- **The SCIE systems model for case reviews & findings from the North West pilots**

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Changing policy contexts? Munro Review

- Adaptive learning organisations
- Requiring strong feedback about how the system is performing
- Learning from practice through case reviews one key ‘feedback’ mechanisms
- Placing SCRs as a sub-set of broader range of multi-agency training & learning activities
- Highlighting need to ‘catch up’ with other sectors in safety management approaches
- Minded to recommend adopting the systems approach
- SCIE model as a working prototype

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Overview

- What the SCIE model is & how it works
- Outline of the series of SCIE pilots
- Findings from the North West
  - Feedback on the findings
  - What we learnt about learning that was accomplished through the process (clip 2)
- Endnote: remembering what it feels like for staff & why creating a constructive learning environment is important (clip 1)

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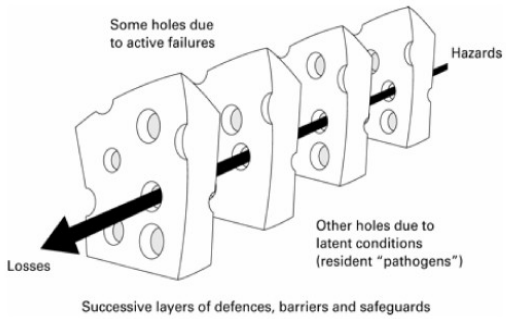
The “systems approach”

- Is a way of thinking or ‘conceptual framework’ for **understanding** practice
  - How do we understand what *causes* good or poor practice?



- and a structured process for **learning** from practice
  - through analysing a particular case

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Starts from a basic assumption

- it is reasonable to assume that most people come to work each day wanting to help children, not to allow them to be harmed.

What leads to good or poor practice?

- Individuals are not totally free to choose between good and problematic practice
- We are all part of the multi-agency systems and our behaviour is shaped by systemic influences
- The standard of performance is connected to features of
  - tasks,
  - tools and
  - operating environment.

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Implications for case reviews

- Provide a '**window on the system**' identifying
  - factors supporting good practice and
  - factors inadvertently making poor practice more likely
- Requires understanding the '**local rationality**'
  - how did this action/inaction/decision seem sensible at the time
- Requires moving beyond the case specific details to identify **generic patterns of influence** on practice
- Premise for improvement efforts: make it harder to safeguarding poorly and easier to do so well

Involves tackling the ‘latent conditions’ that make poor practice more likely

- Active failures are like mosquitoes. They can be swatted one by one, but they still keep coming.
- The best remedies are to create more effective defences and to drain the swamps in which they breed.
- The swamps, in this case, are the ever present latent conditions.

James Reason

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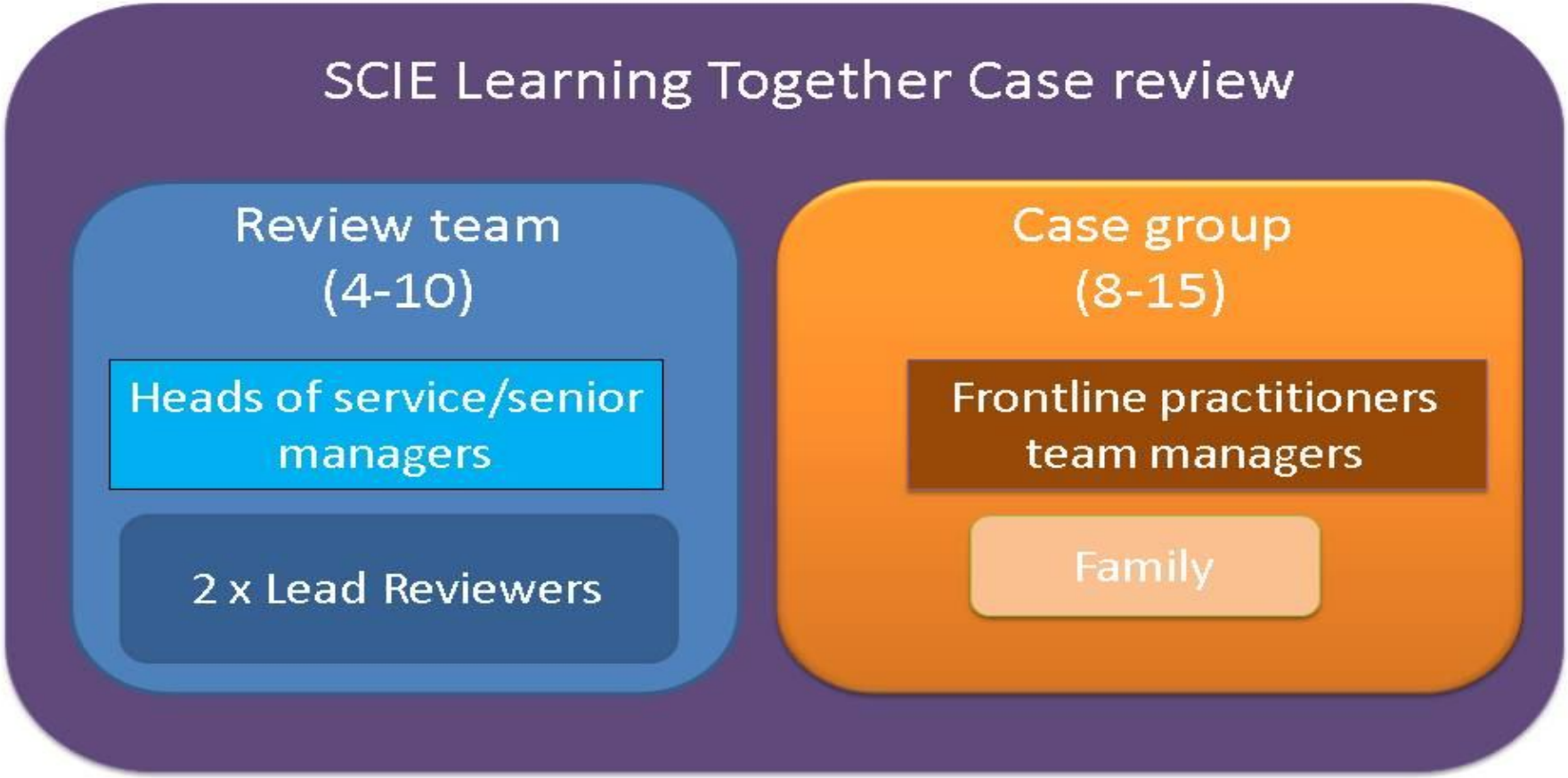
Involves responding with double-loop learning

