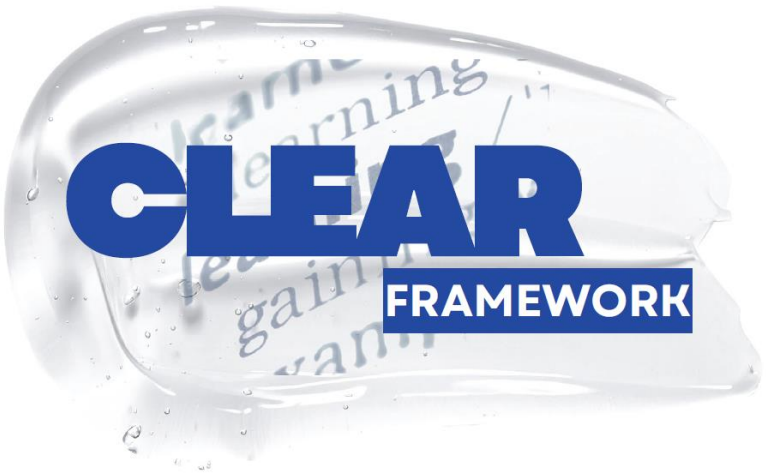

From Learning to Impact

Embedding the CLEAR Framework for Safeguarding Adults Reviews

A guide for Safeguarding Adult Boards, Independent Reviewers and Partners

Author(s):
Frances Millar (Workstream Convenor and Independent Chair, Bury Safeguarding Adults Board and Independent Reviewer/Author)
Karl Mason, Royal Holloway, University of London and Independent Reviewer/Author
Michael Murphy, Independent Reviewer/Author
Sam Lunnom, Independent Reviewer/Author
Dr. Sarah Hutton, Open University)/Independent Reviewer/Author

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Safeguarding Adult Review Authors and Subject Matter Experts for their specialist knowledge of SAR methodology and best practice

Karl Mason Senior Lecturer in Social Work / Course Lead MSc Social Work /Co-Lead Health and Social Care Research Cluster Department of Law and Criminology, Royal Holloway, University of London and Independent Reviewer/Author
Michael Murphy Independent Reviewer/Author
Sam Lunnom, Independent Reviewer/Author

A note of thanks is also extended to Kate Spreadbury Independent Lead Reviewer and SAR Reviewer Group

Executive Summary

This document supports Workstream 3 of the national SAR Impact Project and is designed to help Safeguarding Adults Boards (SABs), independent reviewers, and safeguarding partners evaluate and embed the impact of Safeguarding Adults Reviews (SARs).

It applies the CLEAR Framework — Case for Change, Learning, Evidence, Allocate Responsibility, and Review — to structure and strengthen SAR impact. The framework, originally developed in the context of child death reviews (Buckley et al., 2014), has since been adapted to guide systemic learning in adult safeguarding. It promotes a shared language and consistent structure for tracking how SARs lead to meaningful change.

Each section provides practical guidance, case examples, and reviewer prompts to support implementation:

- **Case for Change (C):** Articulates why the review matters; morally, professionally, legally, and systemically, and how the adult's story connects to national learning and wider reform.
- **Learning (L):** Explores how learning is identified, shared, and embedded throughout the SAR process; not just at publication. Emphasises reflective practice and psychologically safe learning cultures.
- **Evidence (E):** Identifies how change can be evidenced using data, audit tools, practitioner insight, and lived experience feedback. Encourages a broader view of 'impact' beyond action plans.
- **Allocate Responsibility (A):** Emphasises clear ownership, SMART formatting, statutory obligations, and resource alignment across agencies.
- **Review (R):** Sets out how SABs should assess whether actions have led to improved outcomes and what tools can support ongoing assurance.

The CLEAR model enables SABs to move from compliance-driven processes to a culture of learning, accountability, and continuous improvement. The guidance is intended as a practical and adaptable resource to support real-world change in safeguarding practice and systems.

Introduction

Safeguarding Adults Reviews (SARs) are a statutory tool designed to generate learning from serious incidents involving adults with care and support needs. Yet too often, recommendations arising from SARs fail to produce meaningful or sustained change. Reviews may be methodologically sound, but the resulting actions are sometimes overly generic, weakly owned, or poorly aligned with systems-level reform. As highlighted in the national analysis of SARs[1], this contributes to cycles of repetition where lessons are not fully embedded and implementation remains inconsistent.

