Learning together to safeguard children: developing a multi-agency systems approach for case reviews

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Key messages

- Developments in engineering and health indicate the potential benefits of using a 'systems approach' to understanding front-line practice in order to improve the quality and safety of service provision.
- This guide presents an adapted systems model for multi-agency safeguarding and child protection work.
- It is an innovative approach that requires a respectful approach towards the practice experience of street-level workers and their managers.
- It involves moving beyond the basic facts of a case chronology and appreciating the differing views that different workers had at the time.
- The aim is to identify underlying patterns of factors in the work environment that support good practice or create unsafe conditions in which poor practice is more likely.
- This kind of organisational learning is vital to improving the quality of services provision and needs to be applied to ordinary work, not just to tragedies.

Section 1: Introduction

1.1 What this SCIE guide is about

- This SCIE guide presents a systems model for organisational learning across agencies involved in safeguarding children.
- It is an introduction both to a way of thinking and its application in practice.
- It sets out the actions needed for a structured and systematic process of learning from practice.
- It provides documents to support implementation of the approach.
- The systems model continues to be developed in engineering and health. For child welfare this guide is an innovative and important first step.

Children's safety and welfare are key concerns in all countries, with continual efforts being made to improve child welfare and child protection services. Learning is central to these endeavours so that problems and their solutions can be identified. However, are current learning approaches adequate to the task?

A new SCIE report, 'Learning together to safeguard children' (Fish et al, 2008), presents a 'systems' model of organisational learning that can be used across agencies involved in safeguarding and child protection work. It has been adapted from accident investigation methods used in aviation and engineering and, more recently, in health. It should be considered as a preliminary version for child welfare and the basis on which future developments can build. We encourage people to try it out.

This resource summarises the work. It has four main sections:

- **Section 1** provides background information and explains what the model can help with.
- **Section 2** explains key concepts.
- **Section 3** outlines how to conduct a case review using the model and takes you systematically through the different stages.
- **Section 4** discusses next steps.

In addition, the online appendices provide a set of documents to be used in the review.

1.2 Why do we need new methods of learning?

- The findings of serious case reviews (SCRs) and public inquiries tend to be familiar and repetitive, raising questions about their value for improving practice.
- Similar circumstances in engineering, health and other high-risk industries led to the development of the 'systems approach'.
- This gets to the bottom of why accidents occur and so allows for more effective solutions.
- Academics have demonstrated that the approach also works for the field of safeguarding and protecting children *in theory*. To work in practice, the approach needed to be tested out and adapted.

To date our most public way of learning has been through the investigation of the death of a child from child abuse or neglect. In the UK, as in many other countries, these serious case reviews (SCRs) or public inquiries have been a major influence on the way services have developed (Parton, 2003; Stanley and Manthorpe, 2004; Parton, 2004). However, their value has been increasingly questioned as it has become apparent that they regularly identify the same problems in front-line practice and make similar recommendations (e.g. Dale et al, 2005; Rose and Barnes, 2008).

This situation is remarkably similar to the experience of accident inquiries in other sectors such as aviation and health. In those fields steps have been taken to improve matters through the development of the systems approach. This looks for causal explanations in all parts of the system. Rather than stopping once faults in professional practice have been identified, the systems approach explores the *interaction* of the individual with the wider context to understand *why* things developed in the way they did.

Social work academics have argued the need to appropriate this method in theory (e.g. Munro, 2005; Lachman and Bernard, 2006) but almost no research has been conducted on the feasibility of such a move. The Victoria Climbié tragedy underlined the urgent need to explore alternative approaches. Consequently, SCIE decided to try to adapt the model for child welfare work.

The basics of the approach

The goal of a systems case review is not limited to understanding why specific cases developed in the way they did, for better or for worse. Instead, a case is made to act 'as a "window" on the system' (Vincent, 2004, p 242). It provides the opportunity to study the whole system, learning not just of flaws but also about what is working well.

The cornerstone of the approach is that individuals are not totally free to choose between good and problematic practice. The standard of their performance is influenced by the nature of

– the tasks they perform
– the available tools designed to support them
– the environment in which they operate.

The approach, therefore, looks at *why* particular routines of thought and action take root in multi-agency professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice.

Ideas can then be generated about ways of re-designing the system at all levels to make it safer. The aim is to 'make it harder for people to do something wrong and easier for them to do it right' (Institute of Medicine, 1999, p 2).

1.3 How has the model been developed?

- The model builds on *Managing risk and minimising mistakes* (Bostock et al, 2005).
- It is underpinned by a review of the safety management literature (Munro, 2008).
- Two pilot case reviews were conducted using the systems approach, working closely with two local safeguarding children's boards in England.
- Valuable feedback was provided by staff at all stages in order to adapt the model during the process.
- The experience of these pilots was vital to subsequent fine-tuning of the model.

Taking an approach from a radically different area of work such as engineering requires detailed work to adapt it to children's services. Initial explorations focused on the potential of learning from 'near misses' and culminated in SCIE Report 06, *Managing risk and minimising mistakes* (Bostock et al, 2005).

