

# Tools to support SABs achieve the SAR Quality Markers

**Tool D - Beyond reactive, criteria-based decision-making for Safeguarding Adults Reviews (SARs)** 

### **Background**

Current statutory guidance means there are certain circumstances where a SAB has no option but to conduct a SAR; the SAR is mandatory. The SCIE decision-making tool aims to support SABs with compliance in this respect <a href="https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/practical-tools/decision-making/">https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/practical-tools/decision-making/</a>.

The Care Act 2014 Statutory Guidance states that: The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.<sup>1</sup> SABs therefore have discretion to determine the methodology used in any SAR. The first national analysis of SARs conducted, identified that the vast majority used a 'standard' SAR approach (78%). One of the rare alternative approaches used was a 'thematic review' (3%).<sup>2</sup> To-date no resources have been available to support SABs who may be considering commissioning more creatively and proportionately.

#### This document

The aim of this document is to support SABs to take more of a grip of the precise focus and form of any SARs commissioned. The goal is to enable SABs to see options available and chances to be pro-active and creative in the commissioning of a SAR. We hope it will support the commissioning of a wider range of SARs, and learning that is more relevant and useful because SABs better understand what the options available might be.

<sup>&</sup>lt;sup>1</sup> DHSC (2018) Care and Support Statutory Guidance: issued under the Care Act 2014. London: The Stationery Office.

<sup>&</sup>lt;sup>2</sup> Preston-Shoot M., Braye S., Preston O., Allen K. and Spreadbury K., (2020). Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement. London: LGA. See: <a href="https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019">https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019</a>.

# **Quality Marker 5: Commissioning**

SAR Quality Marker number five focuses on Commissioning. The quality statement reads:

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.

#### The SAR Quality Marker Handbook

(https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/handbook/) elaborates on some of the key concepts. This includes thinking about SAR commissioning strategically, rather than only reactively to the incident or circumstances of the case.

**Strategic commissioning** calls for SAR sub-groups to consider what issues the particular case lends itself well to helping them understand, and square that with where learning is actually needed locally, regionally or nationally.

#### Kinds of issue/area of focus

There are a number of different ways to think about the kinds of issues that a particular case lends itself to learning about, and/or to think about where you need learning. Four main lenses include:

# Particular safeguarding issues or type of abuses

• e.g., domestic abuse; self-neglect

### Particular personal circumstances

• e.g., living with dementia; multiple exclusion homelessness

### Particular practice areas or issues

• e.g., MCA assessments

# Particular systemic issues

• e.g., a professional norm; design of a tool; team structure; policy

# **Sources of intelligence**

Individual partners and SABs will have wider data about these different issues, from a range of different sources.



This range of data can be used to determine your local 'learning needs'. This may be because issues are new, or because they are recurring or because they are complex.

# **Strategic commissioning options**

**The 'right approach'** to getting the systems learning can draw from a range of options. The approach needs to be proportionate to the learning needs from this SAR, at this time.

In Quality Marker number five, the section for those with delegated responsibility such as a SAR subgroup, some options of approach are outlined. The schema below develops those options.

#### **Focused SAR**

- A narrow themed focus within a single case
- Single case with analysis only of a particular practice isue/area and/or systemic issue/ area of focus

#### Thematic focused SAR

- A narrow themed focus across multiple cases
- Multiple cases selected because they feature the selected practice issue/area and/or systemic issue/ area of focus
- Multiple cases analysed only in respect of the selected practice issue/area and/or systemic issue/ area of focus; analysis is not comprehensive

#### **Full SAR**

- Focus on the whole case not a narrow theme only
- Single case with analysis of all practice

#### Thematic full SAR

- A whole case focus, across multiple cases
- Multiple cases selected because they feature the particular safeguarding issue or type of abuse and/or personal circumstances
- Analysis of all practice in the cases

# Follow-up on previous learning SAR

- A focus on follow-up to previous organisational learning
- No analysis of practice in the case referred