To address these challenges, this work adopts the CLEAR Framework, originally developed by Buckley et al. (2014) in the context of child death reviews. Their research identified that recommendations are more likely to lead to improvement when they are:

Grounded in a compelling Case for Change

Supported by transferable Learning

Underpinned by a robust Evidence base

Accompanied by clearly Allocated responsibility

Tracked through defined Review mechanisms

The CLEAR framework offers a structured and replicable model to trace the pathway from findings to action and impact. It is organised around five interlocking elements:

- **C** – Case for Change
- **L** – Learning
- **E** – Evidence
- **A** – Allocate Responsibility
- **R** – Review

By working through each element, reviewers and SABs can test whether the learning identified in a SAR has translated into improved outcomes — not only through action completion, but through measurable and sustained change in practice, systems, and safeguarding effectiveness.

The CLEAR model brings structure, precision, and accountability to safeguarding learning. It offers a mechanism for turning review findings into a coherent theory of change — one that is measurable, system-aware, and genuinely action-oriented.

Building on the foundational work of Buckley et al. and more recent developments in adult safeguarding review practice[2], the CLEAR framework has been adapted in this project (Workstream 3 of the National SAR Impact Programme) to evaluate how learning from SARs is embedded, enacted, and evidenced across the safeguarding system.

By applying CLEAR, Safeguarding Adults Boards (SABs) and reviewers are supported to move beyond a compliance culture and toward a more integrated, relational, and impact-focused approach to safeguarding learning and improvement.

[1] Partners in Care and Health, 2023
[2] Preston-Shoot, 2022; SCIE, 2023

CLEAR Framework: C – Embedding the Case for Change

This section defines the moral, professional, legal, and systemic imperatives that underpin the need for change. A strong **Case for Change** provides the essential foundation for all learning and improvement following a Safeguarding Adults Review (SAR). It moves the review beyond retrospective analysis and positions it as a forward-focused, strategic intervention. The case for change should explain *why* the learning matters — not only to the individuals directly affected, but to the safeguarding system as a whole.

This component of the CLEAR framework is about **urgency, accountability, and system transformation**. It ensures that SAR learning has the power to influence leadership decisions, shift organisational culture, and drive sustainable improvement.

Why This Matters

SARs that fail to articulate a clear case for change risk being perceived as procedural exercises. Without a compelling rationale, learning may not be prioritised, resources may not be allocated, and recommendations may be diluted or ignored.

By embedding a strong case for change at the outset, and revisiting it throughout, reviewers and Safeguarding Adults Boards (SABs) reinforce the moral, professional, legal, and systemic need for reform:

Table 1 'Core Components of the Case for Change', Adapted from Preston-Shoot et al. (2024).

Dimension	Description	SAR Application
Moral	Highlights the human impact of the incident — distress, loss, trauma, and avoidable harm.	Centres the adult's voice and dignity; explains what was at stake.
Professional	Demonstrates how practice fell short of standards, guidance, or codes of conduct.	Identifies failures in judgment, coordination, or decision-making.
Legal	Connects the findings to statutory duties, especially under the Care Act 2014 and Human Rights Act 1998.	References breach or risk to Articles 2, 3 or 8 HRA, or failure to safeguard under Section 42.
Systemic	Exposes how structural issues — such as siloed services, poor leadership, or inadequate supervision — enabled harm.	Situates learning in system dynamics, not just individual action.
Reputational	Reflects risks to public trust, media scrutiny, and perceived credibility of the safeguarding system.	Frames how the SAR may impact confidence in services, local leaders, or the SAB itself.
Regulatory	Relates to compliance with statutory duties, quality frameworks, and inspectorate standards.	Links the findings to assurance processes (e.g. CQC Quality Statements, LGA oversight, NHS frameworks).

Reviewer Prompts

SAR authors should explicitly frame the case for change in the **Executive Summary** and early in the **Findings** section. Helpful questions include:

- **What harm occurred, and could it have been prevented?**
- **What does this case reveal about system-wide conditions or weaknesses?**
- **What statutory or ethical duties were missed, minimised, or misunderstood?**
- **Why does this learning matter *now*? What risks remain if no action is taken?**
- **How does this case align with findings from other reviews or national priorities?**

Practice Examples

Example A (Strong case for change):
"The circumstances of Mr J's death expose systemic desensitisation to self-neglect, compounded by unclear pathways between housing, health, and adult social care. Despite multiple indicators of escalating risk, no lead agency took ownership. This review identifies urgent action needed to re-establish professional curiosity, clarify thresholds for action, and embed trauma-informed approaches across the partnership." *[COMMENT: Great contrast – more examples like this throughout other sections would strengthen practical application.]*

Example B (Weak case for change):
"This review identifies several areas for learning and improvement. Agencies have accepted the recommendations."

