Telford and Wrekin Safeguarding Partnership

Best Practice Guidance and Methodologies for Safeguarding Adult Reviews

The Care Act 2014 requires Safeguarding Adult Boards (SAB) to arrange Safeguarding Adult Reviews (SARs), and mandates when they must be arranged and gives Safeguarding Adult Boards the flexibility to choose a proportionate methodology.

The Telford and Wrekin Safeguarding Partnership (TWSP) Safeguarding Adult Review Panel is responsible for carrying out Safeguarding Adult Reviews and other Learning Reviews in order to learn lessons and make improvements to safeguarding systems to safeguard and promote the welfare of adults.

The purpose of a SAR is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'

1. Criteria for a SAR

Criteria from s44 of the Care Act 2014:

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

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious[1] abuse or neglect.

[1] something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

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

On receipt of a referral the SAB must ensure that it explicitly references which of the statutory criteria the case has met and/or how the case features practice issues to be pro-actively reviewed before abuse or neglect has occurred in order to pro-actively tackle them.

In making a decision about whether to undertake a SAR and of what kind, SAB's must ensure that the decision is defensible paying attention to the Care Act 2014, Making Safeguarding Personal principles and ensure that the SAB member agencies have had an opportunity to contribute.

2. Principles for Conducting a Safeguarding Adult Review

1. **Share Learning**
   The aim of a SAR is not to place blame but to share learning that will improve the way agencies work individually and together.

2. **Process**
   Each case and SAR should be treated as unique. The process should include the recommended elements however, it should be proportional to the severity of the case and it should utilise the appropriate methodology that will maximise the learning.

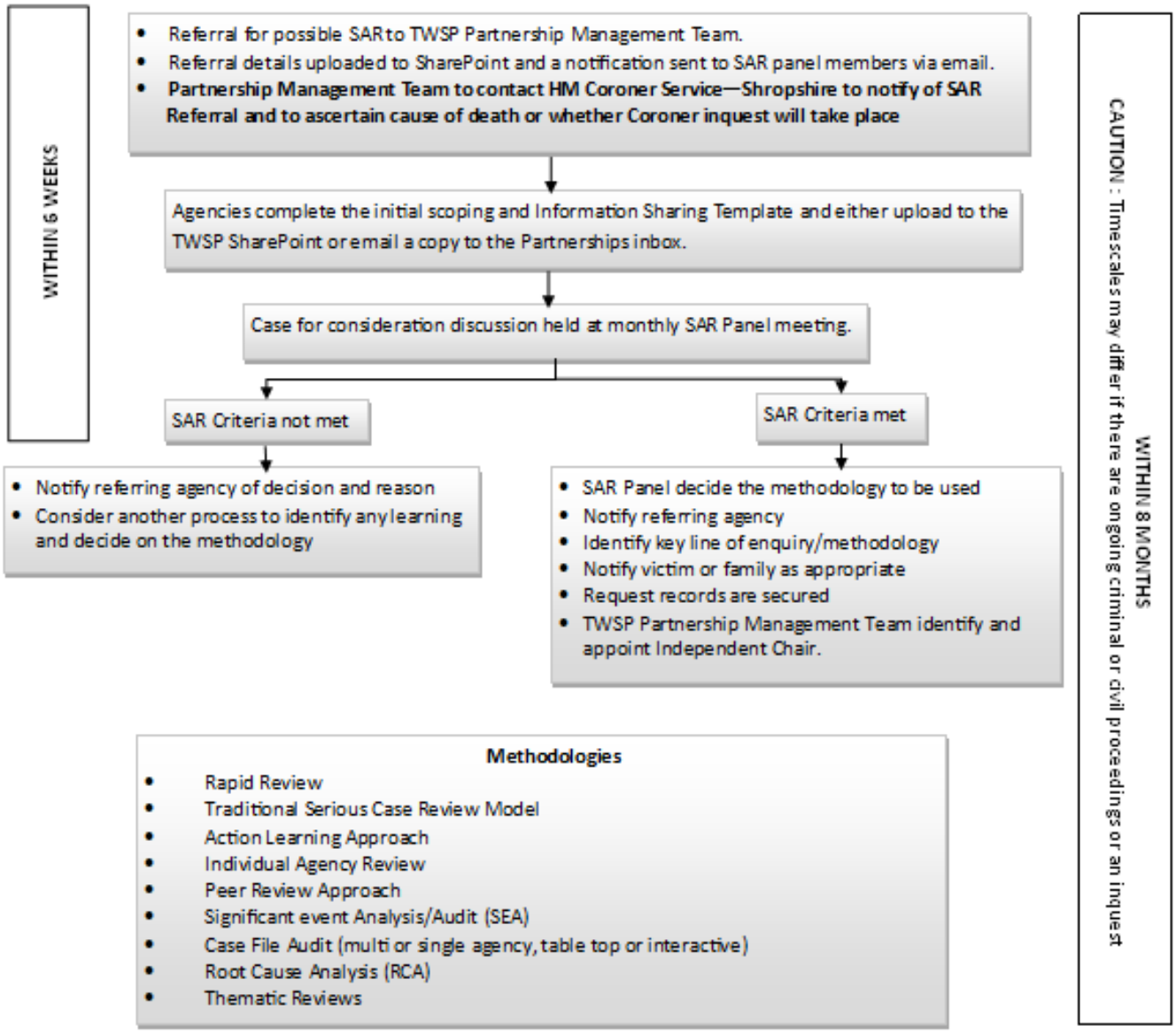
3. **Open and honest**
   Throughout the SAR Process all parties should communicate and voice their opinions and their views openly and honestly with an appropriate "tell it like it is" approach.

