Thematic Review of SW SCRs & SARs

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CONFIDENTIAL

Our research focus

- Documentary analysis
  - What themes emerge from the SCRs & SARs?
  - How do these add to understanding about professional intervention?
  - What recommendations are made in order to apply learning to future cases?
  - A thematic review – specific details of individual cases not included
- Sample = 26 SCRs & 11 SARs
- Organisational abuse (31% SCRs & 27% SARs) and self-neglect (23% and 55%) = prominent
- Two forms of analysis
  - SAR characteristics: type of case, type of review, type of recommendations
  - SAR content: factors contributing to the case outcome

A range of approaches

- Scrutiny of key documents: chronologies and reviews of each agency's involvement (50% and 10%)
  - Useful where multi-agency involvement has been long-term
- Systemic approach – "learning together" (15% and 10%)
  - Useful for promoting participation by those directly involved with the case
- Significant incident learning process (8% SCRs)
  - Useful where key episodes can be identified
- Significant event analysis
  - Useful where a key single event can be identified
- Hybrid approaches are increasingly common (8% and 64%)

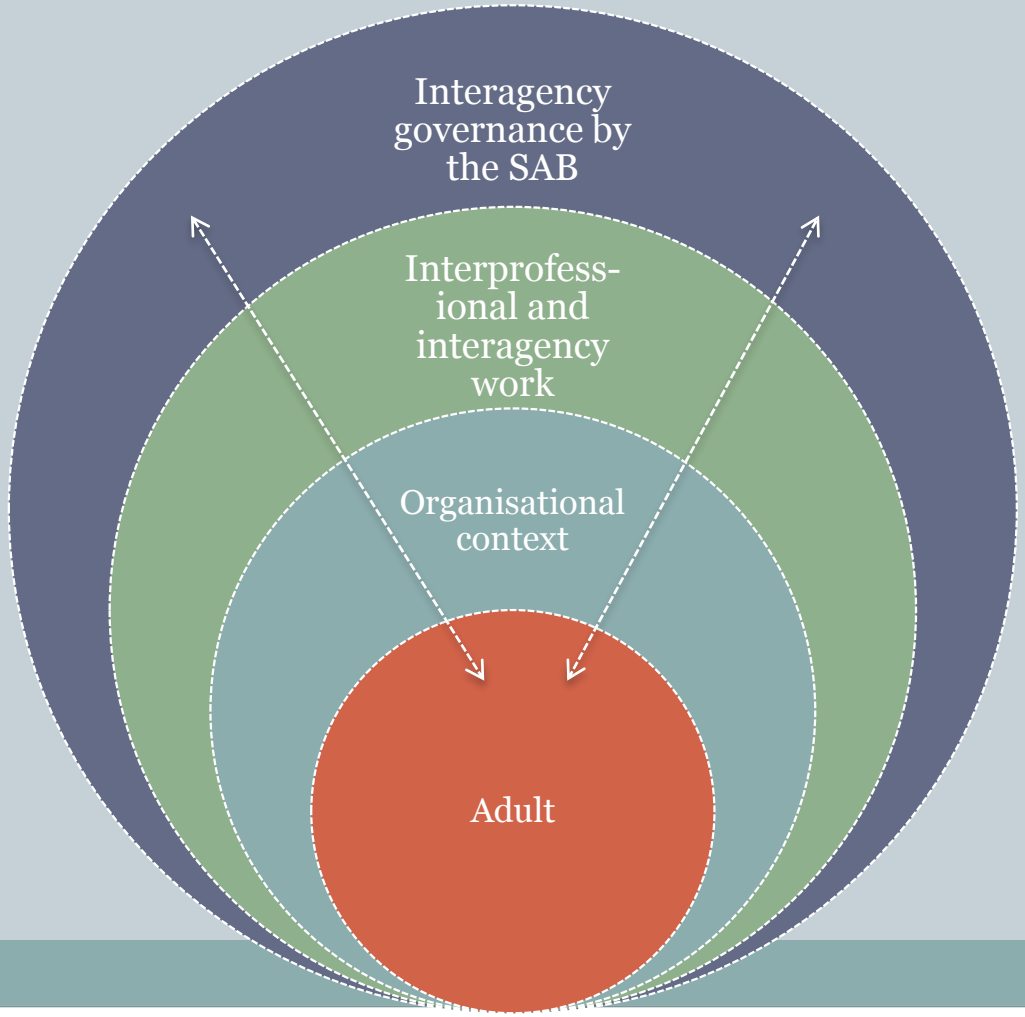
Review characteristics

- Across the lifespan (unlike London review)
- Slightly more men in the sample (as in London)
- 27% of reviews involve some form of group living.
- 54% of reviews involve death of subject (in line with other reviews of specific types of cases – London was higher at 76%)
- Increasing family involvement (from 35% in SCRs to 64% in SARs)
- Much less reference than in the London review to reticence or defensiveness.
- Increasing tendency for reviews to make recommendations just to the SAB, from 35% to 45%

