Safeguarding Adult Review (SAR) Methodology Toolkit
June 2025

This toolkit outlines a range of methodologies to consider and adopt for the commissioning and delivery of Safeguarding Adult Reviews (SARs).

Statutory guidance (14.164) states;

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring.

Where a referral for SAR has been agreed as meeting the criteria (Care Act 2015 s 44), the SAR sub-group will select the appropriate methodolgy which is proportionate for the case under review however the following should also be considered;

* Complexities of the case for review; including the proposed scope period under review.

* Parallel reviews e.g. DARDR/LeDeR; including criminal investigations as this will impact on the review.

* Ensure a proportionate approach is taken which identifies learning in a timely manner, taking into account SAB work priorities already established, or planned including SARs in progress.

* Learning from single agency reviews.

* Family engagement in the process; early engagement with family is essential.

* Appropriate involvement from professionals or organisations involved with the adult.

* Learning from previous SARs with similar themes (locally and nationally) which can inform the terms of reference and methodology.

* Aim for completion within a reasonable period of time or 6 months from initiating; commissioning completed, methodolgy agreed and review process commenced.

A hybrid of methodologies can be considered to provide a lens for learning which supports the terms of reference and is proportionate to the review.
It is essential that the selected methodolgy is the 'best fit' for the circumstances and case for review. Essentially the unique circumstances of the review including the scope period should inform the selected and proportionate methodolgy.
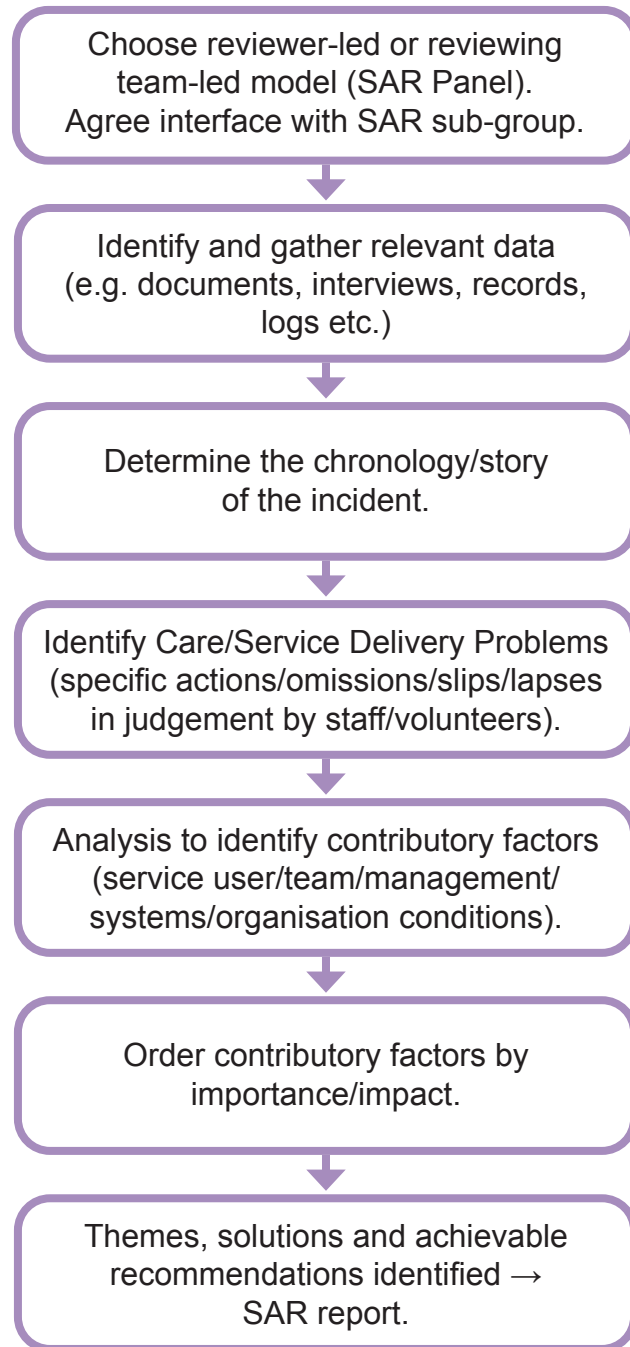
The methodolgies in this toolkit can be considered when commissioning a mandatory (s44.1) or discretionary SAR (s 44.4). The toolkit can also be used where the SAB has agreed to do an informal non statutory learning review and inform the process and methodolgy as best practice.

