatch, Health and Wellbeing Board, Local Safeguarding Children Partnership or Community Safety Partnership) to further the aims of the SAB, establish shared priorities, disseminate learning and raise awareness of best practice/ policy guidance.

Role of an Independent Scrutineer

Where a scrutineer has been appointed, the SAB governing documents should clarify how decisions will be made by the membership including: areas of focus for scrutiny, the key lines of enquiries of any 'deep dive' and methodology used and how this will be resourced. They may also wish to reference how those priorities/ areas for review were identified, e.g. if this was in response to national briefings (such as National SAR analysis' recommendations).

SAB partners should also make clear within any Scrutineer's contract of engagement, the roles and responsibilities of that position. In practice, the role of a Scrutineer may be time and issue specific (as it is for independent reviewers commissioned to undertake a SAR), as such s45 Care Act powers to require information, held by the SAB, may not be extended directly to the Scrutineer unless this is specified within the contract of engagement and/or terms of reference. Therefore, these documents should specify arrangements for information sharing by partners and relevant individuals or organisations, and how experts by experience and interested parties, practitioners and senior managers will be engaged with the work of the Scrutineer. Similarly, the terms of reference and/ or contract of engagement should specify time/ resources allocated to the Scrutineers and accountability issues for reviewing, ratifying findings and taking forward the Scrutineer's recommendations. Given that Independent Scrutineers commissioned for bespoke projects may not have as much scope to develop relational practice with member organisations and the statutory safeguarding partners, the terms of reference should also detail how any disputes regarding findings or recommendations will be resolved and how the Scrutineer should report matters of concern regarding safeguarding practice that fall outside the terms of reference.

***Top Tip**: Within any report, Scrutineers should set out the context of the issues evaluated including limitations imposed by the methodology or engagement of parties. Any report could*

[9] Pg 14.150 Care and Support Guidance

[10] https://assets.publishing.service.gov.uk/media/5f50fc19e90e071ec4e84562/Annex_2_-_Statutory_officers.pdf

also comment on SAB member organisations' responses to the findings and what, if any, actions those agencies had agreed to take to improve practice or address findings.

Responsibilities of Scrutineers and Chairs
Due to the nature of the role, an Independent SAB Chair or Scrutineer or Person commissioned to undertake work on behalf of the SAB (as persons/ legal entities carrying out public functions) should have appropriate public liability and professional indemnity insurance as part of their contract/agreement to provide their services. More information about Insurance Providers is available on the NSCN website.

Both Scrutineers and Independent Chairs have personal responsibility to ensure they' *keep up to date with, and promote, good practice, developments in case law and research and any other relevant material'.* To support this, there are learning and development offers available from SCIE and the LGA/ADASS Partners in Care and Health (PCH). Membership of the National SAB Chair's Network [NSCN] enables SAB Chairs/ Scrutineers to provide evidence of their ongoing professional development and learning as required by the Care Act Statutory guidance (paragraph 14.150). The LGA and ADASS support and regularly consults with NCSN. The NCSN also regularly consults with safeguarding and policy leads from the Department for Health & Social Care, Home Office and Ministry of Justice. There are now established mechanisms for escalating issues of national learning or policy development, as such the NSCN provides essential opportunities for SAB Chairs to share new learning from case law, research, national briefings and safeguarding adult reviews.

It is therefore important that SAB Chairs actively participate in the NSCN, and its regional networks as part of ongoing professional development, and for them to be supported to do so by their SAB through agreement that attendance at meetings is part of the Chair's paid role. Active engagement within these networks, including through contributing expertise to policy development and dissemination of best practice, should be viewed as an essential activity for SAB Chairs and Scrutineers as this enables learning from local reviews and assurance activity to have impact nationally and across the safeguarding system.

Role and Responsibilities of the SAB Business Unit/ Manager
Equally important to the role of Independent Chair or Scrutineer is detailing how day to day management of the SAB work will be completed. Most SABs have dedicated SAB Board Managers, others have additional resource to ensure there is sufficient expertise and resource to undertake SAB activity such as multi-agency case audits, data analysis, policy development and public awareness communication. Again, within the SAB governing documents there should be clarity on how the three statutory partners will oversee responsibility for support to SAB business managers and/or staff within the unit. Particular consideration should be given to ensuring SAB business managers have opportunities for supervision, training pertinent to the role and dedicated time to build relationships with senior leaders across the statutory, provider and third sector organisations. Equally, SAB Chairs should secure opportunities for regular 1:1 meetings with their Business Unit / Manager to ensure effective communication. Business Managers should also be encouraged to participate in the national SAB board managers network.

