social care
institute for excellence

Safeguarding Adult Review Quality Markers – open training session (2)

Flexible and bespoke commissioning of SARs

Dr Sheila Fish

SCIE

16 November 2022

SCIE support for high quality learning from SARs

Phase 1.


Supporting SAR Quality and impact
Refreshed SAR Quality Markers
Handbook
Comprehensive checklist tool
Role-specific checklist tool
Targeted briefings on SAR QMs
Virtual workshops x3:
Setting up the review
Running the review
Outputs, action and impact
Regional SAR Quality Champions
Self-nomination
Induction
Bespoke support
Beginning with regional SAR Subgroup sessions

Phase 2.
Open training sessions to support use of the SAR Quality Markers

SAR QMs targeted training sessions - open to all	SAR QM	Agreed date
1. Decision making whether a SAR is needed	SAR Quality Marker 2	Thursday 26th May 9.30-12.00
2. Flexible and bespoke commissioning -	SAR Quality Marker 5	Friday 17th June, 9.30-12.00
3. “Safety science”	SAR Quality Marker 12	Tuesday 28th June, 9.30-12.00
4. Different audiences for publication and dissemination	SAR Quality Marker 14	Wednesday 20th July, 9.30-12.00
5. Logic Model / theory of change	SAR Quality Marker 15	Thursday 15th September 9.30-12.00

Register to attend

https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022

Today – options for different types of SAR

- What is a SAR?
- What counts as a SAR?
- Do SARs always need to look the same?
- What size or shape can it be?

Distinct from Session 3; ‘safety science’ focus on clarity of purpose and theoretical framework that underpins methodology

Learning Outcomes

By the end of the session participants will have:

- Appreciation the lack of prescription in the statutory guidance
- Increased confidence to use the discretion that is in your gift
- Increased awareness of the range of options beyond a standard SAR process =

Next steps from here: developing worked examples

A flexible session

1	9.30-10.30	Welcome and main input
	10.30-10.45	Short break
2	10.45- 11.15	Break-out rooms. Share reflections from your different areas, helpful approaches and ways of working; what would you like more input on
3	11.15- 11.45	Quality Marker 5
4	11.45-12.00	Wrap up and close

Stay with us for as many sessions as are useful to you

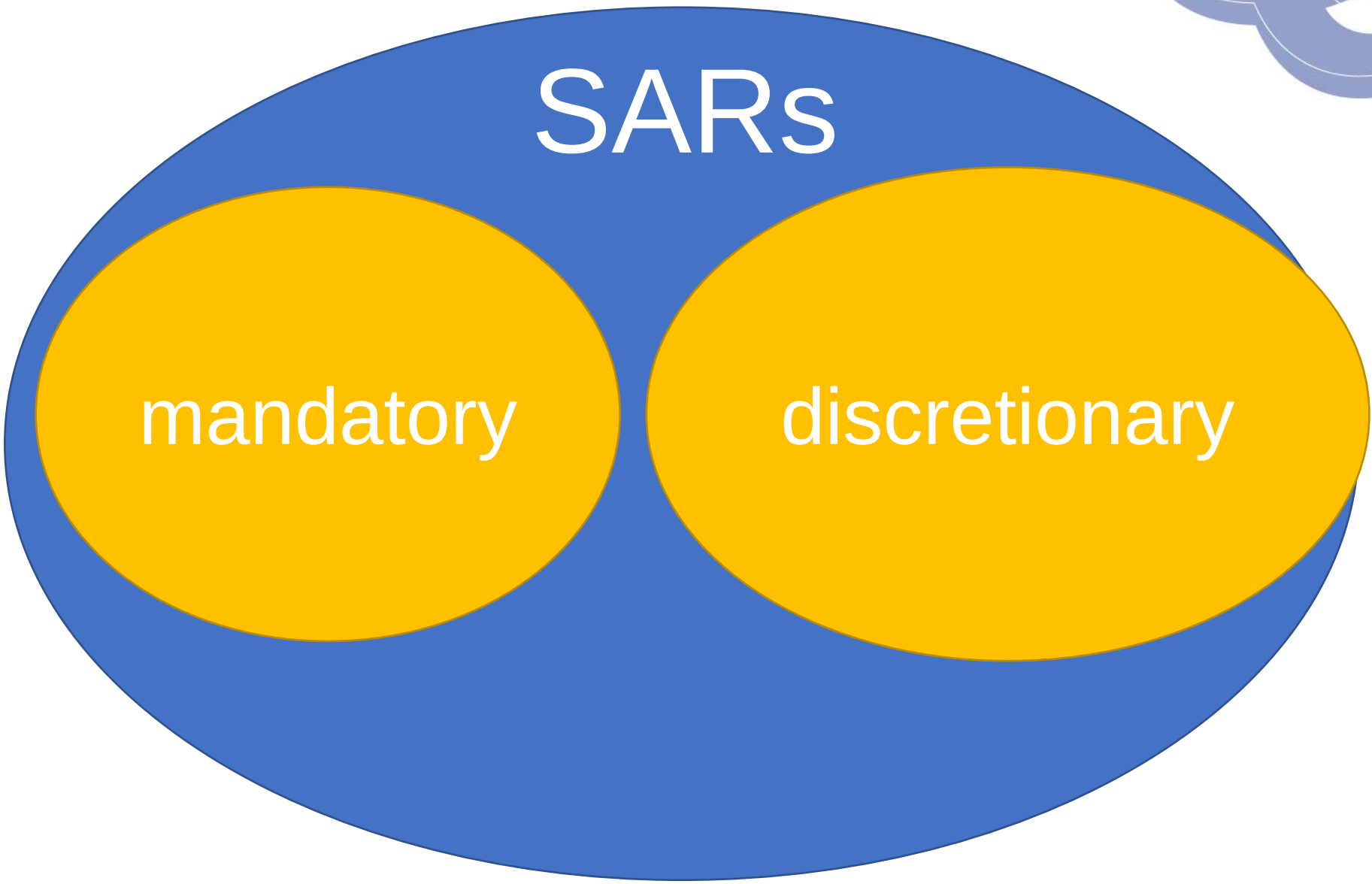
We'll share a link to an evaluation form at the end of each session