Embedding the Case for Change into SAR Processes

Table 2 Embedding the Case for Change into SAR processes, grounded in Preston-Shoot et al. (2024)

Stage	Action
Terms of Reference	Ensure key lines of enquiry include identifying the systemic relevance of the case.
Learning Events	Revisit the case for change with practitioners to help them engage with the review's significance.
Action Plans	Each recommendation should be traceable to an element of the case for change.
Communications	Embed the rationale into briefing materials, media statements, and internal messaging.
Impact Reviews	Use the original case for change as a benchmark to evaluate whether systems have improved.

The **Case for Change** is the ethical and practical core of every SAR. It should be clearly stated, evidence-based, and emotionally resonant. By anchoring learning in a shared sense of purpose, the case for change gives SARs the power not just to explain what went wrong, but to galvanise sustained, meaningful change across safeguarding partnerships.

The Case for Change: A Three-Step Impact Pathway Model

What does the evidence tell us is the best way of engendering change?

1. **High-quality SARs** are produced using a consistent format, underpinned by a coherent agenda and standardised process. Recommendations are framed to be universally actionable and system relevant.
2. **Safeguarding Adults Boards (SABs) and partner agencies** receive these SARs and activate the necessary mechanisms to implement recommendations. This includes influencing organisational culture, professional behaviour, and operational practice. SABs must have the appropriate levers to drive system-wide, cultural change and evaluate its effectiveness.
3. **Where systemic issues extend beyond local resolution**, clear pathways must exist for escalation to regional or national bodies to ensure wider reform and meaningful change. This would extend to for example, the Safeguarding Adults Escalation Protocol for onward sharing issues with the National Network of Safeguarding Adult Board Chairs.

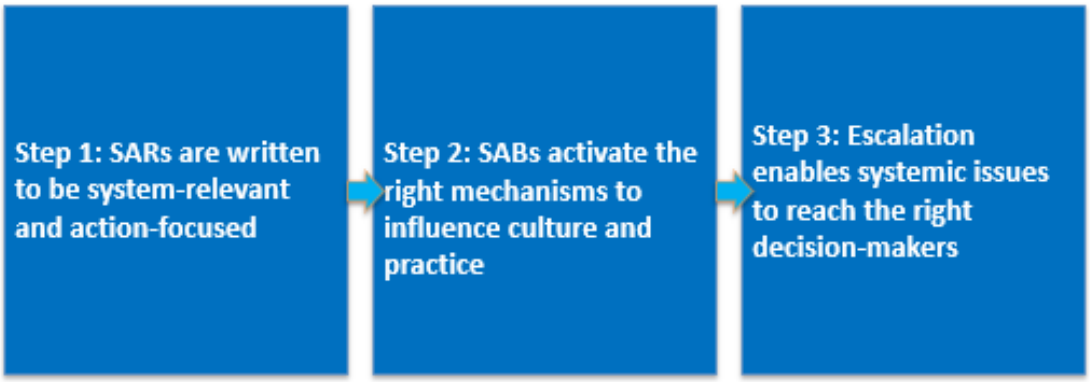

Figure 1 From SARs to Systemic Change: A Three-Step Impact Pathway

Repeated findings from national SAR analyses have highlighted the role of policy ambiguity or absence in contributing to preventable deaths. This raises a fundamental question of accountability: should a designated national body or government department be required to formally own and respond to learning themes that exceed local control? Without this accountability, systemic gaps persist across reviews and remain unaddressed, diminishing the overall impact of the SAR system.

CLEAR Framework: L – Embedding the Learning from Safeguarding Adults Reviews into Practice

Embedding a Culture of Learning

Safeguarding Adults Reviews (SARs) aim not only to identify learning but to generate the conditions in which meaningful change can take place. That includes promoting improvements across policy, training, and frontline practice to reduce preventable harm to adults at risk.

While SAR methodologies have evolved, less attention has been paid to how the review process itself can enable sustainable learning. Embedding learning requires that recommendations are clearly owned, adequately resourced, and time-bound — ensuring that insights are not only recognised but translated into improved outcomes.

One barrier to effective learning is the timing of the SAR itself. Significant delays in completing Individual Management Reviews (IMRs) or unresolved concerns regarding practitioner conduct can compromise the openness and reflectiveness essential to a blame-free process. It is therefore critical that SARs are positioned at a point in the system where they can catalyse learning, not complicate or compete with necessary preceding processes.