The SAB governing document should be clear on the powers of the SAB (through their business support) to request information in line with s45 Care Act powers. It should also empower SAB business managers/ units (in conjunction with the Chair/ Scrutineer) to offer constructive challenge, to escalate where appropriate and to hold partners to account. Given this role, careful consideration should be given to appropriate line management and contingencies if real or perceived conflicts of interest arise.

There are various models of the SAB business unit from the single business manager to corporate functions that work across adult and children's partnerships. SAB Chairs, together

with members should continually assess whether it has the right skills and capacity needed and budget commensurate for the intended board's activity, as this will likely impact on how effectively the SAB operates and the degree to which the Chair/ Scrutineer or key statutory partners must 'lean-in' to achieve the shared strategic objectives.

***Top tip**: In line with the NSCN priorities, make it a priority for the Chair and Board Manager to engage with people and organisations that represent marginalised groups and that offer insights outside of your own area of expertise to understand the breadth of safeguarding matters that will inform your independent view. Resident/co-production groups, local councillors and voluntary sector groups can help to add to your local knowledge.*

Role and Responsibilities of Board membership

The Care and Support Statutory guidance advocates that membership is drawn widely from relevant organisations and individuals given SABs have a '*strategic role that is greater than the sum of the operational duties of the core partners*.'[11] Again, governing documents should require all members of the SAB to have the requisite skills and experience to effectively and efficiently safeguard adults in its area.

Those members who attend in a professional or managerial capacity are expected[12] to be able to commit their organisation to agreed actions. This is particularly important in the context of setting the SAB's strategic priorities, supporting the completion of the work plan, ratifying findings and implementing lessons from SARs. The SAB governing documents should confirm the expectation is on member organisations to provide suitably authorised representation. It is important that member organisations understand their responsibility for underwriting the decision making of their representative, so any professional or managerial liability for decisions on SAB functions forms part of their employment activities. As such it should be understood that they will have access to appropriate managerial, professional indemnity insurance and legal advice or representation if issues of liability arise in respect of involvement with SARs or other SAB activity.

Given the nature of risk and the duty to promote wellbeing across the population, it is important for the SAB Chair to work closely with the Director for Public Health in their area to ensure that strategies for public health also consider the duties to safeguard adults with care and support. Developing strong links will reduce risks of duplication and enable system-wide oversight and governance of shared priorities.

Case example: One SAB identified a 'cluster' of suicides amongst a vulnerable group through SAR referrals. The SAB engaged with the Director of Public Health in respect of their duty to identify learning from suicide clusters. The SAB then agreed to provide governance over the outcome of the Public Health review and a protocol was agreed by the SAB and Public Health for future joint working.

***Top tip**: Newly appointed chairs should schedule meetings with each member agency and key stakeholders. Spend time listening and trying to understand the things that are important to them, why it is and their view of how the partnership is working. Building strong relationships based on an informed understanding of the partner's opportunities and challenges will help you navigate the different perspectives and think through how best to foster collaboration and exercise your soft power. It will also help you identify members whom you think have the time and skills to lead programmes of work and/or chair subgroups.*

[11] Pg.14.133 Care and Support Guidance
[12] Pg 14.149 Care and support Guidance

Working with Experts by Experience, lay members and members of the public
In line with NSCN's strategic priorities, many SABs have explored how to strengthen input from adults who have experienced abuse, service user/ patient groups and members of the public. Specific and regular focus should be given to how each activity is shaped by the voice of adults who have lived experience of abuse and safeguarding processes. This can be achieved through a variety of methods, including appointing lay members or representatives from non-statutory organisations onto the SAB or sub-groups (such as carers and advocacy groups, service user forums or charitable umbrella organisations in the voluntary and community sector). The NSCN has reviewed definitions of lived experience, developed Top Tips for SABs on activities used across SABs nationwide and case studies. These tools are available on the NSCN's website and will continue to evolve.

Equally important will be to capture how each activity has been informed by lived experience. For example, SARs are expected (pg14.165 Care and Support Statutory guidance) to involve the adult, family and friends and will usually involve practitioners to better understand barriers and challenges to policy implementation. Ensuring that the lived experience of residents, their families, carers and advocates shape the work of the Board may be in place to varying degrees. The Board will benefit from your fresh assessment as to the degree to which the principles of making safeguarding personal are meaningfully part of its way of working

Where people engage with SABs outside of their professional or managerial role, the SAB's governing documents should (on the face of any agreement or contract of engagement) clarify they would not be liable personally for decisions/ actions taken in good faith to fulfil the statutory functions of the SAB. The contract of engagement should also specify support to enable a thorough induction into the work of the SAB, their role and expectations regarding confidentiality, data protection and information sharing.

If, in the unlikely event, the legal status of the SAB is changed by legislation, guidance or case law, it would be open to the statutory partners to offer indemnity to these members.