This second phase of work has been a two-year SCIE project in which the work was reframed as a systems approach and trialled with the cooperation of two local safeguarding children's boards (LSCBs) in England. Two detailed case reviews were conducted and valuable feedback was provided by staff at all stages in order to adapt the model during the process. A scoping review of the safety management literature provided the theoretical underpinning (Munro, 2008) and is available on the SCIE website.

Is this model the same as root cause analysis?

Root cause analysis is a term familiar to health colleagues and others in the UK because it has been 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 we 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.

1.4 What will the systems model help with?

The model can be used:

- in serious case reviews (SCRs)
  ensure that the process is a learning exercise in itself
- in reviews of routine case work
  to understand progress on the implementation of new working practices and accompanying tools (e.g. CAF), and to identify solutions to improve effectiveness
- in the collation of findings from multiple case reviews at a local, regional and national level.

1.4.1 Serious case reviews

Serious case reviews (SCRs) in England and Wales and case management reviews (CMRs) in Northern Ireland form one important sub-category of case reviews and are unique in that they are a specific legal requirement. They are triggered, in the main, by the serious injury or death of a child who had been known to social care services.

There is a good match between the systems model and the English government's Working Together guidance (HM Government, 2006) for SCRs. Both prioritise an analysis of practice that gets behind *what* happened to understanding *why* it did so, in order to understand what changes need to be made to improve safety. The systems model supports the implementation of Working Together guidance by providing local safeguarding children's boards (LSCBs) with an explicit methodology for *how* those conducting SCRs should achieve this aim. It should aid LSCBs and children's services authorities (CSAs) fulfil Ofsted's criteria for positive evaluation of SCRs, particularly by encouraging a transparent, systematic and rigorous process for analysis.

Both Working Together and the Ofsted's inspection criteria also stress the need to conduct SCRs in such a way that the process is a learning exercise in itself and promotes a culture of learning. The systems model also supports LSCBs in this aspect because it is an explicitly collaborative method that encourages open and active participation by workers and so facilitates joint ownership of the review process.

Considerable interest has also been expressed in the approach from other countries with similar child protection systems, particularly those with child death review teams responsible for the equivalent of SCRs. These include states within the USA, Canada, New Zealand, Australia and Germany.

1.4.2 Case reviews of routine practice

SCRs fit well into the systems model but should not be the only cross-agency opportunity for learning from practice. Throughout the countries of the UK, the various services dealing with children are currently undergoing major changes in their goals and tasks, the tools they use and the way they cooperate with each other to improve outcomes for children. In times of such major change in service delivery,

there are particular benefits to using the systems approach to review and learn from routine case work.

The systems model can be used to understand progress on the implementation of new working practices, such as integrated teams, and accompanying tools, such as the common assessment framework (CAF). It helps identify what is working well and where there are problematic areas. Crucially, it can help to identify *why* things are going smoothly so that supportive factors can be protected. It also enables explanations to be found for *why* there are difficulties, so that solutions to improve effectiveness can be found. Usefully, it provides clarity about *where* in the system change can be initiated. Some issues are within the power of LSCBs to address; some may need action on regional or national levels.

1.4.3 The collation of findings from multiple case reviews

The systems model can facilitate the collation of findings from multiple case reviews because it helps to ensure that cases are reviewed (both SCRs and others) in a consistent way. This would aid the drawing of wider lessons from similar findings at a local, regional and national level.

Is the approach about learning from incidents/accidents and 'near misses'?

In engineering and high risk industries, systems analysis is used primarily in accident investigations and to review 'near misses'. In health, similarly, root cause analysis tends to be used for the analysis of so-called 'patient safety incidents' and 'serious untoward incidents' – where things have gone wrong and harm has been, or could have been, caused. However, in child welfare it would be premature, we argue, to use equivalent typologies of error, linked to degrees of harm, as triggers for case reviews or the basis of reporting systems.

Identifying 'incidents' or 'near misses' presupposes consensus about what should have happened and what counts as a deviation, error or mistake on the part of a professional. It also assumes that the link between that deviant action and the potential negative outcome can be reliably made. Lastly, it takes for granted agreement/consensus about the nature of adverse outcomes and degrees of harm.

All these are problematic in the field of child welfare, which involves charting a course between two potentially adverse outcomes – leaving children in danger and causing them and their families harm through intervening – and in which intended outcomes are often long term. Compared with engineering and health, the field is also marked by significant uncertainty. There are far fewer processes where there is consensus on exactly the right way to work with families *in all cases*. There are few instances where one can confidently say 'this is the correct course of action' or 'if I do X then the outcome will be Y'. Practitioners also have relatively little scope to control the whole environment where change is sought. Therefore poor or even tragic outcomes for children and young people may or may not be the result of professional action or omission.

1.5 Who needs to learn and from whom?

- Learning, like safeguarding, needs to be everyone's business.
- This is a system-wide approach, not something only for managers to request that practitioners undertake.
- Front-line workers from different agencies and professions need opportunities to learn about and from each other.
- Senior managers and policy makers need to be open to learning from those at the 'sharp end'.
- In a multi-agency context it is increasingly difficult to predict with any certainty the impact of new policies and guidance, strategic and operational decisions on direct work with children and young people, their carers and families.