Barriers to Learning through the review process

Despite their potential, SARs are frequently undermined by persistent system-level barriers. Findings from the *National Analysis of SARs (2024)*, *Rawlings et al. (2014)* and the *Child Safeguarding Learning Support and Capability Project (2025)* identify five interlinked themes that hinder learning:

- **Learning Infrastructure** (e.g. fragmented governance, weak feedback loops)
- **Culture & Blame** (e.g. defensive responses, low psychological safety)
- **Review Fatigue** (e.g. overload, episodic learning cycles)
- **Interprofessional Silos** (e.g. poor cross-agency dialogue)
- **Practice Translation** (e.g. failure to embed learning into practice)

These are summarised in Figure 2 below:

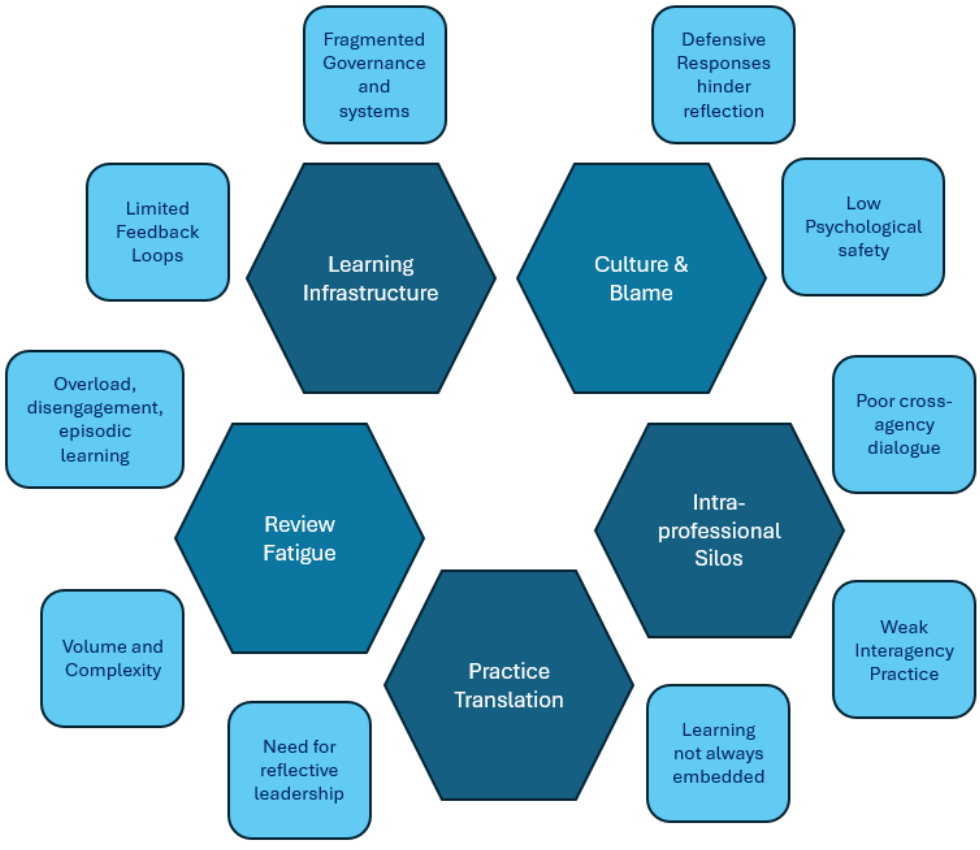

Figure 2 Visual summary of key barriers to learning from SARs and serious case reviews. Synthesised from the 2024 National SAR Analysis (Preston-Shoot et al., 2024) and Rawlings et al. (2014).

These challenges are systemic and long-standing. Unless explicitly addressed, they reduce the likelihood that learning will lead to sustainable change. Safeguarding Adults Boards (SABs),

Independent Reviewers, and agencies must therefore use these insights as a diagnostic lens — evaluating local readiness for learning and proactively addressing cultural and structural blocks.

Developing A Learning Process

Learning from SARs should be seen as an ongoing process, not a static event. Moving from compliance to genuine systems learning means embracing uncertainty, complexity, and relational ways of working.

To support this shift:

- **Psychological safety** is needed so professionals can reflect honestly on "theories-in-use"
- **Review leadership** must model curiosity, humility, and shared responsibility
- **Relational learning** must be prioritised over blame, hierarchy, or defensiveness

Yet, many agencies still lack familiarity with reflective learning cycles, and in some cases, lessons are not revisited until the next crisis occurs.

While person-centred approaches and family involvement are key to ensuring a SAR reflects the life lived and the impact of harm, care must be taken that this does not inadvertently obscure the review's learning focus. Some concerns raised may be more suitably addressed through complaints mechanisms or bereavement services. However, the SAR remains a powerful space where families often seek not blame but assurance that future harm will be prevented—a goal shared by all safeguarding partners.

