Developing the quality and use of SARs for practice improvement

A RiPfA and SCIE proposal, January 2017

1. Contents

Background

There have been requests for a national repository for Safeguarding Adults Reviews (SARs) from colleagues working in safeguarding for a number of years. In developing this proposal we have sought the opinion a range of stakeholders, which has developed our understanding of the range of work which is going on in this area.

This includes

- Work being led by Professor **Jill Manthorpe** on thematic analysis of SARs, and maintaining a collection of SAR reports
- Work undertaken by Professors Michael Preston-Shoot and Suzy Braye on SCRs relating to self-neglect (Braye and Preston-Shoot, 2015)
- Work being undertaken by the safeguarding regions. Of particular note is the London ADASS region's current project to undertake an analysis of London Safeguarding Adults Reviews post Care Act, and identify common themes and lesson that have implications beyond the local system. A number of other regions have also begun to build repositories or map the SARs completed in their area.

It has highlighted that this material is currently not easy to find, and there is potential for confusion about how the different strands are similar or different in purpose.

We suggest that coordination of the work being undertaken would be beneficial to the sector, in order to make best use of limited resources and ensure that learning is effectively shared. Our proposal is therefore designed both to bring together different strands of work, complement, and to build upon and add value to existing relevant activity that colleagues are already undertaking.

For further background and detail about other work in this area, please see the Appendix.

The potential of SARs to support practice improvement

Timely and effective safeguarding requires on-going organisational learning and improvement. SARs are potentially a valuable source of learning for improvement. SARs should help to identify what is getting in the way of timely and effective safeguarding practice, highlighting causes of practice difficulties which can then be addressed to prevent the recurrence of similar problems. They therefore have the potential to provide vital information to guide improvements in multi-agency adult safeguarding.

How SARs can be used

At a local level, individual Safeguarding Adult Boards and their members can use the learning from the SARs they commission to support their own improvement activities. There is also potential for the learning from SARs to inform the practice improvements of others than those who commissioned them. This includes:

- Local areas can use SARs commissioned by other local areas as the basis for self-assessment - could these issues be happening here and if so, what might we do about it?
- The learning from multiple SARs can also be collated in order to identify trends against which to do self-assessments, practice inquiries and to identify issues that could benefit from a regional or national response.

Support mechanisms required

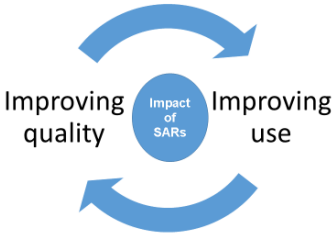
Maximising the value of individual SARs by these means requires robust mechanisms to enable such use. They require:

- access to SAR reports and the potential to search and navigate them
- a variety of kinds of analysis to identify trends and emerging issues
- the translation of the analysis into user friendly products

For all of these aspects, an accessible library of SAR reports is a vital first step.

A ‘whole system’ approach to improving SARs and their impact

There is learning from serious case reviews (SCRs) in the child protection field that is relevant to improving SARs and their impact.



A recent DfE-funded project relating to SCRs emphasised the inter-relationship between the quality of SCRs and effective use to influence practice. See **www.scie.org.uk/lipp**

It emphasised in its conclusions that the usefulness of collation of findings depends on the quality of the reports that are being collated, which in turn depends on the knowledge and skills of those who write them. This suggests that improving the quality of SARs and their impact, could equally benefit from considering a whole system architecture that covers both the quality of individual SARs, the expertise of those who commission and conduct them, as well as supporting a variety of ways that SARs can be used.