Note; following ministerial guidance published in 2024, SAR referrals involving adults who are/were homeless should be considered by the SAB but are not mandatory to progress.

Social Care Institute for Excellence (SCIE) has key best practice for conducting Safeguarding Adult Reviews which should be considered when commissioning and conducting SARs. **List of 15 Safeguarding Adult Reviews Quality Markers - SCIE**

This toolkit is adapted from a model used by Kirklees SAB, thanks and acknowledgment.

Cumbria Safeguarding Adults Board

Option A: Systems Analysis

Choose reviewer-led or reviewing team-led model (SAR Panel). Agree interface with SAR sub-group.

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Identify and gather relevant data (e.g. documents, interviews, records, logs etc.)

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Determine the chronology/story of the incident.

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Identify Care/Service Delivery Problems (specific actions/omissions/slips/lapses in judgement by staff/volunteers).

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Analysis to identify contributory factors (service user/team/management/systems/organisation conditions).

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Order contributory factors by importance/impact.

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Themes, solutions and achievable recommendations identified → SAR report.

Key features:

✓ Reviewer led and/or Panel.
✓ Staff/adult/family involved via interviews.
✓ No single agency management reports.
✓ Integrated chronology.
✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change.

Advantages:

- Structured process of reflection
- Reduced burden on individual agencies to produce management reports
- Analysis from a team of reviewers may provide more balanced view
- Managed approach to staff involvement may fit well where criminal proceedings are ongoing
- Enables identification of multiple causes/ contributory factors and multiple causes
- Range of pre-existing analysis tools available (SCIE)
- Focusses on areas with greatest potential to cause future incidents
- Based on thorough academic research and review
- Root Cause Analysis* tried and tested in healthcare and familiar to health sector SAB members.

Disadvantages:

- Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions.
- Staff/family involvement limited to contributing data, not to analysis.
- Potential for data inconsistency/ conflict, with no formal channel for clarification.
- Unfamiliar process to most SAB members.
- Trained reviewers not widely available
- Structured process may mean it's not light-touch.
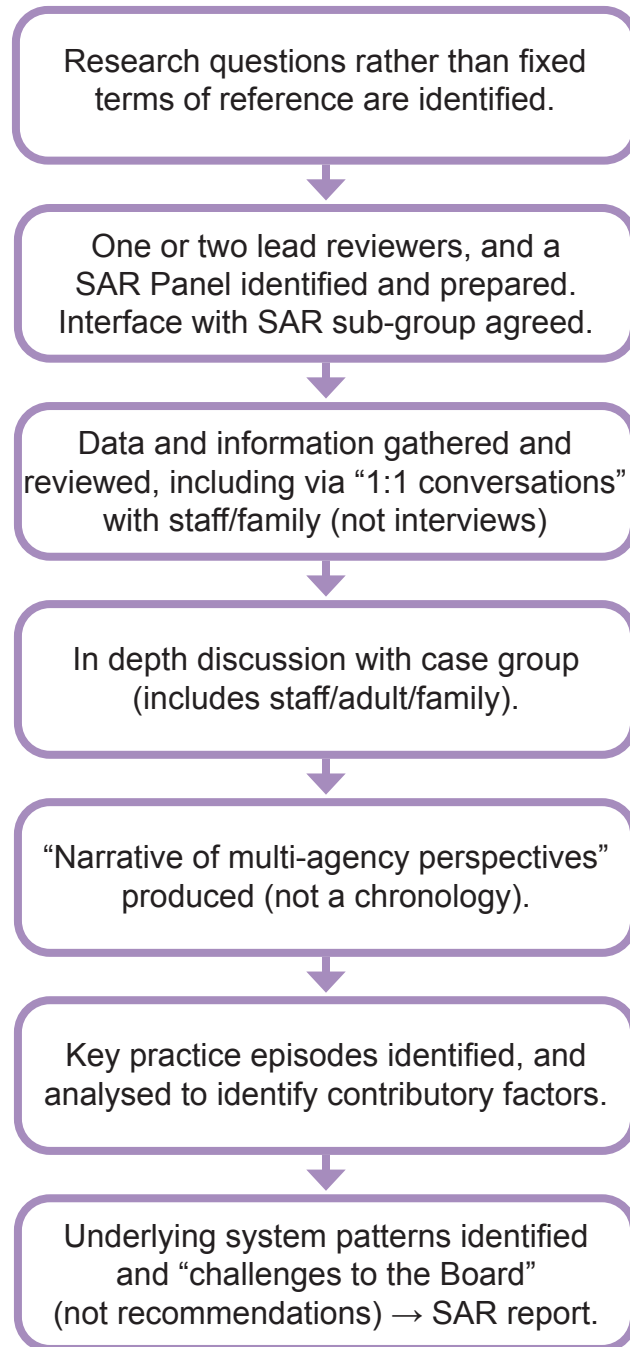- RCA* may be more suited to single events/incidents and not complex multi-agency issues.