Part 5: Undertaking functions: commissioning work and decision making

Initially, the commissioning responsibilities arose predominantly in relation to the duty to carry out a safeguarding adults review [SAR] under s44 Care Act 2014, but there are examples of some SABs[13] commissioning independent expertise to also support with audit activity, including through peer reviews to evaluate adherence to regulatory expectations[14], multi-agency safeguarding training and to enhance community engagement particularly with respect to addressing disparities in reporting from minoritised communities.

Whatever the activity, it is important that SABs reflect that the primary purpose of all SAB activity is to collectively work together to improve practice. As with a SAR, any commissioned activity's purpose should not be to '*hold any individual or organisation to account. Other processes exist for that. … 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 … their response will be defensive, and their participation guarded and partial*.'[15] As such, the focus of quality assurance should be to identify opportunities where SAB members can collectively work more effectively together to achieve common goals to reduce risks of abuse.

[13] SABs that are established as a company, limited liability partnership or other legal entity with have legal standing to enter into contracts independently. Those without that status will need to agree commissioning arrangements are undertaken by a third party (usually one of the three statutory partners).
[14] For example, CQC or the Social Housing Regulator
[15] pg14.168-9 Care and Support guidance

Support and resources for core functions:
Two core functions of the SAB are community engagement and raising awareness both of risks within a local area and of the work of the SAB to address those risks, including those taken in response to findings from Safeguarding Adults Reviews and strategic plans to reduce risks for adults with care and support needs, e.g. suicide prevention and/or homelessness reduction strategies. It is important that the SAB strategic plan clearly sets out how partner organisations will make available resources to support these. Governance documents should also provide the detail on what will be provided to address the obligation to cover:

- an effective community engagement strategy and/or community engagement subgroup arrangements
- consultations on policies and strategies with wider interested parties, for example carer or dementia strategies.
- support to disseminate and socialise learning from safeguarding adults reviews

Part of any Independent SAB Chair's or Scrutineer's role is to provide 'constructive challenge and hold main partner agencies to account' in respect of their active engagement with shared strategic goals. Attention should be taken by SABs that any report promotes the use of clear language, free of jargon and overuse of acronyms, to improve accessibility.[16] The SAB or Chair may also require expert support to communicate the outcomes and learning from SARs to a wider population in an appropriate manner, e.g. easy read materials or via new media (e.g. accessible online platforms). Again, it should be clear within governing documents how this will be resourced by member organisations and how decisions will be made by the SAB regarding publication and communication of SAB activity. Decisions regarding publication should not, by default, fall to communication teams within any one member agency as this is for the SAB membership to take.

Where there exists a potential for multi-agency communications in respect of one SAR, and in particular in organising a Communications Statement to the wider public, it is important that the SAB Chair ensures that all agencies are engaged in a shared communications plan which ensures that the essence of the SAR and its learning is shared widely.

Commissioning SARs
The Care and Support guidance indicates it is a decision of the SAB[17], not the Independent SAB Chair, whether a case meets the criteria for a SAR. However, local arrangements may delegate this to the Independent Chair, often following detailed review of cases by a SAR or Case Review subgroup. Members of that sub-group should be empowered to make recommendations regarding relevant methodologies so these can apply local SAR policy guidance, proportionate to local needs and as recommended by the Second National SAR Analysis[18], is reflective of previous learning. Where there is disagreement or dispute, in line with the governing documents, the Independent Chair can act as mediator and put forward their recommendation, if need be, separately to the sub-group's recommendation.

Likewise, it is the SAB which adopts the recommendations and, crucially, it is for member organisations to provide assurance that they have applied lessons to future cases, s44(5). There is now considerable guidance to support SABs to undertake SARs in a collegial way to ensure the focus remains on learning, rather than attributing blame. However, as noted above, it will be important for policy documents, contract of engagement and any terms of reference to reference how the quality of the SAR will be assured and any professional dispute resolved.

[16] Ideally this would reflect the standards set out in the crystal mark, more details available at: https://www.plainenglish.co.uk
[17] S44 Care Act 2014 and pg14.162 Care and Support Guidance
[18] 'Second National Analysis of Safeguarding Adults Reviews, 2024, Partners in Care and Health. Available at: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

s44(5) Care Act clarifies that partner agencies are responsible for setting out what actions they will take as a result of any recommendation and confirming how they have monitored the implementation of any action plan and measured improvement to practice. The role of the SAB Chair will firstly be to seek agreement from partners about the actions the SAB should lead on, because '*recommendations and action plans from a SAR need to be followed through by the SAB*'[19]. Thereafter, more crucially, the Chair should be empowered through the governing documents and SAB substructure to secure assurance from partners they have completed their organisation's action plans so that partner agencies can demonstrate they have acted in line with their statutory duties under s44(5) Care Act.

