social care
institute for excellence

Safeguarding Adult Review Quality Markers – open training session (4)

Different audiences for publication and dissemination

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SCIE

16 November 2022

SCIE support for high quality learning from SARs

Phase 1.


Supporting SAR Quality and impact
Refreshed SAR Quality Markers
Handbook
Comprehensive checklist tool
Role-specific checklist tool
Targeted briefings on SAR QMs
Virtual workshops x3:
Setting up the review
Running the review
Outputs, action and impact
Regional SAR Quality Champions
Self-nomination
Induction
Bespoke support
Beginning with regional SAR Subgroup sessions

Phase 2. Open training sessions to support use of the SAR Quality Markers

Recordings available here: https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022

SAR QMs targeted training sessions - open to all	SAR QM	Agreed date
1. Decision making whether a SAR is needed	SAR Quality Marker 2	Thursday 26th May 9.30-12.00
2. Flexible and bespoke commissioning -	SAR Quality Marker 5	Friday 17th June, 9.30-12.00
3. “Safety science”	SAR Quality Marker 12	Tuesday 28th June, 9.30-12.00
4. Different audiences for publication and dissemination	SAR Quality Marker 14	Wednesday 20th July, 9.30-12.00
5. Logic Model / theory of change	SAR Quality Marker 15	Thursday 15th September 9.30-12.00

Register to attend

https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/training2022

Today; a flexible session

1	9.30-10.30	Welcome and agenda for today. Context of earlier sessions. Main input: Thinking about the audience and purpose of different products
	10.30-10.45	Short break
2	10.45- 11.30	Break-out rooms. Share reflections from your different areas, helpful approaches and ways of working; what would you like more input on
3	11.30- 11.50	Revisit QM 14
	11.50-12.00	Wrap up and close