Available models:

Vincent et. al. (2003) **Systems analysis of clinical incidents: the London Protocol**

Woloshynowych et. al. (2005) **Investigation and analysis of critical incidents**

NHS National Patient Safety Agency (NPSA)* **Root Cause Analysis**

Option B: Learning Together

Research questions rather than fixed terms of reference are identified.

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One or two lead reviewers, and a SAR Panel identified and prepared. Interface with SAR sub-group agreed.

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Data and information gathered and reviewed, including via "1:1 conversations" with staff/family (not interviews)

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In depth discussion with case group (includes staff/adult/family).

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"Narrative of multi-agency perspectives" produced (not a chronology).

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Key practice episodes identified, and analysed to identify contributory factors.

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Underlying system patterns identified and "challenges to the Board" (not recommendations) → SAR report.

Key features:

✓ Lead reviewer led, with SAR Panel.

✓ Staff/adult/family involved via case group and 1:1 conversations.

✓ No single agency management reports.

✓ Integrated narrative; no chronology.

✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages:

• Structured process of reflection.

• Reduced burden on individual agencies to produce management reports.

• Analysis from a team of reviewers and case group may provide more balanced view.

• Staff and volunteers participate fully in case group to provide information and test findings.

• Enables identification of multiple causes/ contributory factors and multiple causes.

• Tried and tested in children's safeguarding.

• Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity.
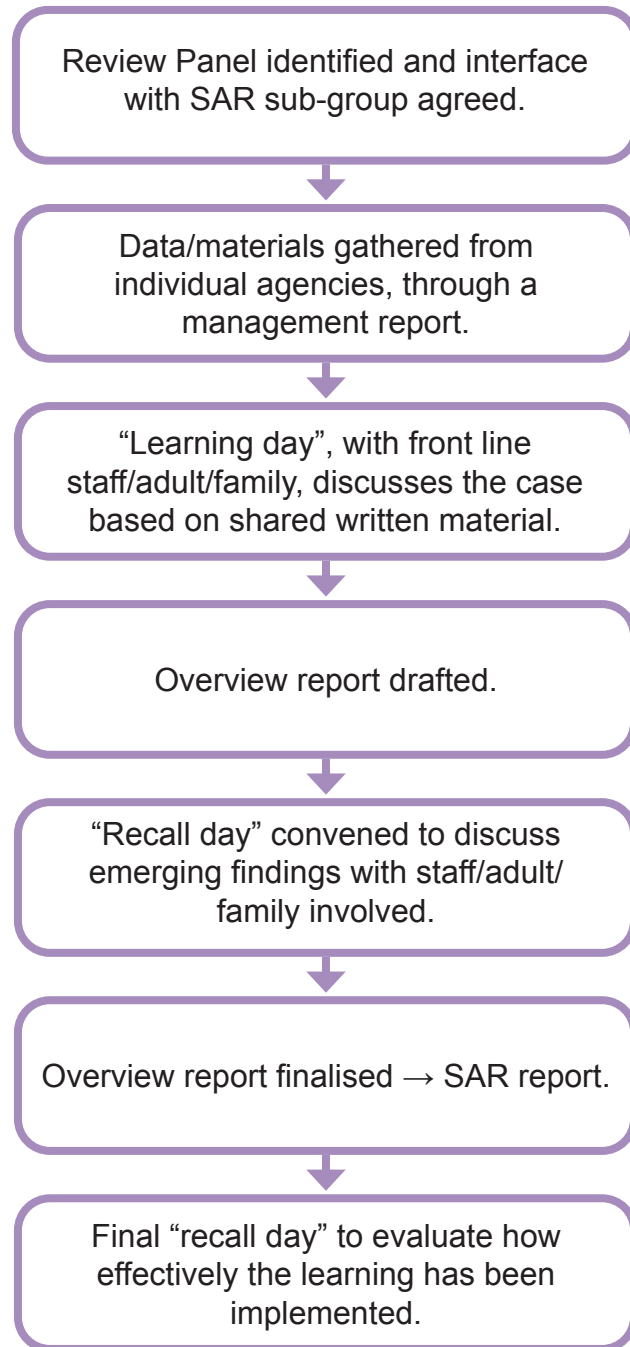
• Range of pre-existing analysis tools.

Disadvantages:

• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions.

• Challenge of managing the process with large numbers of professionals/ family involved.

• Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.

• Cost - either to train in-house reviewers, or commission SCIE reviewers for each SAR.

• Opportunity costs of professionals spending large amounts of time in meetings.

• Unfamiliar process to most SAB members.

• Structured process may mean it is not light-touch.

Available models:

SCIE, Learning Together

Option C: Significant Incident

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│ Review Panel identified and      │
│ interface with SAR sub-group     │
│ agreed.                          │
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┌─────────────────────────────────┐
│ Data/materials gathered from     │
│ individual agencies, through a   │
│ management report.               │
└─────────────────────────────────┘
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┌─────────────────────────────────┐
│ "Learning day", with front line  │
│ staff/adult/family, discusses    │
│ the case based on shared         │
│ written material.                │
└─────────────────────────────────┘
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┌─────────────────────────────────┐
│ Overview report drafted.         │
└─────────────────────────────────┘
              ↓
┌─────────────────────────────────┐
│ "Recall day" convened to discuss │
│ emerging findings with staff/    │
│ adult/family involved.           │
└─────────────────────────────────┘
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┌─────────────────────────────────┐
│ Overview report finalised →      │
│ SAR report.                      │
└─────────────────────────────────┘
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┌─────────────────────────────────┐
│ Final "recall day" to evaluate   │
│ how effectively the learning     │
│ has been implemented.            │
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Key features:

- ✓ Review Panel and learning day led.
- ✓ Staff/family involved via learning day/s.
- ✓ Single agency management reports
- ✓ No chronology.
- ✓ Multiple learning days over time.
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why.

