social care
institute for excellence

SCIE Learning Together®

Safeguarding Adults Review Quality Markers

Handbook

About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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Contents

This is v1 of the SAR Quality Markers handbook, to be updated March 2023.

Introduction

This document supports the Safeguarding Adults Review (SAR) Quality Markers comprehensive checklist.

Safeguarding Adults Review Quality Markers - SCIE[1] – website.

SCIE SAR Quality Markers March 2022[2] – pdf document.

The handbook is intended to be a live document that is regularly updated. It aims to signpost further resources relevant to the different Quality Markers, as well as tools available to support Safeguarding Adult Boards (SABs) to achieve the respective markers of quality for SARs.

The handbook covers each SAR Quality Marker in turn, structured in the following way:

- Quality statement
- Key concepts
- Tackling some common obstacles
- Further reading and useful links
- Supporting tools and resources.

For each Quality Marker, each section is completed as is fitting to that marker at this time. This means some sections are intentionally blank at this stage. We expect additions to others following feedback from SAB Chairs, Business Managers (BMs) and reviewers, particularly what input would be helpful in relation to Quality Markers 6, 7 and 8 which are blank currently.

SCIE is working with Safeguarding Board Business Managers and SAR Quality Champions to develop supporting tools and resources identified as needed in recent open training session provided by SCIE, which are available here: **Training sessions - SAR Quality Markers | SCIE.**[3]

The handbook will be updated to signpost these new tools and resources at the end March 2023. Please send any additional suggestions of links or areas where further explanation would be helpful, to **reviews@scie.org.uk**.

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[1] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers**.

[2] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-quality-markers-comprehensive-checklist.pdf**.

[3] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

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Setting up the review

Quality Marker 1: Referral

Quality statement: **The case is referred for consideration for a SAR with an appropriate rationale and in a timely manner.**

Key concepts

- 'Appropriate rationale' can link to concerns about practice in the case; and/or the criteria for a mandatory SAR; and/or relevance to local learning needs.
- 'Timely' is usually without significant delay but there may also be legitimate reasons for cases only being identified and referred later.

Tackling some common obstacles

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Further reading and useful links

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 2: Decision making – what kind of SAR, if any?

Quality statement: **Factors related to the case and the local context inform decision making about whether a SAR is required and/or desired and initial thinking about its size and scope. The rationale for these decisions is clear, defensible and reached in a timely fashion.**

Key concepts

- Blanket policies and reasons are not defensible according to administrative law standards, so there must be evidence of decision making based on the unique circumstances of the case referred.
- Circumstances of the case will determine if a mandatory SAR is required, where the SAB has no discretion.
- Some cases may allow for learning that is desired, even if a SAR is not required.
- Decisions about what type of SAR is required and what is proportionate in this instance, need to look beyond details of the case to a wider range of issues. This includes importantly the local, regional or national learning needs.

Tackling some common obstacles

- Use of the terminology ‘statutory SAR’ or ‘non statutory SAR’ indicates and perpetuates confusion about legal requirements. All SARs are statutory, whether they are mandatory or discretionary ones.
- The individual and their families may have needs such as acknowledgement of the harm caused to them and support in terms of recovery and healing, that can be addressed by means other than a SAR.

Further reading and useful links

- On administrative law standards for decision making see Preston-Shoot, M. (2019) Making good decisions: Law for social work practice (2nd ed). London; Macmillan/Red Globe Press.
- Safety-II principles and developments in the NHS approach to patient safety encourage learning from all outcomes. See for example: Stretton P. The Lilypond: An integrated model of Safety II principles in the workplace. A quantum shift in patient safety thinking. Journal of Patient Safety and Risk Management. 2020;25(2):85-90. doi:**10.1177/2516043520913420.**

Supporting tools and resources

- SCIE training session on decision making (26 May 2022) is available here **Training sessions - SAR Quality Markers | SCIE**[4]: and accompanying slides here: **PowerPoint Presentation (scie.org.uk).**[5]

[4] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

[5] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-training-session1-decisionmaking.pdf**.