Translating current policy aspirations into practice requires learning across boundaries of two different kinds: across agency and professional boundaries, and across hierarchical and management boundaries. It is for this reason that we have titled the full report 'Learning together' – echoing 'Working Together' (HM Government, 2006), the key guidance in England and Wales on multi-agency working to safeguard and promote the welfare of children. If safeguarding is everyone's business, learning must be too, and this includes people at all levels in the system – senior managers and policy makers as well as front-line practitioners.

Integrated professional practice means that practitioners need to have an understanding of the commonalities and differences between their professional patterns of thought and action. Therefore, they need opportunities and methods for learning from and about each other. By including practitioners from multiple agencies and professions in the case review process, the systems approach offers a valuable mechanism for achieving this.

People at a senior management level locally and regionally, and well as policy makers at a national level, also need opportunities and methods for learning *from* front-line workers and firstline managers. With so many agencies with varying priorities interacting, it becomes increasingly difficult to predict with any certainty what the effects of any change to working practices will be. Factors that, on their own, are safe may become unsafe as they interact with other factors both within and between agencies (Axelrod and Cohen, 1999). A practice-led view is necessary, therefore, in order to help highlight for senior management how new policies and guidance, strategic and operational decisions impact on direct work with children, young people and their carers and families. The systems approach provides this.

Section 2: Key concepts and fundamental assumptions

The challenge of escaping our deeply entrenched frameworks for thinking about and understanding multi-agency front-line practice should not be under-estimated. This was a key learning point from our pilot case reviews. As we all tend to interpret new material in terms of familiar ideas and concepts, it is easy to misunderstand the fundamental nature of the change in moving to a systems approach and, therefore, to misapply the model. Consequently, it is important to explain the key concepts of the model before moving on to describe the process of putting them into practice.

2.1 Underlying patterns of systemic factors contributing to good or problematic practice

- Good or problematic practice may, on the surface, look different in different cases, but the sets of underlying causes may be the same.
- Reviewers need to identify these 'patterns' of systemic factors that contribute towards good or poor quality work.
- They can be either constructive patterns of influence or create unsafe conditions in which poor practice is more likely.
- We have developed a six-part typology of such patterns for child welfare. As more systems reviews are carried out, recurrent issues within each pattern will be identified.

A systems approach uses a particular case as a window on the whole system. This means that the review process does not stop once the multi-agency practice in the case has been analysed. The context-specific details of good and problematic practice identified in the case are considered only the outward signs of underlying patterns of influence on practice. While the surface characteristics may be unique to a particular case, the assumption is that the generic patterns reappear in many situations. It is these patterns that need to be identified. They can be either constructive or create unsafe conditions in which poor practice is more likely.

Building on the work of Woods and Cook (2001) we have developed a six-part typology of patterns relevant to child welfare. Each highlights interactions involving specific elements of the system. In practice, however, the categories are not rigidly distinct but overlap. As more systems reviews are carried out, a more detailed typology of recurrent issues within each pattern will start to evolve. Examples of these from our pilot case reviews can be found in Appendix 6 (online).

Summary of six-part typology of generic patterns of systemic factors

1 Human–tool operation
e.g. the influence of assessment forms

Frameworks for the assessment of need and associated electronic and paper forms, such as those for the initial and core assessment and CAF form, and databases such as the Integrated Children's System, are all tools. Instead of being seen as passive objects that help professionals do the same tasks as before but better or

faster, they actually alter the nature of the task the human does. It is important, therefore, to find out how people and tools 'interact with each other and, over a period, change each other in complex and often unforeseen ways'(Hood and Jones, 1996) and examine whether these changes improve or hinder practice.

2 Human–management system operation
e.g. resource–demand mismatch

Management systems include resourcing issues, performance management and associated indicators, as well as particular styles and content of supervision. They are explicitly designed to influence practice. A systems approach can help highlight for senior management *how* they impact on direct work with families. This includes highlighting trade-offs that staff feel they are being encouraged to make between competing goals, such as completing a thorough assessment of a child and meeting the prescribed timescale and linked performance indicator.

3 Communication and collaboration in multi-agency working in response to incidents/crises
e.g. referral procedures and cultures of feedback

In our case reviews, we found that agencies tend to work relatively well together in crises where they are all using the same, well-established guidance in Working Together.

4 Communication and collaboration in multi-agency working in assessment and longer-term work
e.g. understanding the nature of the task; assessment and planning as one-off event or on-going process?

In day-to-day work, the differences in the roles and responsibilities of different agencies in relation to different members of the family produce very varied patterns of working together. It is important, therefore, to distinguish the two.

5 Family–professional interactions
e.g. salience of the mother in social care involvement

Child welfare professionals do not just act on but interact with the people they are trying to help, and social and emotional interactions shape the nature of the work. A techno-rational approach tends to overlook the significance of the specific relationship a worker forms with parents and children and how this affects what information they receive, how they interpret it, and how they use it. Yet analysis of child abuse inquiries has revealed the powerful impact of the relationships, often in a destructive way (Reder et al, 1993; Reder and Duncan, 1999).

