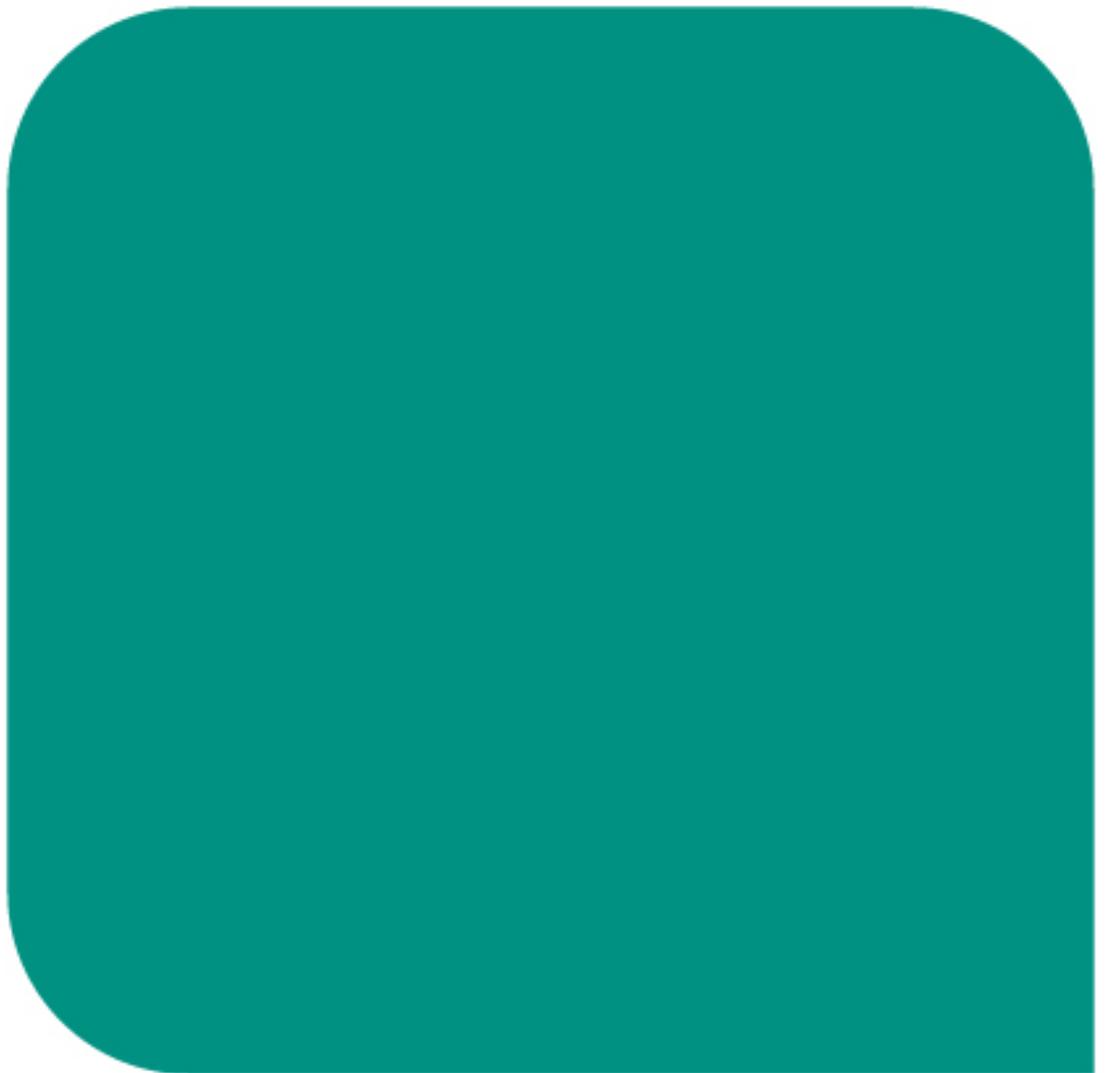




social care  
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# Safeguarding Adults Reviews under the Care Act: implementation support



Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). This resource aims to help SABs in thinking about how they fulfil those responsibilities.

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## Introduction

Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). This resource aims to help SABs in thinking about how they fulfil those responsibilities.