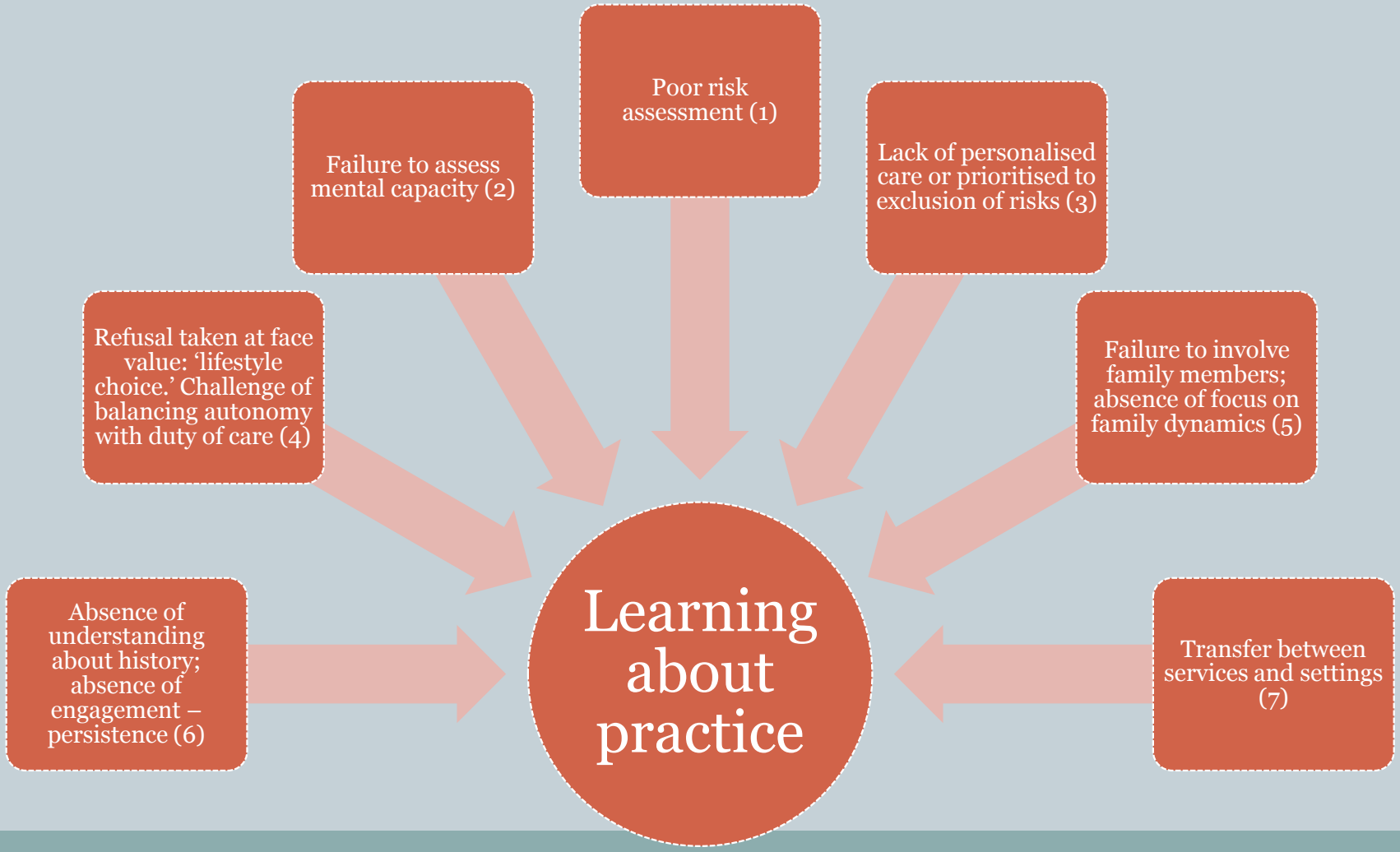
Quality of reviews

- Ethnicity rarely recorded
- Period under review not always specified
- Where the adult was still alive, unclear what consideration given to their involvement (22%)
- In 41% of reviews, unclear how long the review process had taken but very few completed within six months