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Quality Marker 3: Informing the person, members of their family and social network

Quality statement: **The person, relevant family members, friends and network are told what the SAR is for, how it will work and the parameters, and are treated with respect.**

Key concepts

- This Quality Marker relates to informing the family; issues about enabling family members to contribute to the SAR are dealt with separately in Quality Marker.

Tackling some common obstacles

- Drawing on the expertise and advice of health partners who have significant experience of engaging families in statutory reviews such as Mental Health Homicide Reviews, can help build confidence and capability in communicating well with the person and/or family members about a SAR.
- Establishing a routine process of informing families at the same time that the SAB is informed of the Chair's decision to progress a SAR, increases the chance that this does not get delayed or overlooked.

Further reading and useful links

- Wailling J, Kooijman A, Hughes J, O'Hara JK. Humanizing harm: using a restorative approach to heal and learn from adverse events. Health Expect. 2022;1-8. https://doi.org/10.1111/hex.13478.
- See co-designed guidance and templates for involving NHS patients in Patient Safety Incident Investigations: **learn-together.org.uk – Serious Incident Investigation resources.**[6]

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

[6] **https://learn-together.org.uk/**.

Quality Marker 4: Clarity of purpose

Quality statement: **The SAB is clear and transparent, from the outset, that the SAR is a statutory learning-focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities. Any factors that may complicate this goal are openly acknowledged.**

Key concepts

- 'Practical value' is derived from the ability of the SAR to illuminate the social and organisational factors helping or hindering practitioners from safeguarding citizens well.
- If practice areas have already been subject to review and organisational improvements, a new SAR may focus on what has helped or hindered improvements efforts to-date.
- Safeguarding takes place in complex socio-technical systems where systemic risks to the reliability of safeguarding responses may not be self-evident and may span organisational boundaries and so need 'untangling'.
- Organisational learning and improvement will not always be the prime goal of everyone involved in a SAR, there may be divergence of needs, creating tensions and contradictions, with the potential to compound harm caused.

Tackling some common obstacles

- Training in a systems approach enables analysis conducted to move from identifying 'case findings' (what went well or badly in the case and why) to 'systems findings' (generalisable insights about barriers and enablers): to use a single case to give a 'window on the system'.
- It can require courageous leadership to move away from blaming pesky people for poor outcomes, and restricting actions that follow to those related only to training and procedures.

Further reading and useful links

- Vincent, C. A. (2004) Analysis of clinical incidents: a window on the system not a search for root causes. BMJ Quality & Safety 2004;13:242-243. **http://dx.doi.org/10.1136/qshc.2004.010454.**
- Woods, D., Dekker, S., Cook, R., Johannesen, L. and Sarter, N. (2010) **Behind human error**. London: Routledge.

- See resources from Chartered Institute for Ergonomics and Human Factors for example: **Learning from Adverse Events | CIEHF (ergonomics.org.uk).**[7]
- The phrase 'to untangle systemic risk' was coined by Carl Macrae in this article. Macrae C. Investigating for improvement? Five strategies to ensure national patient safety investigations improve patient safety. J R Soc Med. 2019 Sep;112(9):365-369. doi: 10.1177/0141076819848114. Epub 2019 May 22. doi: **10.1177/0141076819848114.**

Supporting tools and resources

- SCIE training session on decision making (28 June 2022) is available here: **Training sessions - SAR Quality Markers | SCIE**[8]**;** and accompanying slides here: **PowerPoint Presentation (scie.org.uk)**[9] and handouts here: **scie-sar-qms-safety-science-handouts.pdf.**[10]

[7] **https://ergonomics.org.uk/resource/learning-from-adverse-events.html**.

[8] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

[9] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-safety-science.pdf**.

[10] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-safety-science-handouts.pdf**.

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Quality Marker 5: Commissioning

Quality statement: **Strategic commissioning of the SAR takes into account a range of case and wider contextual factors in order to determine the right approach to identifying learning about what is facilitating or obstructing good practice and/or the progress of related improvement activities. Decisions are made by those with delegated responsibility in conjunction with the reviewers, and balance methodological rigour with the need to be proportionate.**

Key concepts

- 'Strategic commissioning' means that review sub-groups need to consider what issues the particular case lends itself well to, helping them understand and square that with where learning is actually needed locally, regionally or nationally.
- The 'right approach' to getting the systems learning can draw from a range of options.
- The approach needs to be proportionate to the learning needs from this SAR, at this time.

