social care
institute for excellence

Tools to support SABs achieve the SAR Quality Markers

Tool F - a briefing for staff and agency leads on the use of a systems-based approach to learning in 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 (SARs) to understand what a systems approach is or what it means for SARs, and people's different roles.

This document

The aim of this document is to support SABs and reviewers raise awareness of a systems-based approach to learning in SARs. It can be used proactively to familiarise operational and strategic leads about why and what it means to take a systems approach in SARs. When a SAB has decided to arrange for the conduct of a SAR, the document can also be used to brief operational and strategic staff who are going to be involved.

Using a systems approach in Safeguarding Adult Reviews

Safeguarding Adults Reviews (SARs) should use a 'systems approach' to learning.

This briefing explains why and what it means for your role in the SAR. You may be someone who had an operational role in the case being reviewed. You may have a strategic position in one of the agencies or teams that was involved in the case.

Why should SARs use a 'systems approach to learning?

Evidence across a number of different sectors indicates that a 'systems approach' is the most effective way of getting learning from practice, that can really make a difference.

The Safeguarding Adult Review Quality Markers (QMs) are the national standards for SARs. They promote the use of a systems approach to learning. **Safeguarding Adults Review Quality Markers - SCIE**

What does it mean to take a systems approach to learning?

Taking a systems approach means setting out to produce learning of real practical value. It means aiming to produce learning about what is making it harder and what is making it easier for practitioners to do a good job.

Taking a systems approach to learning means shifting attention away from the 'sharp' end of face-to-face work with citizens, to the 'blunt end' of our complex systems.

Figure 1: The blunt end of a complex system (reproduced from Cooke et. al., 1998).

"The blunt end of a complex system controls the resources and constraints that confront the practitioner at the sharp end. The blunt end of the system is the source of the resources and constraints that form the environment in which practitioners work. The blunt end is also the source of demands for production that sharp end practitioners must meet. The demands are often conflicting." (Cook et. al., 1998).[1]

Taking a systems approach to learning means not seeking to identify mistakes and who made them, like swatting away mosquitos. It means instead focusing determinedly on the 'swamps' in which 'mosquitos' breed. The swamps are the ever present 'latent

[1] 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).**

conditions' that make it harder to achieve standards of good practice routinely, or make it easier to fall short (Reason 2000).[2]

Taking a systems approach to learning means using a single case to open a 'window' on to the workings of our systems more broadly. It means identifying underlying weaknesses and systemic vulnerabilities that impacted on practice in the case, but continue into the present, potentially affecting cases in the future. (Vincent 2004).[3]

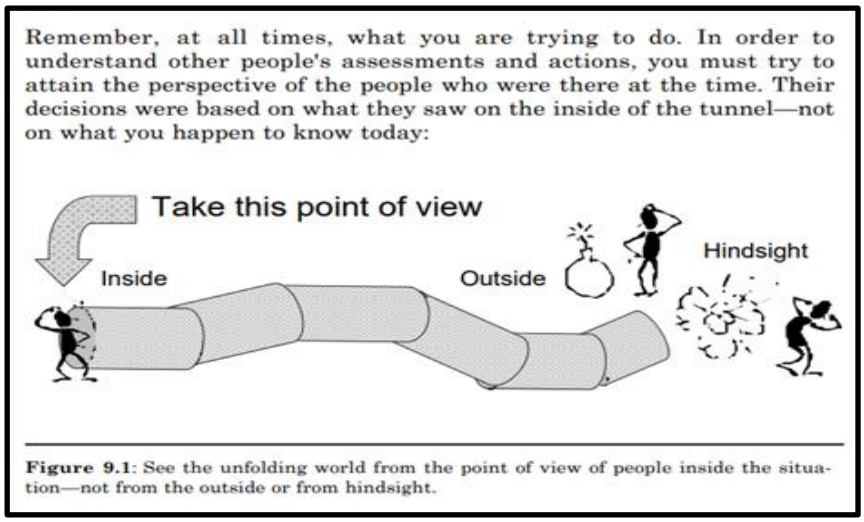
What does a systems approach mean for my role as a practitioner in a SAR?

Using a systems approach to learning means you can relax. This is not an investigation. SAR reviewers starting assumption is that people come to work to do a good job.

Using a systems approach to learning means people who had an operational role in the case being reviewed, hold pride of place in a SAR. You are the stars of the SAR show because your engagement is vital.

Using a systems approach to learning means SAR reviewers are dependent on you to understand how things looked to you at the time. They need your help understanding the thinking behind your actions and decisions.

Figure 2: reproduced from Dekker, 2001.



[2] Reason, J. (2000). Human error: Models and management. BMJ 2000;320:768–70. See: **Human error: models and management** (https://www.bmj.com/content/320/7237/768?ijkey=d29ae5e0a2eeb0c1f36cb69aced9ca05bcbfa96c&keytype2=tf_ipsecsha) (behind paywall).

[3] 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. See: **Analysis of clinical incidents: a window on the system not a search for root causes** (https://qualitysafety.bmj.com/content/13/4/242.long).

Only you can help them understand the view 'inside' the tunnel, rather than the biased hindsight view (Dekker, 2001).[4]

Using a systems approach to learning means SAR reviewers are dependent on you to understand more widely how work actually takes place in today's work environment, as opposed to how it might be planned or imagined in policies.

Only you can help them to appreciate what it is like to walk in your shoes, in your role, in today's operational climate.

What does a systems approach mean for my role as a strategic lead in a SAR?

Using a systems approach to learning means the way you respond, as a manager or leader, matters.

All your actions needs to echo a commitment to learning and improving, and make clear there is no tolerance of defensiveness, scapegoating or blame.

Your responses are vital to setting the tone for all those involved in the SAR.

Using a systems approach to learning means people in strategic positions need to evidence humility about what you already know about where operational difficulties lie.

Enabling operational staff to share their experiences 'warts and all', will often reveal learning about the current working of our complex systems, that are different from initial assumptions the sources of practice issues.

Your responses are key to creating a safe SAR environment, in which operational staff can share openly.

Using a systems approach to learning means you must not jump too fast to conclusions and risk solving the wrong problems.

It is vital that you value the diagnostic work of the SAR.

You need to be curious and expect the SAR to give you new insights into your complex system, illuminating barriers and enablers to good practice and helping untangle existing systemic risks.

Animations of this briefing are available

SAR briefing for operational staff/case group:
https://player.vimeo.com/video/816874639

SAR briefing for strategic leads:
https://player.vimeo.com/video/816874506

---

[4] Dekker, S. (2001). The field guide to human error investigations. See: **Dekkers field guide** (https://www.humanfactors.lth.se/fileadmin/lusa/Sidney_Dekker/books/DekkersFieldGuide.pdf).

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)

Dekker, S. (2001). The field guide to human error investigations. See: **Dekkers field guide** (https://www.humanfactors.lth.se/fileadmin/lusa/Sidney_Dekker/books/DekkersFieldGuide.pdf)

Reason, J. (2000). Human error: Models and management. BMJ 2000;320:768–70. See: **Human error: models and management** (https://www.bmj.com/content/320/7237/768?ijkey=d29ae5e0a2eeb0c1f36cb69aced9ca05bcbfa96c&keytype2=tf_ipsecsha) (behind paywall)

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. See: **Analysis of clinical incidents: a window on the system not a search for root causes** (https://qualitysafety.bmj.com/content/13/4/242.long)

social care
institute for excellence

Social Care Institute for Excellence
Isosceles Head Office, One High Street
Egham TW20 9HJ

www.scie.org.uk