# Thematic follow-up on previous learning SAR

- A focus on follow-up to previous organisational learning across a number of SARs and other sources
- No analysis of practice in the case(s) referred

# What circumstances suit which commissioning options?

#### Focused SAR

#### Suitable circumstances:

- Where a similar case or circumstance has been subject of a recent SAR and/or the target of recent improvement activity and/or,
- Where wider intelligence indicates a strategic need for better understanding barriers and enablers, in <u>particular</u> areas/issues that feature in the case.
- Where a particular type or aspect of abuse was overlooked in an original full SAR.

#### Benefits:

- Avoids duplication and allows a targeting of the SAR only on practice areas/issues that appear to be new or different in comparison with the case(s) previously reviewed or areas/issues that where a local learning need has been identified.
- Allows gaps in earlier analysis to be filled.

**Drawbacks**: A focused SAR may not seem satisfactory to the person and family members. A targeted focus will not give a full understanding of the unfolding case and practice decisions.

#### **Examples:**

In 2023 Swindon Safeguarding Partnership published a thematic review <a href="https://safeguardingpartnership.swindon.gov.uk/downloads/file/1175/a\_thematic\_review\_of\_financial\_exploitationcoercion\_from\_sar\_alison\_authored\_by\_nicola\_sawyer">https://safeguardingpartnership.swindon.gov.uk/downloads/file/1175/a\_thematic\_review\_of\_financial\_exploitationcoercion\_from\_sar\_alison\_authored\_by\_nicola\_sawyer</a> which was used to explore more broadly the practice implications in relation to the theme of financial abuse and exploitation.

The thematic review built on learning gained from the original SAR Alison (published in 2022.

https://safeguardingpartnership.swindon.gov.uk/downloads/file/1030/sar\_alison\_final\_report.

#### Thematic focused SAR

#### Suitable circumstances:

 Where a number of SAR referrals feature similar practice problems and/or where local intelligence had identified a particular practice problem, but less

- clarity about what lies behind it, e.g. conduct of mental capacity assessments in circumstances where the person has drug or alcohol dependences.
- Where previous learning has identified a systemic issue but it is as yet unclear how wide the set of circumstances where it exists, e.g. tools and processes for reporting safeguarding incidents focus on the victim and not on the 'perpetrator' and do not easily allow for the 'assailant' as having their own care and support needs.

#### Benefits:

- Potentially allows for more depth of analysis by having a particular focus. Also allows for a stronger evidence base than analysis of a single case ready allows.
- Allows for testing and consolidating learning identified through internal incident reviews.

**Drawbacks**: A thematic focused SAR may not seem satisfactory to any of the individual people and family members involved. A targeted focus will not give a full understanding of any of the unfolding cases and practice decisions.

#### **Full SAR**

#### Suitable circumstances:

- Where the person's death or serious abuse or neglect appears to have been clearly avoidable and preventable and the review needs to ascertain why it was not averted in this case and what systemic issues need to be tackled to lessen the chances of future deaths in similar circumstances.
- Where areas/issues in the case are new, complex and/or wider intelligence indicates a lack of understanding of strengths and weaknesses in practice and their underlying causes.

**Benefits**: A full SAR allows full benefit of the case review methodology, to gain a rich picture understanding of what happened in the case and why, and what continues to make it harder or easier to attain good practice standards.

#### Any particular methodological considerations:

- Even in a full SAR, decisions still need to be made about what is proportionate in the particular circumstances and relative to other budget and capacity demands and priorities.
- The SAB will need to determine the extent to which they want the SAR to focus
  only on practice of immediate causal relevant to the death or injury, or whether
  there is a wider focus on surfacing learning about what has facilitated or obstructed
  good practice in the case more broadly and over a longer period.