Any SAR process must also comply with public law principles and be closely followed, as decisions may be subject to Judicial Review. The Care and Support Statutory guidance requires process to be determined locally, so (to reduce risk of any legal ramifications for partner organisations or the Independent SAB Chair), partner agencies are required to ensure SAB members have the requisite skills and experience[20] to carry out SAB functions or undertake SARs.[21] Where the organisation requires their representative to seek additional authorisation through internal governance, this must be set out within the terms of reference so that suitable arrangements are in place to protect against unnecessary delay or additional costs.[22] This reinforces the essential obligation for partner organisations to ensure that their representatives have authority to make decisions in respect of a SAR for that agency.

It would therefore be advisable for any SAR process to link to the main SAB governance documents, including any Complaints or Dispute Resolution policy, Information Sharing Agreement and quality assurance tools (e.g. SCIE quality markers)[23], and address:

- how and who can refer cases for consideration by the SAB and any restrictions on this e.g. for vexatious or unjustified requests.
- how information will be collated from relevant agencies to determine whether the case might meet the criteria for a SAR[24].
- the circumstances that might give rise to discretionary reviews (s44(4)).
- what the mechanisms are for linking with other reviews, investigations, coronial[25] or court proceedings[26].
- if cases are considered in the first instance by a SAB Subgroup or Panel and recommendations then made to the SAB, who chairs that group - ensuring that possible conflicts of interests will be addressed[27].
- what happens if there is a dispute between the partners and the role of the DASS and Independent SAB Chair in resolving that dispute and reaching a decision.
- how each agency represented in a SAR Panel ensures that they have the delegated authority to make decisions on behalf of that agency.

[19] 14.170 Care and Support guidance
[20] Pg14.149 Care and Support Guidance
[21] Pg14.172 Care and Support Guidance
[22] SABs may wish to include an expectation that organisations will contribute to any additional costs if they fail to comply with expectations under local SAR protocols.
[23] Available at: https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/list/
[24] This could reference powers under 45 Care Act 2014, Crime and Disorder Act 1998 and clarify that duties to protect persons from inhuman and degrading treatment (art 3, HRA) have paramountcy over the right to respect for privacy (art 8, HRA) as confirmed in *Re F*, [2000]. Any Information Sharing Agreement between partner agencies should also make explicit arrangements for the sharing of personal information without express consent, because the law provides an exceptions to the usual rule, that information cannot be shared without express consent, if it is necessary to meet a legal obligation, public task or for vital interests, including safeguarding!
[25] Coroners Annual Report is available at: www.gov.uk/government/publications/chief-coroners-annual-report-2017-to-2018
[26] Whilst other proceedings/investigation are ongoing, it is accepted that persons/organisations may be reticent to be open and the whole purpose of the review could be lost. It is prudent for terms of reference to enable reviewers/ panel or Independent Chairs to, if necessary, review and amend key lines of enquiry or timescales so as to best achieve learning. Pg. 14.174 Care and Support guidance requires consideration of how DHRs, SCRs and SARs should run in parallel, but any protocol should also provide guidance on how MAPPA reviews, Mental Health Mortality and LeDeR reviews, coronial and criminal investigations should be run alongside a SAR.
[27] For some SABs this has been resolved by asking their local Healthwatch to chair or appointing an independent person to chair and write the report.

- different methodologies for reviews, how decisions are reached on the appropriate methodology for the specific review and how this will be communicated to interested parties within the SAR.
- how the SAB will ensure appropriate involvement in the review process from organisations and professionals involved with the adult.
- how friends, family of the adult (or a surviving adult) will be encouraged to be involved in the process.
- formal procurement processes or mechanisms for appointing an independent reviewer/ author and which partner agency will be responsible for commissioning the reviewer - this is particularly important if the SAB does not have a legal personality to contract (see part 1).
- what quality assurances mechanisms will be in place to ensure the review is undertaken in line with the terms of reference and local process.
- how those involved in the case will be given opportunity to comment on the factual accuracy of the report or findings and, if disputes arise during the review process, how these will be resolved. In particular, the local process should provide guidance on responding to concerns regarding inaccurate factual analysis, alleged breaches of personal information, negligent misstatements and defamation.
- expectations regarding publication and consideration regarding onward disclosure by interested parties prior to publication.
- how the reviewer will record their expertise within the report and how they have arrived at their findings, including detailing any limitations on the how the content can inform other processes, e.g. used as expert testimony in civil proceedings.
- how individual agencies hold responsibility for providing evidence that they have implemented recommendations.

Involvement of interested parties, including the adult at risk, friends, family and representatives in the SAR process.