4. **Understanding and sensitive**
   The conditions of each case will need to be approached with understanding of the different perspective as action may have been taken in good faith. The circumstances of the case will require a level of sensitivity especially when the individual and/or their relatives are involved.

5. **Encourage excellence**
   The act of sharing the learning within and across agencies involved is to promote and encourage excellence within safeguarding.

Appendix A outlies key aspects and best practice when conducting a SAR.

3. SAR Process



4. Roles and Responsibilities

The Panel will be chaired by a representative from Telford & Wrekin Council Legal Services.

The core group of the Panel will be made up of people in the following roles:

- Telford & Wrekin Council Solicitor;
- Director, Adult Social Services, Telford & Wrekin Council;
- Service Delivery Manager Community Social Work and Adult Safeguarding;
- West Mercia Police representative;
- Head of Safeguarding, Shropshire and Telford & Wrekin CCG;
- Head of Safeguarding, Shropshire Community Health NHS Trust;
- Strategic Safeguarding Lead, Midlands Partnership NHS Foundation Trust;

- Adult Safeguarding Lead Nurse, Shrewsbury and Telford Hospitals NHS Trust; and
- Service Delivery Manager Housing and NuPlace.

The SAR should also communicate with the adult and/or their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

a. Knowledge and experience

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

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

b. The Role of the Chairperson

The Chairperson is responsible for:

- Ensuring administration support is available to the Safeguarding Adult Review process and Panel meetings;
- Tasking the nominated lead officer to undertake an audit to present to the Panel Planning Meeting;
- Organising the Panel Planning Meeting to take place within 28 working days of the request being made;
- Chairing all Safeguarding Adult Review meetings;
- Ensuring the minutes are an accurate reflection of the meeting;
- Challenging agencies and partners who are not engaging in the process;
- Ensuring the quality of reports received; satisfy the requirements of the Panel;
- Making sure all information is received in a timely manner to enable timescales to be met;
- Making sure any immediate actions required (including the sharing of information) are acted upon; and
- Storing all the papers relating to the Safeguarding Adults Review.

c. The Purpose of the Safeguarding Adult Review Panel

At the first meeting the SAR Panel will consider the request which will be presented by the person who submitted it.