Tackling some common obstacles

- The volume of SARs and frustration with inefficiency of traditional models of SARs, the amount and repetitiveness of recommendations, can enable development of new, more strategic approaches, to commissioning more flexible and proportionate SARs.

Further reading and useful links

- The new Patient Safety Incident Response Framework (PSIRF) is described as a strategic, risk based approach to Patient Safety Incident Investigations and provides useful wider reading. See: **NHS England » Patient Safety Incident Response Framework.**[11]

Supporting tools and resources

- SCIE training session on strategic, creative, proportionate commissioning (17 June 2022) is available here: **Training sessions - SAR Quality Markers |**

[11] **https://www.england.nhs.uk/patient-safety/incident-response-framework/**.

SCIE[12]; and accompanying slides here: **PowerPoint Presentation (scie.org.uk)**[13]**.**

- As part of the new Patient Safety Incident Response Framework (PSIRF), NHSE/I provide a list of patient safety investigation tools as well as a list of review methods/tools described as 'more appropriate alternatives to investigations', See: **https://www.england.nhs.uk/patient-safety/patient-safety-investigation/**.

[12] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

[13] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-flexible-bespoke-commissioning.pdf**.

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Running the review

Quality Marker 6: Governance

Quality statement: **SAB governance arrangements for the SAR are sound, enabling defensible decision making, reliable over-sight and accountability regarding the SAR process, outputs and impact. The SAR achieves the requirement for independence and ownership of the findings by the SAB and member agencies and enables public accountability for learning and improvement.**

Key concepts

- 'Defensible decision making' has been highlighted in the first national analysis of SARs as compatible with administrative law standards.
- 'Accountability' is one of the six principles of adult safeguarding, first introduced by the Department of Health in 2011 and subsequently embedded in the Care Act. The principle of accountability means recognising the importance of being open, clear and honest in the delivery of safeguarding and ensuring there are mechanisms in place to hold practitioners, services or systems to account.
- The Care Act statutory guidance advises that terms of reference should be published and openly available. It also requires that SAB annual reports provide information about any SARs either ongoing or completed within the reporting year. SABs must indicate what has been done to act on the findings and, if particular recommendations have not been implemented, why. This is one way in which the SAB can meet the safeguarding principle of accountability.

Tackling some common obstacles

- Clarity about roles and responsibilities can assist in resolving any tensions between independence of reviewers and ownership by the SAB and partners of the report, learning and action.
- Care needs to be taken that scrutiny and challenge are not personalised and do not become inappropriate pressure on reviewers.

Further reading and useful links

- On administrative law standards for decision making see Preston-Shoot, M. (2019) Making good decisions: Law for social work practice (2nd ed). London; Macmillan/Red Globe Press.
- See Briefing for SAB chairs and business managers from the findings of the national analysis of SARs study 'Analysis of safeguarding adults reviews April 2017-March 2019' (November 2020): **https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards/chairs-and-business-managers.**

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- For a variety of ways to look at accountability see Dekker, Sidney. 2012. Just culture: Balancing safety and accountability. London: CRC press. ISBN 9781409440604.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 7: Management of the process

Quality statement: **The SAR is effectively and considerately managed. It runs smoothly, is concluded in a timely manner and within available resources. The welfare of all participants is attended to. The process strives to help bring resolution to any tensions or conflicts between individuals or agencies as well as questions of families.**

Key concepts

- Effective management of the SAR process needs to tend both to practicalities and people and relationships.

Tackling some common obstacles

- Good management of the SAR is facilitated by there being dedicated administrative and management time.
- The value given to people being cared for and relationships being fostered through the SAR process can be made explicit rather than remaining implicit as they commonly are.