- In 46% of reviews, unclear how the referral originated
- In 35% of reviews there are recommendations to unnamed agencies
- 58% of SCRs and 55% of SARs draw on best practice research evidence
- Only 42% of SCRs and 18% of SARs draw on other reviews

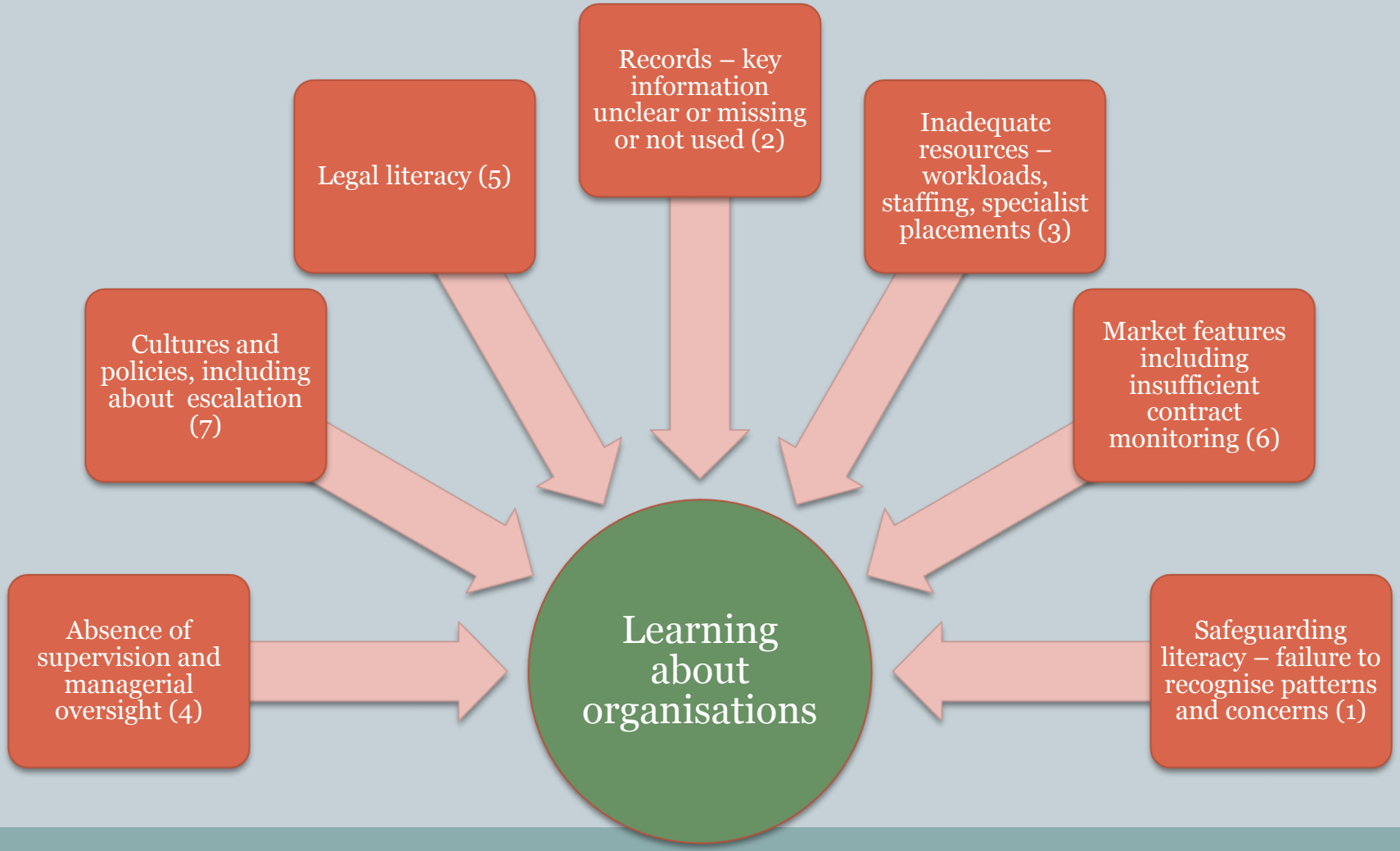
A safe system has alignment of checks and balances between the different layers of the system