Advantages:

- Flexible process of reflection - may offer more scope for taking a light-touch approach.
- Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants.
- Has similarities to traditional SCR approach, so more familiar to most SAB members.
- Agency management reports may better support single agency ownership of learning/actions.
- Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity.
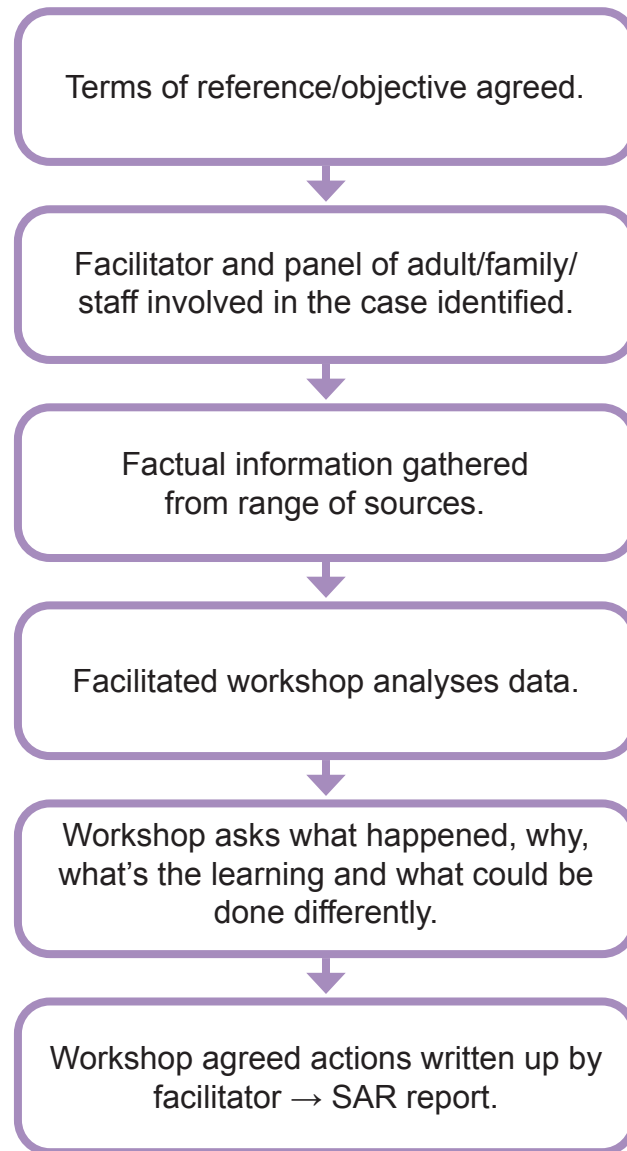
Disadvantages:

- Burden on individual agencies to produce management reports.
- Cost - either to train in-house reviewers, or commission SILP reviewers for each SAR.
- Opportunity costs of professionals spending large amounts of time in learning days.
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.
- Not been widely tried or tested, nor gone through thorough academic research/ review.

Available models:

Significant Incident Learning Process

Option D: Significant Event Analysis (Day review)

Terms of reference/objective agreed.

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Facilitator and panel of adult/family/ staff involved in the case identified.

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Factual information gathered from range of sources.

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Facilitated workshop analyses data.

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Workshop asks what happened, why, what's the learning and what could be done differently.

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Workshop agreed actions written up by facilitator → SAR report.

Key features:

- ✓ Group led (via panel), with facilitator.
- ✓ Staff/adult/family involved via panel.
- ✓ No chronology.
- ✓ No single agency management reports.
- ✓ One workshop: quick, cheap.
- ✓ Aims to understand what happened and why, encourage reflection and change.

Advantages:

- Light-touch and cost-effective approach.
- Yields learning quickly.
- Full contribution of learning from staff involved in the case.
- Shared ownership of learning.
- Reduced burden on individual agencies to produce management reports.
- May suit less complex or high-profile cases.
- Trained reviewers not required.
- Familiar to health colleagues.

Disadvantages:

- Not designed to cope with complex cases.
- Lack of independent review team may undermine transparency/legitimacy.
- Speed of review may reduce opportunities for consideration.
- Not designed to involve the family.
- Staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.

Available models:

NHS Education for Scotland and NPSA, **Significant Event Analysis**

Care Quality Commission, **Significant Event Analysis**

Royal College of General Practitioners, **Significant Event Audit**

Option E: Appreciative Inquiry

Terms of reference/objectives agreed. Panel of staff involved in the case identified and a facilitator.

