social care
institute for excellence

Developing a rapid turn-around of learning from safeguarding incidents and dissemination of learning, during the Covid pandemic

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SCIE

26 August 2020

Overview of today’s session

- 1. Introduction
  - Learning in the Covid context
  - SCIE support to SABs and partners
  - Staged testing and refinement
  - Key principles
- 2. v1 process and tools
  - Overview
  - Set up session
  - Agency record checks
  - Early analysis format and link to SAR Quality Markers
  - Structured multi-agency discussion
  - Succinct report and link to SAR Library
- 3. Next steps; do you want to be involved?

Please tell us in “chat” what you want most from this session?

- Test SARs and feedback
- Tools themselves

Timings of today's session

11.30 -12.10 (40 mins)	**1. Introduction** Learning in the Covid context SCIE support to SABs and partners Staged testing and refinement Key principles **2. v1 process and tools** Overview Set up session
12.10-12.20	Short break 10 mins
12.20 – 13.00 (40 mins)	Agency record checks Early analysis format and link to SAR Quality Markers
13.00-13.20	Lunch break 20 mins
13.20 – 2.00 (40 mins)	Structured multi-agency discussion Succinct report and link to SAR Library
2.00-2.10	Short break 10 mins
2.10-2.30 (20 mins)	**3. Next steps**; do you want to be involved?

How does that relate to your priorities?

1. Introduction

Learning in the Covid-19 context

- An urgent need for a rapid process
- Proportionate given other demands
- Can identify learning from safeguarding incidents occurring in the new corona context
- Makes it possible to share locally, regionally and nationally in a timely way
- Relevant also as lock-down is eased; for recovery and renewal

Department of Health & Social Care

SCIE support to SABs & partners

Part of the DHSC's Covid-19 Action Plan for Social Care

- producing guidance and templates for the SAR In Rapid Time process and outcomes
- supporting familiarisation with the process with webinars, and remote support
- liaising with SABs to enable the submission of rapid review reports to the national SAR library, routine collation of learning, and dissemination of regular learning briefings

Staged testing and refinement

PHASE 1

SCIE facilitated test SARs no. 1 and no.2

(process & tools)

Webinar to launch tools v1

PHASE 2 (a)

SCIE facilitated test SARs no. 3 and no.4 (+ timing)

In response to high levels of interest

PHASE 2 (b)

Non-SCIE facilitated test SARs with SCIE support

What it is and what it isn't

An additional tool in SAB tool boxes

~~an imposition or a requirement~~

~~a one-size-fits-all solution~~

~~A panacea~~

Key principles; building on the knowledge base

- Anchored in the SAR Quality Markers
  - Strategic commissioning
  - Gathering the right information
  - Analysis that moves from what happened in the case to identifying generalisable systems findings
  - Strategic action planning, beyond procedures & training to organisational development approaches
- Compatible with evolving National SAR Library schemes
  - Case findings – evaluation of practice in the case vs.
  - Systems findings – social and organisational conditions that impact beyond the single case

Key principles; building on the knowledge base (2)

- Focus: qualitative understanding of enablers/barriers e.g. MCA
- Building on relevant models of ‘rapid review’ in others sectors and contexts
  - recent developments in the children’s sector
  - Leder
  - Child death overview panels
  - NHS Quality Improvement / patient safety

Responding to your thoughts and questions

- The need
- The solution
- The principles

2. v1. SAR In Rapid Time process and tools

Staged testing and refinement

PHASE 1

SCIE facilitated test SARs no. 1 and no.2 (the analytic tools)

- Management of early outbreak of Covid in a care home
- Help for woman facing multi-exclusion homelessness including mental health problems and chronic drug dependencies

Webinar to launch tools v1

PHASE 2 (a)

SCIE facilitated test SARs no. 3 and no.4 (+the timing)

- Domestic abuse by elderly Jehovah Witness husband
- Risk assessment in grouping of rough sleepers for Covid emergency housing

PHASE 2 (b)

Non-SCIE facilitated test SARs with SCIE group supervision

- High levels of interest; ? Cap on numbers?

Outline SAR In-Rapid-Time

Is a 15 day turn around possible?

incl. time from decision?

Availability of reviewers a real problem

1	Set up meeting
2-3-4-5-6-7	Check of agency records
8-9-10-11	Produce early analysis report to structure discussion
11-12	Participants read report in preparation
13	Structured multi-agency discussion
14-15	Produce systems findings report

Couched in each SABs own processes

Referral

Decision making

Informing the person, family

1	Set up meeting
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8-9-10-11	Produce early analysis report to structure discussion
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Governance