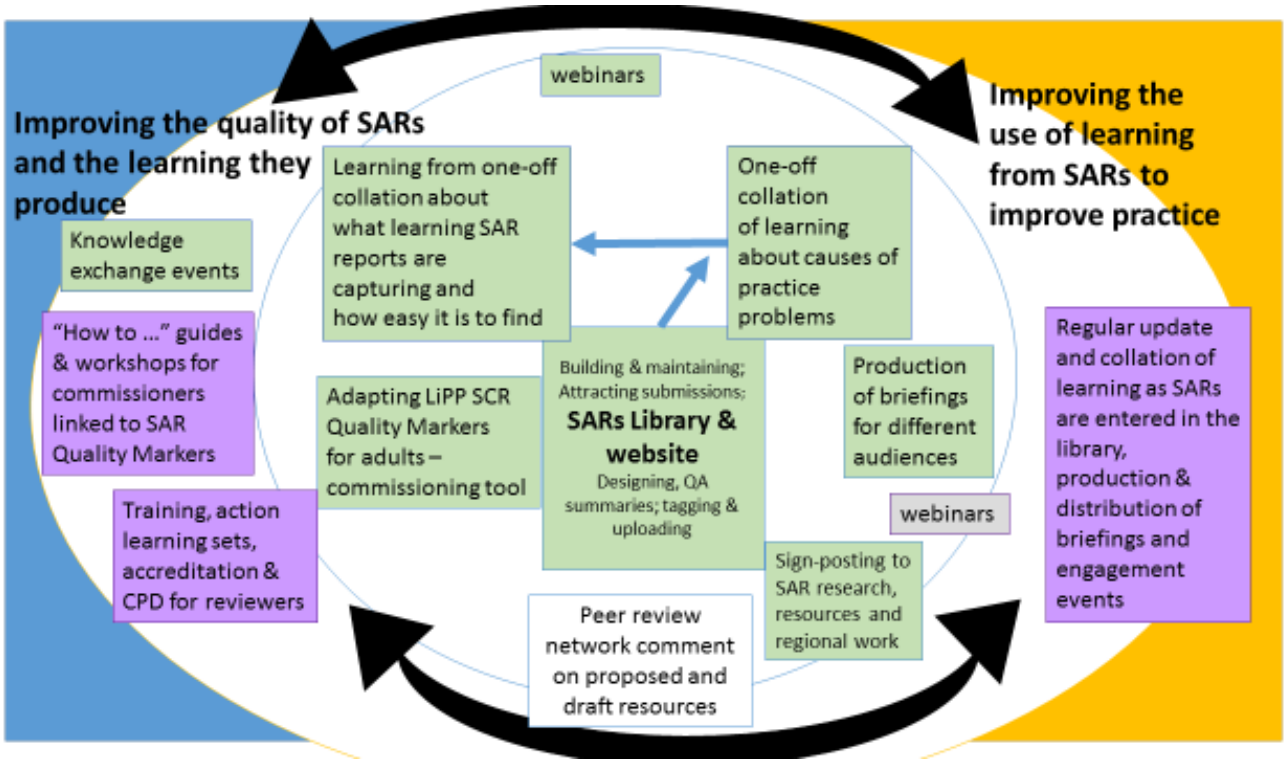
These two strands, improving quality and improving use of SARs, create cycle of continuous improvement.

In terms of improving use, the LiP project focused on the substance of what kind of learning SCRs or SARs can generate. The recent SCR triennial analysis (Sidebotham et al, 2016) focused on how learning can best be packaged and presented to increase engagement with findings. To support this, the messages were collated and translated into a series of audience-specific briefings, video-clips and webinars. These were disseminated through a micro-site, see **http://seriouscasereviews.rip.org.uk/**

Developing the framework

The diagram below illustrates what an architecture for supporting the quality and use of SARs might look like. Activities related to improving the quality of SARs and the learning they produce are on the left hand side (blue) and activities related to improving the use of learning from SARs and impact of the learning are presented on the right hand side (yellow). The black arrows indicate how the two areas feed into and mutually reinforce each other. We have also noted that existing work and expertise should be drawn upon in this project to ensure that the outputs are useful to the sector.

At its centre is the SARs library and website. This gives people access to SARs from across the regions, in a format they can navigate in order to find kinds of cases or types of learning relevant to them. We intend to liaise with other similar planned activity in the regions, with an aim to agree a common approach to key word tagging.



Key:
Green – in budget
Grey – charged to participants
Purple – extra to budget
White – review and QA

The library makes possible a one off analysis of findings from SARs to identify trends and emerging issues. We will build on the approach developed in the LiP project that focuses on learning about what lies behind safeguarding practice problems. We will cross-reference existing frameworks to facilitate comparison of findings over different projects on this topic. We will build on the approach developed in the triennial review of SCRs in the range of briefings produced from the analysis. To maximise value for money, we propose electronic distribution.