Each agency will present information on the person concerned held by their agency, and relevant to the SAR referral.

The SAR Panel are responsible for considering the SAR Criteria, and will make a decision as to whether from the discussions held, the case meets the criteria.

If the case meets the SAR criteria, then the SAR panel will be primarily concerned with weighing up what type of 'review' process will be most appropriate to maximise benefits and outcomes from a review whilst being proportionate.

If the SAR does not meet the criteria, the SAR panel will consider and make a decision as to whether it is still appropriate to undertake a learning review.

The Panel will also agree:

- Which agencies should be invited to attend future meetings of the Panel?
- Type and extent of review to be undertaken;
- The independent author, if relevant;
- To identify an individual to write an overview report where it is not deemed appropriate or proportionate to commission an independent author. For example when there has already been other reviews, or reports from related processes;
- How far back enquiries should go;
- The timescales for completion of the Safeguarding Adult Review (eight months unless an alternative is agreed);
- The agencies/organisations required to produce a report regarding their role in the investigation;
- What consultation with service users and/or their families is required?
- What other investigations should inform or arise from the review;
- Endorse and adopt the action plan which should set out actions with named persons being responsible for their implementation within set timescales. The action plan should include by what means improvements in practice/systems will be monitored and reviewed;
- Clarify to whom the report, or any part of it, should be made available;
- Disseminate the report of key findings to interested parties as agreed;
- Make arrangements to provide feedback and de-briefing to staff, the vulnerable adult and /or family members or carers of the vulnerable adult and the media as appropriate; and
- How to manage public and media interest in the case.

d. The Responsibilities of the Panel Members

Participation in the SAR is a requirement of the Telford & Wrekin Safeguarding Partnership Panel members who are required to:

- Give priority to participation in this process;
- Ensure their organisation complies fully with the Safeguarding Adult Review process, including providing detailed, high quality and professional reports;
- Attend all Safeguarding Adult Review meetings; and
- Actively contribute to the process and meetings.

e. The Role of the TWSP Adult Review, Learning and Training Sub-group

It is the responsibility of the TWSP Adult, Review, Learning and Training Sub-group to make sure that the Safeguarding Adults Review takes place and is completed, and receive a regular update on progress from the Chair of the SAR Panel.

5. SAR Methodologies

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another. *Please note this is not an exhaustive list.*

a. Rapid Reviews

This methodology is based on the Children's Safeguarding Practice Review process as set out in Working Together to Safeguard Children 2018.

The aim of the rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time;
- discuss whether there is any immediate action needed to ensure the adult's safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of the adult; and
- decide what steps they should take next, including whether or not to undertake a Safeguarding Adult Review.

Upon receipt of a notification which may meet the criteria for a Safeguarding Adult Review, a multi-agency rapid review meeting is called, within 15 working days, to consider the case. Scoping and analytical chronology requests are sent to all partners involved to gather facts about the case and determine the extent of agency involvement with the adult. Partners are asked to return information within 5-7 working days, this allows the business unit to review responses and consider key lines of enquiry prior to the rapid review meeting.

During the rapid review meeting the information gathered to date is considered and the case is reviewed against the SAR criteria, initial learning points are established and any further actions agreed. The partners then record a decision on whether there is further merit in progressing to a more detailed review or whether the learning has already been established.

If the rapid review is thorough, it can in some cases, obviate the need for further review and enable areas to move quickly to implement the learning across the system.

b. Traditional Serious Case Review model

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

<u>This model includes</u>

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning

- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

The benefits of this model are:

- it is likely to be familiar to partners
- possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- methodology stems from children's arena so process to adults is not so familiar
- resource intensive
- costly
- can sometimes be perceived as punitive and
- does not always facilitate frontline practitioner input.

c. Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author

- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- cost effective
- enhances partnership working and collaborative problem solving
- encompasses frontline staff involvement
- learning takes place through the process enhancing learning.