Improvement action

Tools, templates and guidance

1	Set up meeting	10 questions
2-3-4-5-6-7	Check of agency records	Document template
8-9-10-11	Produce early analysis report to structure discussion	Methodology & report structure
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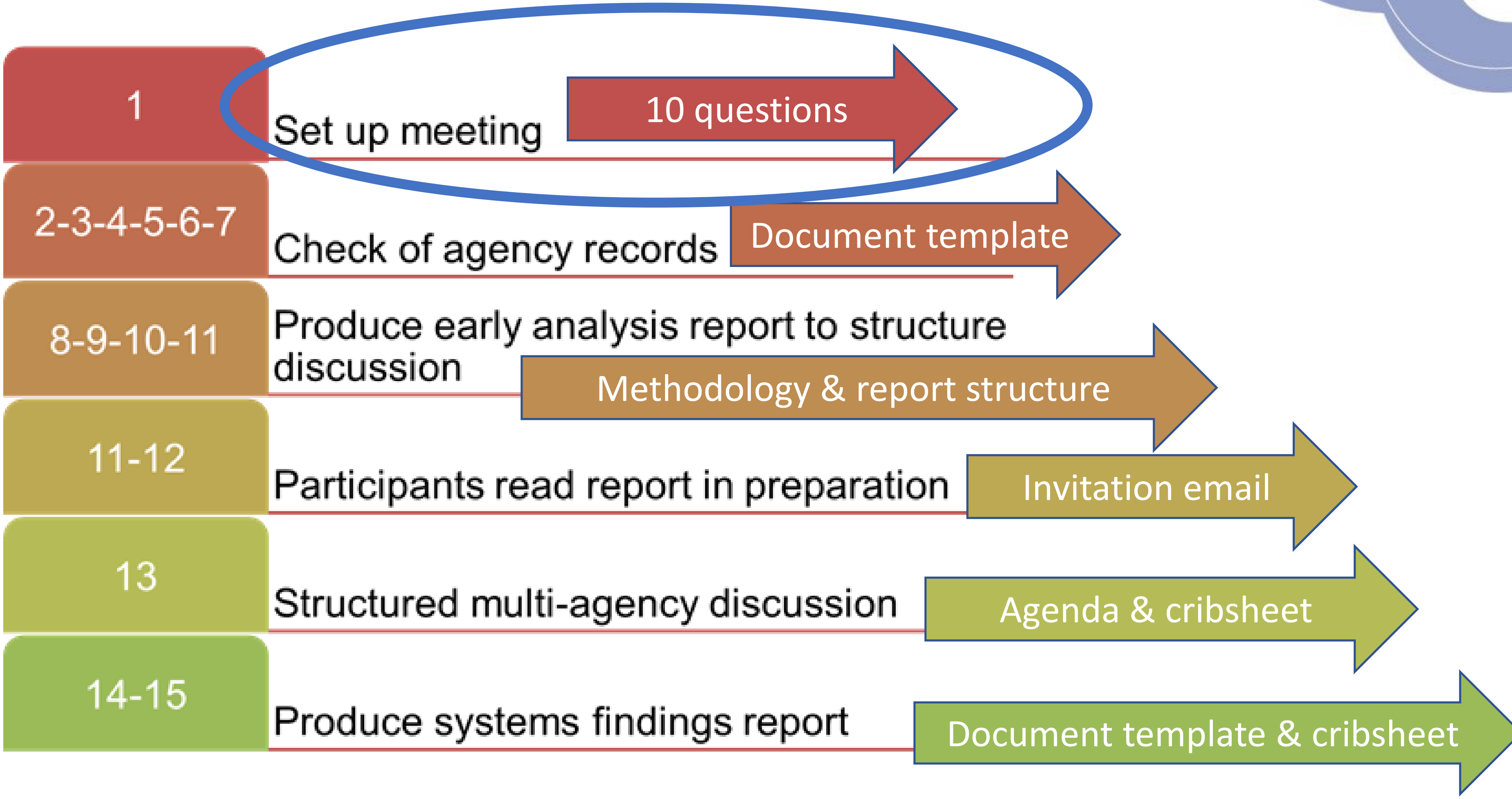
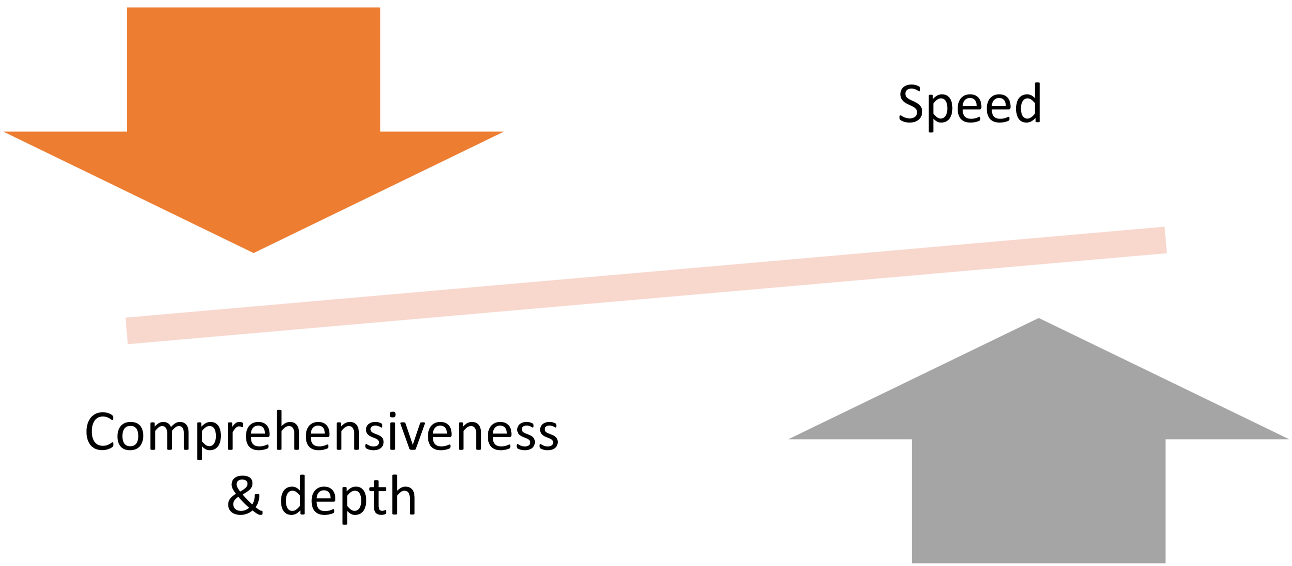
Tools, templates and guidance



10 questions for set up

1. **Brief summary of the case**
2. **Why is there an urgency to identifying and sharing learning from this case?**
3. **What are the wider systems issues or areas that we want to learn about?**
4. **Do these issues require direct participation of front-line practitioners in the review process and/or strategic leads of relevant agencies/sectors?**
5. **What time period of the case do we need to look at to explore these issues?**
6. **Which agencies/individuals need to participate?**
7. **What further information needs to be gathered from the relevant agencies?**
8. **What vulnerabilities, sensitivities and/or tensions are there for individuals and agencies around this case?**
9. **Do we know who needs to be informed from the person, their representatives, advocates or family members? What options can we offer them for contributing to the SAR In-Rapid-Time?**
10. **Agreeing timescales, actions and next steps**

Q2. Why the urgency?