Further reading and useful links

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Supporting tools and resources

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Quality Marker 8: Parallel processes

Quality statement: **Where there are parallel processes taking place, the SAR is managed with the cooperation and communication required to avoid, as much as possible, duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.**

Key concepts

- A SAR may be conducted in parallel with criminal, civil or regulatory investigations and human resources (HR) procedures. Other statutory reviews may also be conducted at the same time. There may be complaints or civil litigation; there may be a coroner's Inquest.

Tackling some common obstacles

- The bespoke, strategic, flexible commissioning of SARs can cause uncertainty or false assumptions for those conducting other reviews, making early discussions helpful.
- Views of police officers the CPS and prosecuting counsels vary as to the constraints that should be placed on a SAR and their willingness to negotiate, so again, early discussion is helpful.

Further reading and useful links

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 9: Assembling information

Quality statement: **The SAR gains a sufficient range and quality of information and input, to determine the relevant objective facts, to 'stand in the shoes' and 'get inside the heads' of those involved and to grasp the way that single and multi-agency/professional practice is shaped both by work environments and conditions, and by social and organisational factors. The kinds of data assembled allows unique versus generalisable issues to be distinguished. The extent of, and methods for, data gathering are transparent and proportionate to the practical value of the SAR.**

Key concepts

- Taking a systems approach requires generating a variety of data from a range of different sources.
- Using the case as a 'window on the system' (see Quality Marker 4 above) will require data from beyond the case itself.
- For a SAR process to be proportionate to the learning gained to inform improvements, data gathering will not always be comprehensive. Transparency is therefore vital.

Tackling some common obstacles

- Training, accreditation and professional supervision for reviewers allows expertise in systems analysis to develop and familiarity with analytic approaches and tools to be consolidated.
- Expertise in qualitative research methods as well as quality improvement approaches can support understanding of what data is needed and how best to gather it.

Further reading and useful links

- On the importance of a curious rather than judgmental attitude see Steven Shorrock on 'work as done' vs. 'work as imagined':
    - **Proxies for Work-as-Done: 1. Work-as-Imagined – Humanistic Systems.**[14]
    - **https://youtu.be/qNk_UfXcq6k.**

[14] **https://humanisticsystems.com/2020/10/28/proxies-for-work-as-done-1-work-as-imagined/**.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 10: Practitioners' involvement

Quality statement: **The SAR is informed by the experiences and perspectives of practitioners and managers, as relevant to the precise form and focus of the SAR commissioned. The process enables practitioners and managers to have a constructive experience of taking part in the review that helps cultivate an open learning culture.**

Key concepts

- Practitioners and managers are an important source of data for a systems approach analysis in a SAR. This is the rationale for their involvement.
- Reviewers and agencies cannot avoid the fact that taking part in a SAR may be difficult for staff and managers. This does not mean that the process should not be constructive.
- SARs sometimes involve sensitive dynamics between individuals and agencies. It is possible to cause harm to participants if such dynamics are not planned for carefully and managed with adequate expertise.
- An 'open learning culture' is one where people are confident to share mistakes or poor practice knowing this will create opportunities for learning rather than blaming. Similarly they are confident to flag risky processes, norms or circumstances, knowing it will be received positively and not heard simply as moaning.

Tackling some common obstacles

- Where there is clarity about the purpose of practitioner interviews, conversations, meetings and/or events it is easier for reviewers to manage risks involved.
- The expertise of the lead reviewer(s) in handling complex group dynamics helps minimise risks associated with group events.
- The stronger the open learning culture of agencies, the easier it is for senior managers to support practitioners to engage openly in the process.

Further reading and useful links

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 11: Involvement of the person, relevant family members and network

Quality statement: **The SAR is informed by the person, relevant members of their family and social network in terms of information they hold, their experiences and perspectives as relevant to the precise form and focus of the SAR commissioned. The process enables the individual and family to see how the SAR is designed to have impact and contribute to positive change.**

Key concepts

- When taking a systems approach, the person, family members and those in their social network are an important source of facts and qualitative data.
- The person and people relevant to them, may support organizational learning, not wanting something similar to happen to someone else. They may also have other needs. These cannot always be reconciled. Partners may need to decide how a person or their family's needs, for example for the acknowledgement of harm or help with recovery and healing, can be addressed outside of the SAR process.