6 Human judgement/reasoning
e.g. failure to review judgements and plans

Designing a safe system means taking into account people's psychological limitations and typical human errors of reasoning and then building in strategies for detecting and

correcting these. One of the most common, problematic tendencies in human cognition, for example, is our failure to review judgements and plans - once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture.

2.2 Local rationality

- 'No practitioner intends to make mistakes' (Woods, 2003).
- We need to understand how limited knowledge (missing knowledge or misconceptions), a limited and changing mindset, and multiple interacting goals shaped the behaviour of people in the evolving situation (c.f. Woods and Cook, 1999)
- The relevant question is: how did the situation look to the practitioner so that the action chosen seemed like the sensible thing to do at the time?

A key assumption in a systems approach is that human behaviour is fundamentally understandable: even actions or decisions that later turned out to be mistaken or to lead to unwanted outcomes, at the time seemed sensible. It becomes important, therefore, to try and avoid hindsight in reviewing professional practice. Instead, a key task is to reconstruct how people were making sense of an evolving situation. This is referred to as their 'local rationality': how the situation looked to someone *at the time*.

What the world looked like for each person involved will differ according to various factors including:

- what information was available to them
- what was capturing their attention
- what bodies of knowledge and experience they drew on to make sense of things
- the goals they were trying to achieve
- the conflicting priorities they were juggling.

2.3 Conversations

- Understanding people's 'local rationality' requires talking with them.
- 'Conversations' describes these meetings better than 'interviews'.

A formal, fact-finding interview of the pseudo-legalistic kind is not well suited to the task of trying to see what the world looked like through someone else's eyes. Consequently, we have chosen not to use the term 'interview' in order to avoid the wrong connotations. Speaking instead of 'conversations' highlights that one of the main aims is to identify, respectfully, the approach taken by the person.

Where do children and families fit?

Jake Chapman memorably said that 'One can "deliver" a parcel or a pizza, but not health or education' (Chapman, 2004, p 10). The same is true of safeguarding services, because achieving good outcomes requires the constructive engagement of the intended recipients. Children and young people, and their parents and carers, therefore, need to be seen as active participants *within* the system, not outside.

SCIE's earlier work (Bostock et al 2005) indicated that involving young people and parents would be less problematic than practitioners might otherwise imagine. Services users in the study wanted an open approach to learning from mistakes and were happy to help prevent the same thing happening to other people even if there was no direct benefit to them. They also generally understood, and were sympathetic to, the pressures that social workers were under.

Much of the systems literature stresses the need to understand and value front-line workers' perception of events and processes, but there is comparatively little detail relevant to facilitating the involvement of families. Practical issues remain about exactly *how* parents and children are best involved. Regrettably, we have not been able to develop this aspect of the model because, despite our initial intentions, we were not able to involve parents or children in either pilot case review. This should be part of the next stage of development of the model.

2.4 Narrative of multi-agency perspectives

- Different professionals will inevitably have something of a differing view of a case.
- Getting to understand the 'why' questions about multi-agency working requires capturing these different multi-agency perspectives.
- A usual 'chronology' is not helpful because it presents a unitary account and so tends to erase differences;
- A more novel-like structure better captures a diversity of perspectives or multiple narratives.

Another assumption is that it is 'a major fault to assume that we all share the same picture of reality' (Gano, 2003, p 60). The nature of different agency involvement with families and the nature of different roles within agencies mean that there will invariably be a diversity of perspectives, although the differences can range from slight to radical.

It therefore becomes important to move beyond the basic factual detail of a case, of the kind usually captured in a chronology – the facts of the child and family's history and the contacts with, and interventions by, different agencies. Instead what is required is to document and coordinate the different local rationalities of individuals and agencies. This involves establishing not a single story but a set of multiple and differing perspectives.

2.5 Key practice episodes

- This describes significant episodes that require further analysis.
- They can include particular actions/inactions or can extend over time.
- They can be good or problematic.
- They are only a selection.

Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term 'key practice episodes' to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects.

2.6 Contributory factors

- Contributory factors include all the possible variables that make up the workplace and influence practice.
- They are *not* just policies, procedures and protocols, but include 'softer' factors such as team and organisational cultures.

The review team needs a sufficiently detailed picture of the circumstances of the key practice episodes to help with the task of identifying 'contributory factors'. These include *all* possible variables that make up the workplace and influence performance (not just 'Are the right systems in place?'). They include the more tangible systems factors such as policies, procedures and protocols and tools and aids, working conditions, resources and so on, and also more nebulous issues, such as team and organisational 'cultures' and the covert messages that are communicated and acted upon.

Drawing again on the work of Vincent et al. (Taylor-Adams and Vincent, 2004), we have developed a single framework of contributory factors relevant to child welfare work. These are divided into three different levels reflecting where in the child welfare system they originate: front-line, local or national.