Outline of part 1

1. Background and why this is necessary and important
2. Care Act statutory guidance
3. What we know about current practice
4. Developments in other sectors
5. Key features of QM 5
6. A local SAB example

1. Background & recap of Session 1

All SARs are statutory



An emerging tension

Renewed focus on compliance with statutory requirements to conduct mandatory SARs in certain circumstances linked to death or serious injury

Evidence base indicating need for a proactive approach; selecting incidents on basis of opportunities for learning not severity of outcome

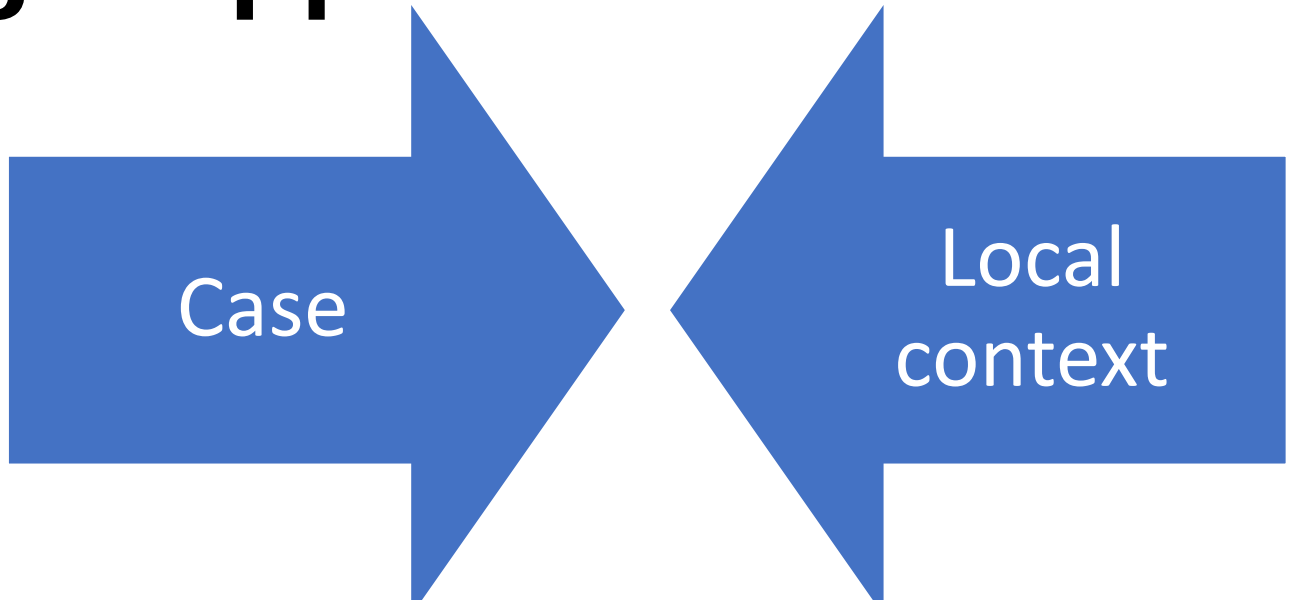
National analysis of SARs highlighted:

- Non-compliance – 22% no SARs April 2017-19
- Lack of precision about the legal basis
- Blatant lack of understanding
- National Rec 5: SABs & partners review understanding of legislation;
- National Rec 6: Regional & national networks review approaches to interpretation and application of s.44

- Safety-I to Safetly-II
- From 'swiss cheese' to Lilypond model
- New NHS Patient Safety Incident Response Framework (PSIRF)
- Child Safeguarding Practice Reviews – from criteria led, to consideration about learning potential

SAR QM2 attempts to recognise both aspects, and encourages a strategic approach using details of both case & local context

SAR QM2 attempts to recognise both aspects, and encourages a strategic approach



2 Quality Marker 2: Decision making – what kind of SAR, if any

Quality statement: **Factors related to the case and the local context inform decision making about whether a SAR is required and/or desired and initial thinking about its size and scope. The rationale for these decisions is clear, defensible and reached in a timely fashion.**

SAR QM 5

- 5.2.4 Have discussions about the precise form and focus of the SAR built on initial information gathering about case and local context (QM 2), drawing on the right range of information including:
  - Evidence of impact on adults with care and support needs and their families, including of any serious public concern and/or potential media interest •
  - Other quality assurance and feedback sources e.g. audits/complaints
  - Relevance to SAB strategic, current and/or future priorities
  - Previous SARs locally, regionally and nationally (as relevant).

Being strategic about identifying areas/themes where we know there are practice problems and we need to understand how organisational and social dynamics are influencing peoples work; Also where we need to understand what is allowing safeguarding to happen well in our complex multi-agency system

Increasing volume of SARs

- Heightens the need to be proportionate
- To be flexible, creative, bespoke, strategic in commissioning
- In order to get the most practical value from our SARs to inform and drive improvements

Very limited consideration of how to be proportionate

- **E.g. Commissioning a SAR involving a type of abuse/neglect that had been the focus of one or more earlier reviews**
- Response generally: to commission a further individual SAR
- Rather than consider a proportionate response e.g. start with the learning and recommendations from earier reviews and then question what has (not) changed, what has facilitated or obstructed change and what further work is required.

2. What the statutory guidance prescribes

Very little

- Gives SABs discretion as to what type of review process is most likely to promote effective learning and improvement action;
- Advises that reviews should be proportionate to the scale and complexity of the case.
- Requirements:
  - Inform and involve the person and relevant family
  - Engage operational staff

The detail

- ‘The SAB should primarily be concerned with weighing up what type of “review” process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again’. (14.164)
- SARs should reflect the 6 safeguarding principles (14.166)
- 5 additional principles should be applied to all reviews:
  - A culture of continuous learing and improvement across the organisations … identifying opportunities to draw on what works and promote good practice
  - The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
  - Led by individuals independent of the case under review
  - Professionals should be involved fully and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
  - Families should be invited to reviews, understand how they are going to be involved and their expectations managed appropriately and sensitively (14.167

The detail

- The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable in all cases (14.170).

- The focus needs to be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. (14.170).

- SAR reports should provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible … contain findings of practical value to organisations and professionals (14.178)

3. What do we know about current practice?

Very limited range of types of review process

Types of review used in the SARs										
Type of Review	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	All regions
Learning review	6%	14%	2%	29%	13%	11%	8%	11%	19%	10%
Standard SAR	76%	43%	92%	53%	79%	75%	79%	78%	63%	78%
Thematic review	0%	14%	3%	6%	0%	4%	4%	0%	6%	3%
Other	18%	29%	3%	12%	8%	11%	8%	11%	13%	9%

- Vast majority used ‘standard’ SAR approach
- Others only thematic review or ‘learning review’ or jointly commissioned SAR/DHR or SCR/SAR
- Most gave no indication of why a particular approach taken
- Terminology frequently obscured rather than clarified the approach being adopted e.g. “learning review” “concise review” or “internal focused review”