Tackling some common obstacles

- Drawing on the expertise and advice of health partners who have significant experience of engaging families in statutory reviews such as Mental Health Homicide Reviews, can help build confidence and capability in communicating well with the person and/or family members about a SAR.

Further reading and useful links

- Wailling J., Kooijman A., Hughes J., O'Hara J.K. Humanizing harm: using a restorative approach to heal and learn from adverse events. Health Expect. 2022;1-8. **https://doi.org/10.1111/hex.13478.**
- Laird, Siobhan. (2017). The representation of the family's voice in serious case review reports of child maltreatment. Australian Social Work. 70. 1-12. doi:**10.1080/0312407X.2017.1309670.**

Supporting tools and resources

- See co-designed guidance and templates for involving NHS patients in Patient Safety Incident Investigations: **learn-together.org.uk – Serious Incident Investigation resources.**[15]

[15] **https://learn-together.org.uk/**.

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Quality Marker 12: Analysis

Quality statement: **The approach and methodology agreed for the SAR is used with optimum rigour within the size and scope of SAR commissioned. Analysis assumes a systems approach to safety and organisational reliability. It is anchored in relevant research and wider evidence base regarding effective clinical/professional practice and that of safety science. It draws on the full range of relevant information and input assembled, to evaluate and explain professional practice in the case(s) or the response(s) to earlier learning. Conclusions are of practical value, evidencing the wider learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date. There is transparency about any methodological limitations and the implications for the comprehensiveness or level of confidence in the analysis and findings.**

Key concepts

- Systems-based reviews or a 'systems approach' are approaches to learning from incidents and practice, that have developed across a range of different industries including aviation, rail and health.
- 'Safety Science' refers the evidence base and innovations related to effective incident reviews, including human factors and ergonomics.
- See Quality Marker 4 Clarity of Purpose and Quality Marker 9 Assembling the Right Information.

Tackling some common obstacles

- Training, accreditation and professional supervision for reviewers allows expertise in systems analysis to develop and familiarity with analytic approaches and tools to be consolidated.

Further reading and useful links

- Woods, D., Dekker, S., Cook, R., Johannesen, L. and Sarter, N. (2010) **Behind human error**. London: Routledge.
- On the basics of a systems approach see:

- **SCIE: Learning together to safeguard children: a 'systems' model for case reviews.**[16]
- **Learning from Adverse Events | CIEHF (ergonomics.org.uk).**[17]

Supporting tools and resources

- SCIE provides training on a systems approach to learning, both through their Learning Together foundation course and SAR Quality Markers foundation course.
- The Health Safety Investigation Branch is developing a range of training courses to support NHS trusts to implement and use a new Patient Safety Incident Response Framework (PSIRF). This includes one on 'A systems approach to learning from patient safety incidents'. See **Our courses | HSIB.**[18]

[16] **https://www.scie.org.uk/publications/ataglance/ataglance01.asp**.

[17] **https://ergonomics.org.uk/resource/learning-from-adverse-events.html**.

[18] **https://www.hsib.org.uk/investigation-education/our-courses/**.

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Outputs, action and impact

Quality Marker 13: The report

Quality statement: **The length and detail of the SAR report match the size and scope of what was commissioned. At a minimum, it makes visible, in a clear, succinct manner, the systemic risks to the reliability of single and multi-agency safeguarding work that the SAR analysis has evidenced, in order to have practical value in directing improvement actions. It is written with a view to being published. Details of the person are included as judged necessary to illuminate the learning and/or in line with the wishes of the individual or their family.**

Key concepts

- There is no one-size fits all standard for all SARs. What is appropriate links to the strategic commissioning decisions for this particular SAR. The clarity of purpose (Quality Marker 4) underpins minimum requirements to capture systems learning.
- Systems findings can relate to a range of different factors and levels of a system hierarchy, such as:
    - the design of tools and equipment;
    - the nature of tasks and interfaces whether intra- or inter-agency;
    - organisational arrangements and the management systems that create the environment and conditions within which work takes place;
    - professional norms and culture;
    - SAB arrangements and governance; and
    - wider national issues of policy and legislation.
- There is not a single right position on whether or how much the story of the individual case, or details about the person, should be included in a SAR report.