The statutory guidance to support implementation sets out the purpose of SARs, and principles for their conduct. However, much about when and how to conduct them is not prescribed. The ideas presented here are therefore also not prescriptive. They are suggestions and questions that draw on evidence from similar practice in other high-risk sectors, from SCIE's knowledge and experience in using that evidence in the development of the SCIE Learning Together approach for case reviews, as well as the small body of literature that exists on serious case reviews in adult safeguarding.

This resource focuses on a selection of key issues. It is intended to supplement the policy development work already underway or completed by SABs. The topics addressed are as follows:

- How to keep a focus on learning not blaming
- The skill requirements of reviewers
- The quality assurance functions of the SAB for SARs
- How to identify non-death or injury reviews that are of value
- The available approaches or models to choose from
- Core elements of a review report

SCIE is also exploring how to provide a place to share reviews and a routine means for collating and sharing findings.

## How to keep a focus on learning not blaming?

The purpose of SARs is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

What SARs are not is also explained: The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for that purpose, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council etc.

Yet it can be difficult to keep a focus on the learning in the face of terrible abuse or neglect, media and public interest. This is especially so if it appears at first that 'human error' was to blame for the failure to prevent it. Four ideas are put forward below to support a focus on learning:

- Clarify how organisational factors can cause of incidents.
- Use techniques to avoid hindsight bias in commissioning and quality assuring SARs reports.
- Demonstrate that top management want SARs to 'tell it like it is'.
- Be transparent about how SARs fit with disciplinary procedures.

### Clarify how organisational factors can cause incidents

How we think about what causes the failure of partner agencies to work effectively to protect an adult from abuse or neglect, affects how we approach investigating and analysing these cases. It also influences the recommendations we make to prevent reoccurrence. So it is useful to give some thought to the concepts that will underpin your approach to SARs.

Accident or incident investigation in high risk industries, health care and the child protection system, have all made efforts to move away from focusing too much on individual members of staff and their failings. Instead they take a much broader approach to understanding the causation of accidents which pays more attention to pre-existing organisational factors. This brings an approach to the review process, and recommendations, that focuses more on organisational learning and improvement and less on blaming and disciplining individuals. It fits well with requirements under the Care Act.

Various models of incident causation exist that have potential applicability to SARs. The dominant one used to analyse medical errors and patient safety incidents is James Reason's 'Swiss cheese' model, which distinguishes between 'active failures' and 'latent failures or conditions' - for error. Active failures are the mistakes that practitioners may have made and latent conditions are the organisational factors that made it easier for those particular practitioners and others to make those kinds of mistakes.

Not all safeguarding adults cases will fit into the linear models that industry and health care approaches often pre-suppose, but there is nonetheless considerable overlap (cf. Brown 2009). Agreeing an incident causation model that contextualises individual practitioner decision-making, actions and inactions will help SABs to arrange and conduct SARs that focus on learning rather than stopping when poor practice is identified. Becoming familiar with the key concepts that such a model provides will also help by giving Board members a common language for talking about causation that includes but is not restricted to 'human error'. This language can be used to make sure that expectations of what the SAR will focus on are unambiguous in the Terms of Reference, and in the focus of Quality Assurance processes.

Questions to consider:

- How ready is your Board to think about incident/accident causation models in relation to SARs?
- Is there an implicit model that the Board has been working to?
- What language does get used at the Board to talk about the causes of incidents where adults have not been effectively protected from abuse or neglect?

## Use techniques to avoid hindsight bias

Hindsight bias poses a great obstacle to learning through SARs. The tendency to 'consistently exaggerate what could have been anticipated in foresight' (Fischhoff 1975) is a well reproduced research finding – the 'knew it all along' effect (Vincent 2006).

When we review professional practice in retrospect, the outcomes of tragic cases powerfully shape the way in which we make sense of practitioners' actions and decisions. Knowledge of the outcome biases our judgement about the process that led up to that outcome. Firstly, the benefit of hindsight leads us to oversimplify the situation confronting the practitioners who were involved at the time. Secondly, we judge decisions or actions that are followed by a negative outcome more harshly than if the same decisions or actions had ended either neutrally or well. Blaming bad outcomes on simple causes such as human error literally seems to make sense because knowledge of the outcome changes our perspective so fundamentally (Woods, Dekker et al. 2010).