Summary of framework for contributory factors

- Front-line factors:
  - aspects of the family
  - personal (staff) aspects
  - aspects of the role
  - conditions of work
  - own team factors
  - inter-agency/inter-professional factors
- Local strategic level factors:
  - organisational culture and management
  - resource allocation
- National/government level factors:
  - political context and priorities

Further details for each category are provided in Appendix 5 (online).

Is there no accountability? What about the 'bad apples'?

The systems approach is sometimes called a 'no blame' approach but a better description of the objective is the development of 'an open and fair culture' (Vincent, 2006, p 158) in which decisions about culpability are more nuanced. This does not forgo recognition of personal responsibility or accountability.

What the approach highlights is that holding a particular individual or individuals *fully* responsible and accountable is often highly questionable because, typically, incidents arise from a chain of events and the interaction of a number of factors, many of which are beyond the control of the individual concerned. The difficulty lies in deciding where the boundary lies or what degree of culpability an individual carries within a faulty system. The UK National Patient Safety Agency has done some work on this problem.

There is, however, nothing inherent in the model to prevent the recognition and identification of, for example, cavalier or malicious practice where there was either a blasé attitude to whether harm resulted or the causing of harm was intended.

Section 3: Putting it into practice

The success of the systems approach depends on translating into a logical process all the aspects of the theory described in Section 2. How to apply the model that we have developed is described in detail this section, but this summary of the process acts as a quick reference guide and shows accompanying tools that are available in the appendices (online).

Summary of aspects of the process and accompanying tools

	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	

3.1 Attending to the quality of process: demonstrating a respectful attitude toward practice and acknowledging uncertainty

- A respectful attitude towards practice is fundamental to the systems approach.
- This includes acknowledging the lack of categorically right and wrong decisions and the prevalence of uncertainty.
- To reflect this we suggest speaking of good and problematic practice and only a careful use of the words 'error' and 'mistake'.

The systems model is a collaborative one. The review team should be aiming to make the review process as much of a joint exercise as possible. Those directly involved in the case under review, from across all agencies, need to be centrally and actively

involved in the analysis. The quality of the learning depends largely on the extent to which participants can engage openly in the process. Consequently, reviewers need to take a fundamentally respectful approach to practice experience.

Compared with engineering and health, the knowledge base of child welfare work is less developed. Much of the decision making is 'moral and contestable' (Taylor and White, 2006, p 945). There are very few clear-cut standards of 'correct' performance that hold for every single child and family in every circumstance: 'There will be some instances in which the "right" answer is clear, but there will be many others where a number of different actions could plausibly be followed, the "rightness" of which may only be retrospectively obvious (Taylor and White, 2006, p 938). In recognition of this we suggest that reviewers use only a limited use of the language of error and mistakes, and talk also of good and problematic practice.

3.2 Preparation

3.2.1 Identifying a case for review

- A review should be initiated to answer a particular question or questions.
- Those questions should not be restricted to understanding why harm has been caused to a child and how it could be avoided in future.
- Curiosity can usefully be focused on a whole range of practice issues.
- There are good reasons to focus on routine practice, practice that practitioners and/or families are happy with and innovations that seem to be working well.

There needs to be a reason for conducting an inquiry or case review regardless of the method of learning used – some curiosity to answer some question. However, the reason does not need to be a specific adverse event happening to a child. It can just as well be:

- recognition of the level of neglect a child is suffering and questioning why it was not noticed sooner
- a decision to remove a child and querying whether this was appropriate and/or timely
- noticing that the family has not changed significantly in a number of years so wanting to re-think how the case is being handled
- surprise at the way a case has developed and wish to understand if anything had previously been overlooked or should have been done differently.

A review triggered by a case considered to represent routine or normal practice can give a deeper picture of how the system is operating to support front-line workers. One featuring new working practices or innovations, for example addressing parental mental health, can contribute towards an evaluation of their effectiveness. Given the 'deep negativity' that surrounds the social work profession in particular, 'whereby few have a good word to say publicly about it' (Jones et al, 2007, p 1) there are also good reasons to highlight cases involving multi-agency working that professionals and families feel positive about. To what extent do these indicate robust systems or involve chance elements?

3.2.2 Selecting the review team

- A systems review requires a team not just one person.
- Knowledge of the key professions involved can be beneficial.
- Outsider status can help workers engage openly in the process.

The systems case review should be carried out by a team of people. The amount of work involved is likely to be too much for any one individual and the critical dialogue between team members is vital to the quality of the analysis and learning. The team should reflect the key professions involved in the case under review. In our pilots, workers' active and open participation seems to have been aided by our independence from the organisations whose practice was being reviewed.

SCIE's model is not premised on the two-part process stipulated for SCRs whereby individual management reviews (IMRs) are undertaken by each relevant service and subsequently brought together by an independent person commissioned in an overview report.

3.2.3 Identifying who should be involved

- People involved in the case include both workers and family members.
- Without family members key perspectives will be missed.
- Identifying the professionals whose roles and contributions were most significant may only be obvious over time.
- It is important to include managers, supervisors etc., not just those who had direct contact with the family.

Ideally, all personnel involved in the case, or part of the case, under review should be involved in the review process. This includes both workers and the members of the family themselves. Research suggests involving the family is possible but this is under-developed in the present model.