The Care and Support Statutory guidance advises that 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*.' It is good practice for SABs to have accessible information for families about the SAR process[28] and other mechanisms for redress if they have concerns/ complaints. The police approach to family liaison may prove a useful starting point for designing the SAB offer of support to families involved in a SAR. In addition, the Local Authority will have a duty[29] to provide advocacy to assist those who might otherwise have substantial difficulty in being involved.

Some SAB Chairs meet families as part of the decision making in respect of a SAR or consult the family on the terms of reference and scope of the SAR. This may take place prior to agreeing a SAR in some cases or with the SAR reviewer/ author. SABs should consider how this is phrased within the contract for the reviewer and whether the reviewer should meet the family alone or whether it would be helpful for all if support can be provided to take notes of the meeting. It will also be sensible to provide office-based contact numbers for families throughout their experience of the SAR process and it is recommended that the Board generic email address and telephone is used by Independent SAB Chairs and Reviewers.[30] Additionally it is helpful if SABs provide families with an information leaflet about the conduct of SARs and specifically setting out that SARs are designed in statute to enable agencies to reflect on learning.

[28] Greenwich SAB has an example at: https://www.greenwichsafeguardingadults.org.uk/wp-content/uploads/2019/07/SAR-leaflet-for-families.pdf

[29] s68 Care Act 2014

[30] Independent Chairs and Reviewers should consider accidental disclosure of personal contact information through social media or publicly available sources, e.g. Companies House.

When reporting findings and recommendations to interested parties whilst a SAR report is in draft form, i.e. before these are formally accepted by the SAB and partner agencies, the information should still be considered confidential until decisions are made to publish more widely. It will be important to consider if there is a foreseeable risk that disclosure of information could give rise to adverse press interest or reputational damage to a partner agency, SAB member or any individual. It is always helpful for reviewers to explain to any interested party the need for confidentiality until the report's findings and recommendations have been accepted. Some SABs consider including the family views after they have had the opportunity to consider the final draft report, and this can be published alongside the report.

Instructing/ Recruiting Independent Reviewers

It is strongly advised that SABs have formal procurement processes in place for appointing an independent reviewer. Where the legal status of the SAB limits its ability to commission, the governance document should address which partner agency will be responsible for commissioning the reviewer. Where this isn't otherwise specified it is likely to be the Local Authority as lead agency under s43 Care Act 2014. Any formal procurement process and contract with the independent reviewer should make reference to the SAR quality markers, and also to the practice guidance issued by the National Panel in respect of Child Safeguarding Practice Reviews. These have been developed to support improvements in quality and consistency with the purpose of a SAR. Independent Reviewers must also ensure, (in line with Chair and Scrutineer's responsibilities detailed above), that they remain up to date with legislative changes, research findings and caselaw so that their reports reflect and build on national learning and best practice. Reviewers should utilise the SAR library, as well as local sources of data and information to provide context. They should also address issues identified within the National SAR analysis reports pertinent to their work, including ensuring that they have accurately presented key information, including with respect to the protected characteristics of the subject of any review, previous learning undertaken by partners and why they believe events occurred, including with reference to the national and local political context where this is relevant.

A SAR Reviewer Peer Network exists, to support SAR authors and aims to improve quality of SARs. The NSCN also helpfully supports SABs by circulating information about requests for SAR reviewers. As with any public sector commission, care should be taken to review references and ensure the reviewer has suitable expertise and insurance to complete the task.

Case Example – A SAR Reviewer instructed because of their expertise in a specialist issue did not, however, have expertise in another area. The SAB agreed to commission that expertise separately and it was referred to within the SAR.

In line with the findings of the SAR national analysis[31], the terms of reference should require a reviewer to review previously published SARs relevant to the issues, to build on previous findings and avoid duplication.

Care should be taken by reviewers to ensure language does not convey civil or criminal liability as this is not the purpose of the review. The Court of Appeal addresses this directly in the Deeqa Mohamed case[32] in respect of the statutory obligation to undertake a serious case review following the death of a child. For example, where as a result of findings from a Safeguarding Adults Review, there could be a perceived conflict of interest between one or more partner agencies and the SAB or if the Independent SAB Chair is at risk of adverse reputational or vexatious/ aggressive communications from members of the public or press.

[31] Available at: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023
[32] *Deeqa Mohamed v Islington LSCB* [2015] available at: https://www.bailii.org/ew/cases/EWCA/Civ/2015/1162.html

In such examples, the statutory partners should provide organisational support to SAB members (including the Chair or Scrutineer) including public relations expertise and legal advice on protective measures if necessary.

Care should also be taken to ensure that SARs are written in plain English, that they include a glossary of terms and translate all acronyms so that the document is accessible to everyone.