Methods used for gathering information

Regional breakdown of methods used for gathering information										
Information gathering method	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	Total
Chronology	71%	57%	48%	29%	68%	75%	50%	42%	63%	57%
IMR	71%	71%	36%	41%	47%	64%	67%	50%	31%	51%
Interviews	6%	14%	29%	12%	29%	39%	46%	17%	13%	27%
Learning event	53%	57%	39%	35%	61%	57%	63%	33%	50%	50%
Not specified	6%	0%	26%	41%	13%	7%	4%	17%	19%	17%
Other	18%	14%	35%	18%	42%	46%	38%	8%	44%	33%

- Limited range of approaches to gather information
- Chronologies, internal agency management reviews and manager learning events most commonly used
- Often not specified

Occasional acknowledgement of proportionality

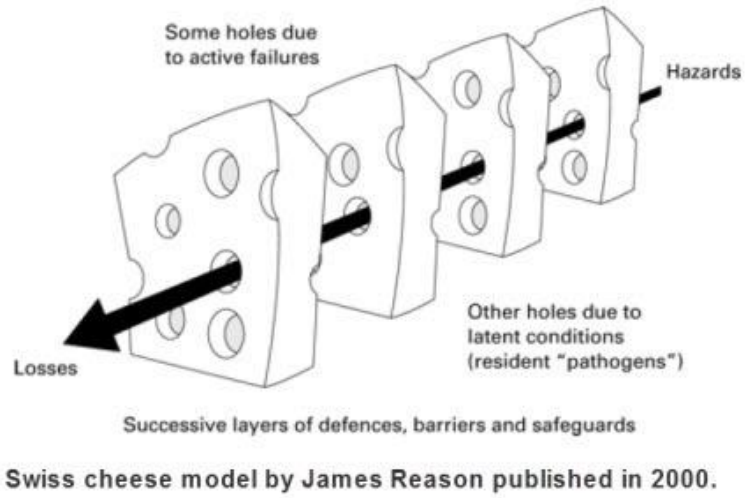
- Local learning review; a thematic review; joint reviews explained as a proportionate response
- “Some SABs have been in the position of commissioning a SAR involving a type of abuse and/or neglect that has been the focus of one or more earlier reviews. The response generally has been to commission a further individual SAR rather than to consider a proportionate response that begins with the learning and recommendations from earlier reviews and then questions what has (not) changed, what has facilitated or obstructed change, and what further work is required”

Improvement priority eleven
Regional and national networks provide a space where SABs can discuss learning regarding a proportional and change-oriented approach to cases involving types of abuse and neglect that have previously been the subject of local reviews.

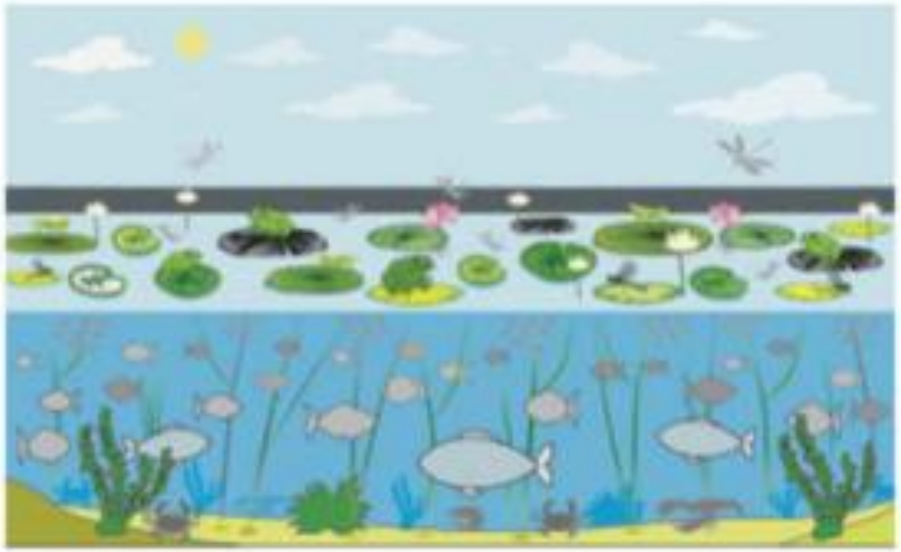
4. Developments in other sectors

Current ‘safety science’ evidence base

From Safety-1 …. to Safety-11



Swiss cheese model by James Reason published in 2000.