**Examples:** The majority of SARs constitute a full SAR as defined in this schema.

#### Thematic full SAR

**Suitable circumstances**: Where local intelligence, possibly including SAR referrals, indicate recurring safeguarding issues, possibly in relation to similar personal circumstances and/or recurring practice problems.

**Benefits**: Allows for a stronger evidence base than analysis of a single case ready allows.

**Drawbacks**: What you gain in breadth you may lose in depth of analysis, depending on how many cases are involved and the amount of capacity given to the review.

#### Methodological considerations:

**Examples**: To-date thematic full SARs have been conducted on:

- Types of abuse e.g.:
  - self-neglect
  - o hoarding and self-neglect
  - o financial exploitation/coercion.
- Personal circumstances linked to premature deaths and/or risks of abuse, exploitation and neglect e.g.:
  - social isolation
  - o women with multiple, complex needs and trauma
  - o elderly people with relatives or unpaid carers involved
  - o women facing multiple exclusion homelessness
  - adults with identified mental health needs as well as physical health conditions and potential self-neglect.
- Practice areas/issues e.g.:
  - hospital discharge for single elderly adults to their home environments
  - o care provision for adults living in care settings
  - managing extraordinary operational pressures where a multi-agency response to a case of abuse or high risk is needed.

Full references are given in the appendices.

# Follow-up on previous learning SAR

**Suitable circumstances**: Where a similar case has been subject of an earlier SAR and/or the target of recent improvement activity. The new SAR can begin with the previous learning identified about barriers and enablers to good practice, and improvement actions proposed. The new SAR can be commissioned 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.

**Benefits**: Avoids duplication of learning. Supports on-going improvement efforts.

**Drawbacks**: There is a risk that although many of the features of the person's circumstances and professional practice responses may appear similar, the underlying influences on practice are different. Therefore the potential for new learning can be missed.

**Methodological considerations**: The skill set needed for a follow-up on previous learning SAR may be different from those required for a case review, effectively to follow-up on whether, how and why improvement actions were implemented, and whether they made any difference.

Examples: none yet identified.

#### Thematic follow-up on previous learning SAR

**Suitable circumstances**: Where there is already learning identified whether locally, regionally and/or nationally about a particular practice area and practice in cases featuring circumstances mean a mandatory SAR is required has already been analysed via other processes, such as coroners inquiries or S.42 enquiries.

**Benefits**: This type of SAR constitutes a wider kind of assurance activity. It avoids duplication of learning and draws out the local relevance of regional and national systems findings. It supports ongoing improvement efforts by focusing on whether local recommendations have been implemented and seeking local assurances about universal systemic vulnerabilities identified through regional or national work.

Drawbacks: n/a

Methodological considerations: n/a

#### Examples:

Sutton SAR. (19 May 2021). Safeguarding Adults Thematic Review of the quality, safety and effectiveness for adults living in care settings in Sutton. Lead Reviewer: Jane Held.

# **Key choices in thematic SARs**

Designing and commissioning a thematic SAR will always involve judgement and decisions about what is proportionate, what is adequately systematic, rigorous and transparent in any particular instance, and what range of data and contributors best suit the need.

The table below captures some of the methodological options about breadth and depth of data and analysis.

#### Selection of cases - HOW & HOW MANY?

- From referrals for SARs only
- Further sampling from wider case work
- A couple of cases or a larger sample? Examples reviewed ranged from covering a single case to nine cases

#### Analysis of the individual cases – WHO CONDUCTS THE ANALYSIS?

- By the reviewer alone
- By a multi-agency 'audit' team
- By the reviewer in collaboration with the practitioners and managers who were involved in each case respectively

#### - WITH WHAT DATA FOR EACH CASE?

- Referral for SAR
- Integrated multi-agency chronology
- IMRs from each agency
- Bespoke survey/questionnaire to involved agencies
- ASC records only

#### - WHAT FOCUS?

- Practice problems identified in the case and/or contributory factors
- Systems findings that impacted on the cases respectively

