social care
institute for excellence

Safeguarding Adult Review Quality Markers – open training session (3)

Safety Science

Dr Sheila Fish

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

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

1		TODAY Welcome and agenda
2		**Thinking about why things go wrong.** Breakout rooms. **Handout 1. Models of why organisational accidents happen.** • What are the explanations for why things go wrong that are offered by these different models? • How are they similar and/or different? • Does it matter which you use and if so why? Feedback and discussion
3		Breakout rooms. **Handout2: Some key concepts** Feedback and discussion
4		Breakout rooms. **Handout 3: Key systemic ideas that can strengthen analysis in reviews.** • Thinking back to reports you've written or read are these insights that are implicit or explicit in your reports? • Do you think they apply? Would they improve our reports? • What would be the barriers to implementing more ideas from systems thinking? Feedback and discussion
5		**What do we need to do to take this forward?** In what ways do these ways of thinking strengthen the analysis in SCRs? Are some structures/approaches to reviews more conducive to this kind of analysis than others? What kinds of understanding and skills would you and your co-workers need? What are the barriers to this kind of analysis?

Learning Objectives

The aims of this session are:

1. To introduce the basic theoretical approaches to understanding the causes of error in high risk fields 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 thinking 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


FRIENDLY FIRE
THE ACCIDENTAL SHOOTDOWN OF U.S. BLACK HAWKS OVER NORTHERN IRAQ
SCOTT A.
STILL NOT SAFE
Drift into Failure
From Hunting Broken Components to Understanding Complex Systems
Sidney Dekker
BEHIND HUMAN ERROR
ASHGATE
SECOND EDITION
DAVID D. WOODS
SIDNEY DEKKER
RICHARD COOK
QUANTUM SAFETY
The New Approach to Risk Management for the Complex Workplace
PAUL STRETTON
Routledge
BOB'S GUIDE to OPERATIONAL LEARNING

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.**

Thinking about why things go wrong

- **Understanding why things go wrong inevitably assumes a theory of causation**
- **Though this may not be explicit**

Different approaches come from different traditions

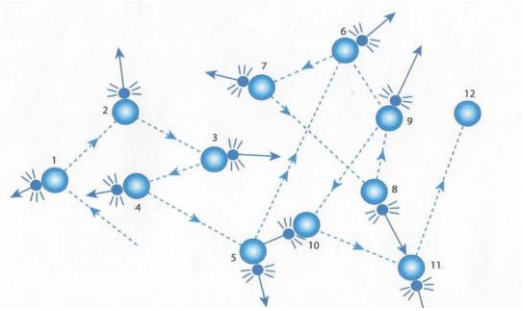
causal models are more or less explicit

Models of why organisational accidents happen

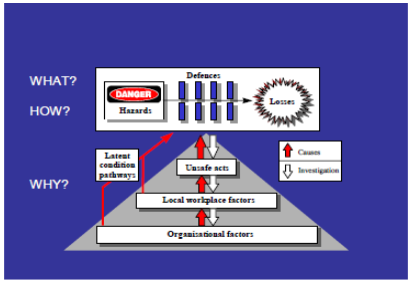
- SMALL GROUP DISCUSSION
- Handout
- What are the explanations for why things go wrong that are offered by these different models?
- How are they similar and/or different?
- Does it matter which you use and if so why?

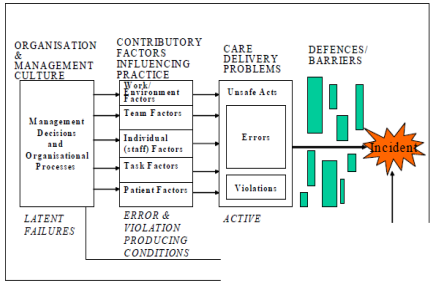
Different available models

- Linear or sequence of events' model
- 'Latent failure' model
- Emergent or complex models