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Discovery phase - appreciation of best work done and system conditions making innovative work possible.

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Meeting between facilitator and adult/family member to ascertain adult's/family views.

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Celebration phase - whole panel discussion to heat from practitioners on what works, including adult's/family views.

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Report of discussion sent to manager of each contributing agency.

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Strategy phase - whole panel meets to agree how to share the findings with the SAB → SAR report.

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Recognition phase - each agency shares good practice internally and endorses practice highlighted from their agency.

Key features:

✓ Panel led, with facilitator.

✓ Staff involved via panel. Adult/family involved via meeting.

✓ No chronology/management reports.

✓ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often.
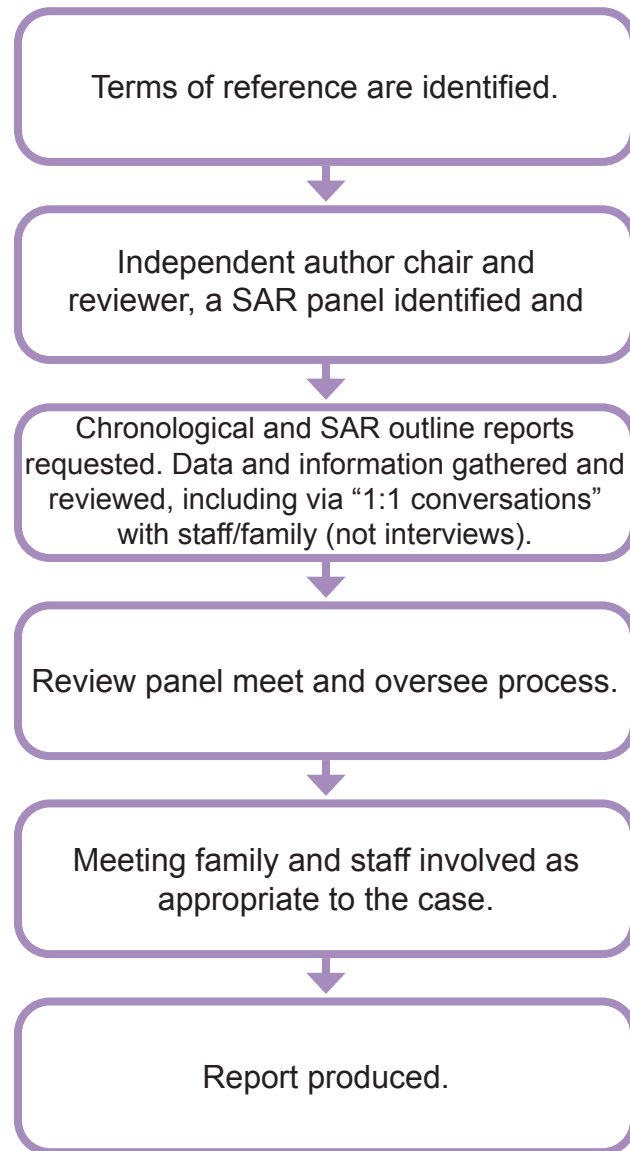
Advantages:

• Light-touch, cost-effective and yields learning quickly - process can be completed in 2-3 days.

• Staff who worked on the case are fully involved.

• Shared ownership of learning.

• Effective model for good practice cases.

• Some trained facilitators available.

• Well-researched and reviewed academic model.

• Model understood fairly widely.

Disadvantages:

• Not designed to cope with 'poor' practice/systems 'failure' cases.

• Adult/family only involved via a meeting.

• Speed of review may reduce opportunities for consideration.

• Model not well developed or tested in safeguarding. Minimal guidance available.

Option F: Safeguarding Adults Review: Traditional Methodology

Terms of reference are identified.

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Independent author chair and reviewer, a SAR panel identified and

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Chronological and SAR outline reports requested. Data and information gathered and reviewed, including via "1:1 conversations" with staff/family (not interviews).

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Review panel meet and oversee process.

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Meeting family and staff involved as appropriate to the case.

