Learning together to safeguard children: a 'systems' model for case reviews

Key points

- The 'systems' model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.

- It provides a way of thinking about frontline practice and a method for conducting case reviews.

- It produces organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe.

- The model has been adapted from the systems approach used in other high risk areas of work, including aviation and health.

- It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken.

- It involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions.

- It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

This At a glance summary presents a new 'systems' model for serious case reviews (and case management reviews in Northern Ireland). 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. The answers can generate new ideas about how to improve practice and so help keep children safe.

Context

When news breaks of a child's death from abuse, the public's response is often one of incredulity. In the case of Baby P, people were baffled that, despite 60 contacts with professionals in the eight months before his death, no-one realised the extent of the abuse he was enduring. In Britain, there is a long history of case reviews into child deaths, aimed at finding out how the tragedy occurred and learning lessons for the future. These case reviews, however, tend not to dispel the public's bafflement.

After conducting an extensive inquiry into the care provided to Victoria Climbié, Lord Laming concluded that he 'remained amazed that nobody in any of the key agencies had the presence of mind to follow what are relatively straightforward procedures on how to respond to a child about whom there are concerns about deliberate harm.'

When case reviews leave such amazement at poor practice unexplained, the amazement quickly turns to anger and condemnation of those involved. It is hard to believe that a motivated, well-meaning, competent worker could act this way, so the tendency is to conclude that it must be the result of stupidity, malice, laziness or incompetence. This is bad for public confidence and also for staff morale.

In children's services, it is reasonable to assume that most people come to work each day wanting to help children, not to allow them to be harmed. So better explanations are required as to why things go wrong and, indeed, why, more often, they go right.

The systems approach to case reviews is explicitly designed to address these 'why' questions.

Essence of the systems approach

The systems approach originates in the aviation industry. This is perhaps not surprising since when a pilot makes an incomprehensible error, such as crashing into a mountain, the pilot dies along with his passengers and crew. Therefore it seems implausible to put the error down to laziness or stupidity.

Hindsight bias leads us to grossly overestimate how obvious the correct action or decision would have looked at the time and how easy it would have been for the worker to do the right thing.

The central idea of the systems approach is that any worker's performance is a result of both their own skill and knowledge and the organisational setting in which they are working.

In the aviation model, if a cockpit is designed in such a way that it is easy for a pilot to confuse two instruments, more errors will occur than if the instruments can be easily told apart.

Improving safety therefore means clarifying which aspects of the work context make errors more likely to happen, and which support workers to accomplish their tasks successfully.

This clarification triggers ideas for re-designing the system at all levels to better support people to carry out their work to the highest standards.

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

From: *To err is human: building a safer health system,* Institute of Medicine (1999)

In order to learn the right lessons to improve practice we need first to ask: how did the situation look to the practitioner so that the action chosen seemed like the right thing to do at the time?

Common misunderstandings

This is not a 'no blame' approach

The slogan of 'moving beyond a culture of blame' ... is a call to abandon *poor* systems of accountability and ... *not* a tolerance for an absence of accountability.

From: Conflicts between learning and accountability in patient safety, Woods, D.D. (2004), Online

The objective is to develop 'an open and fair culture' which 'requires a much more thoughtful and supportive response to error and harm when they do occur.'

From: *Patient safety*, Vincent, C. (2006)

How does safeguarding children resemble engineering?

Transporting approaches across fields of practice is difficult. Sensitive adaptations are invariably required to take account of differences between the domains. So, how is child welfare similar to the field of engineering and how does it differ?

Engineering systems appear predominantly technical (involving machines) and children's services predominantly social (involving people). Yet both are 'socio-technical' systems. This means that the interactions between people and equipment are fundamental in shaping the way work gets done.

Assessment frameworks, procedure manuals and electronic databases have all been introduced with the aim of improving frontline performance in children's services. However, it is difficult to predict all the consequences of their introduction in advance.

In a systems approach, the focus is on the quality of work produced by the combination of the worker and the tool. Poor practice may be due to a flawed design or a clumsy user – or a combination of both.

Systems vs individuals

Commentators on the Baby P case have tended to see the problem as resting either with individuals or with the system.

The systems approach sees people as being part of the system because their behaviour is shaped by systemic influences. It looks, therefore, at the *interactions* between people and factors in the workplace. In the systems approach, people and processes jointly *create* the system.