Any terms of reference or contract of engagement could also require a SAR reviewer to report information to the Independent SAB Chair where it appears the facts could give rise to liability issues, namely:

- civil liability, including negligence by a public body
- criminal liability
- regulatory enforcement issues
- employment law issues in respect of a particular person or organisation.

A SAR may, however, reveal a set of circumstances which were previously unknown and cause the police to consider criminal offences, including misconduct in public office proceedings; or consideration of a referral of someone in a regulated profession to their regulator due to conduct revealed as part of SAR. Any terms of reference or contract of engagement with a reviewer should therefore make clear that where, in the course of a review, it appears to the reviewer that an individual or agency has acted in a manner that is in breach of professional standards such to give rise to civil or criminal liability, this should be reported to the Independent SAB Chair and responsible partner agency/ Police for action. Family/ representatives of an adult at risk subject to a s44 review should be signposted to the relevant legal process/ professional body if they have concerns.

Crucially, an independent reviewer is responsible for ensuring their findings are evidenced based and that the report is written in an accessible style. The SAB as commissioner of the report, if it is not satisfied that the report meets the expected outcomes as set out in the Terms of Reference, will decide whether to ratify and publish the report. Some SABs have published alongside reports an appendix setting out any differing views or actions taken to address areas that remain in dispute.

Issues of Onward disclosure

Local SAR processes ought to make clear that, whilst not the primary purpose of a review, information collated during the SAR process may be disclosed, if so requested, as part of civil or criminal proceedings. Normally, requests for disclosure of preliminary reports (such as individual partner agencies' internal management overview reports) will be directed to the relevant agency to respond to as this is not 'owned' by the SAB. However, given the circumstances that give rise to a duty to undertake a SAR and the obligation on Coroners to hold an 'enhanced inquest' where there are concerns that statutory partners or 'its agents' have 'failed to protect the deceased against a human threat or other risk' local SAR processes could also highlight duties for partner agencies to provide full disclosure to the Coroner.

It is a criminal offence to do anything that is intended, or is likely, to have the effect of distorting, altering or preventing any evidence or document that is given for the purposes of a coroner's investigation. Including intentionally suppressing, concealing, altering or destroying a relevant document. A document is relevant if it is likely that a Coroner conducting an investigation would, if aware of its existence, wish to be provided with it. The Coroner has the power to issue Witness Summons, meaning it is a Contempt of Court if a witness does not attend. Where there is concern that disclosure of a draft report may undermine the purpose of the review, local processes should make reference to the NSCN

and SAB Manager's Network best practice guidance on the interface with Coroners. This guidance will have the greatest impact if SAB Managers and Chairs have taken time to discuss local needs with their Coroner.

As noted above, as reviewers and chairs may be legally required to attend to give evidence, it would be important for any contract of engagement to set out what arrangements are in place for Independent SAB Chairs and reviewers to seek legal advice (taking into account information in part 3 of this document) or make representations to the Coroner requesting consideration of withholding full disclosure of draft materials to interested parties until completion or publication of the SAR report. The SAB Chair will not be responsible for disclosing reports prepared by organisations regarding their own internal investigations into the circumstances that gave rise to a SAR and, where these are requested, the Coroner should be provided with contact details of the relevant person from that agency to request this information directly.

The SAB could also set out expectations in respect of publication at the same time as it considers approval of a SAR. Any terms of reference or contract with an independent reviewer also needs to be clear that the reviewer understands the onus is on them to only comment on areas within their expertise and that they should only make assertions if they can justify, on the relevant burden of proof, their findings. It might be prudent to make it explicit that a reviewer may be personally liable if their report contains libellous material and that any third-party information has been verified or the third party given a right to comment. The reviewer could also be required to give assurances that, where a report could identify a living person, duties under the Data Protection Act (DPA) have been given very careful consideration.

Any contract should also make clear that whilst Reviewers can use published materials freely, they should seek agreement from the SAB before disseminating information from unpublished reports (either within research papers or for any other means).

Holding and processing data

A core function of the SAB is to analyse data from a multi-agency perspective to secure assurance about the effectiveness of adult safeguarding. It is therefore important that the SAB has a robust Information Sharing Agreement that sets out partner agencies' responsibilities for processing data and personal information in a way that enables the SAB to conduct multi-agency audits or collate information to enable a SAR.

Under the Data Protection Act 2018 ['DPA'] Section 6 adopts the definition in Article 4(7) of the General Data Protection Regulations ['GDPR'] as the definition of data controller. In Article 4(7) data controller is defined as the '*natural or legal person, public authority, agency or other body which alone or jointly with others determines the purposes and means of processing the personal data.*' 'Person' is not defined in the Data Protection Act 2018 (DPA). Public authority is also defined, and a SAB is not a public authority for the purposes of FOI so is not likely to be a public authority for the purposes of the DPA.