Supporting Organisational and Cyclical Learning

The framework in **Figure 2** offers practical ways in which SABs, Independent Reviewers, and agencies can embed learning through:

- Strategic dissemination
- Integration into training, audit and governance
- Ongoing review through feedback and follow-up mechanisms

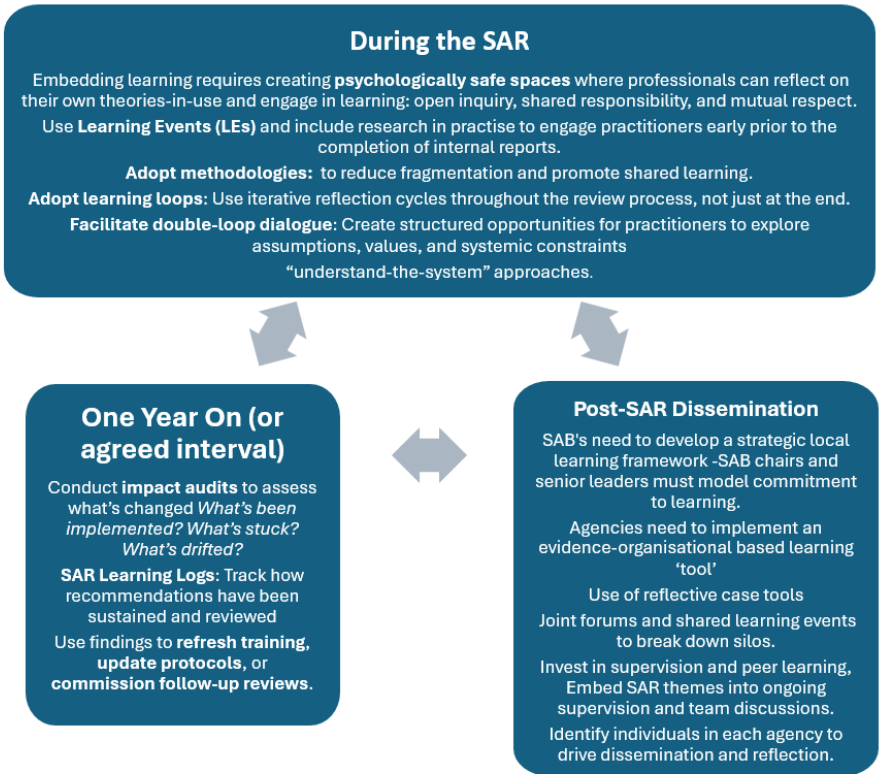

Figure 3 Supporting Organisational and Cyclical Learning

Embedding learning from safeguarding reviews is not simply a technical task; it is a cultural and relational endeavour. Reviews must be understood as learning journeys, not endpoints. Real impact depends on creating the right conditions, across leadership, culture, and systems, to ensure that learning drives action and ultimately protects adults at risk.

CLEAR Framework: E – Evidence

From Action to Evidence

Once actions have been allocated, Safeguarding Adults Boards (SABs) must evidence whether those actions are making a difference. Review is not about ticking off recommendations; it's about demonstrating real-world change. This includes identifying where progress has been made, where barriers remain, and whether improvements are embedded in frontline practice, organisational culture, and system-wide accountability.

Evidence collection is crucial not only for regulatory assurance but also to support reflection, identify learning gaps, and adapt strategies over time. SAR learning should be grounded in a robust evidence base[3], including national research, practitioner insight, and audit data. SARs become tools for understanding not just what happened, but why it happened—and what might prevent future repetition (Preston-Shoot, 2020).

What Counts as Evidence?

SABs should adopt a broad view of what constitutes evidence of impact. This includes both quantitative data and qualitative insights. No single metric provides a full picture; triangulation is essential. The table below provides a guide for Boards and reviewers on the types of evidence that can demonstrate implementation and impact.

Adapting Evans and Hardy's (2010) work on types of knowledge and evidence in social care, five types of evidence can be identified for SARs:

Table 3 Five Types of Evidence that can be used for SARs, adapted from Evans and Hardy (2010)

Type of Evidence	Why Use this type of evidence?	What constitutes this type of evidence?	Practical advice for SAR reviewers	Examples
Research Evidence	Research Evidence points to broader patterns and aspects of knowledge that helps to generate learning for local practitioners, but more crucially to validate the case for change. It provides an up-to-date account of the bigger picture around a phenomenon so that stakeholders can see that the issues in the single instance of a SAR is likely to re-occur if action is not taken.	1. Patterns and prevalence of abuse types. 2. Experiences of adults relating to contextual factors such as self-harm, homelessness, neurodiversity etc. 3. Practise research which identifies effectiveness in practise.	52% of SARs included reference to research according to the second national analysis. Although research can illustrate the context and circumstances of the person's situation, it is more helpful when research highlights wider learning that is needed to improve practise and organisational culture.	*Good evidence*: "Practitioners should be supported to appreciate the overlapping nature of homelessness, substance use and mental ill-health (Fitzpatrick et al, 2011) and move beyond seeing homelessness as a housing issue only. In this adult's situation…." *Weaker evidence:* "Research illustrates that the adult's situation was predictable"

[3] As highlighted by SAR Quality Marker 9, which asks reviewers to consider research evidence, practice knowledge, guidance and theory, statute, national policy, other SARs and inspection reports in order to articulate the underpinning knowledge base relevant to your analysis.