- Judgement is required
- Transparency of rationale is important

Illustrations

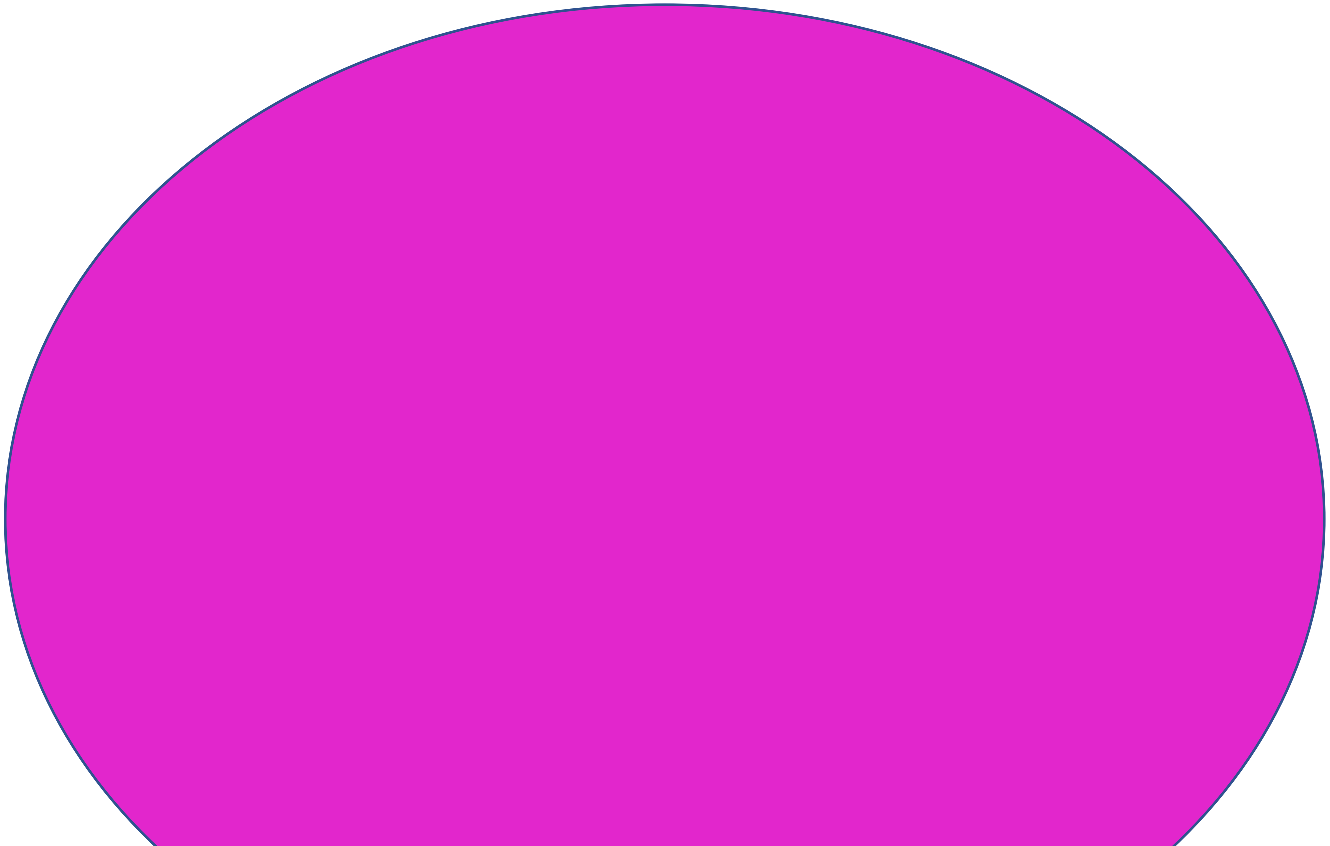
Q3. Wider systems issues or areas

- … that the case has the potential to illuminate
- … that we need to better understand

The SAR Quality Markers emphasise a strategic approach to commissioning SARs.
Look out for reference to "case and context"

- Relate discussion about SAR to what is already know and outstanding learning needs locally
- Use intelligence from other quality assurance(existing audits, reviews etc) and feedback sources
- Explore if issues in the case and/or systemic causes are new, complex or repetitive
- Relate discussion to SAB strategic plan, current and future priorities

Illustration from test SAR



Feedback from SAR Champions

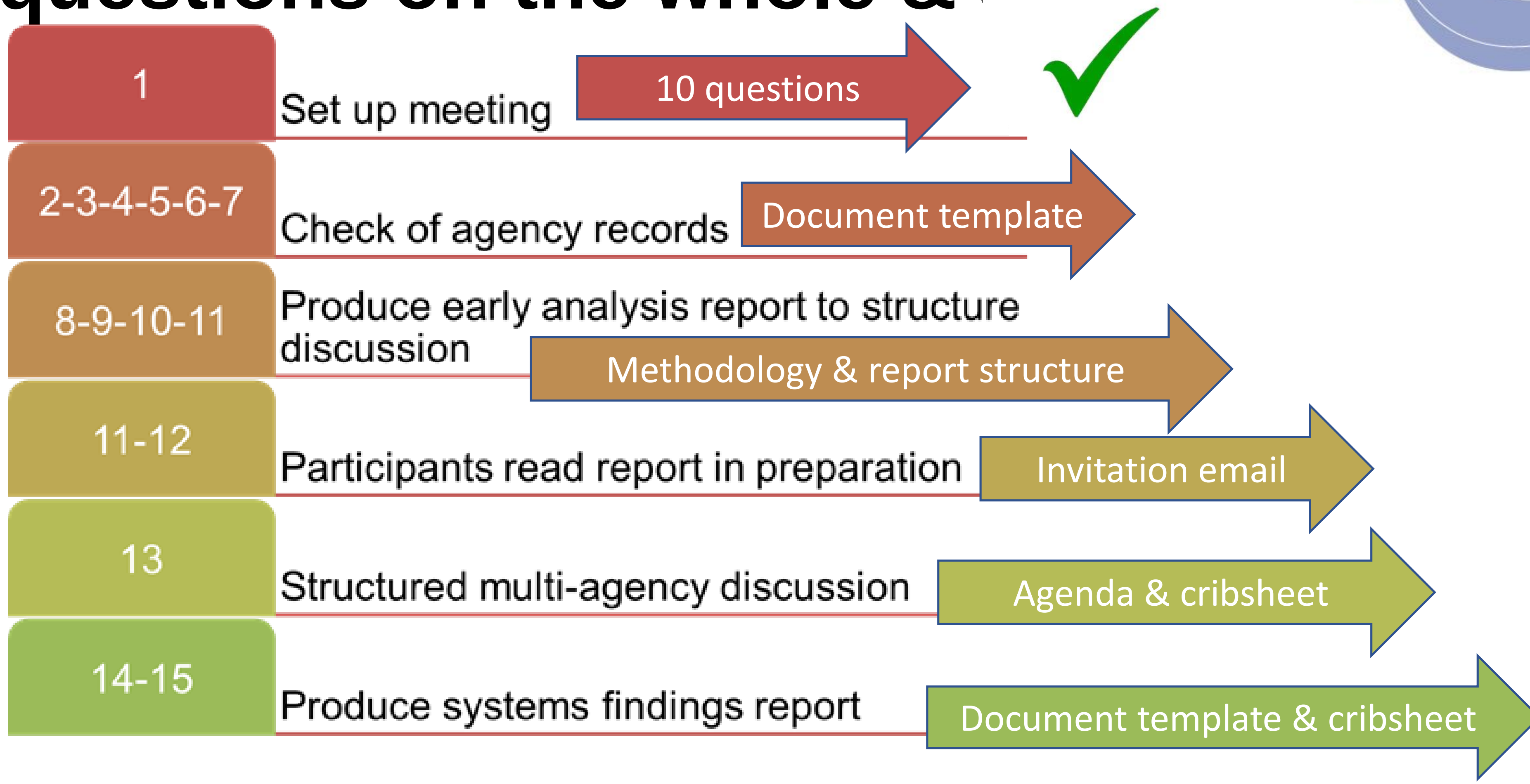
- Potential to develop regional criteria

Q.9 Involving the person, family, friends – who? How?