Stay with us for as many sessions as are useful to you

We'll share a link to an evaluation form at the end of each session

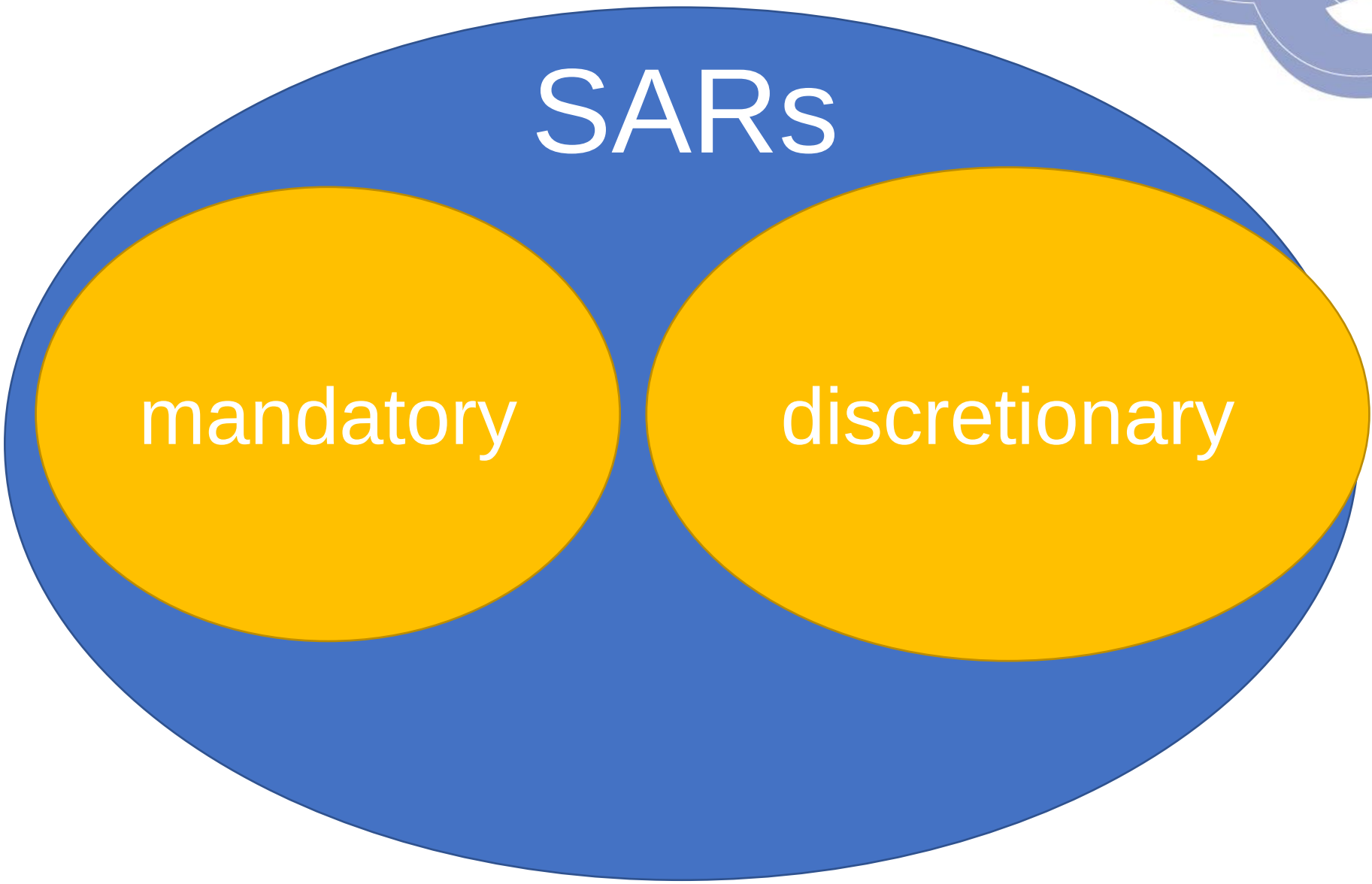
Learning Outcomes

By the end of the session participants will have:

- Appreciation of the importance of putting thought to identifying different audiences for SAR outputs
- Understanding of the need for clarity about the purpose(s) of any SAR output
- Increased confidence to innovate with compelling and engaging means of circulating findings from SARs for different audiences
- Increased awareness of wider range of publication and dissemination options

1. Background & recap of Session 1

All SARs are statutory



Session 1 highlighted an emerging tension

Renewed focus on compliance with statutory requirements to conduct mandatory SARs in certain circumstances linked to death or serious injury

Evidence base indicating need for a proactive approach; selecting incidents on basis of opportunities for learning not severity of outcome

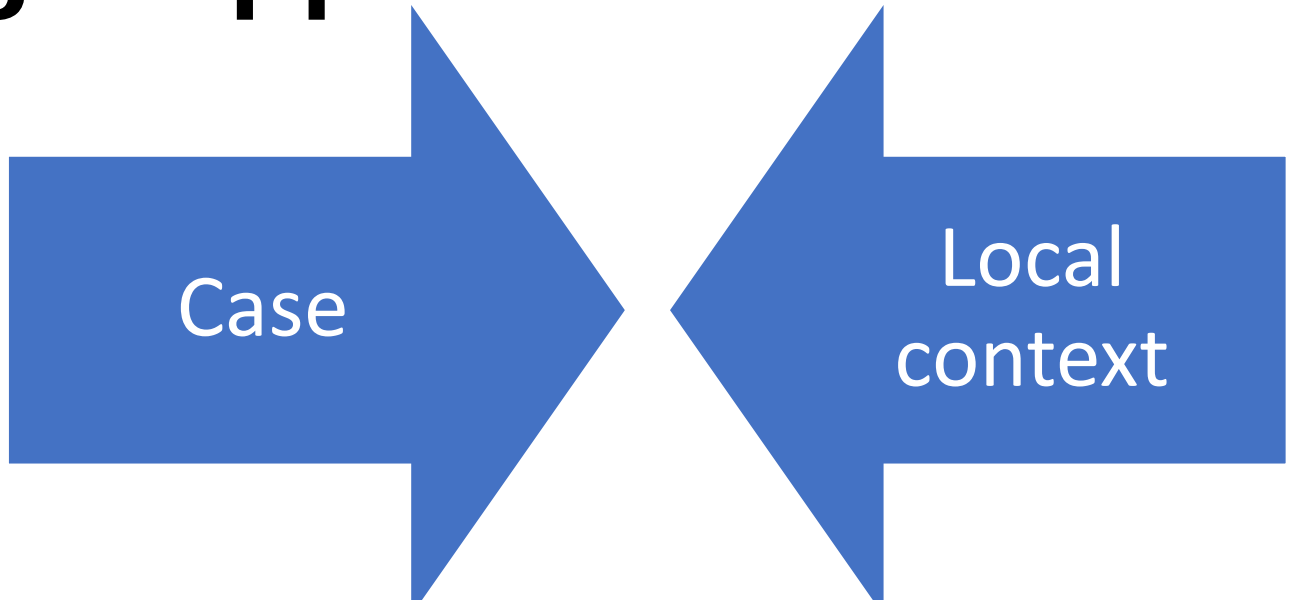
National analysis of SARs highlighted:

- Non-compliance – 22% no SARs April 2017-19
- Lack of precision about the legal basis
- Blatant lack of understanding
- National Rec 5: SABs & partners review understanding of legislation;
- National Rec 6: Regional & national networks review approaches to interpretation and application of s.44

- Safety-I to Safetly-II
- From 'swiss cheese' to Lilypond model
- New NHS Patient Safety Incident Response Framework (PSIRF)
- Child Safeguarding Practice Reviews – from criteria led, to consideration about learning potential

SAR QM2 attempts to recognise both aspects, and encourages a strategic approach using details of both case & local context

SAR QM2 attempts to recognise both aspects, and encourages a strategic approach



2 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.**

SAR QM 5

- 5.2.4 Have discussions about the precise form and focus of the SAR built on initial information gathering about case and local context (QM 2), drawing on the right range of information including:
  - Evidence of impact on adults with care and support needs and their families, including of any serious public concern and/or potential media interest •
  - Other quality assurance and feedback sources e.g. audits/complaints
  - Relevance to SAB strategic, current and/or future priorities
  - Previous SARs locally, regionally and nationally (as relevant).

Being strategic about identifying areas/themes where we know there are practice problems and we need to understand how organisational and social dynamics are influencing peoples work; Also where we need to understand what is allowing safeguarding to happen well in our complex multi-agency system

SAR QM 5 – Strategic commissioning

5 Quality Marker 5: Commissioning

Quality statement: **Strategic commissioning of the Safeguarding Adult Review 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.**

Increasing volume of SARs

- Heightens the need to be proportionate
- To be flexible, creative, bespoke, strategic in commissioning
- In order to get the most practical value from our SARs to inform and drive improvements

Very limited consideration of how to be proportionate

- **E.g. Commissioning a SAR involving a type of abuse/neglect that had been the focus of one or more earlier reviews**
- Response generally: to commission a further individual SAR
- Rather than consider a proportionate response e.g. start with the learning and recommendations from earier reviews and then question what has (not) changed, what has facilitated or obstructed change and what further work is required.

Session 2 – options for different size/shape of SAR

- What is a SAR?
- What counts as a SAR?
- Do SARs always need to look the same?
- What size or shape can it be?

By the end of the session participants will have:

- Appreciation the lack of prescription in the statutory guidance
- Increased confidence to use the discretion that is in your gift
- Increased awareness of the range of options beyond a standard SAR process

Distinct from Session 3; ‘safety science’ focus on clarity of purpose and theoretical framework that underpins methodology

Be flexible, bespoke, creative in determining how best to be proportionate and generate the learning you need

1. Background and why this is necessary and important
2. Care Act statutory guidance
3. What we know about current practice
4. Developments in other sectors
5. Key features of QM 5
6. A local SAB example

Makes a good case for grasping the opportunity for a more flexible, bespoke, creative, strategic, proportionate approach to commissioning SARs

Session 3 – Safety science

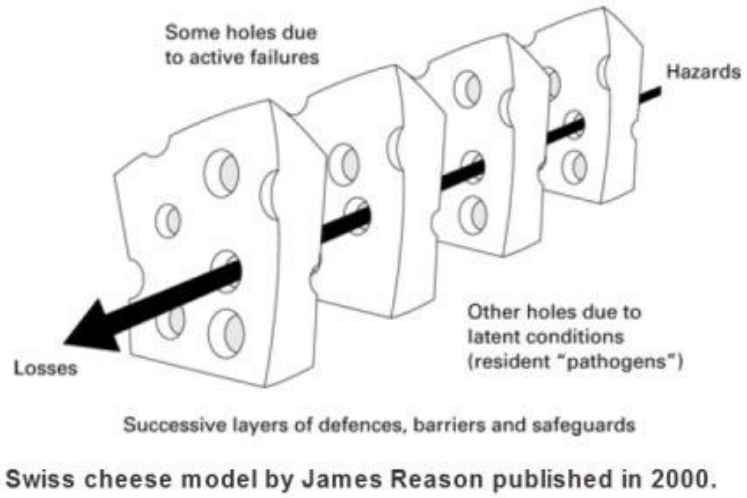
1. Models of why organisational accidents happen.
2. Key systemic ideas that can strengthen analysis in reviews.