Procedural Evidence	Procedural Evidence comprises law, policy, statutory guidance, evidence from parallel processes. Such evidence helps to highlight where the local practice could develop, how local practise gaps highlight problems with implementing law and policy or identify where law and policy may not support local practice.	1. Statute law 2. Case law 3. Statutory Guidance (esp. Care and Support Statutory Guidance or Mental Capacity Act Code of Practise) 4. Policy documents (national or local) 5. Inspection reports 6. Ombudsman findings 7. Coroner reports 8. Other parallel process reports	Statute is the most frequently cited form of evidence with 51%-58% of SARs citing law according to the first and second national analyses. Case law was rarely used in SARs. Statutory Guidance can be helpful to see where the guidance supports practise and where gaps remain.	*Good evidence*: "Three previous reviews have been undertaken by the SAB that link to self-harm over the last five years. A recommendation linking to X recurs in this current SAR and partners have agreed that this should be re-visited and partner agencies should take account of this by…." *Weaker evidence*: "Substance use arises in previous SARs undertaken by the SAB in the following ways…"
Practice Evidence	Almost all SARs refer to agency chronologies or IMRs and many use practitioner events. These provide rich details of practise, which can be used to show how patterns developed and where improvements might be made. Practitioner events focus on embedding learning but can also provide testimonial evidence about practise that can clarify gaps in written evidence. Looking at previous SARs can help to highlight thematic issues that have previously arisen in relation to the pertinent issues in the current SAR. Previous SARs can also identify commitments made by local partners and can add transparency, urgency and accountability to the case for change, reducing repeat recommendations and identifying patterns that need improvement in the local safeguarding system.	1. Chronologies 2. IMRs 3. Case documents such as assessments 4. Previous SARs 5. Practitioner Events 6. Key informant / stakeholder interviews	On average, SARs seek evidence from 8 agencies according to the first national SAR analysis. Reviewers should consider if the right stakeholders are represented and whether any perspectives are missing. Previous SARs are only referenced in 21% of SARs in the second national analysis citing previous learning. SAR authors should ask at the point of commencing a SAR about previous SARs in the local safeguarding system that relate to a similar theme and make use of the national SAR library to identify other relevant evidence.	*Good evidence*: SAR Quality Marker 9 advises that there should be sufficient clarity about the methodological purpose of plans to gather practitioners together, specifically about the kind of data they are able to provide and by what means it is going to be sought during the meeting?
Personal Evidence	Human stories sit at the heart of SARs (Preston-Shoot, 2023) and provide compelling, moral material that can be persuasive for the case for change. Human stories also allow for intersectional and identity-related knowledge to be foregrounded as distinct to professional knowledge.	1. Interviews with the adult affected 2. Information from family, friends or professionals about what the adult might have to say about the SAR and the practise they encountered 3. Interviews with families	Most adults who are the subjects of SARs have died (86% in the second national analysis). Creative approaches, wellbeing-oriented support and advocacy may be required. Family should be involved unless there is a compelling case not to do so. In some cases, it may be appropriate to involve people with similar lived experiences.	*Good evidence*: The second SAR analysis includes some good practise examples: "Relatives sometimes also made written contributions to the report and in one case a family member wrote their own report and presented it at a practitioner learning event. In another example, the reviewer facilitated a restorative meeting between family members and their relative's care home"

		4. Focus groups with people who have similar lived experiences		
Theoretical Evidence	Theoretical insights can be used in SARs but should be delineated from other forms of evidence as they offer hypotheses rather than more solid evidence. Insights from theory may allow for an interrogation of causal factors and decision traps in the case.	1. Theory on human development 2. Theory on methods of intervention 3. Theory on safety and risk 4. Theory on decision making and decision traps	The SCIE Quality Markers (Quality Marker 12 on analysis) discuss the use of safety science.	*Good evidence*: "These views expressed at the practitioner event suggests that fear and intimidation played a role in fewer visits being offered, confirming elements of defensive practise (Whittaker and Havard, 2016)".

