**Fig. 1: SAR methodology decision tree:**

**Is there reasonable cause**

**for concern about how partners worked together?**

**NO**

**YES**

**Statutory SAR.** Consider methodology

[A](#OptionA) or [B](#OptionB) or hybrid

**Has an adult at risk died**

**(including suicide)?**

**NO**

**YES**

**Because of (or suspected to be because of) abuse or neglect?**

**NO**

**YES**

**Has an adult at risk**

**suffered significant harm?**

**(See** [**para. 2.2**](#para22)**)**

**NO**

**Statutory SAR.** Consider methodology

[C](#OptionC) or [D](#OptionD) or hybrid

**Is the case likely**

**to: be complex; run alongside**

**criminal proceedings; and/ or**

**generate public interest?**

**(See** [**para. 5.4**](#para54)**)**

**NO**

**YES**

**Has an adult at risk died**

**(including suicide)?**

**NO**

**YES**

**Has an adult at risk**

**suffered significant harm?**

**(See** [**para. 2.2**](#para22)**)**

**NO**

**YES**

**YES**

**Because of (or suspected to be because of) abuse or neglect?**

**YES**

**NO**

**Non-statutory SAR.** Consider methodology

[C](#OptionC) or [D](#OptionD) or hybrid

**No SAR required.** Return to requestor to consider internal review if they wish.

**Is there potential**

**to identify sufficient valuable learning from the case?**

**(See** [**para. 4.3**](#para43)**)**

**NO**

**YES**

**Is there reasonable**

**cause to identify good practice from the case to improve partnership working?**

**NO**

**YES**

**No SAR required.** Return to requestor to consider internal review if they wish.

**Non-statutory SAR.** Consider methodology

[D](#OptionD) or [E](#OptionE) or hybrid

**Option A: Systems Analysis**

**Key features:**

* Team/ investigator led
* Staff/ adult/ family involved via interviews
* No single agency management reports
* Integrated chronology

* Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Choose investigator-led or reviewing team-led model. Agree interface with SAR panel.

Identify and gather relevant data (e.g. documents, interviews, records, logs etc.)

Order contributory factors by importance/impact

Determine the chronology/ story of the incident

Identify Care/ Service Delivery Problems (specific actions/ omissions/ slips/ lapses in judgement by staff/ volunteers)

Analysis to identify contributory factors (service user/ team/ management/ systems/ organisation conditions)

Themes, solutions and achievable recommendations identified 🡪 SAR report

|  |  |
| --- | --- |
| Advantages | Disadvantages |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers may provide more balanced view * Managed approach to staff involvement may fit well where criminal proceedings are ongoing * Enables identification of multiple causes/ contributory factors and multiple causes * Range of pre-existing analysis tools [available](http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) * Focusses on areas with greatest potential to cause future incidents * Based on thorough academic research and review * RCA tried and tested in healthcare and familiar to health sector SAPB members. | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions * Staff/family involvement limited to contributing data, not to analysis * Potential for data inconsistency/ conflict, with no formal channel for clarification * Unfamiliar process to most SAPB members * Trained reviewers not widely available * Structured process may mean it’s not light-touch * RCA may be more suited to single events/incidents and not complex multi-agency issues |

**Available models:**

Vincent et. al. (2003) [Systems analysis of clinical incidents: the London Protocol](http://www1.imperial.ac.uk/cpssq/cpssq_publications/resources_tools/the_london_protocol/)

Woloshynowych et. al. (2005) [Investigation and analysis of critical incidents](http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0006/64995/FullReport-hta9190.pdf)

NHS National Patient Safety Agency (NPSA) [Root Cause Analysis](http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/)

**Option B: Learning Together**

**Key features:**

* Lead reviewer led, with case gorup
* Staff/ adult/ family involved via case group and 1:1 conversations
* No single agency management reports

* Integrated narrative; no chronology
* Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Research questions rather than fixed terms of reference are identified

One or two lead reviewers, and a case group identified and prepared. Interface with SAR panel agreed

Key practice episodes identified, and analysed to identify contributory factors

Data and information gathered and reviewed, including via “1:1 conversations” with staff/ family (not interviews)

In depth discussion with case group (includes staff/ adult/ family)

“Narrative of multi-agency perspectives” produced (not a chronology)

Underlying system patterns identified and “challenges to the Board” (not recommendations) 🡪 SAR report

|  |  |
| --- | --- |
| Advantages | Disadvantages |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers and case group may provide more balanced view * Staff and volunteers participate fully in case group to provide information and test findings * Enables identification of multiple causes/ contributory factors and multiple causes * Tried and tested in children’s safeguarding * Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity * Range of pre-existing analysis tools [available](http://www.scie.org.uk/publications/guides/guide24/practice/index.asp) | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions * Challenge of managing the process with large numbers of professionals/ family involved * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses * Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR * Opportunity costs of professionals spending large amounts of time in meetings * Unfamiliar process to most SAPB members * Structured process may mean it’s not light-touch |

