1.0 SCIE – SYSTEMS REVIEW (also known as Learning Together)[1]

This methodology known as the "systems approach" has been specifically designed to really get behind why things are not going well. The model provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to be mistaken, or to have led to an unwanted outcome, seemed to those involved, to be the sensible thing to do at the time. It has been widely used in child protection and in response to interest from the adult safeguarding sector it is now being developed in this sector. The term *Learning Together* is fundamentally about how the organisations learn from the incidents.

The central idea of this approach is that any workers performance is a result of both their own skill and knowledge and the organisational setting in which they are working. Therefore the approach looks at the quality of work produced by the combination of the worker and the tools. Importantly, as well as the more tangible factors such as procedures, tools and aids, working conditions, resources and skills, a systems approach also includes issues such as team and organisational cultures – these factors are all part of the system in which we work.

The aim is to make it harder for people to do something wrong and easier for them to do it right.

1.1 What happens?

There are three elements to the methodology.

- **Reconstructing how professionals saw the case at the time**: speaking to staff to get their perspective on the case as it unfolded, and why they chose the actions they took.
- **Identifying and analysing key practice episodes, and the contributory factors behind them**: looking at significant periods and aspects of the case, the practice that occurred and the factors that influenced the work the professionals did.
- **Interpreting the broader significance**: analysing the ways in which what happened reflects wider issues in the system

Through individual conversations with staff, service users and families, and joint meetings of all key professionals involved in the case, the reviewers build up an iterative and multi-disciplinary analysis. They discuss what happened, what practice and organisational factors lay behind the events, and what the events show about the systems and how they can be improved.
The **learning** is presented to the Safeguarding Adults Case Review Group and/or the SAB in a report with key findings.

1.2 Benefits of undertaking this process in adult safeguarding

- Case reviews involving partner organisations will engage providers in a shared attempt to identify more effective approaches to safeguarding;
- It may strengthen the use of the Mental Capacity Act, as much of the adult safeguarding work hinges on service users mental capacity and how professionals use the Act;

[1] SCIE's *Learning Together* is a programme of support that helps organisations to learn systems thinking and improve how they safeguard adults and children.

- It is much less bureaucratic than traditional Serious Case Review methodology as it cuts out processes such as panel meetings, individual management reviews etc;
- It is more time and cost effective
- The implementation of any emerging actions can be immediate, without the need to wait for the final report and recommendations – unlike SCRs where it can take several months to see any recommendations.
- The outcome is purely the learning rather than the detail of the actual case.

1.3 What is analysed?

The systems approach draws on two data sources – the formal documentation of the different agencies involved and in-depth one-to-one conversations with key personnel involved in the case.
Good analytical skills are needed to interpret both the formal documentation and what is being said. To date many of the people who have been involved in this type of review have found it a helpful process which has given them a greater understanding of their own and their colleagues' performance.

1.4 What happens with the final report?

A report is produced with findings and an action plan. The findings are presented in a specific format in terms of a statement, supporting evidence and lastly a series of questions for the Safeguarding Adults Review group to consider. The group will discuss the findings, prioritise them, and agree a process for monitoring them.

1.5 Summary of systems process

Preparation	Identifying a case for review Selecting the interview team – usually senior managers. Identifying who should be involved – the staff who were directly involved in the case. Preparing participants Selecting documentation
Data Collection	One-to-one conversations Producing a narrative of multi-agency perspectives
Organising & Analysing data	Identifying and recording key practice episodes and their contributory factors. Reviewing the data and analysis Identifying and prioritising generic patterns Making recommendations

1.6 Successes experienced with this type of review

Agencies who have undertaken this type of review in adult safeguarding have found that:

- They have produced learning that is already, and will continue to be acted upon.

- There was also a significant amount of learning across agencies about each other's areas of practice, both for the case groups and the review teams.
- Participants have stated that the time involved is "time well spent".
- Participants have found the experience to be very constructive and helpful for their professional development.

1.7 Some challenges which may occur

As this model is in its infancy within adult safeguarding there will be some challenges which review teams will be faced with, these include:

- How to involve family members (see section **4.0** on Engaging with Adults at Risk during reviews)
- Being able to successfully chair or facilitate participative review groups.
- The unpredictable nature of an open enquiry as the model does not propose setting Terms of Reference for the review period.
- Treating all data equally – including conversations with staff.
- Having a conversation about a case with someone not from your own agency or profession.

1.8 Key messages

- The approach has been successfully applied in three pilot case reviews in the North West of England;
- The model produces explanations about why professionals had acted in the way they did;
- The approach identifies conditions supporting good safeguarding practice, as well as those influencing professional practice in negative ways.
- Having a multi-agency 'review team' working together from the beginning created a common endeavour, greater challenge and confidence to find new ways of working and effective solutions.
- Actively involving frontline workers and team managers throughout the process is a vital aspect of the model.
- Participants using the model for the first time stressed that taking a 'systems' perspective is a new and different way of thinking that means learning new skills.

More information on this model can be found on the Social Care Institute for Excellence website www.scie.org.uk