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Tools to support SABs achieve the SAR Quality Markers

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Tool E - commissioning a systems-based approach to learning for your SARs

Background

There is a long history across numerous sectors of trying to learn from practice through incident and case reviews as a means of improving services and safety. This has allowed an evidence base to develop about more and less effective ways of learning. Effective approaches to learning are premised on a systems-based approach. However, to-date there have been few resources available to support everyone involved in Safeguarding Adult Reviews to understand what a systems approach is or what it means for SARs, and people's different roles.

This tool

This tool aims to support SABs in growing confidence about what it means to take a systems-based approach to learning, and to use this in their commissioning processes. It should be read in tandem with the briefing for staff and agency leads on the use of a systems-based approach to learning in SARs. It aims to support clarity of learning outcomes sought through a systems-based SAR.

Clarity about the kind of learning sought

SAR Quality Marker number four (**Safeguarding Adults Review Quality Markers** (https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/)) captures good practice concerning the purpose of a SAR. The Quality Statement reads as follows:

> **Clarity of purpose:** 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.[1]

In line with these national standards, therefore, all SARs should aim to:

a) produce learning about the 'barrier and enablers to good practice' and/or
b) progress improvement activities.

Below we provide some additional clarity on each.

Producing learning about the 'barriers and enablers to good practice'

The term 'learning' can be used to refer to a range of different things. This risks people using the same word while potentially meaning different things. SAR reports show a confusing range of terms and meanings. In order to avoid confusion and talking at cross-purposes, SCIE has introduced some new terminology to differentiate different kinds of learning.

Case findings, which are judgements about the handling of a case, identifying what went well and where there were practice problems.

Systems findings, which identify explanations for why things have happened, identifying generalisable learning about enablers or barriers to good practice that have influence beyond the single case.

Recommendations or questions for consideration which focus on what to do to tackle social and organisational systems findings, create more conducive work environments, and minimise the reoccurrence of similar case findings.

In the SAR Quality Markers, learning about barriers and enablers to good practice is also referred to as producing 'systems findings'. Addressing how to tackle some common obstacles, the **SAR Quality Markers Handbook** (https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers/handbook) states:

- 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'.[2]

[1] Fish, S. (2022) SCIE SAR Quality Markers check list. London: SCIE. See **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers.**

[2] Fish, S. (2022) SAR Quality Markers Handbook. London: SCIE, page 7. See **https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers**.

Quality Marker 13: the Report, prompts those conducting the review to consider:

- Have you distinguished case findings and presented clearly your systems findings that explain particular practice problems which featured in the case or cases and represent wider learning about enablers or barriers to good practice?[3]

Systems findings can relate to a range of different factors and levels of a system hierarchy – see Figure 1. The 'blunt end' of the system is the source of the resources and constraints that form the environment in which practitioners work (Cook et al. 1998).[4] See Figure 1, below, (based on Cook Et al. 1998).

These different systems issues inevitably interact and potentially have a compound impact in any individual instance. For the purposes of learning and improvement it is useful to separate them out and be as specific as possible about each one.

The organisational triangle analogy illustrates the interaction between 'blunt end' factors and the 'sharp end' of direct practice. It helps illuminate how 'blunt end' factors impact on direct practice, as well as drawing attention to the fact that many of the systems findings are not within the gift of operational staff to address.

Coding systems findings for clarity

SCIE has developed a four-part coding scheme for systems findings. This requires each systems finding to specify as follows:

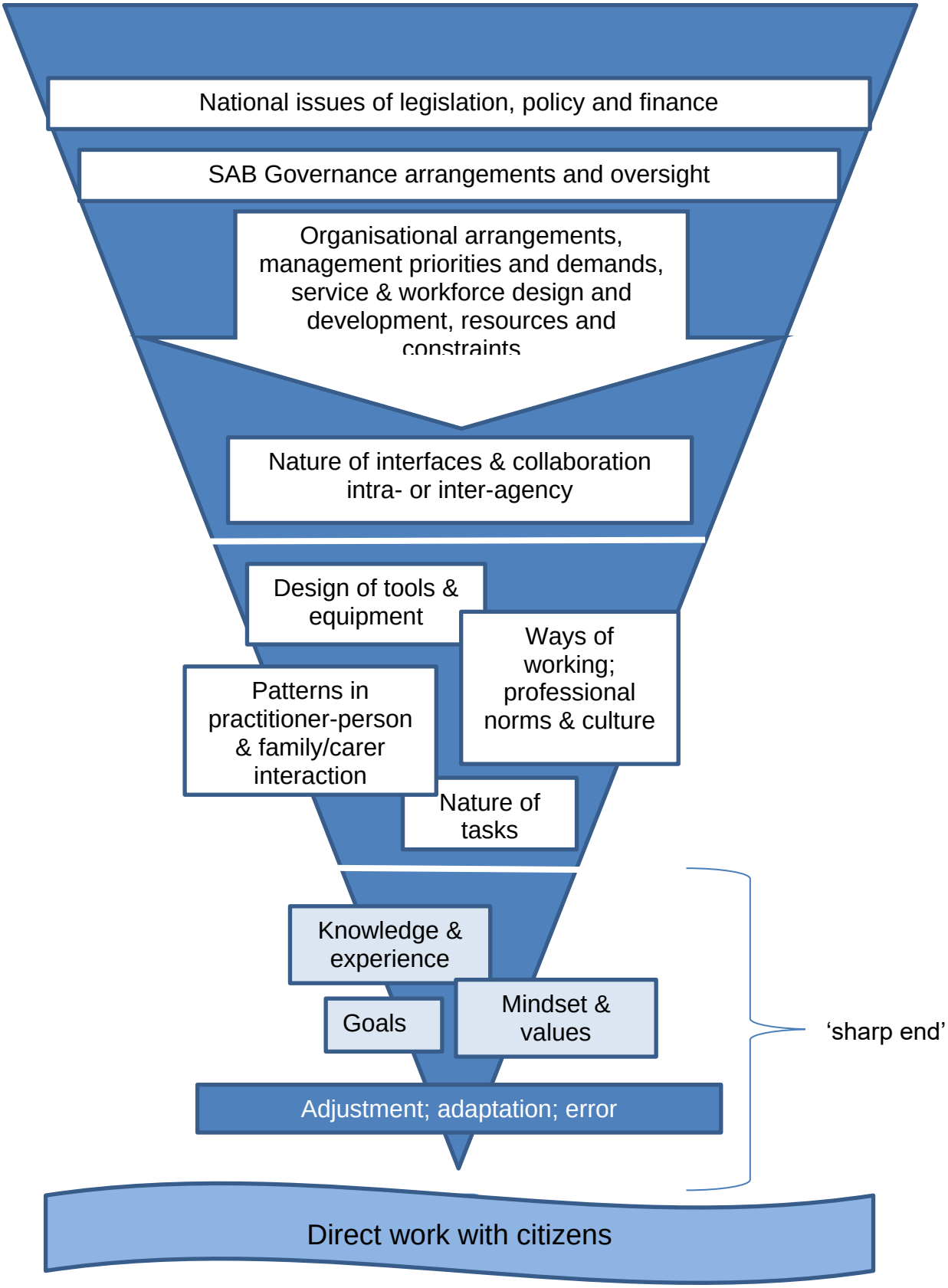
Which group of people or situation is this finding relevant to?	Which profession, agency or inter-professional dynamic is the finding relevant to?	Does the finding relate to a particular aspect or type of work within the health, care and support system?	What type of systems issue is it: what kind of thing needs to change?

[3] Fish (2022): Para 13.3.2.

[4] Cook, Richard & Woods, David & Miller, C.A.. (1998) A tale of two stories: Contrasting views of patient safety. See: **A tale of two stories: Contrasting views of patient safety** (https://www.researchgate.net/publication/245102691_A_Tale_of_Two_Stories_Contrasting_Views_of_Patient_Safety)**.**

Use of this coding scheme helps aid clarity and specificity to the systems findings identified through a SAR. It also enables comparison and collation of systems findings across different SARs.

Figure 1 - Types of systems findings impacting on the 'sharp end'.



References

Cook, Richard & Woods, David & Miller, C.A.. (1998) A tale of two stories: Contrasting views of patient safety. See: **A tale of two stories: Contrasting views of patient safety** (https://www.researchgate.net/publication/245102691_A_Tale_of_Two_Stories_Contrasting_Views_of_Patient_Safety)**.**

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