Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board
Abuse must stop

SAR 4d: Safeguarding Adults Reviews - Methodology Options

The Care Act 2014 outlines the expectation that Safeguarding Adult Boards will commission and learn from Safeguarding Adults Reviews. It is not prescriptive in terms of methodology and there are many ways for the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) to achieve learning. It is important that the partnership has a range of options to ensure proportionality in conducting reviews whilst optimising learning opportunities.

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 again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

A paper written for the London SABs (Sue Bestjan 2012) outlines a number of options and has been used as the basis for this briefing note. Each methodology is valid in itself and no approach shall be seen as holding more value than another. All methodologies have some degree of flexibility, for instance as to external or internal facilitation and the scope of the review.

There are a number of external organisations/professionals who have considerable experience in facilitating reviews, some of whom are referred to in this document. This does not represent an endorsement per se but is provided for information and to assist with option choices. There will undoubtedly be other sources of expertise.

The methodology options outlined are as follows:

- Traditional Review by Individual Management Report (IMR)
- Action learning
- Peer review
- Significant Event Analysis
- Multi agency combined chronology

Where the Safeguarding Adults Review criteria are not met the following options may be considered:

- Single agency review
- Multi-agency learning review
- Case file audit
- No further action

Option 1: Traditional Review by Individual Management Report (IMR)

This broadly follows a traditional model:

- Appointment of a SAR panel, including chair and core membership which oversees progress
- Appointment of an independent overview report author
- Chronologies of events
- Production of IMRs outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Production of action plan
- Formal reporting and ongoing monitoring by SAB

This methodology is more likely to be applicable where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

Advantages	**Disadvantages**
More familiar to SAB partners	Overly bureaucratic and protracted, there is potential that lessons learnt will not be responsive to time considerations
Tried and tested process which is familiar to public/politicians giving confidence in the approach	Can preclude direct contact with the frontline practitioners and when they are seen is done in a single agency format missing opportunities to maximise learning
Works well for complex and serious incidents or high profile cases	Costly – costs may not justify the outcomes
Methodology is similar to that used in Children SCRs and Domestic Homicide Reviews	Can be perceived as punitive, attributing blame

Option 2: Action Learning

Characterised by reflective/action learning approaches which do not seek to apportion blame but identify both good practice and those areas for improvement. This is achieved by close collaborative partnership working, including those actually involved at the time, in the joint identification and deconstruction of the incident, its context and recommended developments.

This involves:-

- Appointment of a facilitator and overview report author
- Production of relevant evidence, the procedural guidance and a chronology
- Material circulated to attendees of the learning event which is to include members of the SAB, frontline staff and managers, experts where necessary and the facilitator or overview author
- Learning event to consider what happened and why, areas of good practice areas for improvement and lessons learnt.

- Consolidation into an overview report including analysis and recommendations
- Event to consider first draft of the overview report and action plan
- Overview report presented to SAB to agree dissemination of learning and response to recommendations
- SAB ongoing monitoring of action plan progress

The exact nature of this methodology can be adapted, dependant upon the individual circumstances, case complexity and requirements and preferences of the partnership, giving flexibility over the scale and costs.

There are a number of individuals and agencies who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE Learning Together Model)
- Significant Incident Learning Process (SILP)
- Root Cause Analysis – as used in the Health Service
- Health and Social Care Advisory Service (HASCAS)
- Mindful Practice

Advantages	**Disadvantages**
Significant evidence approach is much more efficient	Methodology is much less familiar to many
Swiftness of conclusion and embedding the learning	Complexity of process management with large numbers of practitioners involved
Considerable reduction in overall costs compared to more traditional approaches	Wide practitioner involvement may not suit cases where criminal proceedings are ongoing and practitioners are witnesses
Action learning enhances partnership working and understanding of each other's roles and perspectives	Costs associated with training in-house reviewers or commissioning external reviewers
Collaborative problem solving	Associated costs of practitioners spending large amounts of time in meetings
Frontline engagement and perspective of systems	
Identification of strengths	
Learning takes place in real time	

Option 3: Peer review

This approach encompasses a review by one or more people who know the area of business. It accords with self-regulation and sector-led reviews of practice. This can either be peers from within the same partnership or outside the partnership but within a specified region (e.g. West Midlands). Peer review methods are used to maintain standards of quality, improve performance and provide credibility.