As a SAB is not a 'public body' for the purposes of a request for information under the Freedom of Information Act 2000, as such any request for information relating to SAB functions would likely be processed by the Local Authority as lead agency. That said, it will often be the SAB's Manager/ support team who can most easily respond to FOI requests or requests from the judiciary or parties to proceedings for disclosure of information relating to SARs or multi-agency audits and other quality assurance work of the SAB.

It would also be prudent for SABs to directly address how it will store information, what will be published and how it will make those decisions (and resolve disputes) within its governance documents. These should address issues of retention and disposal of relevant

materials, including SAR reports. It is open to any of the members to offer to host a SAB and make available resources[33], so it isn't necessary for the Local Authority to undertake this role, if another partner is willing and able. In the absence of another willing host, the local authority, as the agency responsible for establishing the SAB, may take the view that it would be prudent for all personal data to be processed in line with their information governance arrangements and seek confirmation (through contract with Independent Chairs, Scrutineers and Reviewers) that they will adhere to those standards.

Whilst it is generally accepted that ownership of the SAR report remains with the SAB, any restrictions imposed on Independent Reviewers will need to consider the matter of intellectual property rights. Contract of engagement with Reviewers should require the reviewer to cite references for any open-source information. It should also be made clear that reviewers should not assign comments to specific individuals as this may undermine the overarching purpose of the review. The contract of engagement may also specify any restrictions on how a reviewer can use information, including those disclosed for the purpose of the review, prior to wider publication and, if the full report is not published, but the reviewer or interested party wishes to reference findings in future activity (for instance because this demonstrates an issue of regional or national importance), how the reviewer can secure permission. Consideration will also be needed to what documents a reviewer can retain (or subsequently access via the SAB) if required in respect of any future litigation.

A SAB will also need to provide practical support if there are subsequent legal proceedings, such as agreeing to provide access to draft reports, agency IMRs or chronologies, minutes of practitioner discussions etc., where these might be required to assist a reviewer or Independent SAB Chair prepare for subsequent legal processes such as Disciplinary Hearings, Inquests etc.

Part 6: Evidencing Impact of SAB activity through **audit and quality assurance**

Importance of data: reporting prevalence of abuse locally and impact of SAB activity
Historically SABs have relied on data reported by the local authority to NHS Digital for their Safeguarding Adults Collection [SAC] reports. These key performance measures were predominately identified prior to the Care Act coming into effect and therefore provide only a limited picture. NSCN has escalated, as part of the priorities for system improvement, this issue to DHSC in order to address the current shortcomings in consistency of data collection nationally.

Most SABs have also embraced '*Making Safeguarding Personal*' principles, and whilst the reporting of compliance with these measures remains discretionary to NHS Digital, most SABs have access to this information locally. Presently the SAC data doesn't, provide any measures to evidence work done by partner agencies to prevent abuse or neglect by undertaking their functions cognisant of safeguarding adults' duties. There are also no centrally agreed key performance data to evidence impact of multi-agency safeguarding risk management activity (usually undertaken by 'high risk' or 'Community MARAC' or Multi-Agency Risk /Safeguarding Management Panels [MASP or MARMs].

Some SABs have been able to secure agreement locally from partners so that data dashboards include key performance measures which evidence safe, preventative practice. For example:

- Fire & Rescue Services report on the number, source of referrals for Home Safety Fire Visits, timescales for completion and outcomes to demonstrate positive impact

[33] sch 2.2 Care Act 2014

of awareness activity and identify ongoing opportunities to enhance practice following SARs into fire safety.

- NHS Acute and Community Trusts report pressure ulcer data to evidence compliance with safe care and provider concerns processes. Some SABs have agreed local protocols.
- Local Authority reports data on DoLS authorisations.
- Police forces report detentions under s136 MHA to evidence interventions comply with Mental Capacity Act principles that the least restrictive intervention is used to protect the adult and public.
- Requested demographic and outcomes data from Chairs of Multi Agency Risk Management Panels or High Risk panels to evidence risk is removed or reduced following multi-agency care management interventions. Some SABs also offer to host quarterly meetings between multi-agency panel chairs to explore common barriers or issues emerging from their case discussions.

Some SABs have also used s45 Care Act powers to request specific data to enable a 'deep dive' assurance in respect of an emerging risk or to evidence improvement in practice over time. For example, several SABs now receive regular reports on mortality reviews undertaken in respect of any adult who dies whilst homeless.

Importance of qualitative analysis: capturing evidence that safeguarding is embedded as part of the culture of public service.
Often working regionally to support consistency and enable benchmarking, SABs have developed a range of quality assurance processes or tools to evaluate locally how well partner agencies, providers and third sector organisations have embedded safeguarding into their organisations. Examples of these tools are provided within the NCSN website. Over time, these have been refined to enable SAB board managers to collate the information and use this to identify key priorities for strategic plans or shape discussions during annual development/ work planning discussions.