This table is not exhaustive but illustrates the range of evidence types SABs should consider when assessing impact. Multiple sources should be drawn upon to assess not just what has been done, but what difference it made.

Embedding Evidence into Assurance Cycles

Tracking impact over time allows SABs to identify patterns, spot drift, and escalate where progress stalls. Recommendations should be reviewed at set intervals (e.g., 6, 12, or 18 months), supported by documented mechanisms for follow-up.

This approach enables Boards to move beyond static action plans and adopt a learning loop, one that supports reflection, adaptation, and continuous improvement.

Where evidence is lacking or weak, this should be seen as a signal to:

- Revisit whether the actions were sufficiently SMART
- Examine whether they were implemented as intended
- Consider further engagement, support, or escalation to senior leadership

Summary

Evidence is the cornerstone of impact. It allows Boards to track progress, adjust course, and demonstrate that learning from SARs has led to improved practice and outcomes. Embedding evidence collection into assurance cycles ensures SARs are not endpoints, but catalysts for measurable, lasting change.

Reviewer Checklist: Is Evidence Balanced and Well-Integrated?

✓ Have both practitioner and service user perspectives been included?
Ensure the evidence base reflects lived experience as well as professional insight.
✓ Are national frameworks and local data sources used together?
Balance broad sector standards with contextualised, place-based evidence.
✓ Is evidence triangulated from multiple sources (e.g. audits, feedback, case reviews)?
Draw on quantitative and qualitative material to strengthen validity.
✓ Have examples from both successful and limited implementation been included?
Illustrate variability in impact to support learning and honest appraisal.
✓ Are structural and cultural barriers to evidence use acknowledged?
Recognise limitations and address why some data may be absent or incomplete.
✓ Is there clarity on how evidence will be revisited or updated over time?
Show the Board's commitment to ongoing review and adaptation.

CLEAR Framework: A – Allocate Responsibility

Making Actions Count

Implementing SAR learning requires more than consensus; it requires a strategic and accountable action plan. Actions must be clearly defined, resourced, and embedded within governance and assurance processes. True impact involves understanding whether the learning identified has led to demonstrable and sustainable improvements in safeguarding practice, organisational culture, and system-wide accountability.

It is important to reaffirm that the SAR process is owned by the Safeguarding Adults Board (SAB), not the Independent Reviewer. While reviewers may facilitate events or frame learning, the SAB is ultimately responsible for determining participants, shaping review activities, and ensuring implementation. This principle maintains accountability, prevents drift, and reinforces the SAB's strategic leadership role in embedding learning.

Embedding Action Across the Partnership

All SAR recommendations should include:

- A defined outcome
- A named lead agency or role
- A clear timeframe for delivery
- An agreed review or reporting date

SABs should ensure actions are:

- **Time-bound**, even for ongoing or complex work
- **Resourced**, with leadership and operational ownership
- **Integrated** into strategic plans, quality assurance cycles, and partnership governance

This approach strengthens accountability and enables partnerships to track whether actions are not only assigned but actively implemented and sustained.

Before-and-After Example: Applying the CLEAR Model to Action Planning

Before (Traditional Format)

"Ensure housing and mental health services work together more effectively."

- No defined outcome
- No named lead
- No timescale or review mechanism
- No assurance of accountability

After (CLEAR-Aligned Format)

"By June 2025, the Local Authority (Lead: Housing Commissioner) and NHS Trust (Lead: Community Mental Health Manager) will co-develop a joint escalation protocol for clients at risk of eviction due to mental health-related tenancy breakdowns. Effectiveness will be reviewed quarterly via the SAB's audit subgroup, starting October 2025."

✓ Clear, measurable outcome

✓ Named leads from both agencies

✓ Timeframe and review date

✓ Embedded into the SAB's quality assurance cycle

This transformation demonstrates how embedding the CLEAR model can convert vague aspirations into actionable, auditable commitments that drive real change.

Statutory, Ethical and Financial Responsibilities

While not all recommendations create a direct legal duty, the allocation of responsibility should consider a wider set of accountabilities — legal, ethical, and financial. The Care Act 2014 (Section 6) mandates inter-agency cooperation, while the Human Rights Act 1998 reinforces duties to protect life and prevent inhuman or degrading treatment (Articles 2 and 3). Failure to implement agreed actions may result in breaches of these obligations and expose the partnership to reputational or regulatory risks.

Courts and inquests are increasingly referencing these frameworks when assessing organisational responses to safeguarding failures. Allocating responsibility must therefore be approached as a matter of public duty, not administrative convenience.