Key differences from engineering

a) Limits of the knowledge base

Safeguarding children is not as straightforward as fixing a broken car – it is an area that requires a great deal of learning. Strong feedback loops are necessary within the multi-agency work environment in order to understand how the service is operating, and to identify any strengths and weaknesses.

We cannot assume that simply following procedures is a good enough test of performance. Even when a procedure has good knowledge behind it, it may be less productive in a real world setting where it interacts with other variables.

b) Working with families

Families are very different from planes or power plants. Professionals interact with families; they form relationships to gain information and to help the family change. These relationships can influence professionals' thinking, for good or ill. A poor relationship, for example, may lead to a worker missing key information, or compassion for a mother may distract a social worker from the misery being experienced by her child.

> ❛ You can deliver a pizza but you cannot deliver a child welfare service. You need the 'customer' to be an active agent in the production of the required outcomes. Child welfare services simply fail if the intended recipients are unwilling or unable to engage in a constructive way; outcomes are co-produced by citizens. ❜

Adapted from: *System failure: why governments must learn to think differently*, Chapman J. (2004)

c) Complexity of 'Working together'

Unlike the team in a cockpit or an operating theatre, the team working with one family in children's services are located in various agencies and, while all share the long-term goal of safeguarding children, they can each have different intermediate goals and different working relationships with different family members. This adds considerable complexity to any analysis of how they work together and the contribution each one of them makes to the final outcome.

These three differences from engineering have all been taken into account in producing a suitable adaptation of the model for safeguarding and child protection work.

What do we mean by 'systems'?

When talking about 'systems', people often think in terms of policies, procedures and protocols, hence the question: 'Are the appropriate systems in place?'

In the systems approach the term is used in a far broader sense and includes all the possible variables that make up the workplace and influence the efforts of frontline workers in their engagement with families.

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 treated as systems issues as well.

A framework for understanding the influences on practice

Instances of problematic practice may, on the surface, look different in different cases, but underneath they can have much in common because the poor quality of the work is influenced by the same factors. The same can be true of instances of good practice.

It is these similarities or patterns that need to be identified in case reviews. They can be either constructive patterns of influence or patterns that create unsafe conditions in which poor practice is more likely.

> ❛ In a systems case review, a particular case is made to act 'as a "window" on the system' – providing the opportunity to study the whole system, learning not just of flaws but also what is working well. ❜

From: 'Analysis of clinical incidents: a window on the system not a search for root causes', *Quality and Safety in Health Care*, vol 13, Vincent, C. (2004)

The SCIE report *Learning together to safeguard children: developing a multi-agency systems approach for case reviews (2008)*, provides a framework for organising the complex set of factors that influence work with children, families and carers – see table 1 below.

Key influences on safeguarding practice

This framework for analysis is focused on the interactions between different parts of the system

1. human-tool operation
2. family-professional interactions
3. human judgement/reasoning
4. human-management system operation
5. communication and collaboration in multi-agency working in response to incidents/crises
6. communication and collaboration in multi-agency working in assessment and longer-term work

Ideas can then be generated about ways of re-designing particular parts of the system in order to better keep children safe.

> Heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is re-designed so that it is easier for average workers to do so.

This approach enables cumulative learning from a series of case reviews. Because data is collected and analysed in a consistent way it is possible to make comparisons across cases.

> ❛ It's not always a comfortable process … bravery is needed venturing into sensitive territory. ❜

Participant in pilot systems case reviews

The importance of all workers' views

Translating policy aspirations into frontline practice is far from straightforward. Intelligent reforms can inadvertently create new problems. This is because reforms do not take effect in a vacuum. Instead each innovation interacts with others, as well as with existing aspects of practice. It is therefore difficult to predict with any certainty what the effects of any change to working practices will be.

Consequently, in order to learn how the system is operating at all levels, people at all levels need to be consulted. Senior management's view from the top omits key details of how the world looks at the frontline and to families.

> ❛ … well-intentioned observers think that their distant view of the workplace captures the actual experience of those who perform technical work in context. Distant views can miss important aspects of the actual work situation and thus can miss critical factors that determine human performance in the field of practice. ❜

From: 'Nine steps to move forward from error', *Cognition, Technology & Work*, vol 4, Woods, D.D. and Cook, R.I. (2002)

Rigorous analysis

A systems case review draws on two data sources: the formal documentation of different agencies and in-depth one-to-one conversations with key personnel.