Advantages	**Disadvantages**
Objective, independent perspective, but with some local knowledge	Capacity issues may restrict availability and responsiveness
Usually trusted sources sharing common experiences	Potential to view peer reviews from SAB members as not sufficiently independent, especially in high profile cases
Arrangements can be reciprocal	Potential skills and experience issues
Very cost effective	

Option 4: Significant Event Analysis

This approach brings together managers and/or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development. Significant Event Analysis has been used for many years in the health service to analyse a significant event *'in a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements.'*

A Significant Event Analysis approach involves:

- Information gathering – collation of as much information as possible from a broad range of sources
- Facilitated workshop to analyse the event. It is crucial that this workshop is operated fairly, openly and in a non-threatening environment
- Analysis of the significant event

The key questions to be considered in a Significant Event Analysis are:

- How could things have been different?
- What can be learnt from what happened?
- What has been learned?
- What has been changed or auctioned?

Option 5: Multi Agency Combined Chronology

Developing a chronology of events is a useful way of achieving an overview of a case and considering the areas for development. With a combined chronology and multi-agency participation this perspective is greatly enhanced and enables not only the identification of gaps in service provision or practice but also missed opportunities for communication between agencies. Lead practitioners and managers can use a combined chronology to analyse and reflect on a case within a facilitated workshop setting as part of a desk-based review or a multi-agency panel and develop timely recommendations for change.

Option 6: Single Agency Review

Single agency reviews may be conducted where agencies from the SSASPB undertake their own reviews, e.g. Serious Incident reviews conducted by health partners. The SSASPB (via the SAR sub-group) may task an agency to undertake a Single Agency Review to support them in strengthening internal arrangements where there is a safeguarding element but no concerns regarding involvement of other agencies, e.g. an emerging pattern of issues/concerns or even where serious harm or abuse had been prevented by good practice.

Any agency undertaking a Single Agency Review with a safeguarding element will be expected to inform the SSASPB in order for the Board to consider transferable learning across the partnership.

Advantages	**Disadvantages**
An opportunity for detailed internal scrutiny of practice by	Restricts scope and doesn't embody a wider perspective of

single agency	other partners
Opportunity to identify areas for improved practice	Can be viewed as outside the SAR purpose of multi-agency learning
Assists a 'Duty of Candour'	

Option 7: Case File Audit (CFA)

This option was not referenced in the original London paper, but has been included for consideration by the SSASPB as a tried and tested approach effectively used for cases where the potential for learning was apparent but the specific case fell short of the threshold for either a Children's SCR or adult equivalent.

The CFA can include all contributing agencies specific to the case, or just a few who will be identified at the scoping meeting.

A case file audit involves a 'walk through' of the case within the time parameters set by the Scoping Panel Meeting. It is usual for the audit to be undertaken chronologically with agencies sharing information and pausing to explore opportunities for learning as necessary.

Advantages	**Disadvantages**
Opportunity for a very swift response to lessons learnt - actions can be agreed on the day	No interaction with frontline staff, the information tends to be shared by an operational head
Internal facilitator can be used as no specialist skills are required. Where outsourcing is necessary costs are minimal as it is usually only a one day commitment.	Likely to take a full day to complete
No lengthy report writing - detailed minutes and agreed actions are produced	Advance preparation of a detailed chronology is required to expedite the review process
Policies and Procedures both single and inter agency are made available on the day from which to check detail.	
Interactive discussion facilitated, but issues can also be paused for lengthier debate between those involved to allow momentum to be maintained	