A person exhibiting the hindsight bias will typically ask questions such as: 'Why didn't they see what was going to happen? It was so obvious!'. Or, 'How could they have done X? It was clear it would lead to Y!' (Woods, Dekker et al. 2010: 203). SABs will therefore need to ward against this bias in the commissioning and quality assuring of SARs if the SARs are to produce learning that has potential to underpin improvement.

However, research has also shown that simply being aware of hindsight bias and trying to avoid it is not effective. Particular strategies need to be deployed, such as considering possible alternative outcomes of events, even when the actual result is already known. This helps counter our usual tendency to ignore information that challenges our initial understanding. Identifying and deploying tactics to avert this trick of the mind, will help SAB members keep focused on learning from SARs.

Questions to consider:

- What are the occasions when your Board would be at risk of acting on hindsight bias?
- When could tactics to avoid this trick of the mind most usefully be deployed and by whom?

## Demonstrate that top management want SARs to “tell it the way it is”

Gaining an understanding of what happened in a case and why, that is not biased by the knowledge of hindsight, and assumes a broad idea of what causes failures to protect adults effectively, requires individuals and organisations active involvement in the process with openness and honesty. As stated in the Statutory Guidance (paragraph 14.140): It is vital, if organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

Ultimately, whether SARs are safe and effective learning processes for those involved, will depend on whether each agency is prepared to have the process act to hold a mirror up to themselves. It will depend on each agency being prepared to accept what is reflected in the SAR mirror, metaphorical ‘warts’ and all. This requires SAB member agencies to take a mature approach and recognise that systemic factors, for which they have some responsibility, are implicated in many incidents where adults die or are seriously injured from abuse or neglect. (Woloshynowych, Rogers et al. 2005). Keeping a focus on learning in SARs will therefore be helped if the SAB and member agencies demonstrate that top management do want people involved in the SAR process and the final report itself to ‘tell it the way it is’ and find multiple ways of conveying this.

Questions to consider:

- Have the Board ever had a conversation about what works against SARs ‘telling it the way it is’?
- Is there a clear directive in all SARs Terms of Reference to take a broad organisational learning approach and reflect current practice realities?
- Is the requirement to participate openly and honestly in SARs written into commissioning contracts as standard?
- Has the Board discussed ways and phrases of conveying cross-agency support for practitioners involved in SARs to ‘tell it like it is’ so that real learning and improvement can happen?
- How does the Board check whether it is becoming disconnected from the realities of direct work with adults with needs for care and support, their carers and families?

## Be transparent about interface with disciplinary procedures

The purpose of SARs is to promote effective learning and improvement action. That does not mean there is no individual or organisational accountability. Rather, as stated in the Guidance, this takes place via other processes than SARs. For those involved therefore, the distinction may not hold much sway – there is still the possibility that they will be held to blame and punished accordingly. In practice, if concerns about an individual's practice are thrown up during the SAR process, they are fed back to their agency where they can trigger disciplinary or capability processes by that agency. There are therefore real tensions between learning and apportioning blame. In order for claims about SARs to be about learning to be genuine, SABs need to develop transparency about how they interface with individual accountability.

In health the notion of 'fair blame' has been developed to indicate a huge shift away from blame but to convey that individual responsibility is not dissolved altogether. Tools have been developed to help systematise decisions about culpability. The UK National Patient Safety Agency (NPSA) developed an 'Incident decision tree' that built on James Reason's 'culpability matrix' (Reason 1997). This aids decision making about culpability in the grey area between reckless and malicious behaviour, on the one hand, and clearly systems induced or 'honest' mistakes, on the other. The aim is to make the process fairer, more explicit and more supportive of effective improvement action.

We recommend SABs and member agencies are able to articulate their position about how decisions about culpability are made in the context of SARs, in order to cultivate the trust with practitioners necessary for learning.

Questions to consider:

- Has the Board had a good discussion about what 'fair blame' means?
- Is there consensus across agencies about the how decisions about culpability are made in the context of a SAR?
- How might health colleagues help share the learning from patient safety in this area?