The one-off analysis will provide the analytic frameworks to allow for an on-going collation of findings about the cause of practice problems over time, in real time as the SARs are added to the library.

The process of conducting the one-off analysis of learning in turn also generates learning about the quality of the individual SARs analysed – what kind of learning individual SARs are capturing and how easy is it to find in the way it is presented in the report. This provides a bench-mark against which future assessments of SAR report quality can be made. It also serves to indicate areas where training and development could usefully be targeted, through 'how to …' guides, workshops etc.

A separate section of the website signposts other related SAR research, resources and regional work, clarifying the particular purpose of each, how they complement each other and how they relate to this project.

A set of evidence-informed and peer reviewed SAR Quality Markers will be developed, based on the LiP project SCR Quality Markers, to provide a base-line for achieving quality, regardless of particular approach or methodology used – a tool for those commissioning as well as those conducting of SARs. Added value

RiPfA and SCIE are national organisations with wide-ranging delivery programmes that deliver resources to stakeholders across the landscape of adult social care. Learning generated from the SAR library and related work will therefore be integrated into our existing and future programmes and communications, achieving additional reach and impact.

We will be building on previous relevant work, including the LiPP SCR Quality Markers, SCIE's online library, Research in Practice's Triennial Analysis of SCRs microsite and academic and regional work as mentioned above. This provides significant added-value to previous investments of public funds, reducing significantly the costs of this proposal, and supporting a timescale of delivery that would not otherwise be feasible.

The project will also add value to previous and on-going SAR research and related activity by drawing it all together in one place, in order that it can be readily identified and accessed. The SAR website will have the potential to become a hub for information about learning from SARs, bringing together learning from numerous different projects into one place.

Engaging with users of the SAR library, website, products and activities

SAB Chairs, SAB managers and safeguarding leads of agencies will be key users of the SAR library, website, products and activities. It is therefore vital that we engage with them to maximise relevance to practice, and a grounding of the resources in the priorities and challenges that the sector is facing. We aim to request opportunities for dialogue at existing meetings, to avoid creating extra capacity strain. We plan meetings to:

1. share plans
2. share analysis and ideas for products
3. feedback and discuss options for future work

Feedback on draft products will be requested electronically.

Fostering dialogue about frameworks for analysis

We plan to meet with other knowledge producers in the start-up to the project to share our plans, and discuss how best to foster coherence between different SAR research and clarify, where relevant, differences in purpose.

Staged development

The table below indicates the activities that can be covered within the available budget 2017-2018 – replicating the colour coding in the diagram above.

Within budget	
	Activity
	Build & maintain the SAR Library & website including Set up a) technical; b) substantive: developing pro-formas, search/tag scheme; c) comms plan to attract submissions Running: moderating summaries, doing tagging, chasing submissions
	Additional page on website to sign-post related SAR research, resources and regional work. Updated quarterly throughout the first year.
	One-off collation of learning from SAR reports about barriers and facilitators to good safeguarding practice
	Production of briefings based on the collation, for different audiences. Electronic distribution
	One-off report outlining what kind of learning SAR reports are producing and how easy it is to find. Electronic distribution
	Adapt SCIE/NSPCC LiPP SCR Quality Markers for adult safeguarding policy and practice context. Electronic distribution
	Project management
	Engagement with SAB Chairs, SAB managers and safeguarding leads of agencies using their pre-existing meetings
	Webinar 1: Existing thematic reviews of SARs (TBC) Webinar 2: Quality Markers for SARs (TBC) To be recorded and hosted on the website. (details subject to review)
Extra to budget (optional)	
	Activity
	Additional webinars
	Regular update of collation of trends and emerging issues from SARs
	Training and support for reviewers and commissioners

Sustainability

Sustainability of the programme is central to the approach we are proposing for the library of accessible SAR reports and related resources. We are explicitly aiming to use the current funded period to set up processes that can be readily maintained on an on-going basis at minimal cost. Additionally, we will be developing some income generating options, such as webinars, training etc. Options for future sources of support will be explored as part of the project, including possibility of a mixed-revenue made up of both direct contributions, as well as income generated indirectly.