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Report produced.

Key features:

✓ Panel led with independent author/chair.

✓ Staff/adult/family involved via case group and 1:1 conversations.

✓ Single agency management reports.

✓ Single agency, no chronologies, then considered.

✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages:

• Structured process of reflection.

• Analysis from a panel and may provide more balanced view.

• Managers participate in SAR Panel.

• Practitioners participate in learning event to provide information and test findings.

• Enables identification of multiple causes/ contributory factors and multiple causes.

• Familiar process to most SAB members and wider partners.

• Range of pre-existing analysis tools available.

• Applicable if the case also meets the criteria for a Domestic Homicide Review.

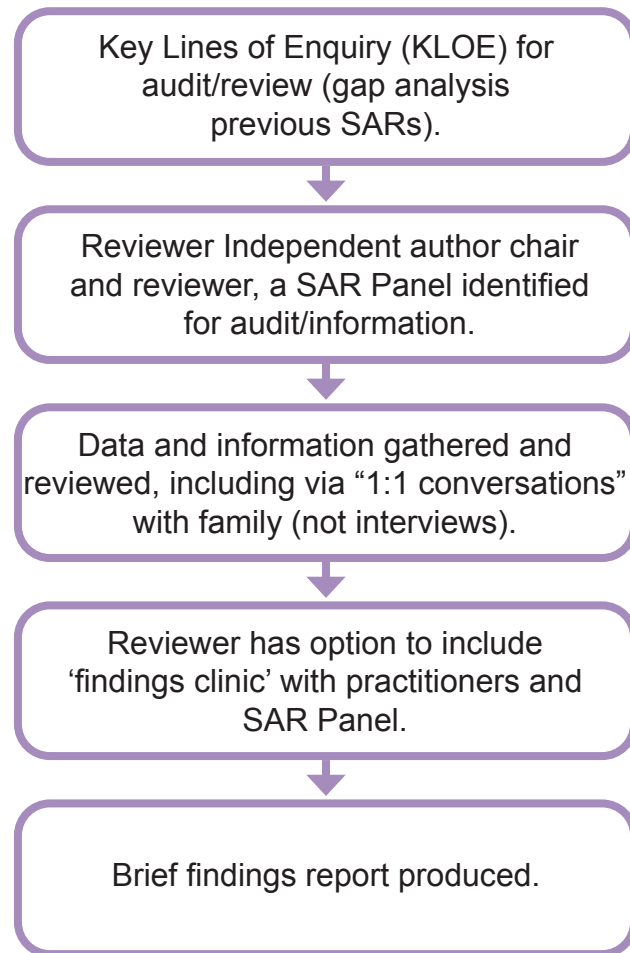**This approach can be used when conducting thematic reviews.**

Disadvantages:

• Burden on individual agencies to produce management reports.

• Challenge of managing the process with large numbers of professionals/family involved.

• Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.

• Cost - either to train in-house reviewers, or commission SCIE reviewers for each SAR.

• Opportunity costs of professionals spending large amounts of time in meetings.

• Structured process means it is not light-touch.

Available models:

SCIE Learning Together

Option G: Measurement of change analysis - desk-top review/case audit

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┌─────────────────────────────┐
│  Key Lines of Enquiry (KLOE) │
│  for audit/review (gap       │
│  analysis previous SARs).    │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│  Reviewer Independent author │
│  chair and reviewer, a SAR   │
│  Panel identified for        │
│  audit/information.          │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│  Data and information        │
│  gathered and reviewed,      │
│  including via "1:1          │
│  conversations" with family  │
│  (not interviews).           │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│  Reviewer has option to      │
│  include 'findings clinic'   │
│  with practitioners and SAR  │
│  Panel.                      │
└─────────────────────────────┘
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┌─────────────────────────────┐
│  Brief findings report       │
│  produced.                   │
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Key features:

✓ Reviewer led (independent or internal).

✓ Can be used to test out previous SAR learning; explore unique factors.