Ideally, all personnel from whatever sector and/or agency and at all levels within organisations should be involved in the review. However, as the majority of cases run over a significant period of time, this will often not be realistic. Consequently, judgement is required as to whose roles and contributions were most significant. This is not necessarily self-evident at the beginning of the review, but instead can emerge gradually over time. It is important to try to identify staff who were seen as key by members of the family as well as by professionals. It is useful to involve staff and family members themselves in this process.

Given their management roles and responsibilities related, for example, to supervision, budgets and performance indicators, it is important to include significant first-line managers and not only the staff who had worked direct contact with the family.

3.2.4 Preparing participants

- Participants need a detailed introduction to the approach.

- A face-to-face meeting is recommended.
- The requirements for confidentiality must be made clear.

It is vital that participants are given a thorough introduction to a systems approach before the case review begins. Otherwise it would be difficult for them to participate actively. In the pilot case reviews we initiated contact with participants using an introductory letter (see Appendix 1 online).

Subsequently, an introductory meeting in which participants can meet the review team face-to-face is recommended. The aim of this is to ensure that they understand the aims of the approach, what it entails and the part they are being asked to play. It also serves to demonstrate in a very tangible fashion the nature of the relationships and dialogue with participants that the review team wants to develop. It can also serve to foster the beginning of a group identity and, therefore, the possibility of joint ownership, across agencies, of the review process and findings.

Confidentiality

It is crucial at an early stage that the review team clarify and reassure participants about the priority given to learning over blaming in the systems approach. Organisational backing for this stance also needs to be concretely stated and details about confidentiality clarified.

As a collaborative approach involving a multi-agency group of workers the review team cannot guarantee to keep everything that all individuals tell them confidential. Interim and draft final reports, for example, will draw on the content of individual conversations and need to be shared and discussed with the group. It is important, therefore, that all draft reports remain confidential to participants in the review team and are not, for example, shared with other staff or managers from the participating agencies.

In final reports that might be made public, geographic identifiers should be removed, professionals referred to only by their role and the family by pseudonyms.

3.3 Data collection

There are two important sources of data relevant to a systems investigation – the written records of different agencies and conversations with key staff, service users and carers. Reviewers need continually to be comparing the data from these different sources, so that each helps to make sense of the other – critically appraising documentation in light of participants' narratives as well as further questioning staff about their narratives in light of information the documentary sources reveal.

3.3.1 Selecting documentation

- Documentation forms the formal record, but access may be restricted.

- Records provide checks on accuracy but also insights into cultures of communication and how tools are shaping practice.
- The order in which formal records and one-to-one conversations are accessed is arbitrary; each brings its own bias.

Records provide the formal account of professional involvement. In an SCR, access to these documents is legally permitted. In other contexts, access may be restricted, with a consequent limiting effect on the analysis of practice. These written documents provide essential details but are necessarily and intentionally selective and, therefore, incomplete.

Documentation provides a vital check on the accuracy of the basic factual details of the case. People's individual accounts are likely to be influenced both by lapses in memory and in being remembered through the filter of knowing what happened later in the case. Separate agency sources also provide a check on accuracy of any one, thus identifying gaps or mistakes in understanding that need to clarified.

Documentation can give significant insights into the cultures of communication both within and between sectors. It can highlight what is included and what becomes written out of the formal record, and to what effect. It can give an indication of how tools are actively shaping practice through the ease or difficulty review team members have in making sense of the information contained (c.f. White et al, 2008, p 12).

Reviewers can choose whether to examine the multi-agency documentation before conducting conversations with participants or vice versa. Each will bring its own biases because what you see as significant depends on what you have already found out. New information will continually come to light against which you have to rework your developing overview and analysis. You may realise that you have omitted an important data source, be it document or person, or that you have incomplete information from a particular data source because certain questions and issues have only just become apparent and therefore could not have been explored earlier. Consequently, there will often be the need to return to both participants and documentation in order to follow up. For some individuals, a second conversation may be necessary.

3.3.2 One-to-one conversations

- Conversations provide the essential viewpoints of the people involved.
- We have developed a structure for the conversations, but this can be used flexibly to guide the discussion.
- The style of engagement should be relaxed and the conversation conducted with genuine curiosity and respect.
- We found it advantageous that the same two members of the review team conduct all conversations.
- A written record of the conversation is essential.

One-to-one conversations are essential because they provide the data that allows us to build a picture of how things looked to the people involved, at the time they were

involved. For this reason, the conversation begins with a narrative account of the person's involvement, unstructured by the interviewers. Participants are then asked to identify key practice episodes which they believed influenced the way the case developed. Referring to the list of 'contributory factors' from various aspects of the wider system, described earlier, the person is then encouraged to consider why they acted as they did.

It is particularly important that the style in which conversations are facilitated should be relaxed and conversational and demonstrate genuine curiosity, openness and respect. If we are asking participants to trust us enough to speak to us in detail about the intricacies of their involvement, we need to respond in such a way that shows we are indeed worthy of such trust.