- Involves going beyond assessing compliance
- Are we doing what is specified vs. have we specified the right thing?

How does it work in practice?



Process structured around key meetings

- The review team meet with the case group for
  - an **introductory meeting,**
  - **individual conversations and**
  - two group **‘follow on’ meetings**

- The review team meet alone for
  - an initial **planning meeting**
  - to **review relevant documentation and for**
  - ‘**analysis meetings’.**

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Tools provided include:

- Structure/schedule for individual conversations with key staff
- Framework of contributory factors
- Table layout for organising analysis of practice in ‘key practice episodes’
- Typology of underlying patterns of systems influence to organise the findings

Series of pilots in progress

- Aim to build up the evidence base & ensure continual methodological development

1. North West
2. West Midlands
3. London
4. South West

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Illustrations from the North West

A. Learning encapsulated in the findings & recommendations

B. Learning accomplished through the process

Findings: questioning the takenforgranted

- Case specific issue: S47 during school holidays
- Input from staff highlighted how they would never wait, overrun timescale, if case going to be closed
- Usual response: find ways round the problem
- Systems alternative: rethink the basics
- Generic issue: lack of availability of schools to provide timely info
- Challenge to the Board: how to achieve above

Positive feedback from LSCBs

“these recommendations are more strategic, so that’s a struggle, but that’s as it should be. You can imagine these more easily informing the Business Plan or CYP’s plan, rather than ticky-off action plans”

“we can’t unlearn what we’ve learnt today – we will be more critical of recommendations that suggest tinkering with policies and procedures. You can see how these will change practice; others just turn into churn”

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Learning accomplished through the process

- SCIE Guide states that staff directly involved in the case play an active role when using this model
- Quality of their engagement is linked to quality of understanding of practice and of learning gained
- But what of the impact of the process itself on learning outcomes and impact?
- A key learning point from the pilots is how the process itself becomes a powerful learning exercise for those involved
- The extent to which surprised us

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Feedback from staff

- “in relation to a domestic violence offence, for example, standard practice would be to fill in the paper work, and then refer to social care, and feel that’s it. Being involved in this pilot has made me look at how I can support the social worker – it’s made me look at my own practice, not just referring and thinking that’s it” (Probation)

- “I’ve learnt ..in terms of the outcomes of the case review – now I always have in mind the “garden path” thing. I’ve gone back to other cases and thought; actually, why am I working with this family?” (social care)

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- Participants were not waiting on a final report;
- learning was happening from the word go
- By the end some had reviewed their own practice, & revised their own knowledge
- Changes both for individual workers but also examples of ‘ripple’ effect as they talk with their colleagues about the process and learning

For further info

- Learning together publications & social care tv films available on www.scie.org.uk

- Contact: sheila.fish@scie.org.uk

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Endnote

- remembering what it feels like for staff & why creating a constructive learning environment is important (clip 2)

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Learning outcomes were supported by:

1. Not having a detailed terms of reference but going in 'with an open mind'
2. Gaining richer data through staff involvement
3. Multi-agency 'review team' working/learning together from the beginning – no IMRs
4. Analysis focuses on 'why' – 'key practice episodes' & 'contributory factors' framework
5. Use of social science research methods – rigour and reliability
6. Staff having chance to be part of developing analysis
7. Use of typology of underlying patterns to guide deeper level of analysis

Not all plain sailing!

- Administration and Co-ordination
- ‘Fear of the unknown’
  - “Getting your head around it is a really big deal and that shouldn’t be underestimated”
- Because it is more open in lines of enquiry, it is a messier process which can provoke anxiety
- Involving the right practitioners at the right time to militate against potential reluctance
- Who would be leading the analysis if not SCIE?
  - Importance of social science research methods knowledge & group facilitation skills