Timescales

Quarter 1: April – June 2017

- Project set-up; book event dates; begin planning website architecture
- Consultation with stakeholders
- Begin work adapting LIPP Quality Markers for use with SARs

Quarter 2: July – September 2017

- Web architecture outlined, pilot website launched
- Event planning; two Knowledge Exchange events and webinar
- Finalise cover sheets for new SARs to be added to library

Quarter 3: October – December 2017

- Develop reports and briefings about quality and use of SARs
- Add SAR reports to website

Quarter 4: January – March 2018

- Project summary webinar
- SAR library website launched
- Review and forward plan

References

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Braye S and Preston-Shoot M (2015) Learning lessons about self-neglect? An analysis of serious case reviews. *The Journal of Adult Protection*, 17, 1-16

Cooper A and Snow D (2016) Project brief: an analysis of safeguarding adult reviews (SARS) since the Care Act. London ADASS.

DH (2016) Care and support statutory guidance (updated 9th December 2016). Available online: **https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1**

Sharp-Jeffs N and Kelly L (2016). *Domestic Homicide Review (DHR) Case Analysis. Report for Standing Together.* Standing Together and London Metropolitan University.

Sidebotham P, Brandon M, Bailey S, Belderson P, Dodsworth J, Garstang J, Harrison E, Retzer A and Sorenson P. (2016) *Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014.* Final report. Department for Education.

Appendix

How many SARs are there?

National data collection systems outline that 90 SARs were undertaken in 2015/16, as outlined in the table below.

Table 4.1: Serious Case Reviews (SCRs)/Safeguarding Adult Reviews (SARs) 2013-14, 2014-15 and 2015-16, England

Year	Number of councils supplying data	Number of councils with SCRs / SARs	Number of SCRs / SARs	Number of people involved in SCRs / SARs	Number of individuals who died	Number of individuals who suffered serious harm
2013-14 (SCRs)	152	42	60	100	45	55
2014-15 (SCRs)	152	53	65	190	60	135
2015-16 (SARs)	151	60	90	110	60	50

Data Source: SAC Table SG5a and SG5b
i. SAC data based on 60 serious case reviews in 2013-14 and 65 in 2014-15 provided by 152 councils and 90 in 2015-16 provided by 151 councils
ii. Numbers are rounded to the nearest 5 for SCRs, SARs and numbers of individuals
iii. Figures may not add up due to rounding

Figure 1: Adults Social Care Statistics, NHS Digital, 2016: 30

How are SCRs in children's services collated?

It is helpful to some extent to consider how a similar repository operates for *Serious Case Reviews* relating to children – however, the recommendations of the **Wood Review** and the **government response** to these means that there will be changes to SCRs (see below) alongside the new multi-agency safeguarding arrangements that will replace LSCBs.

Currently, a repository is hosted by NSPCC (**national case review repository**). This SCR repository is hosted on the NSPCC main website.

Published reports are added to the Children's national repository by the NSPCC, when Local Safeguarding Children Boards (LSCBs) in England submit newly published SCR reports via email to NSPCC.

Discussions with NSPCC last year offer some helpful insights into this process:

- The repository is seen as part of the NSPCC Library, and so costs related to running it are absorbed by the charity as part of their day to day work.
- LSCB Chairs were consulted before beginning the work to ensure sign up to the idea.
- New SCRs are not always submitted to upload to the repository, despite the duty to publish SCRs
- Each report is read, catalogued and tagged, and an abstract is written. This is estimated to take on average 2-3 hours per report, sometimes longer depending on the quality and length.
- The volume was estimated at 10-12 reports per month (this is likely to change under the new arrangements)
- The reports belong to the commissioning LSCB, and the NSPCC is clear that they do not have responsibility for the content of them. Because the reports have to be written to be published, significant time is likely to have been spent ensuring that they are properly redacted. It is unclear whether SARs will be subject to the same level of scrutiny as there is no equivalent requirement to publish SARs (the Care Act guidance states that SABs should 'consider publishing the reports within the legal parameters about confidentiality' (DH, 2016)).
- NSPCC acts as gatekeeper and moderator for this online content.
- SCR reports remain available electronically for five years (subject to any specific legal rulings), after which the link to the electronic version will be removed, but the catalogue record will remain.
- Electronic versions of the case review reports stored by the NSPCC are only available by searching the NSPCC Library Online; they are not found via search engines such as Google.