## What are the skill requirements for reviewers?

Conducting SARs to meet the requirements of the Care Act guidance requires a diverse range of expertise. The guidance specifies that the skills and experience expected of those undertaking a SAR will include:

- strong leadership and ability to motivate others
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- collaborative problem solving experience and knowledge of participative approaches
- good analytic skills and ability to manage qualitative data
- safeguarding knowledge
- inclination to promote an open, reflective learning culture.

Many of these areas of expertise are transferable from other areas of activity but this is less likely to be the case with the analytic skills required to conduct SARs. The experience of accident and incident investigation in other sectors suggests that the analytic skills required are quite specific, and particular accident investigation training is therefore provided and indeed required. In aviation, training requirements range from seven day to seven week courses. The NHS in England has found that the two-day course provided by the then National Patient Safety Agency was insufficient to support reliably good quality investigations of serious health incidents. This suggests that SABs can usefully consider undertaking SARs as an area of specialist expertise. The Care Act requirement to conduct SARs therefore creates a need for capacity building in the adult safeguarding sector and SABs individually and collectively might consider how to support such capacity building.

Recognising the conduct of SARs as a specialist activity does not necessarily mean that SABs have to rely on external consultants, with the budget implications that would have. The Guidance requires SARs be led by individuals who are independent of the case under review and of those organisations whose actions are being reviewed. In a lot of cases, it is also possible to identify such individuals from among salaried professionals in the local safeguarding network – as some SABs are already doing.

Where SABs are planning not to rely on external consultants to bring the required independence, but instead to find local professionals whose agencies were not involved in the case, it will be useful for SABs to plan ahead in terms of the skill requirements. This could include considering what transferable skills exist amongst individuals likely to be leading and/or be involved in SARs as well as identifying gaps where capacity building is required. It is a diverse range of skills required and may therefore be more realistic and useful to aim for a team of people to cover them all, rather than expecting too much from any individual.

SABs will need to make decisions about capacity building in methods for investigation and analysis. It will be useful to consider whether it is more cost-effective to invest in developing in-depth expertise in a single available model initially, or spread expertise

more widely but thinly in all available models and/or initiating some research and development work on as yet untried approaches and techniques – see section on what models and approaches are available.

SCIE's experience of training and accrediting 'in house' lead reviewers in investigation and analysis methods for SARs suggests there is significant added value, compared to the exclusive use of consultants. Individuals have fed back improved understanding of other agencies and the realities and challenges of working together, as well as increased professional confidence.

Questions to consider:

- When commissioning an independent consultant does your personal specification cover all necessary areas of expertise?
- Are the ways that you expect the consultant to evidence their knowledge and experience in these adequate?
- How are you going to build capacity among individual professionals within the safeguarding network to conduct effective SARs?
- What would you like to achieve in terms of capacity building in the short, medium and long term?

## What are the quality assurance functions of the SAB for SARs?

How SABs approach the quality assurance of SARs ideally supports and reinforces the focus on learning and improvement action. SABs must ward against quality assurance processes turning into opportunities for agencies to try to protect themselves from difficult truths to which they would rather not draw attention.

This is not necessarily straight forward for a number of reasons. Firstly, SARs must be led by individuals independent of the case and the organisations whose actions are being reviewed but the quality assurance function will usually be carried out by the case review subgroup. The subgroup will be made up of a range of agencies, and is likely to include those agencies subject of the review. Secondly, quality assurance functions take place at the end of the review process, so agencies are faced with the reality rather than the rhetoric of having SARs ‘tell it as it is’ (cross-reference section a focus on learning). Organisational defensiveness can therefore arise

When defensiveness arises between agencies, the quality assurance process can easily stall at the beginning of this list of five aspects of learning. Much time can be spent quibbling about minute points of detail in accuracy of the chronology, for example, or arguing that the focus has been disproportionately on one’s own agency’s failings overlooking those of others. This can result in insufficient focus on the crucial learning about why failings have occurred, whether they reflect generalizable issues, and therefore what remedial action might be effective at securing improvement.

Consequently, it is helpful for SABs to establish clarity about the different aspects of ‘learning’ that a SAR needs to accomplish.