- A Care Act requirement
  - “Early discussions need to take place with the adult, family and friends to agree how they with to be involved”
- Detail of whether, how and when to be determined on a case-by-case basis
  - Preferences of the individuals
  - How critical to identifying systems findings

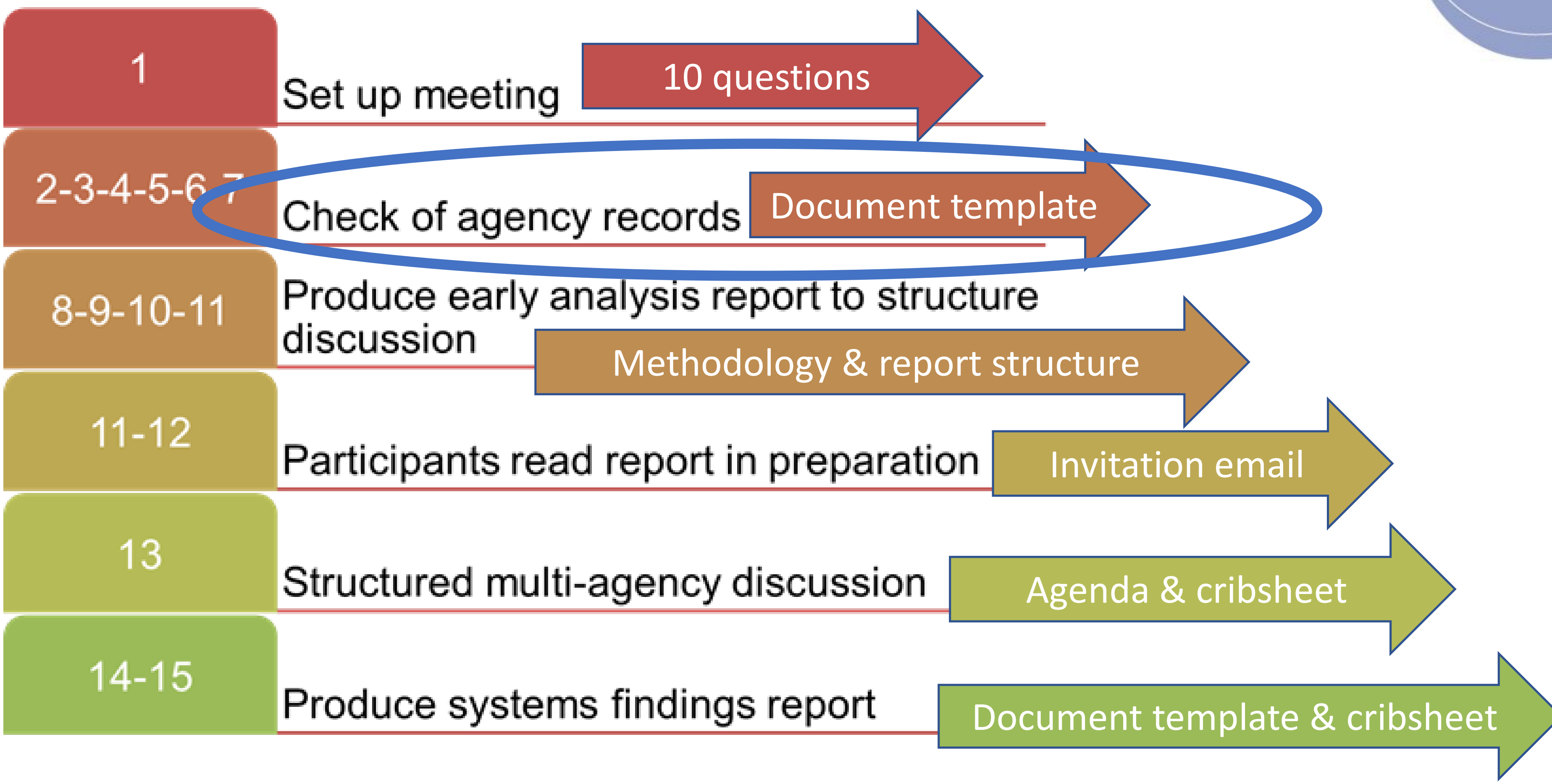
Illustrations

Responding to your thoughts, questions on the whole &



Quick break

Tools, templates and guidance



Agency record check template

- Includes write up of Set Up x10 questions
- Initial ask: :
  - Check your agency's records to see if you have had contact with the person, their family members or close associates listed
  - Complete the brief chronology template below
    - Brief description of nature and frequency of involvement during period under review
    - Brief summary of any involvement prior to period under review
    - Chronology template with names of key staff; and comments on quality/appropriateness
  - Provide brief reflections on quality / appropriateness of practice
    - Systems framing: areas of strength/concern & contributory factors; wider systems issues at play (root causes)
    - Anything else

Agency record check / trawl

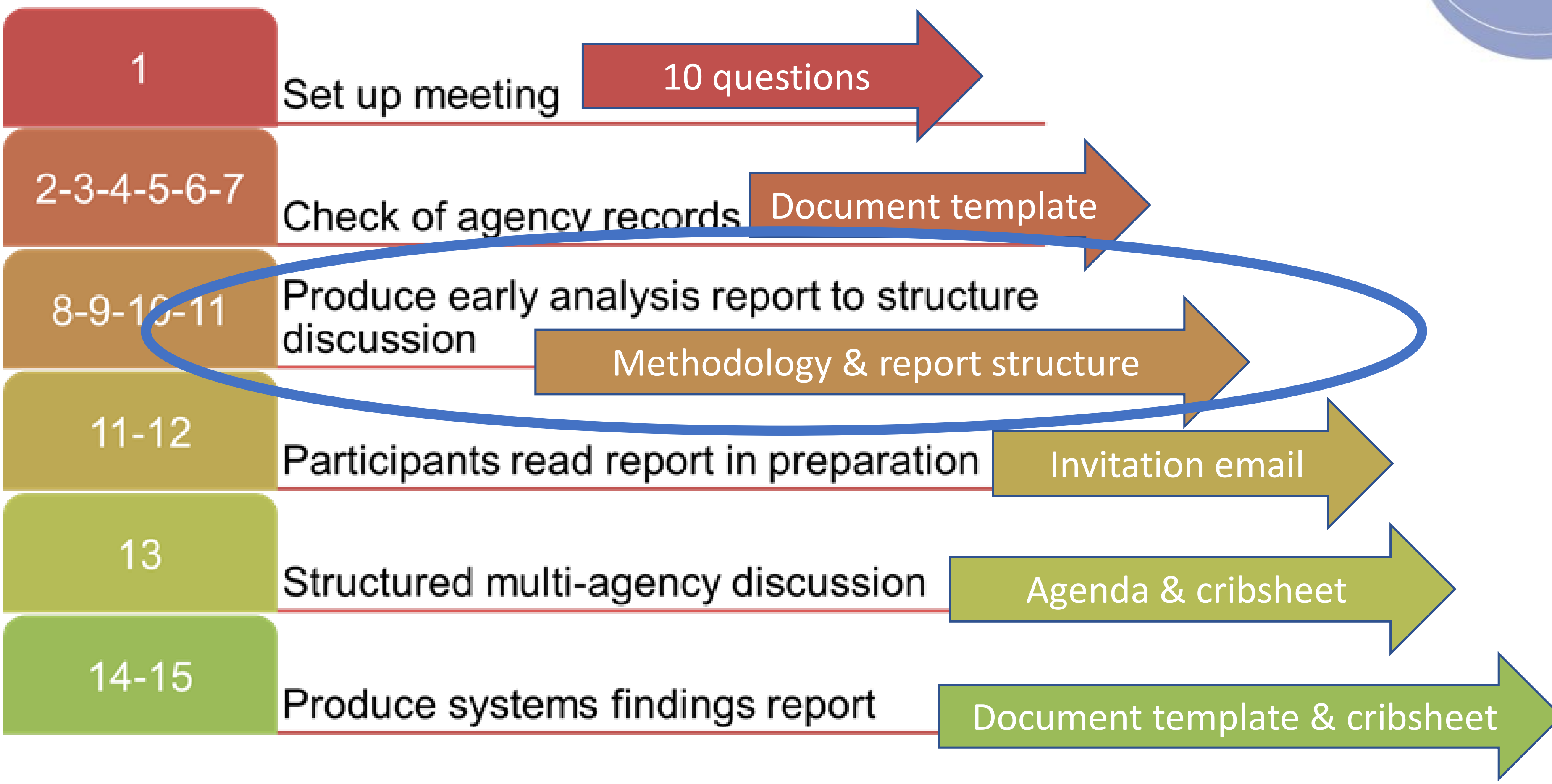
Dos

- Build on your experience of what works locally
- Have person who took part in Set Up do/oversee in order that rational does not get lost