We found that it is better not to give rules as to how participants should prepare for these conversations. This allows people to bring their own approach and professional or personal norms, which become a further data source, throwing light on both individual and sometimes wider team cultures e.g. relating to the value of paperwork. An excerpt from the letter we sent to participants concerning the conversations forms Appendix 2 (online).

Conversation structure summary

1 Introduction
2 Hearing their story/narrative
3 Identifying turning points or 'key practice episodes'
4 Clarifying their 'local rationality'
5 Discussing contributory factors
6 Highlighting things that went well
7 Their ideas about useful changes
8 Summing up
9 Reflections on conversation process

A more detailed version of the conversation structure can be found in Appendix 3 (online).

Two members of the review team should take part in the conversations. This allows one to take the lead in listening and taking notes, recording 'subtle points that may otherwise be overlooked' (Taylor-Adams and Vincent, 2004, p 11), with the other taking the lead in responding and asking questions to get the participant to elaborate or to prompt their thinking.

We also learnt that there are significant benefits to the same two people facilitating all the conversations. This allows for the overview of the case to be developed more quickly in the course of successive conversations and, consequently, overlaps and discrepancies to be pursued in the course of conversations, thereby minimising (thought not eradicating) the need for follow-up later.

Some form of written record or transcript of the conversation is essential. We learnt from the pilots that shortcuts, such as filling in a data extraction form straight after

a conversation, are likely to be too distorting because they will reflect our picture of the case at the time so omit what might be crucial counter-evidence.

3.4 Organising and analysing data

3.4.1 Producing a narrative of multi-agency perspectives

- The conversation structure organises the data so that the review team can draw together the differing accounts of the history of the case.
- Reviewers must be transparent about their sources of evidence, whether documentation or conversation.
- Gaps and disputes need to be highlighted.

The conversation structure creates an initial organisation of the data. This helps the review team reconstruct the differing accounts of the history of the case. Drawing together these potentially disparate narratives is a critical part of the working method. Reviewers need to continually manage the recurrent tendency to want to assert what really happened, or the reality of the situation.

As data is organised, it is important to identify where descriptions come from. This includes noting where key perspectives are missing and where information is unavailable. Any significant discrepancies between sources also need to be highlighted. The review team's own judgements or responses to participants' narratives should be kept separate.

3.4.2 Identifying key practice episodes and their contributory factors

- The narrative of multi-agency perspectives contains various episodes that participants identified as key to the way the case developed or was handled.
- The review team need to judge the adequacy of practice in these episodes.
- They then need to identify contributory factors which meant that the practice contained seemed sensible or the right thing to do at the time.

From studying the official records and conversations with participants, the review team can then identify a number of key practice episodes within the narrative. These then need to be analysed in more detail to identify their contributory factors.

The selection of key practice episodes draws strongly on participants' views of what episodes were significant but also requires the review team's judgement. The review team needs to be explicit and transparent about the significance of the episodes selected – how each influenced or might have subsequently influenced actions and decisions and the way the case was handled. Ultimately a judgement needs to be made on how a particular episode was linked to outcomes for the child(ren) and family. This will involve the use of hindsight and by looking beyond the individual episode to the wider picture of the case as a whole. Each episode should be briefly described, keeping as close as possible to participants' accounts.

Secondly, the review team need to comment on the adequacy of the judgements and decisions that make up each particular episode. It is helpful, for example, to consider

what information was or should have been used to inform the process. The review team needs to consider how the using, or ignoring, of available information actually influenced, or potentially might have influenced, subsequent episodes. We found that each key practice episode tended to include both good and problematic elements of practice. As opposed to a one-off judgement, therefore, it proved more useful to break the episode down into smaller constituent parts and make judgements of each part explicit.

The final aspect involves identifying contributory factors from across the various participants' accounts.

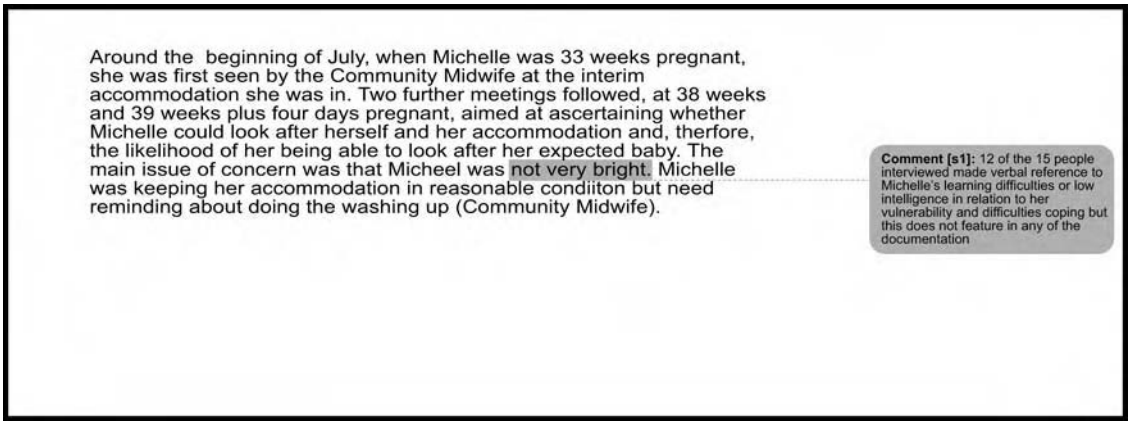
3.4.3 How to record the analysis on paper

- A multi-stranded narrative requires a flexible form of recording; a standardised framework would obscure the choice and judgement involved.
- Microsoft Word's 'comment' function and tabular formats have proved useful tools.