Other SABs have quality assurance frameworks in place with a schedule setting out the quantitative and qualitative reports the SAB will review in order to receive assurance on the effectiveness of their arrangements locally. This enables Chairs to report regionally and nationally through the NSCN networks on issues or initiatives that could have a wider impact if adopted nationally.

There isn't a prescribed method as to how the information should be used or tested by each SAB, but many SABs (often through their quality assurance sub-group) will review the information provided and evaluate the evidence provided by organisations to identify where there are opportunities to offer cross- discipline support to enhance practice, for example by linking practice leads for trauma-informed care to those supporting adults experiencing multiple disadvantage. These tools also provide organisations an opportunity to showcase excellent work done to prevent abuse and support the recovery of those who have experienced harm, for example, through peer support initiatives.

In addition to those tools many SABs benefit from the guidance and tools to support 360 assurance collated by PCH and NSCN. These are available on the NSCN website. Over time, as CQC and HMIC inspections provide detailed scrutiny of safeguarding practice, those inspection reports will provide a baseline for what good system assurance of partnership working looks like. As such, Chairs and Scrutineers should review regulatory reports and secure means to hear from partner organisations on the implementation of their organisational safeguarding improvement plans.

Case example: A number of SABs across England have used their powers under s45 Care Act to request and then triangulate data from the local authority, police, fire & rescue service, ambulance service and the local mental health trust to seek assurance regarding the implementation of the 'Right Care: Right Person' policy. This demonstrated that, whilst police had seen a significant reduction in deployment of police officers for welfare matters, the corresponding increase in activity by the local fire & rescue and ambulance services was impacting their ability to achieve their core functions. In one area, the Mental Health Trust reported no sufficient rise in risks for their patients, but the local authority's housing teams reported their staff were using s42 processes to seek support more frequently for vulnerable tenants in their supported accommodation. This has enabled the SAB to consider increasing their training offer, audit and awareness activity to address risks associated with adults who experience multiple disadvantage, particularly for those housed in temporary accommodation. Work has also started on a regional approach to safeguarding adults at risk in temporary accommodation, as they are frequently required to accept offers 'out of area' which (as numerous SARs have demonstrated) increases risks if continuity of care duties are not properly considered.

Embedding the learning following a SAR

It is important to ensure that any methodology used for a SAR takes account of learning which can be applied easily at the frontline of all organisational practice. There are many useful learning methodologies e.g. summaries of learning sent to partners- such as 7 minute briefings, Learning Review events undertaken during and on completion/ publication of the SAR, recorded short summaries that can be used in team meetings or daily briefings.

A SAB may consider the application of learning by the Board in relation to past SARs that may continue to be reviewed sometime after each event. This is especially important where analysis show themes established from more than one SAR. In line with the finding from the second National SAR analysis, any newly commissioned SAR should explore if previous local, regional or national SARs have already considered similar cases and explore additional learning in that context, including exploring what the system barriers were to effective improvement following previous reports. To address this as part of 'business as usual' some SABs conduct bi-annual 'challenge and progress' summits with partners to review whether partner organisations have completed actions arising from reviews and measure the impact of those actions for safer practice. Other SABs conduct multi-agency audits to explore how practice has changed in response to similar risks emerging.

As a system leader, the Independent SAB Chair should assume responsibility for clearly articulating the expectations that all partners will provide assurance that learning has been disseminated in their own organisations and that organisations will report on the progress made to effect system changes and embed practice improvement. Equally, SAB partners must (as part of their core responsibilities as representatives of their organisation) have clear means to report to the SAB and their own senior leadership any organisational risk if recommendations have not been actioned. Many SABs have a 'Board risk register' to record centrally such concerns and provide a mechanism for partners to collectively consider how to overcome barriers to achieve a common goal. The Independent Chair or Scrutineer should also have agreed communication routes to escalate concerns if assurance is not provided as, ultimately, it is the organisation and not the SAB that is responsible under s44(5) Care Act for evidencing that learning from SARs protects against future harm.

It is good practice to report, within the SAB annual report, the outcome of assurance work. Chairs will find it useful to have this recorded centrally by the SAB to support provider, partner agencies (including the three statutory partners) evidence the positive impact of partnership working within any regulatory inspection, but also to influence relevant strategic plans. This will also form an important evidence base for Chairs to include in their response to the bi-annual SAB Chairs survey undertaken by the NSCN.

Top tip: With the advent of more regulatory obligations on key member organisations, SABs should review their capability to use data and qualitative assurance tools to provide insight into the impact that key initiatives have had on prevalence of abuse against adults with care and support needs locally.