From ‘swiss cheese’ ….

…. to ‘lily pond’ model

Reflected in changes in the NHS

- The Patient Safety Incident Response Framework (PSIRF) replacing the Serious Incident Framework 2015
- Supported with the first systemwide patient safety syllabus, training, and education framework for the NHS.

	Changes related to patient safety *incident management and investigation*
A strategic, risk-based approach to PSII	• Moves **away** from reactive and hard-to-define thresholds for Serious Incident investigation and **towards** a proactive approach to safety and learning investigations. • Selects incidents for PSII based on the opportunity for learning. • Selects PSIIs for learning to ensure the wide range of outcome severities is covered. • Introduces local provider patient safety incident response plans (PSIRPs), agreed with commissioners. • Highlights alternative, proportionate and effective responses to incidents (eg case note review, timeline mapping, 'being open' conversations, after action review, audit), to better describe common review activities and address queries. • Prioritises the quality of PSII to support improvement. • Supports more balanced allocation of resources to develop

Patient Safety Incident Response Framework (PSIRF)

Patient safety incident investigation tools

The following are provided as an adjunct to investigation training. Patient safety investigation is an important and complex task. It is not intuitive and should not be undertaken by those who have not attended training and gained skills and experience from specialists in the field.

- PSII incident mapping – worksheet – A template to assist in the compilation of a timeline/chronology of events leading up to a patient safety incident. A flowchart or a two-dimensional depiction of the work/task can add great value.
- PSII contributory and mitigation factors classification – A taxonomy of key factors (including ergonomic and human factors), which underlie patient safety incidents.
- PSII contributory, causal and mitigating factors analysis – worksheet – A tool designed for use in conjunction with the contributory factors framework above, to guide and organise the analysis of interconnected, contributory, causal and mitigating factors
- PSII change analysis tool – A template to identify and document variations to policy, protocol or expected practice (work as imagined). It is important to note that variations are common and are most often the result of efficiency-thoroughness trade-offs.
- PSII nominal group technique tool – A template to prioritise problems and their further analysis.
- PSII options appraisal and impact analysis tool – A tool to assess and compare the relative efficacy, value and cost of a range of solutions. This can be used either at the improvement development stage, or after the solutions/improvements have already been implemented.

- Risk assessment tool – A tool to assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and sensible control measures applied (eg clinical, safety, business risks).

https://www.england.nhs.uk/patient-safety/patient-safety-investigation/

Review methods/tool (more appropriate alternatives to investigation)

- Incident Recovery – Taking urgent measures to address serious and imminent: discomfort, injury, threat to life, damage to equipment or the environment.
- Case record review/Case note review – To determine whether there were any problems with the care provided to a patient by a particular service (when routinely identifying the prevalence of issues; or when bereaved families/carers or staff raise concerns about care).
- 'Being open' conversations – To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
- Hot debrief – To conduct a post-incident review as a team by discussing and answering a series of questions
- Safety huddle – A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data to:
  - improve situation awareness of safety concerns
  - focus on the patients most at risk
  - share understanding of the day's focus and priorities
  - agree actions
  - enhance teamwork through communication and collaborative problem-solving
  - celebrate success in reducing harm.
- After-action review – A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely
- LeDeR (Learning Disabilities Mortality Review) – To review the care of a person with a learning disability (recommended alongside a case note review
- Perinatal mortality review tool – A systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care
- Mortality review – A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients
- Audit – To systematically determine whether the activities, resources and behaviours and outcomes are as expected/intended
- Clinical Audit – A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes
- Risk assessment – To determine the likelihood and severity of identified hazards and apply sensible measures to control those risks (eg clinical, safety, business).

Child Safeguarding Practice Reviews similarly -

- Key change to Working Together to Safeguarding Children 2018 was a move from criteria led decisions about conducting LCSPRs, to a requirement to consider whether a review is needed

“Still too many rapid reviews focus on whether the criteria have been met, rather than on the subsequent considerations about whether there is any further learning to be gained beyond the rapid review” (Mark Gurrey, National Panel)

Beyond IMRs, combined chronologies, and long overview reports

"LSCPRs are not SCRs by another name. … There's a real need for us to put behind us the SCR method of thinking and get into a different, more creative way of conducting reviews into serious incidents. … Chose the best design of method to surface the learning" (Mark Gurrey, National Panel)

Recap

1. Background and why this is necessary and important
2. Care Act statutory guidance
3. What we know about current practice
4. Developments in other sectors