**Available models:**

SCIE, [Learning Together](http://www.scie.org.uk/children/learningtogether/)

**Option C: Significant Incident Learning Process**

**Key features:**

* Review team and learning day led
* Staff/ family involved via learning days
* Single agency management reports
* No chronology

* Multiple learning days over time
* Explores the professionals’ view at the time of events, and analyses what happened and why

Review team identified and interface with SAR panel agreed

Data/ materials gathered from individual agencies, through a management report

Overview report finalised 🡪 SAR report

“Learning day”, with front line staff/ adult/ family, discusses the case based on shared written material

Overview report drafted

“Recall day” convened to discuss emerging findings with staff/ adult/ family involved

Final “recall day” to evaluate how effectively the learning has been implemented

|  |  |
| --- | --- |
| Advantages | Disadvantages |
| * Flexible process of reflection – may offer more scope for taking a light-touch approach * Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants * Has similarities to traditional SCR approach, so more familiar to most SAPB members * Agency management reports may better support single agency ownership of learning/ actions * Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity | * Burden on individual agencies to produce management reports * Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR * Opportunity costs of professionals spending large amounts of time in learning days * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses * Not been widely tried or tested, nor gone through thorough academic research/ review |

**Available models:**

Tudor, [Significant Incident Learning Process](http://www.reviewconsulting.co.uk/about-silp/)

**Option D: Significant Event Analysis**

**Key features:**

* Group led (via panel), with facilitator
* Staff/ adult/ family involved via panel
* No chronology
* No single agency management reports

* One workshop: quick, cheap
* Aims to understand what happened and why, encourage reflection and change.

Terms of reference/ objective agreed

Facilitator and panel of adult/ family/ staff involved in the case identified

Workshop agreed actions written up by facilitator 🡪 SAR report

Factual information gathered from range of sources

Facilitated workshop analyses data

Workshop asks what happened, why, what’s the learning and what could be done differently

|  |  |
| --- | --- |
| Advantages | Disadvantages |
| * Light-touch and cost-effective approach * Yields learning quickly * Full contribution of learning from staff involved in the case * Shared ownership of learning * Reduced burden on individual agencies to produce management reports * May suit less complex or high-profile cases * Trained reviewers not required * Familiar to health colleagues | * Not designed to cope with complex cases * Lack of independent review team may undermine transparency/ legitimacy * Speed of review may reduce opportunities for consideration * Not designed to involve the family * Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses |

**Available models:**

NHS Education for Scotland and NPSA, [Significant Event Analysis](http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/patient-safety-and-clinical-skills/tools-and-techniques/significant-event-analysis/sea-guidance-and-tools.aspx)

Care Quality Commission, [Significant Event Analysis](http://www.cqc.org.uk/content/gp-mythbuster-3-significant-event-analysis-sea)

Royal College of General Practitioners, [Significant Event Audit](http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/significant-event-audit.aspx)

**Option E: Appreciative Inquiry**

**Key features:**

* Panel led, with facilitator
* Staff involved via panel. Adult/ family involved via meeting
* No chronology/ management reports

* Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Terms of reference/ objectives agreed. Panel of staff involved in the case identified and a facilitator

Discovery phase – appreciation of best work done and system conditions making innovative work possible

Strategy phase – whole panel meets to agree how to share the findings with the SAPB 🡪 SAR report

Meeting between facilitator and adult/ family member to ascertain adult’s/ family views

Celebration phase – whole panel discussion to hear from practitioners on what works, including adult’s/ family views

Report of discussion sent to manager of each contributing agency

Recognition phase – each agency shares good practice internally and endorses practice highlighted from their agency ted

|  |  |
| --- | --- |
| Advantages | Disadvantages |
| * Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days * Staff who worked on the case are fully involved * Shared ownership of learning * Effective model for good practice cases * Some trained facilitators available * Well-researched and reviewed academic model * Model understood fairly widely | * Not designed to cope with ‘poor’ practice/ systems ‘failure’ cases * Adult/ family only involved via a meeting * Speed of review may reduce opportunities for consideration * Model not well developed or tested in safeguarding. Minimal guidance [available](http://www.nscb.org.uk/staff-and-volunteers/procedures/appreciative-inquiry) |

**Available models:**

Julie Barnes, [A new model for learning from serious case reviews](http://www.julie-barnes.co.uk/pages/safeguarding.htm)

Newcastle Safeguarding Children’s Board, [Appreciative Inquiry Champions Group](http://www.nscb.org.uk/staff-and-volunteers/procedures/appreciative-inquiry)