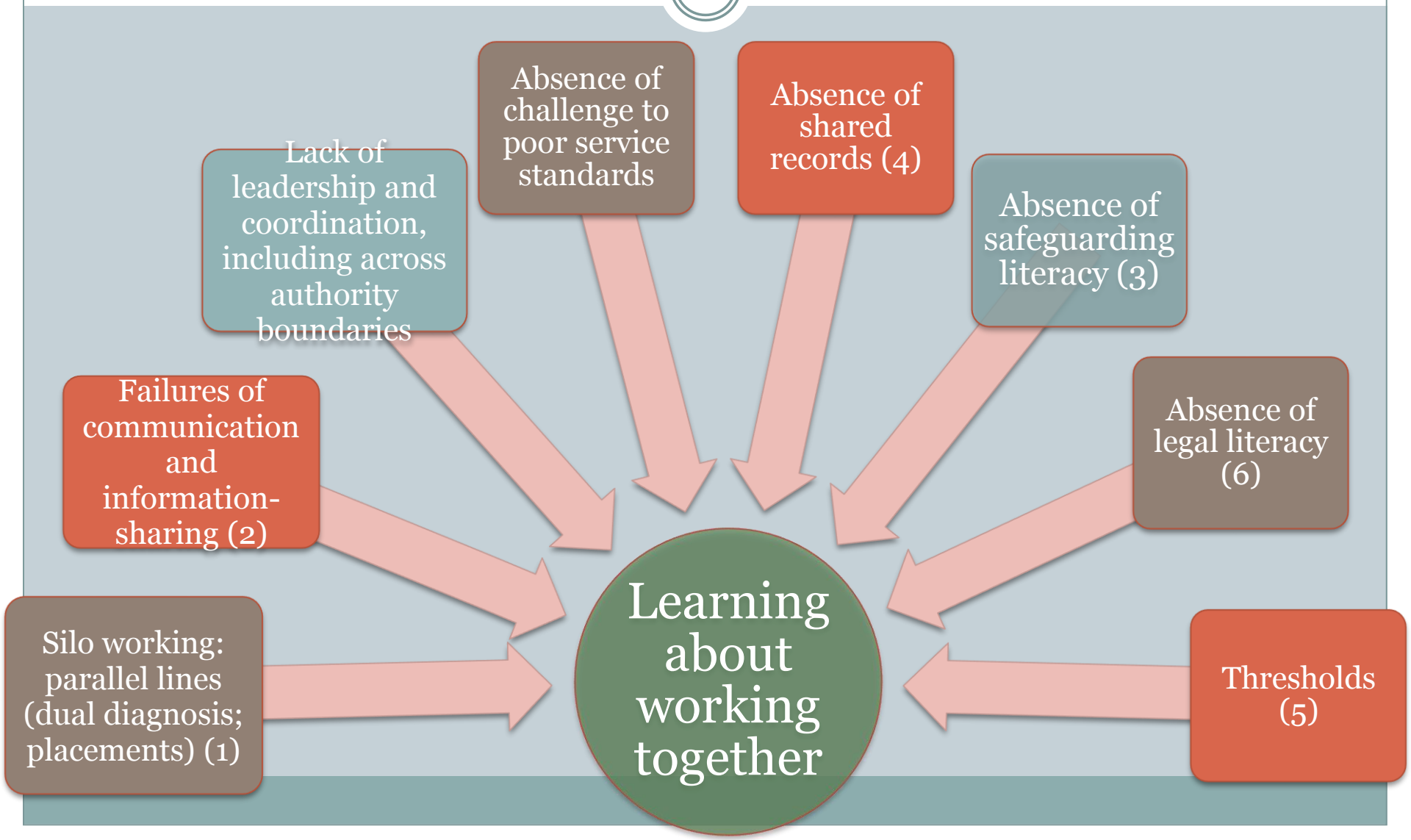
Direct practice with the adult



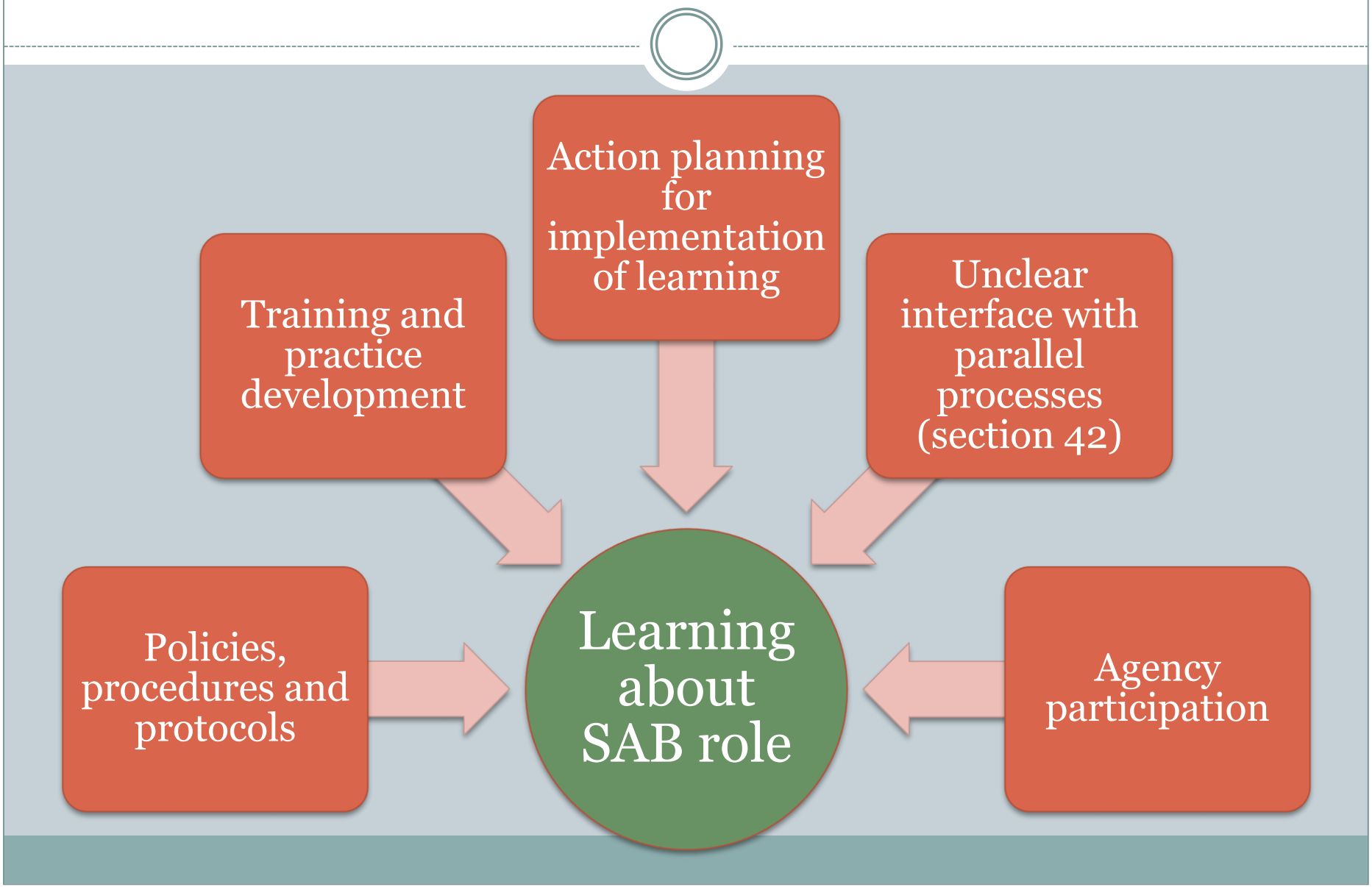
Organisational context



Interagency cooperation



SAB governance



Recommendations

- Direct practice – (risk & capacity) assessments, person-centred practice
- Organisational – guidance, training, supervision, commissioning, case management
- Inter-agency – information-sharing & communication, case co-ordination, professional roles
- SAB governance – audit and quality assurance, use of SAR

Taking learning forward

- 88% of SCRs and 91% of SARs published as whole reports or executive summaries (London – only 45% of SARs). What weighs in the decision-making here?
- Action plans, routinely monitored and updated, with outcomes reported to SABs
- Dissemination mainly within a locality but also regionally and nationally to promote learning and service development
- Briefing notes for a wide variety of audiences
- Learning and service development seminars & conferences
- But – how do we address current concerns about impact and effectiveness of the review system – learning the same lessons?
- Key themes – under-reporting of "low level" concerns; balancing autonomy with duty of care; effectiveness of placement monitoring and CQC; dual diagnosis; risk assessment
- What is NOT talked about – impact of public sector cuts, adequacy of market models of care, fragmentation of health and social care, adequacy of legal frameworks