Elaborating on the statutory guidance, SARs need to achieve understanding of:

1. What happened
2. Any errors or problematic practice and/or what could have been done differently
3. Why those errors or problematic practice occurred and/or why things weren’t done differently
4. Which of those explanations are unique to this case and context, and what can be extrapolated for future cases so become findings.

NOTE: The statutory guidance does not explicitly refer to the issue of extrapolation but it is implicit in the directive to take remedial action in relation to the findings. You would not after all, take remedial action against one-off issues. It makes sense, therefore for quality assurance processes to check the adequacy of the evidence presented for a finding being generalizable rather than unique to the particular case, time and the professionals involved.

5. What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases

Quality assurance can usefully be focused on each of these five aspects. The SAR report will need to contain enough of the 'working out' process, for those conducting quality assurance to be able to check and challenge the analysis.

Quality assurance processes should aim to build on rather than duplicate the work already completed in the course of the review. It can be useful therefore to understand a) the analytic techniques and tools used in the particular model the SAB is employing for any particular SAR and b) the content of any supervision that is provided as part of that model.

Questions to consider:

- Does your standard Terms of Reference require the transparency of the analysis process necessary to enable others to critique it? Are you explicit that leads should 'show their working out'?
- Is the quality assurance task of the sub-committee adequately distinct from the work of the review itself, so as to avoid duplication of effort?
- Are you clear about what quality assurance is inherent in the different available models?
- Do you know whether the approach used includes model specific supervision and if so what this entails?
- Has the Board discussed how organisational defensiveness can best be handled?

## How to identify non-death or injury reviews that are of value?

‘Serious Case Reviews’ were triggered, as the name indicates, by the seriousness of the harm caused to the individual by the abuse or neglect they experienced. Safeguarding Adults Reviews, in contrast, are not restricted to serious cases or determined by outcomes. The Care Act signals a fundamental change from a yes/no decision on whether to have an all-or-nothing SCR to a more proportionate and nuanced approach to organisational learning.

Under the Care Act, SABs are required to arrange for a SAR under certain conditions related to impact of abuse or neglect on an individual. However, SABs may also arrange SARs where it believes there is value in doing so. This can be *in any other situation* involving an adult in its area with needs for care and support. The goal is still the same - to promote effective learning and improvement action to prevent future deaths or serious harm occurring – and this is what should be the rationale for case selection.

This means that it is not necessary for SABs to reserve SARs only for the most serious cases, though they are free to do so. SABs can instead choose to do more SARs. The possibility of doing more SARs is supported by the principle in the Guidance that the approach taken should be proportionate according to the scale and level of complexity of the issues being examined, and that the specification of the process for any particular SAR be determined locally according to the specific circumstances of the individual. It has raised some concerns that ‘an increase in volume may result in a potential loss of their impact’ (Flynn, Keywood et al. 2011: 214). So how might you identify cases of value to arrange a SAR on, other than the criteria of death or serious injury? And what advantages would it have?

SARs triggered by the death or serious injury of an adult involving abuse or neglect person are by their nature reactive activities. Being free to initiate SARs for other reasons creates the possibility for the SAB to take a proactive stance, so taking some control over where the SAR gaze is put. It allows SABs to pre-emptively tackle practice areas or issues before an incident of harm occurs. SABs might select cases for either of the reasons noted in the statutory guidance:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases

SABs can take advantage of data from other quality assurance and feedback sources such as audits and complaints, to inform decision making about the kind of case or issue there would be benefit in reviewing. This might include new, complex or repetitive issues, incidents, areas of practice or range of agencies. It also becomes possible to tie proactive SARs into strategic plans.

The move to supplement reactive learning and improvement activity with SARs that are initiated proactively mirrors developments in other high risk industries. In many of these, such as aerospace, more emphasis is now put on assuring the reliable functioning of

systems prior to commissioning than on post-accident review and remedial action.(Woloshynowych, Rogers et al. 2005).

Questions for SABs to consider:

- What are the pros and cons of reserving SARs for the most serious and complex cases?
- Has the Board considered carrying out a set number of proactive SARs each year?
- Is the selection criteria for non-death or injury SARs clear and transparent?
- Are there any topics/issues that could be usefully set in advance as needing exploration through a SAR?