Common Risks to Implementation – and How to Mitigate Them

Table 4 Common Implementation Risks and Mitigation Strategies

Risk	Possible Mitigation Strategy
Lack of clear ownership or coordination	Assign named leads for each action, with clear reporting responsibilities and escalation routes. Embed roles into existing partnership governance structures.
Absence of SMART formatting	Use the CLEAR model to ensure recommendations are Specific, Measurable, Achievable, Relevant, and Time-bound, with outcome, responsibility, and review date clearly stated.
Poor integration into existing structures	Align SAR actions with existing strategic priorities, governance cycles, and reporting tools (e.g. quality assurance dashboards, performance reviews).
Inconsistent engagement by partners due to capacity pressures	Secure senior-level buy-in, highlight statutory obligations (e.g. Care Act Section 6), and develop lighter-touch but meaningful engagement options (e.g. short reflective sessions, written assurance updates).

Table 4 supports reviewers and Boards in anticipating common pitfalls and proactively designing implementation strategies that are realistic, resourced, and embedded across the safeguarding system. Timely identification of these risks, and clear escalation routes, are essential to ensure accountability and avoid implementation drift.

CLEAR Framework: R – Review Date

The final section addresses how SABs can evaluate impact over time through structured review processes and meaningful follow-up.

From Completion to Impact

Review is not about ticking boxes — it's about demonstrating real, measurable change. Safeguarding Adults Boards (SABs) must go beyond confirming that actions have been completed

and instead evaluate whether those actions have led to improvements in safeguarding practice, culture, and outcomes for adults at risk.

Reviewer Prompts and Checklist for Impact Assessment

- **Have agencies engaged with follow-up activity**, including learning audits, reflective sessions, or progress monitoring?
- **Are SAR recommendations being resourced and prioritised** across the partnership, or is there a disproportionate burden?
- **Are the Care Act duties** (co-operation, oversight, learning) **being met in practice**?
- **Are there risks to implementation** that should be escalated to the SAB?
- **What forms of evidence exist** (e.g. audit outcomes, lived experience feedback, practitioner narratives) that demonstrate change?

What Should a Review Process Include?

- **Scheduled follow-up reviews** (e.g. quarterly or annually)
- **Multi-agency learning logs** to track progress
- **Audits or re-audits** of case files to assess change in practice
- **Practitioner and service user feedback** on perceived impact
- **Mechanisms to escalate barriers** to senior leadership where necessary

Effective review cycles create opportunities to adapt, reinforce learning, and ensure recommendations are not only implemented but embedded.

System-Level Accountability

Reviewers and SABs should assess:

- Whether multi-agency engagement has been consistent and sustained
- If Care Act duties (particularly Section 6) are met in practice
- How outcomes are evidenced through data, narratives, and frontline insight

Illustrative Case Examples:

Effective practice: In the SAR *'Maya'* (South Tyneside SAB, 2021), quarterly reviews, learning logs, and assigned leads helped embed learning across the partnership over 18 months.
Ineffective practice: In the SAR *'Philip'* (Brent SAB, 2020), absence of lead accountability and a lack of follow-up mechanisms meant that change could not be evidenced — resulting in continued risk and missed learning opportunities.

These examples illustrate that effective impact measurement is not simply about agreement on recommendations, it requires clear ownership, shared responsibility, and mechanisms for review. Reviewers should therefore assess whether post-SAR activity reflects these principles and whether Boards are genuinely fulfilling their statutory oversight duties.

Review Dates for SAR Recommendations

Each SAR recommendation should have:

- A timeframe for completion
- A responsible agency or lead
- A review or reporting date, aligned with SAB assurance cycles

Recommendations without review dates risk being deprioritised or forgotten. Embedding review points creates visibility, supports external assurance, and enables stories of change to be told credibly.

Sustaining the Impact

As SAR practice continues to evolve, there is growing recognition of the need to define what constitutes a high-quality review methodology. While different models, such as SARiRT and SCIE's systems methodology, offer valuable approaches, developing a shared set of core competencies could help standardise expectations, strengthen quality assurance, and support impact evaluation. This document does not seek to prescribe a single method, but it does encourage national dialogue about the features of effective SAR methodologies. Clarifying these core elements could help ensure that the process remains robust, proportionate, and focused on generating sustainable learning.

Ultimately, measuring the impact of a SAR is not a one-off task — it is a continuous cycle of reflection, adaptation, and action. A robust review framework allows partnerships to learn from the past, respond to the present, and plan more effectively for the future.

Suggested References and Resources

Care Act 2014 (England) - Section 6 – Duty to co-operate, Sections 14.145–14.150 – SAB functions and accountability: https://www.gov.uk/government/publications/care-act-statutory-guidance

Local Government Association (LGA) & ADASS (2023) - Making Safeguarding Personal: Outcomes Framework: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

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