The aims of this session are:

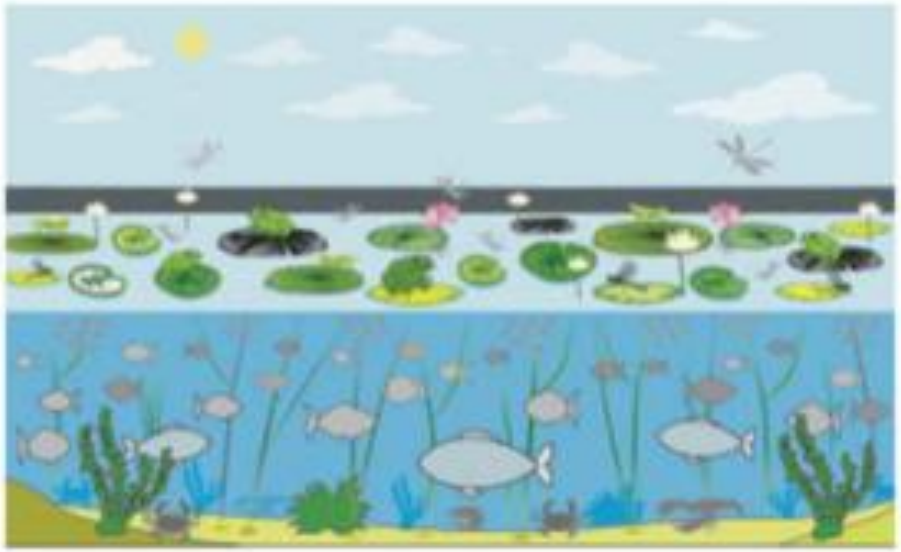
1. To introduce the basic theoretical approaches to understanding the causes of error in high risk field such as aviation, engineering and health.
2. To give an awareness of some key concepts from these approaches
3. To encourage participants to make connections between some key concepts from systems thinkin and their own practice related to SARs
4. To give participants the opportunity to consider what further support would be needed in order to be able to apply systemic thinking in their reviews

Current ‘safety science’ evidence base

From Safety-1 …. to Safety-11



Swiss cheese model by James Reason published in 2000.



From ‘swiss cheese’ ….

…. to ‘lily pond’ model

Quality Marker No.4: Clarity of purpose

4 Quality Marker 4: Clarity of purpose

Quality statement: **The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (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.**

Quality Marker No. 12 – Analysis

12 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 responses 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.**

CHIP/SCIE webinar on SAR In Rapid Time model: The model, process and tools assume key methodological principles

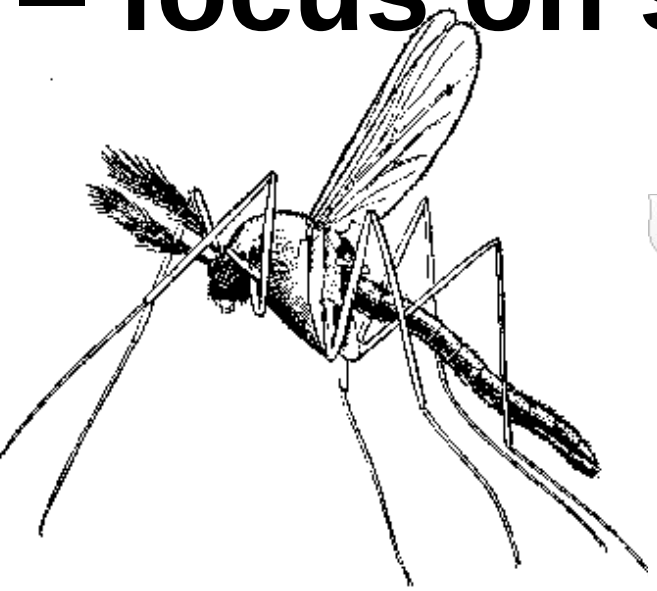
- Assumes and promotes a ‘systems approach’ to practice reviews
  - In line with NHS Patient Safety developments; seen as a discrete specialism see https://www.england.nhs.uk/patient-safety/incident-response-framework/
  - Reflected in the SAR Quality Markers
- Focuses on generating qualitative understandings of social and organisational factors that make it harder or easier for practitioners/clinicians to do personalised, timely and effective adult safeguarding
  - Not ‘root causes’ or linear causality

SAR In Rapid Time model encourages clarity about the kind of learning needed

- The SAR in Rapid Time enables SABs to move from describing practice problems
- To illuminating what lies behind those practice problems
- To understanding the social and organisational drivers for current practice problems

When we say we “keep learning the same things”, is it because we keep identifying the practice problems?