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

d. Individual Agency Review

This model would be relevant when a serious incident identifies just one agency involvement or one agency learning identified. There are no implications or concerns regarding involvement of other agencies and it is appropriate that lessons are learnt regarding the conduct of an agency and in the absence of the need for a multi-agency review.

Such reviews could be requested by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking an Individual Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships.

Circumstances when this model might be appropriate:

- Serious Incidents
- Implications relate to an individual agency but lessons could be shared, applied and learnt across the partnership
- Where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

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The benefits of this model are:

- Provides an opportunity for learning from an individual agency
- Enables individual agency scrutiny into a specific area
- Assists a ‘Duty of Candour’

The drawbacks of this model are:

- Can be seen as outside the SAR purpose of multi-agency learning

- Risks individual agency opposition.

e. Peer Review Approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasing used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- peers can be identified from constitute professionals/agencies from the Safeguarding Adults Board members or
- peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- increased learning and ownership if peers are from the SAB
- objective, independent perspective
- can be part of reciprocal arrangements across/between partnerships
- cost effective

The drawbacks of this model are:

- capacity issues within partner agencies may restrict availability and responsiveness
- skill and experience issues if SARs are infrequent potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

f. Significant Event Analysis/Audit (SEA)

SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it.

The benefits of this model are:

- It is not a new technique – doctors have long discussed cases for educational and professional purposes.
- NHS England has published Serious Incident Framework in March 2015

The drawbacks of this model are:

- Seen as a model that relates only to Health.

g. Case File Audit (multi or single agency, table top or interactive)

Case file audit can be a powerful driver in improving the quality of front line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

- As a table-top exercise (therefore no input from practitioners)
- Interactive with partners and or practitioners.
- Interactive with the adult and or their family.
- Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- Flexible – in that they can be conducted in many different ways.
- Quicker learning can be achieved.

The drawbacks of this model are:

- Learning for some models will only come from written records without relevant context.

h. Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors - the Root Causes- of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes
- to be effective, RCA must be performed systematically, with conclusions and

causes backed up by evidence
- there is usually more than one potential root cause of a problem
- to be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:
- The methodology is well known and frequently used in the NHS
- Focus is on the root cause and not on apportioning blame or fault
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:
- Requires skills and knowledge of RCA tools;
- Resource intensive

i. Thematic reviews

A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or investigation. Themes may also be identified by the Performance and Quality Assurance Subgroup. A thematic review considers an individual case as a starting point, but looks at issues raised generally, rather than the details specific to the case.

- Findings are collated from involved agencies or previous reviews
- The legal framework, risk and communication are considered
- An academic literature review is undertaken
- Policy documents are reviewed
- Interviews are held with practitioners
- Multi-agency response is considered

The benefits of this model are:
- Increased opportunity for wider learning
- Cost effective
- Engagement with staff and managers at different levels within organisations

The drawbacks of this model are:
- Workloads of those involved may create capacity issues
- Resource intensive
- Unfamiliar methodology

Appendix A

Safeguarding Adult Review Checklist

Section A	
Criteria for a Safeguarding Adult Review The TWSP Safeguarding Adult Review Panel (SAR) has the lead responsibility for arranging and conducting a SAR and must do so when: • An adult in a dies as a result of abuse or neglect AND • There is concern that partner agencies could have worked more effectively to protect the adult OR • Where an adult is still alive but has experienced serious abuse or neglect. Note: "Serious abuse or neglect" may include where: • It is likely that an individual would have died if not for an intervention. • The individual suffered permanent harm as a result of abuse or neglect. • Reduced capacity or quality of life (whether because of physical or psychological effects) led to the abuse or neglect.	
Select from the options below	Selection
i. An adult in Telford & Wrekin has died as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult	
ii. The adult is still alive but has experienced serious abuse or neglect	
iii. There are concerns and issues are reoccurring and the SAB are looking to proactively review these in order tackle practice areas or issues before serious abuse or neglect arises. (Non Statutory)	
iv. There is learning from good practice in interagency working can be identified and applied to improve practice and outcomes for adults. (Non Statutory)	