Questions for SABs - Commissioning

- Organisational abuse and self-neglect also prominent in London survey but higher representation of other types of abuse/neglect in SW. What might influence the referral process here?
- Are referrals appropriate and do all agencies refer?
- How do we understand differences in the number of reviews being commissioned by different SABs (here and in London)?
- What are the explicit and implicit thresholds being used for commissioning different types of review?
- Statutory SARs and parallel SCRs dominate. What influences are at work here? How do we balance proportionality with commissioning the familiar? How do the six principles work here? Is the statutory guidance too restrictive? When might you use shared learning events?
- Finding reviewers?
- What influences or would facilitate choice of methodology?
- When does the six month timeframe commence – from the date of the decision to review or when the reviewers commissioned, or …?

Questions –Managing the Process

- What aspects of the statutory guidance on SARs have proved helpful or unhelpful? When does a review begin and end?
- Family involvement – how explicitly do we clarify family expectations? What are we learning from an apparent increase in family involvement? How do we deal with litigious relatives?
- Practitioner and manager involvement – the rhetoric is that SARs are about learning and not blame. Is that how the process is experienced? What is the SABs contribution here? Do we really reach an understanding of "why?"
- Panel membership – CQC? Care home owners or representatives from RCA etc?
- Parallel processes – how is it best to manage the interface with criminal proceedings, Coroner inquests, IPCC investigations, s 42 enquiries?
- Are SCIE and/or London ADASS quality markers being used to oversee the structure and content of the report?
- What is the panel's role on number and SMART content of recommendations?

Questions – Capturing Learning

- How useful are the different methodologies for understanding what influenced case processes & outcomes?
- What influences the decision about whether to publish and what to publish?
- Are web pages and annual reports compliant with Care Act requirements regarding publication of annual reports and their content with respect to SARs?
- There is no quality standard for recommendations – what might one contain?
- Do SABs consider it appropriate to direct recommendations to national bodies, including government? Very few recommendations about the legal, policy, financial and market contexts.

Questions – Embedding Learning

- Reviews rarely comment on SAB SAR procedures – increasing refinement? What about experience with thresholds and the six principles?
- Do all SABs have dissemination strategies – general or specific to individual cases?
- How do SABs know that learning is being sustained?
- What level of investment is feasible – cost/benefit analysis?