#### - HOW SYSTEMATICALLY?

- Systematic approach and transparent approach e.g. Using a structured audit framework or not; e.g. for each case selecting and analysing Key Practice Episodes to identify good practice and practice problems, and contributory factors. All analysis written up
- Themes 'emerge' on reading by reviewer; not written up

#### - WITH WHAT FOCUS?

- Case findings? Evaluating practice in each case and/or identifying contributory factors to different strengths and problematic areas
- **Systems findings?** And/or identifying generalizable social and organisational issues that helped and/or hindered in each case

#### Thematic analysis across all cases – WITH WHAT FOCUS?

- Themes in practice problems identified in the case and/or themes in systems findings that impacted on the cases
- Also issues unique in cases or only themes across cases

# Identification and/or further testing and refining of understanding of analysis and systems findings

- Workshop bringing together all the practitioners and managers involved in all the cases reviewed
- Workshop bringing together a representative sample of relevant practitioners and managers who were not involved in the cases reviewed
- Workshop bringing together ONLY strategic leads of agencies
- Surveys
- Individual conversations with practitioners/managers/strategic leads
- Comparison with other completed SAR findings local or national

#### References

DHSC (2018) Care and Support Statutory Guidance: issued under the Care Act 2014. London: The Stationery Office.

Preston-Shoot M., Braye S., Preston O., Allen K. and Spreadbury K., (2020). Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement. London: LGA. See: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019.

# **Appendix – sample of different thematic SARs**

	Commissio ning Board	Date of publicatio n	Reviewer(s)	No. of refera Is or cases consi dered	Note on how cases selected, and how analysed	theme area	focus of the analysis	phrasing used
1	Sutton	27th January 2021	Jane Held	2		care provision for adults living in care setting	This thematic review did not undertake any detailed review of either of these cases and does not deal with the facts of what happened. In both cases this has already been done through other processes.	
2	Hillingdon	2022	Sheila Fish & Anna Muller	2		adults with identified mental health needs as well physical health conditions and potential self-neglect.		
3	North Somerset		Michael Preston- Shoot & Mike Ward	3		Self-neglect		
4	Lewisham		Mick Haggard	2		hospital discharge for single eld	erly adults to their home environment	
5	West Sussex	Mar-21	Claire Foreman	3		managing extraordinary operational pressures		
6	Haringey		Michael Preston- Shoot	3		Homelessness		
7	East Sussex		Patrick Hopkins	4		women with multiple, complex needs and trauma		
8	Newham					Self-neglect		
9	Worchester shire							

1 0	Oxfordshire		Michael Preston- Shoot & Adi Cooper	9		Homelessness		
1 1	Greater Manchester		Deborah Jermiah	3		Self-neglect		
1 2	Portsmouth			4		Homelessness		
1	Greater Manchester		Michael Preston- Shoot			Homelessness		
1 4	Barnet			2		Hoarding		
1 5	Tower Hamlets	20-Mar-20	Michae Preston- Shoot	2		women facing multiple exclusion homelessness, substance misuse	n homelessness: Self-neglect, e, multiple physical health problems	
1 6	1 Cornwall and the Isles of			7		vulnerable, elderly people died or were admitted to hospital with safeguarding concerns present and relatives or unpaid carers involved in providing varying levels of support, personal care and emotional well-being support to an adult at risk.		
1 7	Tower Hamlets			5	nb. 2 referred, the rest selected	Social Isolation		
1	Gloucesters hire		Kate Spreadbury	5		deaths of women with multiple and complex needs		
1 9	West Berkshire		Claire Crawley	6		1 the focus, then compared to 5 previous local SARs	Ken as focus then compared with 5 other SARs previously commissioned	
0	Swindon	2022	Nicola Sawyer	1			there had been a SAR Alison completed; this thematic review focused only on the theme of financial exploitation and coercion	A Thematic Review of Financial Exploitation /Coercion

				From SAR Alison