## What approaches or models are available to choose from?

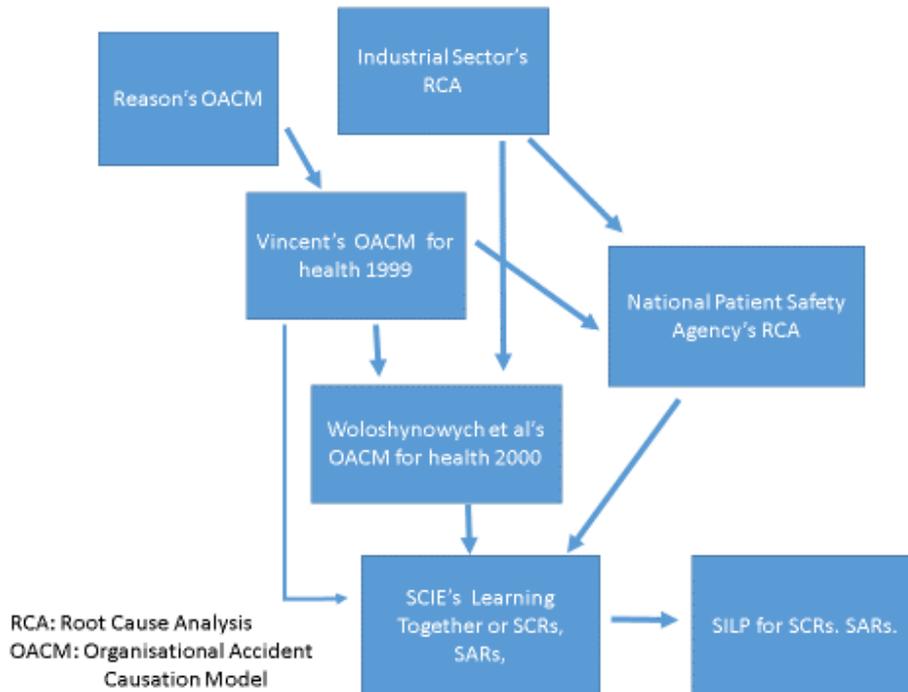
Under the Care Act, SABs must determine locally the process for undertaking SARs. No one model is prescribed. SABs therefore need to know what options are available to choose from, and think about the basis on which they would choose. How you conduct a review will affect the kind of learning you get from it, and whether the process is constructive and educative for those involved. The choice of approach is therefore significant.

Industry, transport and military fields have led the way in developing methods for investigating and analysing incidents and accidents. The industrial sector call their approach Root Cause Analysis (RCA). A key player in this field is James Reason (Reason 1990) whose approach can be called an Organisational Accident Causation Model (OACM), to distinguish it from RCA.

Industry methods have the benefit of being explicitly designed to understand why accidents have happened, and what can be extrapolated from them to improve future safety. They take a broad approach to accident causation looking at the organisational environment, culture and ways of working that affect individual actions and decisions. To understand these influences, they involve the professionals who were directly involved in the incident. Lastly, they provide a systematic approach to gathering information and a transparent process for analysing that information gathered. By this means they reduce the extent to which you only get the perspectives and views of the individual leading the review. It should not be a surprise therefore that industry accident investigation methods have been taken up in health care, and multi-agency child and adult safeguarding spheres. And it is for these reasons that SCIE presents them here as the available models to choose from.

Figure 1 below gives an idea of the familial links across the different domains. The RCA and OACM models of industry have subsequently been taken up and developed for use in health care settings. A model called Root Cause Analysis (RCA), in recognition of its heritage, has been developed by the National Patient Safety Agency and its use is required for Serious Incidents (SIs) in the NHS. Heath Academics at Imperial College, London, influenced by James Reason, also developed an Organisational Accident Causation Model (OACM) for the analysis of clinical incidents in health care settings (Vincent, Taylor-Adams et al. 1999) (Woloshynowch, Neale et al. 2000). More recently, SCIE has been at the forefront of developing these models for use in the multi-agency child protection field, resulting in a model called Learning Together (Fish, Munro et al. 2009). Another model developed for use in the children's sector, the Serious Incident Learning Process or SILP has retrospectively incorporated systems theory. Both Learning Together and SILP have since been used in safeguarding adult reviews.