Making sense of the material requires detailed analysis. Good analytical skills are needed to interpret the data and minimise the risk of bias. Techniques of qualitative research play a crucial role.

The reliability of the analysis is also helped by taking an explicitly collaborative approach that encourages the open and active participation in the process of analysis, by those directly involved in the case under review, from all agencies.

Empirical research studies may also be cited to strengthen findings.

In the case reviews using the systems model undertaken so far, the degree to which participants have constructively engaged in the process and been willing to reflect deeply on their own work has been impressive. Many have reported finding it a helpful process that gave them greater understanding, both of their own and their colleagues' performance.

❛ All SCR's make judgements and interpret findings – but are not always so explicit about the process, which makes joint ownership of both the process and the learning more difficult for workers taking part. Redrafting the report after sharing it with workers can enable these judgements and interpretations to be more precise and based on discussions with all those taking part. ❜

Participant in the pilot systems case reviews on the most valuable aspect of the model

Case example

A baby boy, taken to hospital with feeding problems, was found to have a fractured skull and bruising on his chest. His mother could provide no adequate explanation and he was placed in a foster home while further investigations were made. The duty social worker who had dealt with the referral then passed the case on to the social work child protection investigation team. The new social worker took over. She did not pursue the inquiries into the unexplained injuries. The family were anxious to have the baby returned and eventually she agreed on condition that the male partner did not live at the house. A month later, the baby suffered a further fracture to his skull.

When the case review was conducted, people expressed amazement at the social worker's failure to explore how the first injury had occurred and her assessment that it was safe to let the baby return to his mother. The system's inquiry found that her first contact with the case had been to receive a phone call from a police officer saying that the mother had suggested the injuries had occurred while the baby was with two teenage babysitters who might have let him fall out of the buggy and then been afraid to mention it. This led the social worker to classify the case in her mind as 'possibly not intentional abuse and not due to any family member'.

This error of reasoning is called 'being led up the garden path' – her first contact with the case gave her a vivid but inaccurate impression and influenced all her subsequent thinking. Evidence that challenged her picture of the family was not as vivid and failed to be taken seriously. Her supervisor did not read the file but relied on verbal reports from the social worker because it was quicker and so failed to note the inconsistencies in the available evidence.

This explanation does not excuse the social worker's error of judgment but it does show how she thought she was acting reasonably at the time. It also highlights the dangers of supervisors using verbal reports only when these are inevitably selective and coloured by the social worker's existing view of the case and so likely to prioritise the evidence that fits that view.

TABLE 2

Learning together (2008) provides a way of thinking and a structured process for case reviews

Summary of aspects of the process and accompanying roles		
	ASPECTS OF PROCESS	ACCOMPANYING TOOL
Preparation	Identifying a case for review	
	Selecting the review team	
	Identifying who should be involved	
	Preparing participants	Introductory letter (Appendix 1)
Data Collection	Selecting documentation	
	One-to-one conversations	Example of explanatory communication to participants (Appendix 2) Conversation structure (Appendix 3)
Organising and analysing data	Producing a narrative of multi-agency perspectives	
	Identifying and recording key practice episodes and their contributory factors	Template for table of key practice episodes (Appendix 4) Framework for contributory factors (Appendix 5)
	Reviewing the data and analysis	
	Identifying and prioritising generic patterns	Typology of underlying patterns (Appendix 6)
	Making recommendations	

Common misunderstandings

Is this model the same as root cause analysis?

Root cause analysis is a concept taken up and promoted by the National Patient Safety Agency as a method for the investigation of patient safety incidents. It is a concept that overlaps closely with a systems approach but because the term itself is misleading the SCIE report authors have chosen not to use it (c.f. Taylor-Adams and Vincent, 2004).

The term implies that there is a *single* root cause to any incident, but incidents often arise from a chain of events and the interaction of a number of factors. It also implies that the purpose of the investigation is restricted to finding out the cause of the particular incident under investigation, rather than learning about strengths and weaknesses of the system more broadly, and how it may be improved in future. We have chosen instead to put the word 'system' in the name because this draws attention to a key feature of the model – the opportunity it provides for studying the whole system, learning not just of flaws but also about what is working well.

Making recommendations

Understanding the complex influences on practice does not mean that there are any simple solutions.

Three different kinds of recommendations emerge from a systems case review:

> Learning, like safeguarding, needs to be everyone's business. This is a system-wide approach – improving practice can require change from people at all levels of the system, not just on the part of frontline workers.