Don’ts

- Encourage unfiltered record ‘dump’
- Make it a purely administrative task

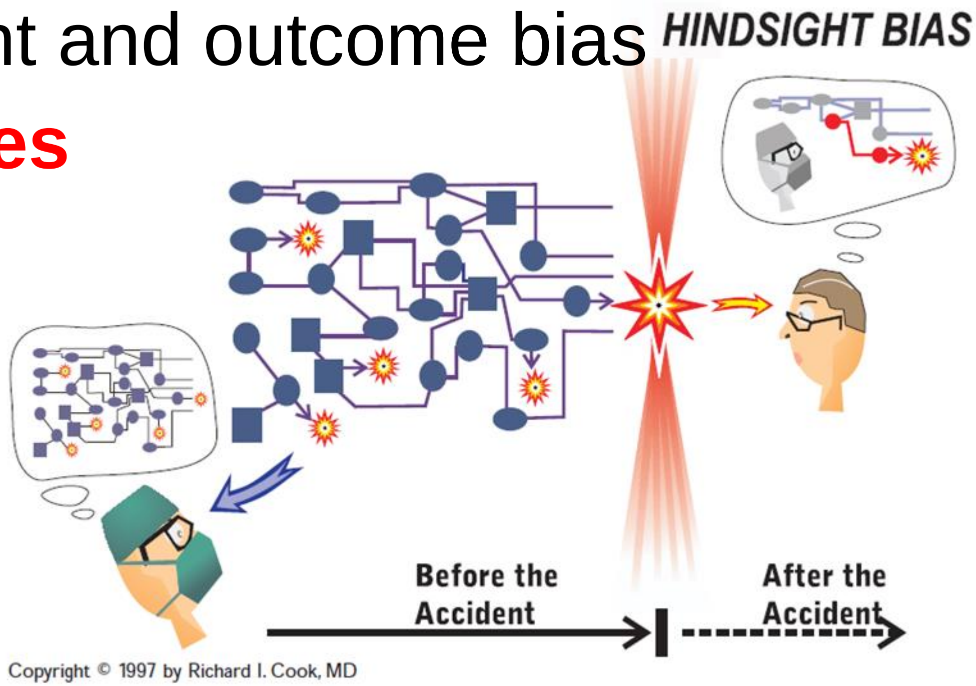
Tools, templates and guidance



Early analysis

- Using the agency record check returns to:
  - Make the data manageable within the timeframes
  - Frame the forthcoming multi-agency discussion, identifying gaps and questions
  - Minimise hindsight and outcome bias

NB. Cognitive biases are strong



Sequencing of steps for early analysis

- **Timeline-on-a-page**
- **Break down the timeline into a limited number of periods for analysis**
- **Analyse each time period**
- **Note early reflections on wider systems findings**

Underpinned by the Quality Markers and a 'systems' approach

Quality Marker No. 9 – Assembling the right information

- Does the type of information identified cover:
  - The facts of what happened in the case – who did what and when
  - The rationale for decision –making, action and inaction
    - Why did people do what they did
    - What were they trying to achieve
    - What was influencing their practice
  - How normal was their behaviour – is this the way things are usually done?
  - The current relevance of past practice issues and their systemic conditions

Quality Marker No. 12 – Analysis

- **Quality statement**:

- The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard adults.

Breaking timeline into useful periods

	BREAKING THE TIMELINE INTO USEFUL PERIODS
1.	**Descriptive title for episode:**
	Summary of relevance of this period of time, at the time, given what had gone before but ignoring what happened subsequently
2.	
3.	
4.	

Illustration from test SAR

Number	Descriptive title Minimising of hindsight bias by describing relevance of this period of time at the time, in context of what had come before but not what came afterwards
1.	**Responses by partners locally to knowledge of Covid and likely pandemic (Feb 2020)**
	At this stage, proactive preparations were needed, including identifying care homes with a history of concerns, particularly in relation to infection control and leadership
2.	**Responses by Care Home to first residents becoming ill with Covid symptoms (first half March uptill end March)**
	It was known locally about Covid and that a national pandemic was likely. It was therefore imperative at this time that care homes recognised possible indicators of Covid among their residents, even in the absence of testing, so that more stringent isolation and barrier nursing could be put in place escalated. The escalation of potential outbreaks needed to be prompt, so that local partners including LA commissioners, local PH and CCG could provide support and have a correct overview of Covid developments locally.
3.	**Collective responses to outbreak being declared in Care Home (end March onwards)**
	Once the outbreak was confirmed and formally declared, there needed to be a coordinated response by all partners to support Care Home in best managing the outbreak and plan for the likely implications including need for: additional expertise; additional training; additional communications with family members; additional staff; significant PPE supplies; communications strategy.

Framework for early analysis of each period within the timeline

- 1. What needed to happen during this period? How do we know what ‘good’ would have looked like?
- 2. How does that compare to what actually happened?
- 3. a) How usual, standard, typical were the different aspects of the responses at the time?
- 3. b) Would the same response be likely now?
- 4. a) What were the respective supports, constraints and barriers for different aspects of practice?
- 4. b) Do these contributory factors still hold today?

Questions 3 and 4 reflect back on how things were at the time AND help us think about how much has since changed.

Table layout

<table>
<tr><td colspan="3">Title:

Summary of relevance given what had happened up to this point:</td></tr>
<tr><td colspan="3">1. What needed to happen during this period? How do we know what ‘good’ would have looked like?</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="2">2. How does that compare to what actually happened?
Where did reality exceed?
Where was practice what was needed?
Where were there gaps?
Where were the inadequacies?</td><td>3. a)

How usual, standard, typical were the different aspects of the responses at the time?</td><td>4. a)

What were the respective supports, constraints and barriers for different aspects?</td></tr>
<tr><td>3. b)

Would the same response be likely now?</td><td>4. b)

Do these contributory factors still hold?</td></tr>
</table>

Reflections on early analysis from test SARs In Rapid Time

- Suggested reviewer time x2 days for reading & analysis
- Can help to pursue a couple of key documents or email exchange for clarification issues stemming from the returns
- Need to keep number of time periods reasonably restricted – you will have only 3 hours to discuss them with the multi-agency practitioner group
- Judgement is needed to draw out the core points only, so discussion can be reasonably succinct
- You need to keep pulling yourself back from turning the SAR In Rapid Time into a bigger ‘proportionate’ SAR

Early thoughts on systems findings

Very brief at the early analysis stage; review assumptions at set up meeting and note any changes

Quality Marker No.12 Analysis

CASE SPECIFIC ANALYSIS

Has your analysis gone beyond commenting on compliance with relevant procedures, to provide explanations of professional behaviour that call on a range of cultural and organisational factors?