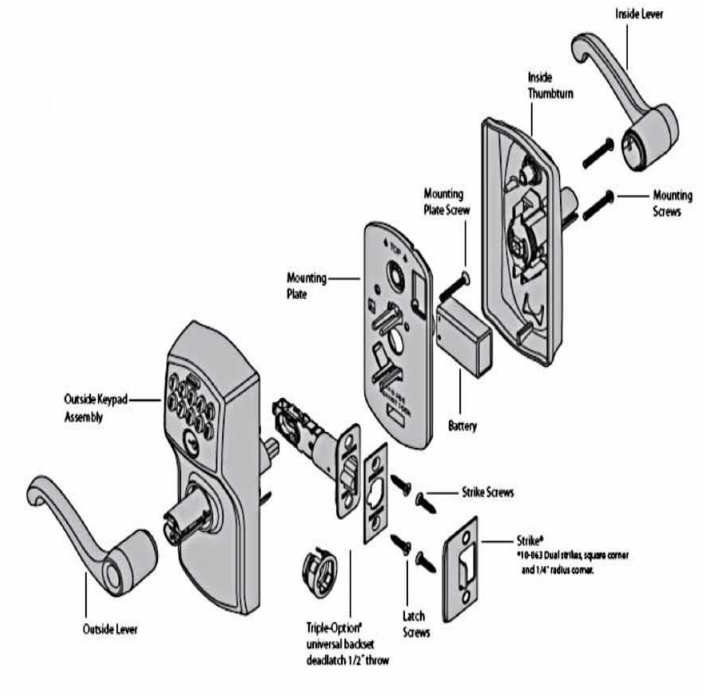


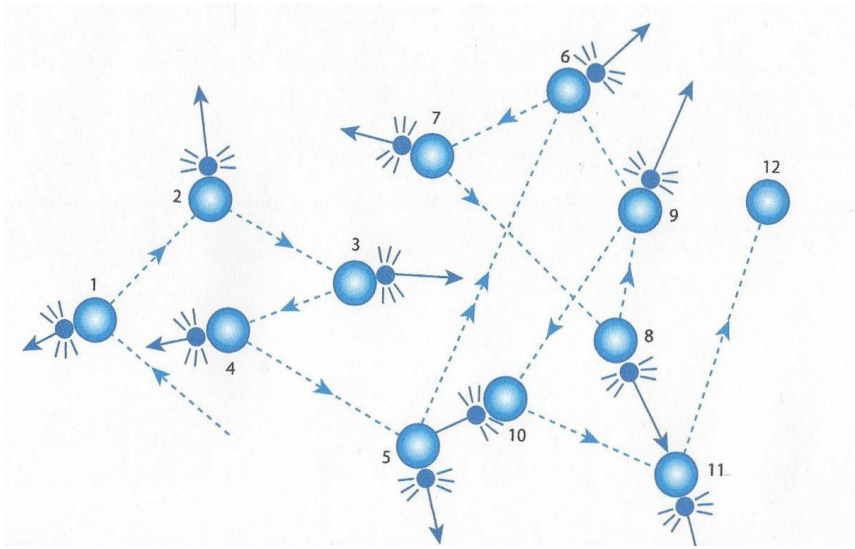
Always works in progress, evolving constantly





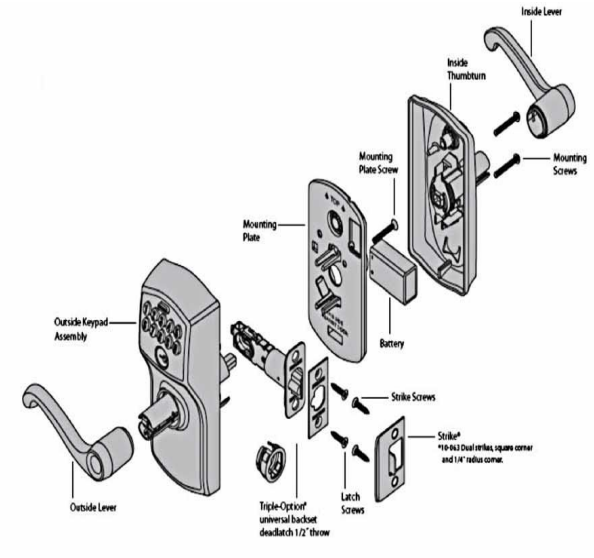
Complicated, determined



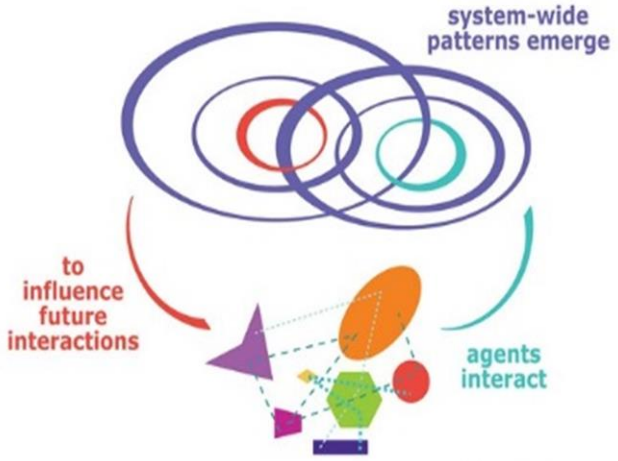


Complex, adaptive systems

Complicated, determined



vs Complex, adaptive systems



respond and adapt to changes in its environment that are unexpected or novel … in non-linear, often unpredictable ways.

scie social care institute for excellence

Handout 1: Models of why organisational accidents happen.

Discussion in small groups:

- What are the explanations for why things go wrong that are offered by these different models?
- How are they similar and/or different?
- Does it matter which you use and if so why?

Feedback and discussion

Why causal models matter

- The model you have of why things go wrong will shape the review
  - Ideas about why this happened
  - Focus of investigation
  - Methods for gathering evidence
  - Analysis undertaken
  - Focus of the report and nature of the recommendations
- Will tie into your model of how organisations learn and improve

A model of causation that fits safeguarding must address…

handout

- These are “organisational accidents” not just individual errors
- Safeguarding is a “wicked” problem, i.e. one to which there is no final, agreed solution
- Staff involved make unpalatable choices on the basis of imperfect information
- Harm is usually caused to children by behaviour and conditions located outside the professional system
- Knowledge of the risk posed by individuals varies enormously from case to case, and is sometimes nil
- Every presentation has unique features

HANDOUT 2: Key concepts

Handout

- Complexity
- Tight coupling
- Normal accidents
- Latent and active failures
- A ‘just culture’
- Outcome and hindsight bias

Handout 3: A selection of systems concepts to help making sense of front line practice

Handout

- Trade-offs
- Risks associated with innovation and organisational change
- Drift to failure
- Difficulty bringing knowledge to bear in the work context
- Clumsy introduction of technology

Handout 3:

Discussion in small groups:

- Thinking back to reports you've written or read are these insights that are implicit or explicit in your reports?
- Do you think they apply? Would they improve our reports?
- What would be the barriers to implementing more ideas from systems thinking?
- Feedback and discussion

What do we need to take this forward?

- In what ways do these ways of thinking strengthen the analysis in SCRs?
- Are some structures/approaches to reviews more conducive to this kind of analysis than others?
- What kinds of understanding and skills would you and your co-workers need?
- What are the barriers to this kind of analysis?
- Feedback and discussion

Thank you!

- SCIE team

Sheila Fish, Suzanne Cottrell, Anna Muller and Yvonne Watkins-Knight

Sheila.fish@scie.org.uk
Reviews@scie.org.uk

References