**Figure 1. How industrial models have influenced models in health and safeguarding.**



In London this family of approaches have been described as 'action learning' approaches (London SABs 2012) which draws attention to the participative nature of all these approaches - dealing with a real live problem, involving a diverse group, undertaken in the spirit of curiosity, solution focused (Reg Revans 1982). London SABs listed the advantages and disadvantages as follows (London SABs 2012: 6):

<b>Advantages</b>	<b>Disadvantages</b>
Significant evidence approach is much more efficient	Methodology less familiar to many
Swiftness of conclusion and embedding the learning	
Action learning approach enhances: <ul style="list-style-type: none"> <li>• Partnership working</li> <li>• Mutual recognition of alternative partner perspectives</li> <li>• Collaborative problem solving</li> </ul>	
Involvement of both frontline staff/senior managers secures both strategic and operational perspectives	
Unique perspective of staff involved in the case, reflective of the systems operating at the time	
Approach allows for the identification of system strengths and positive practice	
Learning takes place through the process and there is enhanced commitment to its dissemination	

Margaret Flynn and colleagues from the North West of England have voiced concern that adult safeguarding review processes are ‘in danger of becoming tethered to a template of how to conduct a SCR that is derived from children’s SCRs’ (Flynn, Keywood et al. 2011: 214). Here we are not proposing that the ‘traditional’ SCR approach, derived from the children’s sector is an available model or approach for SARs. The traditional approach stipulates lots of the process whereby a review should occur (a comprehensive integrated chronology, Individual Management Reports (IMRs) brought together in an Overview Report) as well as the key personnel (a Panel with its own Chair, Overview Report authors and IMR authors). What it does not include is any specification of how analysis occurs, what techniques or tools support this. While the process may be familiar to SABs, it is worth noting that it has never been evaluated so any claims that it is ‘tried and tested’ should be treated with caution. In the children’s sector, where it originated, it was replaced in part because SCRs were proving less successful at understanding why things were going wrong. The statutory guidance was revised in response to the recommendation of The Munro Review that LSCBs be required to use a ‘systems’ methodology i.e. one of those originating in industry, discussed above.

## Short-term options

For SARs, therefore, SABs may want to consider either going back to 'source' industry models, and/or using those that have been developed and adapted either for healthcare and/or for children and/or adult safeguarding. Hilary Brown has, for example, recommended developing a shared methodology between Serious Untoward Incidents in the NHS and SARs, by including root cause analysis with a focus on multi-agency working (Brown 2009: 43). In the children's and adults safeguarding sectors, only Root Cause Analysis and SCIE's Learning Together have a transparent process of analysis and tools to support this. SILP is less developed in this aspect.

SABs will want to consider the cost effectiveness of developing in-house expertise initially in a single approach as against trying out the range of options.

## Longer-term options

There is another alternative which would require a longer term strategic plan. If you look in detail at the holistic models such as RCA and SCIE's Learning Together, they are in fact made up of a variety of smaller, more specific techniques that are helpful at different stages of the investigation and analysis process. A useful review of industry investigation methods conducted by health care academics highlighted further, that a broader range of potentially useful techniques exist that have not been wrapped up into particular models. They concluded therefore that:

*Results would seem to suggest that accident investigators must have a 'toolbox' of approaches available to them, which should be utilised dependently on the type of accident scenario and the particular stage of the accident investigation (Woloshynowych, Rogers et al. 2005).*

This opens the way to an alternative way of thinking about different approaches available for SARs, which would distinguish stages of the process from different analytic techniques. Which analytic techniques and tools are potentially helpful at which stages in the review would need to be clarified. This is a longer term option however because the techniques would need to be tested, and training and support provided to reviewers, in order to build an effective 'toolbox' of approaches. SABs may therefore want to consider research and development options in parallel with use of the pre-packaged approaches detailed above.

