social care
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Learning from Safeguarding Adult Reviews (SARs)

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What are we covering today?

1. Introductions
2. Safeguarding Adult Reviews - their process and purpose
3. Types of learning and improvement work
4. How can SARs make a difference to frontline practice?
5. Local SAR learning in Surrey

1. Introductions

Three quick polls

Poll 1 - Have you had any direct experience in a multi-agency SAR process?

a) Yes

b) No

Poll 2 – Would you describe your role in relation to multiagency SARs as ….

a) A commissioner of reviews

b) A member of the subgroup that considers SAR referrals

c) A member of the subgroup that undertakes quality assurance of the SAR

d) A member of the Board Business Team that manages the SAR process

e) A SAR reviewer

f) A member of operational or strategic staff who uses the learning from SARs

Poll 3 - Have you found SARs (either local or national ones) to be useful in your professional development/CPD?

a) Very useful

b) Some use

c) I have tried to engage in the learning but have not found it useful

d) I have not yet engaged in learning using outcomes from SARs

2. Safeguarding Adult Reviews - their process and purpose

What is a Safeguarding Adult Review?

- Two types of SARs outlined in The Care Act 2014, Section 44 Care Act 2014 (legislation.gov.uk)

- **Mandatory SARs** - when an adult dies or is seriously injured as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked together more effectively to protect the adult.

- **Discretionary SARs** - any other situations involving an adult in its area with needs for care and support.

What the Care Act says about the purpose of SARs

- To promote effective learning and improvement action, that will help to minimise the likelihood of future deaths or serious harm.
- To generate insights into how organisations are working together
- To provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible

What the Care Act says about the SAR process

- Should be a trusted and safe experience that encourages honesty, transparency and sharing of information
- Involvement from the adult and family
- Participation from the practitioners and their first line operational managers

Further details in the Care Act Statutory Guidance (chapter 14,162-179) [Care and support statutory guidance - GOV.UK (www.gov.uk)]

The SAR Quality Markers

There are 15 quality markers that provide guidance and best practice for all the key stages including:

- Setting up the SAR
- Running the review
- SAR outputs, action and impact

- You can find full details of the Quality Markers on the SCIE website at List of 15 Safeguarding Adult Reviews Quality Markers | SCIE

3. Types of learning and improvement work

Case specific learning and systems learning

Quality Marker 12

- **Case specific learning** – ‘to evaluate and explain professional practice in the case ….’

- **Systems learning** – ‘…learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change’.

SARs help us to hold a mirror up to ourselves and our system

SARs help us to explore:

- What is supporting good quality work
- Our current systemic vulnerabilities making it harder to do a good job
- Organisational factors that make it more likely, that anyone in a similar position might make similar poor decisions or inappropriate actions or inactions

4. How can SARs make a difference to frontline practice?

Do SARs make a difference?

- Why does it sometimes seem that SARs don't make a difference and we find the 'same old' problems in each SAR?

- **Case specific learning** - individual responsibility of practitioners

- **Systems learning** – service improvements are the responsibility of system leaders and managers

What supports case specific learning for frontline staff’?

Even if you or your organisation were not directly involved in a SAR – these are ways you can support improvement:

- Support a culture of continuous learning and improvement across the local organisations
- Time and focus on CPD
- Know where to look for relevant learning and resources
- The SAB will publish SAR findings, action plans and details of improvements achieved in the SAB annual report

Taking forward learning and improvement work

Leaders and managers	• To make system improvements happen
Practitioners	• To use practice learning & consider the system improvements
Service users, families and citizens	• To be reassured that service improvements will reduce risk

Current practice regarding improvement work and evaluating the impact of SARs

National analysis of SARs (2017 – 19)

https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

5. Local SAR learning in Surrey

Mary – Domestic Homicide Review and Safeguarding Adult Review (published July 2021)

- Mary had a history of drug misuse and mental health issues. She experienced increasing violence and coercive controlling behaviour by her partner. At the time of Mary's death in 2017, she was living alone as her three children had recently been taken into foster care. In the months leading up to her death she had contacted the police on fourteen occasions reporting that her relationship had become abusive and violent. Mary died by hanging.

- Local context – increased number of DA referrals

Mary – the key learning points highlighted the need for :

- **More effective joined up working across child and adult services**
- **Better support for parents involved in care proceedings**: Mary's needs were not considered when the children were taken into police protection despite being identified as being vulnerable, e.g. mental health issues, suffering from domestic abuse and substance misuse.
- **Increased focus on professional curiosity and understanding the victim's experience**: If agencies had researched historical incidents in Mary's life it would have given agencies a better understanding of Mary's needs. This includes the need for professionals to have a **trauma base approach** when working with adults who are experienced domestic abuse and the impact it has on their life.
- **Consider barriers to services -** how to improve engagement with an individual who may be perceived to be reluctant to engage?
- **Recognise and respond to underlying barriers (**organisational cultural barriers) to recognising when domestic abuse meets adult safeguarding criteria (Section 42, Care Act 2014)

The Mary SAR and DHR

- **Surrey SAB website** : Safeguarding Adults Reviews (SAR) - Surrey Safeguarding Adults Board (surreysab.org.uk)
- **Report published** in July 2021 - full report and exec summary

- **Half day learning event held (on SAB website) covered key learning for practice including:**

  - signs of domestic abuse and coercive control,
  - trauma informed practice and suicide,
  - whole family approach & family safeguarding model
  - recognizing when a DA concern meets safeguarding criteria

SAR MARY

- The Surrey SAB learning webinar was arranged following the SAR/DHR Mar: Learning from the Death of Mary - YouTube

- The early part of the webinar responds to **practice issues**, then towards the end of the webinar (about 75% of the way through the webinar, 1 hour and 10 minutes into the webinar) a session is led by Clement Guerin (Head of Adult Safeguarding, Surrey County Council) which explores at practice **and the underlying systemic reasons** that had contributed to a pattern of domestic abuse concerns not being recognised by adult social care as section 42 safeguarding cases.

Breakout rooms

Points for discussion in your group

1. Thinking about your own practice and CPD, what actions do you think would support more effective **practice improvement** after a SAR?

2. Thinking about your own team and organisation, what actions do you think would support more effective **system improvement** after a SAR?

(15 minutes discussion)

Feedback

Thank you!

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