Section B	
Requesting a SAR to be undertaken	Tick when complete
The requestor has reasonable grounds to believe that a SAR has been met	
The local SAR request form has been competed	
The SAR has been logged	
The Director for Adult Social Care has been notified	
The SAR Panel Chair has convened a panel to consider the SAR request	
Enough information has been submitted to make a decision as to whether the SAR criteria has been met *Note: if the board members have decided that there request does not meet the criteria for a SAR please go to section B.1*	
The Director for Adult Social Care has been notified	
The requestor has been notified	
The Panel and SAR Panel Chair have agreed the most appropriate/beneficial methodology to be employed	
The SAR has been commissioned	
Section B.1	
Process if the request has not met the criteria for commissioning a SAR	Tick when complete

The SAR Panel have considered whether an alternative review/ learning event/ audit are in place	
The SAR Panel Chair has been notified of the decision	
The referrer has been notified by letter from the Chair of the SAR Panel, within a reasonable time scale, outlining the reasons for the decision *Note: the requestor has the right to appeal the decision, if the appeal is upheld the SAR process will continue to from this point onwards however, if the SAR criteria has not been met and the requestor's appeal has not been upheld, the SAR log should be updated and the request should be closed. Refer to section B.2 below on the process to holding a learning event. Section B2 Learning event*	
Section B.2	
Learning event A learning event can be organised when the decision has been made that the criteria does not meet the SAR threshold. Learning events are a way of having open and honest conversations using an action focussed approach. The approach will vary with each case. However, their benefit and value is not to be underestimated. Learning events can encourage excellence within an organisation and improve the way organisations and agencies work together.	Tick when complete
The agencies involved have been contacted and are willing to partake in a learning event	
A facilitator has been appointed	
The group have met and the discussions have led to an action plan with dates for completion	
The responsible person has ensured that the actions agreed have been completed in a timely manner and has logged the outcomes	

Section C	
Making decisions on the SAR Methodology The circumstance of the case will dictate the most appropriate methodology. Despite the methodology employed the following elements should feature in the SAR. The range and type of learning will be impacted by the type of methodology used.	Tick when complete
The Panel and Chair have appointed a SAR Chair, who is independent of the case under review and of the organisations involved. They have the appropriate skills, knowledge and experience. They will be able to: • motivate others • handle multiple competing perspectives with strong leadership skills • analyse qualitative data • use their Adult safeguarding knowledge and experience to implement a collaborative approach to problem solving • This person could be drawn from a list of multiagency professionals in a senior role to promote transparency and independence	
A SAR Panel of relevant people responsible for scrutinising information submitted has been appointed. They will be responsible for appointing a reviewer with the relevant skills, experience and references. *Note: The size of the panel should be proportionate to the nature and complexity of the review*	
The Terms of Reference have been developed outlining roles, responsibilities, scope and focus. This does not include issues that are being resolved using other legislation.	

Discussions have been had with the family / individual involved as to the level of engagement and their expectations (See section E for more details)	
Professionals and organisations involved with the individual have been notified that they have the opportunity to contribute (See section F more details)	
The methodology includes a final report which set out recommendations and wider learning (See section H more details)	

Section D	
Methodology options	Tick when complete
Rapid Review	
Traditional Serious Case Review Model	
Action Learning Approach	
Individual Agency Review	
Peer Review Approach	
Significant Event Analysis/Audit	
Case File Audit (single or multi)	
Root Cause Analysis	
Thematic Review	
All members of the SAR panel are aware of the methodology chosen and agree its suitability	