1. Issues with clear cut solutions that can be addressed locally and by all relevant agencies e.g. creating a consistent rule across agencies of when and why to copy someone in to a letter rather than addressing the letter to them directly.

2. Issues where solutions can not be so precise because competing priorities and inevitable resource constraints mean there are no easy answers e.g. if we want more attention to be given to the critical aspects of the supervisor's role, we can not assume spare capacity. Such decisions are the responsibility of the senior management.

3. Issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level e.g. addressing problems identified in new software would require experimentation to find solutions through more user-centred design.

How can it be used?

- **Serious case reviews /Case management reviews**

The systems approach can readily be used in conducting serious case reviews (case management reviews in Northern Ireland). It matches the emphasis in *Working together* (HM Government 2006) and *Cooperating to safeguard children* (DHSSPSNI, 2003) guidance on an analysis of practice that gets behind what happened to understanding why it did so, in order to establish the changes necessary to improve safety. It provides an explicit methodology for how to accomplish this.

It should aid Local Safeguarding Children Boards (LSCBs) and Children's Services Authorities (CSAs) fulfil Ofsted's criteria for positive evaluation of SCRs. In Northern Ireland it should aid the Regional Child Protection Committee (RCPC) which currently has responsibility for undertaking CMRs (although this function will be transferred to the Safeguarding Board for Northern Ireland due to be established during 2011) by:

a) encouraging a transparent, systematic and rigorous process for analysis and

b) ensuring that the process is a learning exercise in itself and promotes a culture of learning.

- **In reviews of routine case work and 'good' practice examples**

The systems review process is also applicable to less serious cases. Indeed, there is much to be gained in studying examples of routine case work as well as cases that go well. This helps in reaching a better understanding of what is working well, and also of problematic areas so that solutions can be found to improve effectiveness before harm is caused to a child or family.

- **Incorporating the case review model into day-to-day work**

Developments in the health field also suggest that the systems approach can usefully be incorporated into day-to-day work.

In multi-agency safeguarding, frontline staff and their managers, in all agencies, could use the model in relation to current and ongoing work, to guide a constructive multi-agency review and revision of assessments and plans. This would be the equivalent of case discussions that are routinely held in parts of the health sector but for which there is neither an established culture nor accompanying forums or policies in social care. This could be put into action by the multi-agency group itself, or take place in individual or group supervision.

Background

- There is currently little transparency concerning methods used in the conduct of serious case reviews (SCRs)/case management reviews (CMRs). This makes it difficult to assess the quality of the findings or likely effectiveness of the recommendations.

- Other high risk areas of work, such as aviation, have developed a systems approach to understanding and reviewing frontline practice with the aim of improving the quality and safety of service provision.

- The systems approach has been adopted in the health field where it is promoted by the World Health Organisation (WHO) and, in England, by the National Patient Safety Agency (NPSA).

- SCIE has led an innovative research and development project to adapt this 'systems' methodology for multi-agency safeguarding and child protection work.

- The SCIE *Learning together* report presents the adapted model. It provides both a theoretical framework and a practical guide to its application in case reviews.

Key audiences

The systems approach will be of interest to chairs and members of local LSCBs (RCPC in Northern Ireland) and directors and assistant directors of children's services, their children's services managers and professional leads, including safeguarding coordinators and training specialists.

It will also be of particular use to multi-agency members of serious case review subgroups of LSCBs, SCR Overview Report authors and people across agencies in quality assurance roles.

Next steps

The Munro Review recommended that LSCBs use a systems methodology in Serious Case Reviews and Government has agreed that this should be a requirement. SCIE is pleased to be working with the Department for Education to build capacity in the sector to use a systems approach, in this critical phase.

We are funded to run a practice-based training and accreditation programme for Learning Together. The resulting pool of accredited reviewers will be available to conduct reviews using the SCIE model. They will also continue the important work of continuing to refine the model and its application through on-going evaluation and development.

There continues to be high interest in using the systems approach to learn from multi-agency professional safeguarding practice. This includes interest from the adult services sector and in other countries in Europe. Application of the model in these new settings is underway.

In the context of financial constraints and of the need to offer good value for money, we are working with the sector to adapt how the Learning Together model can be used to provide a less resource-intensive, differentiated approach that responds to the type of case, context and learning needs of boards.

We encourage anyone interested in finding out more about these developments to get in touch.

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Further information

Both Report 19 and accompanying Guide 24 are available free at www.scie.org.uk

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