<b>Stage of analysis</b>	<b>Illustrative examples of techniques that could be developed</b>
Diagrammatically depicting chronology	Events and causal charting
Identifying causes	Wheel of misfortune Fault trees
Identifying remedial action	Barrier analysis

For more detail see (Woloshynowch, Neale et al. 2000)

### Links to key organisational review approaches

Descriptions are taken from the respective websites and publications

#### **The London Protocol (Vincent, Taylor-Adams et al. 1999)**

The London Protocol is the revised and updated version of our original 'Protocol for the Investigation and Analysis of Clinical Incidents' first published in 1999.

The protocol outlined a process of incident investigation and analysis for use by clinicians, risk and patient safety managers, researchers and others wishing to reflect and learn from clinical incidents. This approach has now been refined and developed in the light of experience and research into incident investigation both within and outside healthcare. It is designed to be a structured process of reflection on incidents providing a 'window on the healthcare system' (Vincent, QSHC 2004) which can be adapted for use in many contexts and used either quickly for education and training or in substantial investigations of serious incidents.

The Protocol is free to download.

[http://www1.imperial.ac.uk/cpssq/cpssq\\_publications/resources\\_tools/the\\_london\\_protocol/](http://www1.imperial.ac.uk/cpssq/cpssq_publications/resources_tools/the_london_protocol/)

#### **The investigation and analysis of critical incidents and adverse events in healthcare (Woloshynowych, Rogers et al. 2005 Chapter 6)**

This chapter consists of the guide for the investigation and analysis of critical incidents and adverse events in healthcare and its development and piloting. The process of developing and piloting was conducted in three specialties: acute care, mental health and primary care. The guide is a self-contained document with accompanying case analyses in the appendices designed to assist clinicians, risk managers and others in investigating and learning from clinical incidents.

The purpose of the guide is to permit a comprehensive and thoughtful investigation and analysis of an incident, going beyond the more usual quick identification or assumption of fault and blame. Case examples from three specialties are given in Appendix 11 to illustrate the approach and a simple format for presenting the analysis and recommendations. The cases have been fictionalised to preserve the anonymity of all involved. Fictional cases are always based on real events, but incorporate events and details from more than one case from different locations.

[http://www.journalslibrary.nihr.ac.uk/\\_\\_data/assets/pdf\\_file/0006/64995/FullReport-hta9190.pdf](http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0006/64995/FullReport-hta9190.pdf)

### **RCA Investigation resources**

Every day a million people are treated safely and successfully in the NHS. However, when incidents do happen, it is important that lessons are learned to prevent the same incident occurring elsewhere. Root Cause Analysis investigation is a well recognised way of doing this.

Investigations identify how and **why** patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients.

<http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

Training in RCA investigation is no longer available from the NPSA or NHS England. Alternative training providers may be sourced from an internet search.

### **SCIE's Learning Together (Fish, Munro et al. 2009)**

Learning Together supports learning and improvement in safeguarding adults and children.

Through a range of activities, Learning Together helps local safeguarding children boards, safeguarding adults boards, and their equivalent organisations to:

- use systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture
- build internal capacity by having staff trained and accredited in the Learning Together approach to reviewing
- undertake rigorous case reviews and audits using a core set of principles and analytic tools
- access a pool of accredited independent reviewers as required by statutory requirements
- build on the experience and findings of previous reviews as part of the Learning Together community

<http://www.scie.org.uk/children/learningtogether/>

### **SILP (Significant Incident Learning Process)**

SILP is a tried and tested approach to reviewing cases, whether in the context of a serious case review or other form of learning activity.

SILP explores the professional's view of the case at the time the events took place. It analyses significant events and deals not only with what happened but why it happened. SILP can show us what affected the practitioner's actions and decision making at the time and what needs to change.

The SILP approach is rooted in systems methodology, with each review being scoped to offer a proportionate approach according to the requirements of the case. The systems focus reduces any notion of blame, and our trained SILP Lead Reviewers offer an expert approach to ensuring practitioner events invite participation without fear of being blamed for actions taken in good faith. Families and significant others are offered opportunities to engage with our reviews in a variety of ways. SILP reviews see equal value in learning from good practice highlight what went well.

<http://www.reviewconsulting.co.uk/about-silp/>

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## Safeguarding Adults Reviews under the Care Act: implementation support

Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). This resource aims to help SABs in thinking about how they fulfil those responsibilities.

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