SYSTEMS FINDINGS

Has your analysis drawn attention to what professional activity in the case reveals about how service delivery worked at the time, or is working more generally and routinely?

Does the analysis show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice?

Responding to your thoughts, questions so far

1	Set up meeting	10 questions ✓
2-3-4-5-6-7	Check of agency records	Document template ✓
8-9-10-11	Produce early analysis report to structure discussion	Methodology & report structure ✓
11-12	Participants read report in preparation	Invitation email
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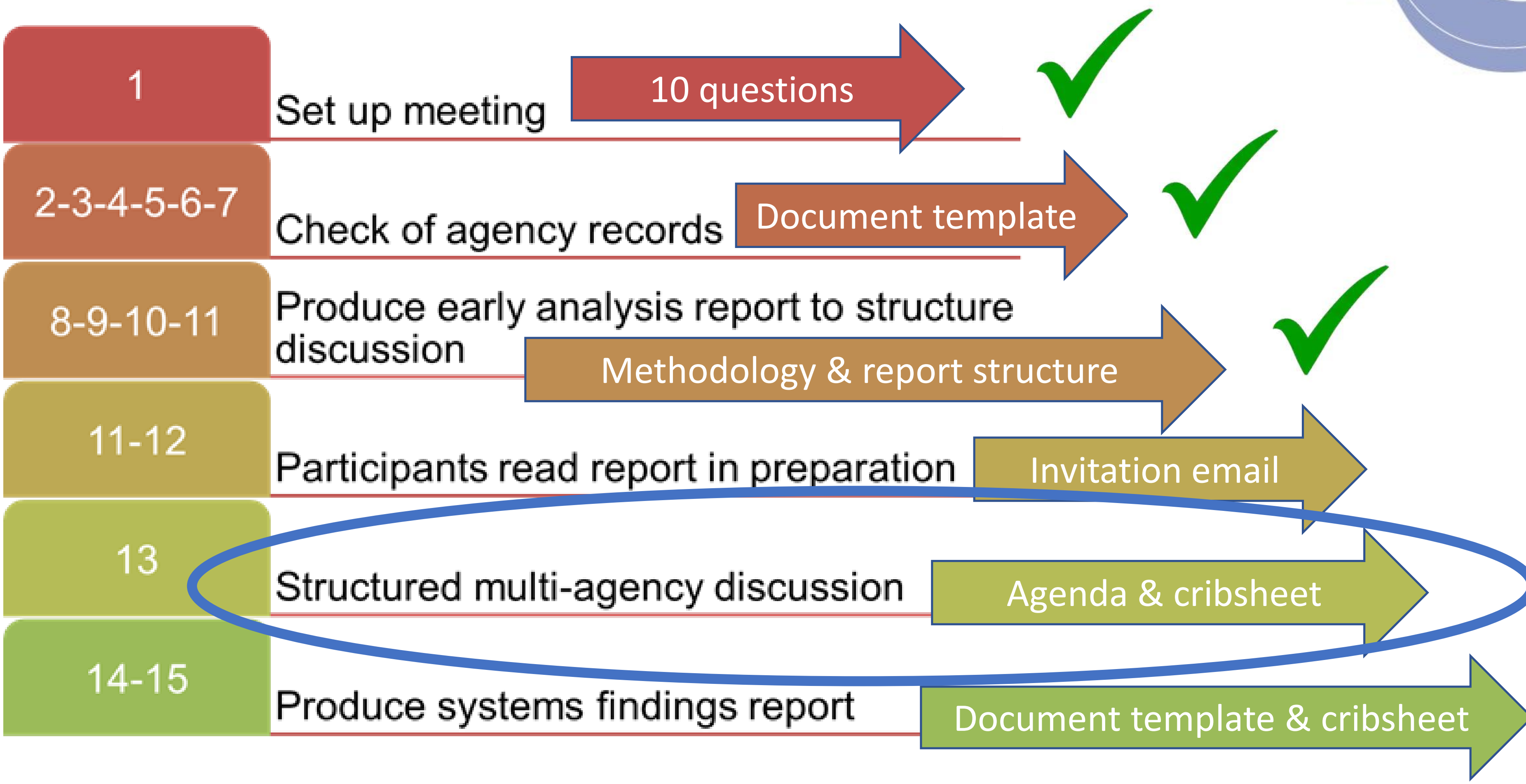
14-15	Produce systems findings report	Document template & cribsheet

Lunch break

Tools, templates and guidance



Structured multi-agency discussion

- Early analysis report provides structure
- Discuss each episode sequentially, using the questions

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Would the same response be likely now?</td><td>4. b)
Do these contributory factors still hold?</td></tr>
</table>

Agenda

- Welcome
  - Purpose of the meeting
  - Systems areas we think this case can help us learn about
  - Who is in the room – graphic of involved agencies and roles
- Quick introductions
- Discussion of episodes
- Break
- Discussion of episodes continued
- Drawing out the learning; what’s needed and the enabler/barriers
- Reflections, next steps and close

Nb. Important to try to time Episodes

Reflections on MA structured discussion from test SARs In Rapid Time

- Suggested 3 hour meeting with break
- Preparation key – selecting the right people and knowing what they can speak to; be strict on who can take part
- Early analysis is vital to getting the most from short time
- Anticipate the need for warm up – give more time to first episode, or an additional exercise
- Encourage participants to use of ‘chat’ bar if facilitators do not come to them
- Keep the end goal in mind; you need to keep pulling yourself back from turning the SAR In Rapid Time into a bigger ‘proportionate’ SAR

Tools, templates and guidance

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Succinct systems findings report

- Why focus on systems findings?
  - A variety of different kinds of information is possible from SARs, which serves different purposes
  - If our purpose is to inform improvements to practice, what we need from SARs is an in-depth understanding of what's making it harder and what's making it easier to do timely and effective safeguarding

Underpinned by the Quality Markers and a 'systems' approach

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As we highlighted earlier

Quality Marker No. 12 – Analysis

As we highlighted earlier

- **Quality statement**:

- The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard adults.