Make a good case for grasping the opportunity for a more flexible, bespoke, creative, strategic, proportionate approach to commissioning SARs

5. SAR QM 5

5 Quality Marker 5: Commissioning

Quality statement: **Strategic commissioning of the Safeguarding Adult Review takes into account a range of case and wider contextual factors in order to determine the right approach to identifying learning about what is facilitating or obstructing good practice and/or the progress of related improvement activities. Decisions are made by those with delegated responsibility in conjunction with the reviewers, and balance methodological rigour with the need to be proportionate.**

SAR QM 5 Commissioning, includes

Agreeing the right approach

5.2.5 Where it has been agreed that the review will focus on surfacing learning about what is facilitating or obstructing good practice in the case, have you made it clear whether or not you expect the SAR to:

- establish whether what obstructed or facilitated good practice in the case, was more widespread at the time and/or
- assess the current relevance of past practice barriers/facilitators identified in the case being reviewed?

5.2.6 Where a similar case has been subject of an earlier SAR and/or the target of recent improvement activity, has there been adequate consideration of what a proportionate approach would look like?

- For example, beginning with the previous learning identified about barriers and enablers to good practice, and improvement actions proposed, and commissioning the new SAR to focus on where good practice has been facilitated, where barriers to good practice still need to be confronted and what has obstructed change, or whether the barriers have changed since the original SAR.
- For example, targeting the SAR only on practice areas / issues that appear to be new in comparison with the case previously reviewed.

5.2.7 If consideration of the case and wider intelligence has identified an urgency to identifying and tackling the barriers to good practice in particular areas, have approaches that allow a speedy turn-around of learning been considered?

- For example, the SAR In Rapid Time model.

5.2.8 Where similar cases or circumstances have been considered recently for a SAR, that suggest a local learning need in this practice area, has consideration been given to a themed SAR?

6. Local example

Background

- History of using very traditional model for SARs
- Recommendations proved difficult to work with
- Volume of SARs increasing especially since Covid
- Knock-on on the amount of recommendations
- Duplication of recommendations across different SARs
- Frustrating - inefficient & ineffective

Taking a grip of commissioning process; focusing on the ToR

- Developed a new process
- Terms of Reference more flexible, more varied
- Capture result of sub-group considerations of what issues the particular case lends itself well to helping us understand
- Always mindful to avoid going over same areas again, where we already have learning
- Using the ToR to keep the reviewer tightly to that focus

e.g. one case, focusing only on issues of support to unpaid carer

e.g. Had previously done a thematic self-neglect SAR. Since then had two more cases. Commissioned a very small review to check no additional practice issues: “gap analysis”. Record review; meet family; survey with practitioners

From the chat – reflections, comments, questions, concerns?

Phase 2.
Open training sessions to support use of the SAR Quality Markers

SAR QMs targeted training sessions - open to all	SAR QM	Agreed date
1. Decision making whether a SAR is needed	SAR Quality Marker 2	Thursday 26th May 9.30-12.00
1. Flexible and bespoke commissioning	SAR Quality Marker 5	Friday 17th June, 9.30-12.00
1. "Safety science"	SAR Quality Marker 12	Tuesday 28th June, 9.30-12.00
1. Different audiences for publication and dissemination	SAR Quality Marker 14	Wednesday 20th July, 9.30-12.00
1. Logic Model / theory of change	SAR Quality Marker 15	Thursday 15th September 9.30-12.00

Register to attend

https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022

Coffee break

SESSION 2. Break-out rooms

- Sharing reflections on input this morning
- Any local practice / developments that are useful to share?
  - Examples of flexible, creative, bespoke ‘types’ of review?
- What more would you like clarity or support about?

SESSION 3. SAR QM5 encourages a strategic approach

Thank you!

- SCIE team

Sheila Fish, Suzanne Cottrell, Anna Muller and Yvonne Watkins-Knight

Sheila.fish@scie.org.uk
Reviews@scie.org.uk

References

- Michael Preston-Shoot, Suzy Braye, Oli Preston, Karen Allen and Kate Spreadbury (November 2020). Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for sector-led improvement. London: LGA https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

- Paul Stretton (2020) Lilypond: An integrated model of Safety II principles in the workplace. A quantum shift in patient safety thinking. Journal of Patient Safety and Risk Management 2020, Vol. 25(2) 85–90
- NHS England » Patient Safety Incident Response Framework