Pending the progress of The Children and Social Work Bill[1] it is likely that the current SCR system will be replaced with a system of national and local reviews. A National Panel will be established. This will be responsible for commissioning and publishing national reviews and investigating cases which can offer national learning. Local partners will be required to carry out reviews into cases which are considered to lead

[1] The Children and Social Work Bill passed Second Reading on 5 December 2016. The Public Bill Committee is scheduled to conclude by 17 January 2017.

(at least) to local learning. These changes will likely affect the volume of SCRs being undertaken and published, and has implications for the national repository.

Domestic Homicide Reviews

We recognise that Domestic Homicide Reviews (DHRs) can also provide valuable sources of learning for adult safeguarding. In some cases where the victim had social care needs, DHRs are commissioned alongside SARs. We propose that the repository includes relevant DHRs, and the accompanying resources include those related to DHR analyses, for example including work by Standing Together (e.g. Sharps-Jeffs and Kelly, 2016).

LIPP

Serious Case Reviews: Learning into Practice Project (LiPP)

Improving the quality and use of Serious Case Reviews in multi-agency practice to safeguard children

The Learning into Practice Project was undertaken between March 2015 and March 2016 by the NSPCC and the Social Care Institute for Excellence, funded by the Department for Education Innovation Programme.

The project developed and tested a number of ways to improve the quality of Serious Case Reviews (SCRs) and their impact on local and national child protection practice.

The goal was to help local safeguarding children boards and SCR reviewers to improve the quality and use of Serious Case Reviews. To that end, we developed and tested four mechanisms: two for improving the quality of SCRs, and two for improving their use. These were:

Improving quality:

- supporting commissioning and conduct of reviews through a set of **Quality Markers**
- improving lead reviewer expertise through a series of **masterclasses**.

Improving use:

- developing a mechanism for collating and producing accessible information on practice issues identified in SCRs, resulting in an **overview map and range of briefings on inter-professional communication**
- establishing an Alliance of national strategic and leadership bodies to consider and implement improvement work, from a national perspective.

Further detail can be found at www.scie.org.uk/lipp

Triennial analysis

In **June 2016** RiP published - in collaboration with The University of East Anglia, the centre for Research on Children & Families and The University of Warwick - five practice briefings regarding the *Triennial Analysis of Serious Case Reviews (2011-2014).* Each briefing is targeted at a specific key audience: social workers and family support workers, education practitioners, health practitioners, Local Safeguarding Children Boards, and the police and criminal justice agencies. The project has been well received by the sector.

London regional work

The London ADASS region is commissioning an analysis of London Safeguarding Adult Reviews (SARs) undertaken since the Care Act and to identify common themes and lessons that have implications beyond the local system.

The key deliverables will be:

- An analysis of SARs during the agreed period of time.
- To develop and establish a repository of a range of SAR methodologies to be held by LondonADASS.
- To develop a consistent approach across London on how the statutory criteria for SARs are applied and to understand how decisions regarding what becomes a SAR are made.
- To produce a set of themes and categorise recommendations.
- To identify issues specific to London.
- To provide interim and final reports for the London Safeguarding Adults Board on themes and issues arising from the analysis with pan-London implications.

(Cooper and Snow, 2016)

Regional repositories

A number of SABS/ regions have begun work cataloguing and gathering information about SARs undertaken in their local area.

The West Midlands and East Midlands region have a database of SARs undertaken in the region

Hampshire Safeguarding Adults Board have developed a repository and have encouraging Boards to send in their SAR reports. The repository can be found here: **http://www.hampshiresab.org.uk/learning-from-experience-database/serious-case-reviews/**

Discussion with the Adult Safeguarding Leaders group concluded that the Hampshire work was a very useful resource, and it would be useful to build on it to provide a national resource. To ensure sustainability and mitigate risks they would prefer to host a repository via SCIE.