The evolving SAR Library is set up to collate systems findings

- Distinguishing different kinds of “learning”

case findings

systems findings

recommendations

Example

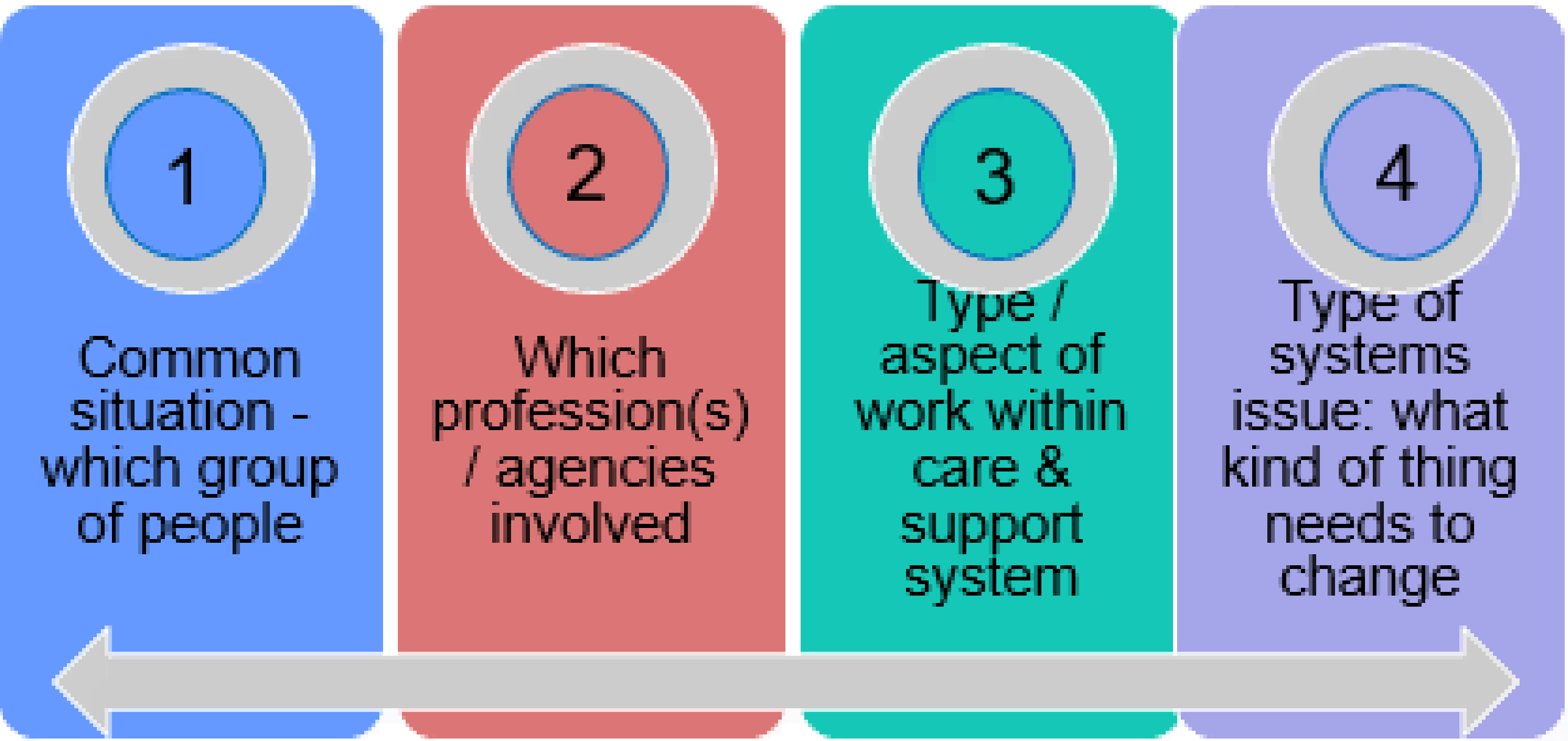
There is no established palliative care pathway or related roles for people with long term addictions

The SAB bring together agencies to map out what a possible care pathway for people with addictions needing palliative care would look like.

Andrew was left to die with no palliative care or support to die with dignity.

The evolving SAR Library is set up to collate systems findings

- Enabled by a common categorisation :



	Coding example of Andrew earlier	Common situation: which group of people or circumstance is this finding about?	Which agency or agencies, profession or professions.	Type of work: which aspect of work within the care & support system does this issue apply to?	Type of systems issue: what type of thing is this finding telling you needs to change?
1	There is no established care palliative care pathway or related roles for people with long term addictions	People with long term addictions This is explicitly stated in the finding.	Not relevant to this systems finding The wording of this finding does not relate to the actions of a particular staff group – any group of professionals or agency could use such a pathway/ be working with someone with a long term addiction who is at the end of their life.	Palliative care / end of life This finding is only relevant to working in end of life situations.	Management systems The words 'pathway and related roles' indicate this is a management systems issue – a management level decision needs to be taken to create/ coordinate the work to create such a pathway.

Making learning from SARs useful and useable

- Consistency in output; what 'learning' generated

- The goal is to create more than just a repository of reports, but an accessible database of findings that can be searched

Illustration of (draft) systems findings from test SAR

- MULTIPLE-EXCLUSION HOMELESSNESS
- There is currently no robust infrastructure to support small neighbourhood organisations engaged with people facing multiple-exclusion homelessness and enable joined up working with statutory and voluntary sector agencies, increasing the chances that those the person trusts are least integrated in multi-agency efforts to help them.
- Recommendation: Are there tactics, set ups and attitudes used in engaging with serious youth violence that could be mirrored?