✓ Managers/case group conduct single agency audit; opportunity to meet as group reflect.

✓ Opportunity to include practitioners.

✓ Family involved via 1:1 conversations.

✓ Single agency audit, no chronologies or IMRs - information through KLOE questions.

✓ Aims to identify unique factors and learning to case drawing on previous learning identified.

✓ Reduces repeating previous SAR learning.

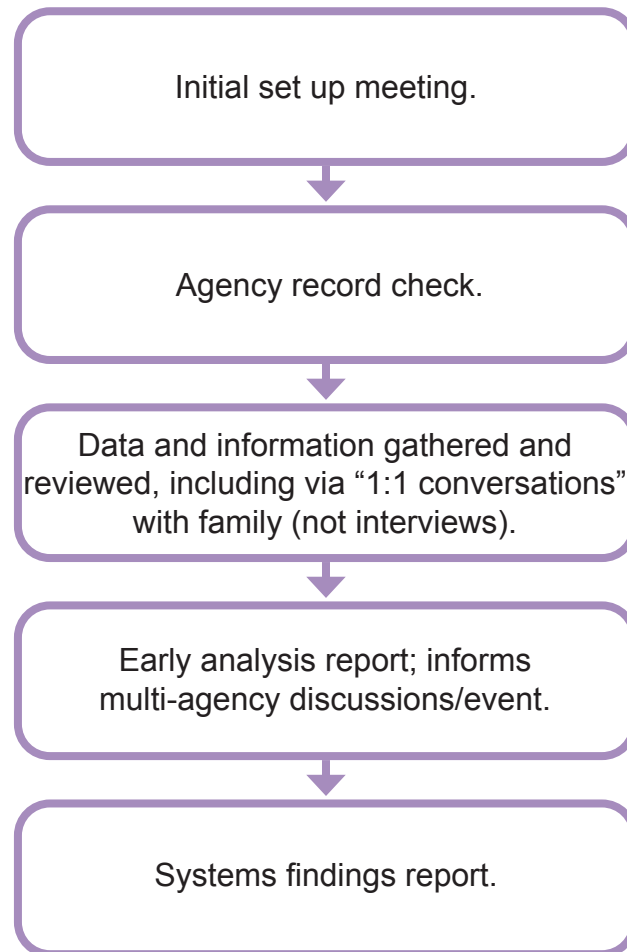✓ Assurance and update regarding embedding previous learning.

Advantages:

• Structured KLOE to inform review/audit and specific questions.

• Opportunity to include 'findings clinic' with case auditors and practitioners for reflections and more balanced view.

• Enables identification of unique factors and learning.

• Proportionate approach; reduced duplication opportunity to 'test' previous learning embedded.

• Flexibility of approaches ensures proportionate; can include 'findings clinic' with practitioners.

• Cost effective.

• Identify learning in a timely way.

Disadvantages:

• Requires review of previous SAR learning; inform gap analysis with case.

• Need to ensure effective engagement and contributions from family considered and inform report.

• SAB members not familiar with approach.

Option H: SAR in Rapid Time

Initial set up meeting.

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Agency record check.

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Data and information gathered and reviewed, including via "1:1 conversations" with family (not interviews).

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Early analysis report; informs multi-agency discussions/event.

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Systems findings report.

Key features:

✓ Reviewer led (independent or internal).

✓ Rapid review process.

✓ SCIE templates and guidance.

✓ Nationally trained reviewers in methodology.

✓ Standardised processes and templates support this speedy turnaround.

✓ SCIE can independently facilitate the approach, or the templates and tools can be used by anyone who would like to use the model.

Advantages:

• Aims to identify learning in rapid time (SCIE model.

• Could be adapted to lengthen the 'rapid time' period.

• Trained reviewers in the methodology.

• Toolkit and templates available.

• Cost effective.

• Questions for SAB consideration; systems approach.

Disadvantages:

• Commitment required to complete in rapid time.

• SAB members not familiar with approach.

• Due to time pressures; potential impact on family engagement during the review window.