Effective approaches to learning – focus on systems findings



What is making it harder and what is making it easier to do timely and effective safeguarding

SAR in Rapid Time output is a succinct systems findings report

- 5-6 pages
- Only brief paragraph of the case
- Focus on the systems findings

- Feedback to-date positive:
  - Very practical
  - Keeps focus on action required to tackle what's helping and hindering
  - No chance to be distracted by case detail

Nb. There are inevitably compromises to be made, for the benefits of reducing capacity demand and increasing speed of turnaround

Sessions to date and link to today

QM 2

Decision making : a tension between compliance with mandatory SARs and evidence base to look at a range of outcomes/practice

Strategic, proportionate, creative commissioning

QM 5

Safety science; grappling with systemic risks and complex causality; take a systems approach

QM 4

QM 12

CHIP/SCIE webinar on SCIE SAR In Rapid Time model – uses a systems approach; short practical reports focus on 'systems findings'

QM 13, 14 & 15

Today: what are the implications for thinking about our audiences of publication and dissemination activity

2. What do we know about current practice regarding audiences, products and dissemination?

Very little

The quantitative data indicates that SABs published the full report in 82 per cent of cases (n=189/231). A variety of other publication methods were also used to disseminate findings and learning, most notably executive summaries, staff briefings and SAR responses. Attached to staff briefings in some instances were short questionnaires for practitioners and managers to complete to indicate how they would act upon the findings and learning for best practice in the SAR.

SAR outputs published by region										
Number of outputs by type	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	All regions
Board response published	4	0	15	1	4	4	6	2	0	36
Exec summary in report	1	1	8	2		0	1	0	0	13
Exec summary standalone	6	4	18	3	4	4	4	3	2	48
Family resource	0	0	1	0	0	1	3	0	0	5
Full report	12	2	45	8	26	22	18	10	9	152
Other	1	0	7	4	3	3	4	0	1	23
Staff briefing	4	2	4	6	21	13	9	6	6	7

Other means of disseminating SAR findings were principally publishing details in annual reports (10 mentions), PowerPoint presentations for seminars and conferences (5), and press releases (6).

No reflections in the reports analysed or in the analysis itself of the audience or purpose of the different outputs or means of disseminating SAR findings

3. The SAR Quality Markers on audiences, outputs and dissemination

Quality Marker No.13: The report

13 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 minimum 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.**

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;
- organizational 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.

Nb. Many will not be within the gift of operational staff to address

Quality Marker No.14: Publication and dissemination

14 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.**

Quality Marker No.14: Publication and dissemination

14.1.3 Are you satisfied that dissemination plans engage all the right audiences given the learning of this SAR, in compelling and engaging ways?

14.1.6 Does the communications plan secure the right level of engagement from senior leaders of all relevant partners, regionally and nationally? Has active engagement

14.2.8 Are all those who have a responsibility in addressing issues raised in the SAR, included in dissemination plans? Has adequate consideration been given to disseminating 'up' to strategic leads in relevant organisations locally, regionally and nationally?

14.2.9 Have the additional products and mediums and activities needed from this SAR for different audiences been discussed and agreed? Do they add up to a compelling and engaging means of circulating the findings?

14.2.10 Is the learning being made as accessible as possible to all relevant audiences through the range of products and extent of dissemination and engagement plans? How well are they designed to foster active responsibility for addressing systemic issues identified in the SAR?

14.4.2 Have relevant champions, forums and/or networks been identified that can support dissemination to the range of different audiences?

Quality Marker No.15: Improvement action

15.2.1 Do the proposed responses by agencies and the SAB genuinely tackle the systemic risks identified by the SAR and at the right levels of a system hierarchy, and avoid assuming that disseminating SAR outputs to operational staff is adequate?

15.2.3 Have you considered who is best placed to decide what an effective response to each of the findings would be, and how to engage them in these discussions?

The multiple audiences and purposes of published SAR outputs

In relation to a different field see 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/

From the chat – reflections, comments, questions, concerns?

Coffee break

SESSION 2. Break-out rooms

- Sharing reflections on input this morning
- Any local practice / developments that are useful to share?
  - Examples of the audiences you consider, products/mediums and their purposes?
  - Any particular challenges
- What more would you like clarity or support about?

Thank you!

- SCIE team

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