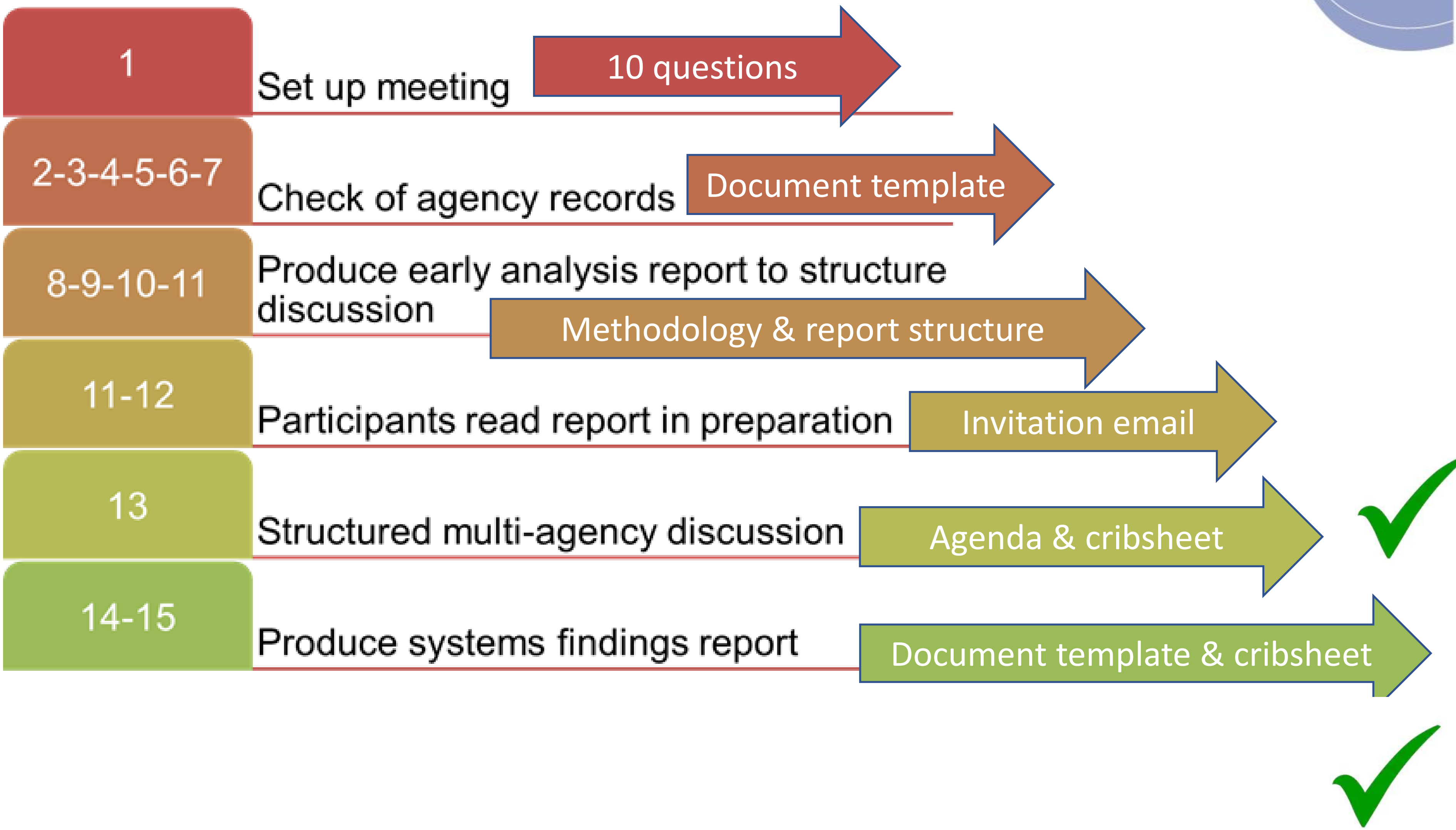
Also brief case evaluation

- Building on the early analysis report and multi-agency practitioner discussions
- High level evaluation of practice for each of the different periods that you have broken the case down into
- Build on the structure of early analysis report

Summary of evaluation of practice in the case

	BREAKING THE TIMELINE INTO USEFUL PERIODS
1.	Descriptive title for episode:
	Summary of relevance of this period of time, at the time, given what had gone before but ignoring what happened subsequently
	Evaluation of practice
2.	

Responding to your thoughts and questions



We're done! SAR In Rapid Time

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Staged testing and refinement

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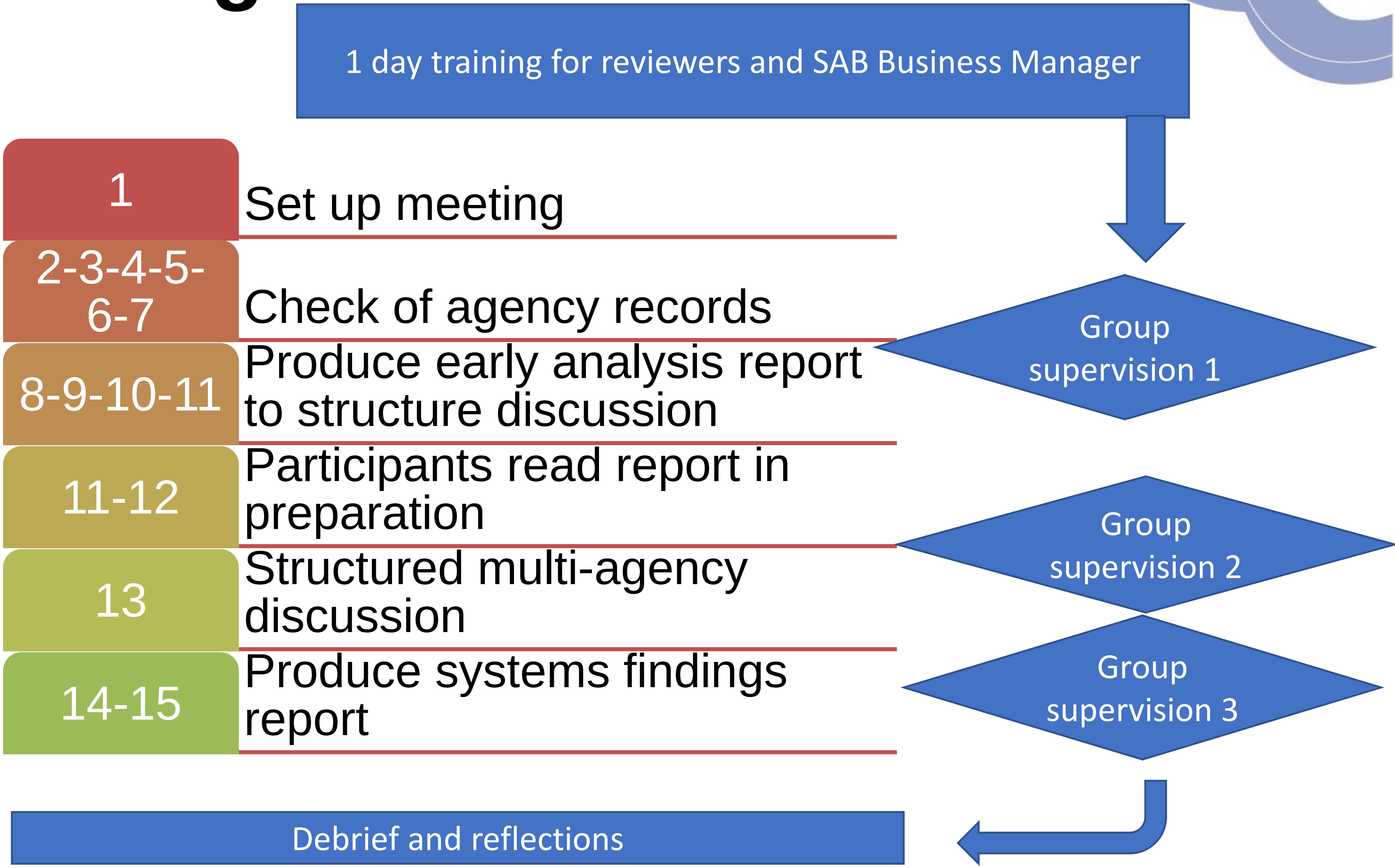
SAR In Rapid Time? Phase 2 testing cohort



Poll – would you be interested being part of that cohort

Yes

Not now

Not sure

Never

SAB would need to provide:

- A SAR where there is an urgency to identify and share learning
- Reviewer(s)
- Commitment to participate in all training and group supervision sessions

- SCIE would provide the training and group supervision sessions free of charge

Project team

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