Tackling some common obstacles

- Keeping the SAB and partners briefed as to the expected size and format of the final SAR report, helps minimise conflicting expectations about the final SAR report.

Further reading and useful links

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Supporting tools and resources

- Additions to this section will be made progressively as the Quality Markers are used, and tools developed.

Quality Marker 14: Publication and dissemination

Quality statement: **Publication and dissemination activities are timely and publicise the key systemic risks identified through the SAR, as well as features supporting high reliability of single and multi-agency working relevant to safeguarding. Compelling and engaging means of circulating the findings are used, adapted as necessary for different operational and strategic audiences. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and other families; professionals who participated are kept informed and supported as needed. Publication and dissemination foster active responsibility and public accountability for addressing barriers identified to good practice or progressing improvement work.**

Key concepts

- SARs have a range of audiences with different needs.
- SABs can have different responsibilities to the different audiences. Different audiences can have different needs from SAR publications:
    - For leaders and managers, a SAR report needs to identify where improvement action needs to be targeted.
    - For practitioners, the purpose of a SAR products is
        - allow them to test and refine the understanding of barriers and enablers to good practice
        - to demonstrate that those responsible are doing something.
    - Public facing publications speak to the need to restore trust and provide assurances.

Tackling some common obstacles

- Common practice is to focus predominantly on operational staff as the audience for learning, even though much systems learning will not be within their gift to address.
- A SAB publication strategy can often focus only on the question of do we publish the SAR report and what are the risks, rather than thinking of the range of audiences and their different needs.

Further reading and useful links

- In relation to a different field see:

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- **https://www.adaptivecapacitylabs.com/blog/2018/10/08/the-multiple-audiences-and-purposes-of-post-incident-reviews/.**
- **https://www.adaptivecapacitylabs.com/blog/2021/08/22/what-makes-public-posts-about-incidents-different-from-analysis-write-ups/.**

Supporting tools and resources

- SCIE training session on audiences for SARs (20 July 2022) is available here **Training sessions - SAR Quality Markers | SCIE**[19]; and accompanying slides here: **PowerPoint Presentation (scie.org.uk)**.[20]

[19] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

[20] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-audiences.pdf**.

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Quality Marker 15: Improvement action and evaluation of impact

Quality statement: **Improvement actions agreed in response to the SAR set ambitious goals, seeking to align the motivations of different stakeholders, bringing partners together in new ways and foster collaborative working. Actions are integrated, wherever possible, with wider strategic improvement activity, plans and priorities, led locally, regionally or nationally. Evaluation of impact is designed from the start, supported by a logic model or similar, using measures that demonstrate whether the underlying causes of systemic risks identified have been addressed. The SAB maintains a public record of findings, actions and commentary to enable public accountability.**

Key concepts

- Decisions about how best to address systemic risks identified need careful consideration by the right people in the right positions.
- Improvement action from a SAR is likely to be more effective, if integrated rather than isolated from other improvement efforts.
- Tools and approaches from other fields can support evaluation of the impact of actions taken in response to SARs.

Tackling some common obstacles

- It may be useful to rethink the balance of resource/time dedicated currently to completing a SAR report versus determining and following-up on action.

Further reading and useful links

- On measures to use in evaluation of impact, see section 3.3.5 Failures to monitor and evaluate the effectiveness of change: **Learning from Adverse Events | CIEHF (ergonomics.org.uk).**[21]

Supporting tools and resources

- SCIE training session introducing ‘logic models’ and ‘theory of change’ approaches (27 October 2022) is available here **Training sessions - SAR**

[21] **https://ergonomics.org.uk/resource/learning-from-adverse-events.html**.

Quality Markers | SCIE[22]: and accompanying slides here: **PowerPoint Presentation (scie.org.uk).**[23]

- Toolkit available from Nesta here: **Theory of change | Nesta.**[24]

[22] **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022**.

[23] **https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-qms-logicmodels.pdf**.

[24] **https://www.nesta.org.uk/toolkit/theory-change/**.

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