Section E	
Adult and family involvement	Tick when complete
Support and advocacy has been considered and organised for the individual involved if they are to engage with the review	
Support and advocacy has been considered and organised for the relatives of the individual involved if they are to engage with the review	
Arrangements have been confirmed for any on-going support (e.g. legal support)	
The individual and their families have been made aware that the SAR is not to apportion blame but to use the learning to improve practice and working within and between the agencies involved	
There has been clear consideration given to the specific input of the individual and their family if they have survived	
Due diligence, compassion and appropriate support has been provided to the individual involved and /or their relatives	

Section F	
Supporting staff and others in involved	Tick when complete
The staff and agencies have been notified that they have been involved in a case that will be reviewed and they have considered how they would like to/ would like their staff to engage with the SAR	
The nature, scope and time scales have been communicated to the staff involved and their managers	
Staff have been encouraged to share their opinions and views in an open and honest way, as this will facilitate beneficial learning	

Agencies are aware that they have a responsibility to providing a safe environment for their staff to discuss their feeling and receive support	
Agencies have decided how they will share the learnings once the conclusions have been published	
Agencies have made it clear to their staff that they may need to engage in learning despite not being involved in the SAR themselves	

Section G	
Professional conduct	Tick when complete
The West Midlands Safeguarding Adults Policy and procedure has been reviewed in conjunction with this section	
It has been made clear to staff and all agencies that the SAR Panel are not to deal with issues of professional conduct that may become apparent during a SAR	
The SAR Panel Chair has fed back the individual conduct issues to the relevant agency as it is their responsibility to trigger any action in proportion with the concerns passed on by the SAR Panel	

Section H	
SAR reports and recommendations	Tick when complete
The West Midlands Safeguarding Adults Policy and procedure has been reviewed in conjunction with this section	
The SAR panel chair has facilitated sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process.	
The SAR report has been based upon the systematic, practice and procedural issues and the key learnings have been identified	
The SAR panel have reviewed the report and are in agreement with the conclusions and recommendations proposed before it is presented to the SAB	
The individual involved and / or their relatives have been offered the opportunity to review the report	
The SAB have made a decision as to who the report will be made available to and to what extent i.e. full / part of the report. They have considered the reputational risk and national learning	
The report has been anonymised	
The report has been stored according to legal requirement, the Data Protection Act and the local authorities information sharing agreement	

Section I	
Quality assurance of the SAR Quality assurance of the SAR Quality assurances are embedded throughout the SAR process from appointing an Independent Chair to lead the review, to the giving the individual involved/ their families an opportunity to review the report. The first element of quality assurance is to demonstrate clear evidence that the SAR learning report has been embedded. There are other arrangements that could be put in place which will allow for further assurance. You could ensure you have:	Tick when complete
Employed the most appropriate SAR methodology for the individual case	

Commissioned a suitably skilled, experienced and independent SAR reviewer to lead the review and analysis. They have the appropriate skills and training/shadowing experience	
Chosen independent SAR panel members with no conflict of interest	
Focussed on outlining the causal factors and systems learning	
Requirements have been written into the terms of reference for the SAR to take a broad learning approach	
The report provides a sound analysis of what happened, why and what action needs to be taken to prevent the same issues occurring again	
The report has enough information for the SAB to review and quality assure	
The report provides practical value to the individuals and organisations involved	

Section J	
Acting on the recommendations of the SAR	Tick when complete
SAR Panel have translated the recommendations from the report to into a multiagency action plan *Note: The SAR will need to be published within the TWSP Annual Report even if they choose not to implement these actions.*	
The action plan includes: • The actions that are needed. • Who is responsible for specific actions • Timescales for completion of actions are appropriate with specific end dates • The intended outcomes: what will change as a result • Mechanisms for monitoring and reviewing intended improvements. • The plan for dissemination of the SAR report or its key findings.	
The individual agencies have produced their own action plan where necessary as per internal governance processes	
The SAR Panel are aware that they are responsible for ensuring that the actions have been implemented from the multiagency action plan	