Abandoning the single storyline of a chronology means that decisions are required about how to present the differing perspectives in a way that helps the reader understand the ensuing analysis of practice. We do not offer a standardised framework for structuring different perspectives in a case review. A standardised or preferred model would make it easier to compare across a range of case reviews and readers would become familiar with the layout. However, it would obscure the fact that there are always other possibilities and that the one finally chosen inevitably reflects aspects of the interpretation of the case.

In our pilots we experimented with using the 'comment' function in Microsoft Word to mark emerging questions and issues as we put together the multi-agency narratives. This proved useful and is illustrated below. It helped to keep judgements separate from renditions of people's 'local rationalities'. It also encouraged us to make our own input explicit.

Use of Microsoft's 'comment' function – an example



To record the description and analysis of key practice episodes and their contributory factors we developed a table; this is reproduced in Appendix 4 (online). In comparison with the narrative alternative, we found this format made the distinction between the different parts of the analysis clearer. Listing the contributory factors aided clarity and repetition across different episodes stood out strongly.

3.4.4 Reviewing the data and analysis

- There is no absolute truth about a case and putting together the various accounts requires interpretation by the review team.
- Participants provide a vital check on basic accuracy of the facts.
- They also need to validate the prioritisation of issues by the reviewers.
- Draft reports need to be shared for comment and group discussion meetings need to take place.

Neither data source provides a reliable, consensus view. The documentation of different agencies may conflict in the basic factual details presented or they may provide a very different focus. Similarly, interviews reveal how people's different reasons for involvement lead them to focus on different aspects of the family. Putting together the various accounts involves a degree of interpretation by the review team. It is therefore important that reviewers check their work with participants. This includes the accuracy of the adapted chronology, key practice episodes and contributory factors. It also entails getting feedback about the appropriateness of the review team's emerging analysis of key themes. Have any key details and/or connections have been overlooked?

Checking can be done by sending draft reports to participants for comment as well as holding group discussion meetings. This is likely to produce some corrections or challenges to the review team's interpretation and also some valuable additional insights. These inputs should feed into subsequent drafts of the report. In our pilots we used a three-staged process of dialogue between the review team and participants as detailed below.

Suggested stages of the dialogue with participants

1 **Preliminary report**
  Individual comment
  Preliminary group meeting
2 **Interim report**
  Individual comment
  Interim group meeting
3 **Final draft report**
  Individual comment
  Closing meeting

Creativity and innovation is required in terms of the content and structuring of these different reports or meetings. The review team needs to think about how they can best facilitate these exchanges and be as flexible as possible about the way they accept feedback from participants on draft reports.

In our pilot sites, we held group discussion meetings over lunchtime that ran for two hours. We were delighted with the turn-out to meetings in both sites. People's willingness to come seemed to indicate that the meetings served an important function in making concrete their joint ownership of the process.

3.4.5 Identifying and prioritising generic patterns of systemic factors

- The deeper analysis of data identifies underlying patterns of systemic factors that either support good practice or create unsafe conditions in which poor practice is more likely.
- This involves categorising types of systems issues in non-case-specific language.
- Not all patterns can be covered so selection is necessary.
- Different patterns will stand out to differing extents for different people so debate is necessary. There is no magic formula.

Once the multi-agency practice in the case has been analysed, the reviewers need to bring some deeper analysis to the varied and repeated practice episodes and their contributory factors that have been identified. This involves moving from context-specific data to identifying the underlying patterns of systemic factors that are either contributing to good practice or making problematic practice more likely. The six-part categorisation of types of patterns are useful here:

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

These can be used to prompt reviewers' thinking and to organise the data into non-case-specific language.

In one of our pilot case reviews, for instance, there were several occasions in which social care had presented, and other agencies had accepted, assessments as comprehensive and definitive, rather than seeing them as ongoing works in progress linked to a clear plan that could be evaluated. This raised concerns that, across agencies, assessment was not seen as a continuous dynamic process but as a discrete stage with a service user. The underlying pattern identified here was one of human–tool operation, specifically the influence of the case management framework assessment, planning, implementation and review (APIR). Under this framework, assessment has a fixed box in the flow chart and review similarly, but falling towards the end of an intervention. So even though written guidance mentioned the need to review and add to assessments, the basic picture had already been set so that revision became an interruption in the flow of practice. Input from the participants suggested that the APIR framework encouraged 'review' to be understood as checking whether a plan had been implemented and not whether it had been

effective, or whether, in the light of new information about the family, it was still the appropriate plan.

Any case review is likely to lead to the identification of numerous different patterns of systemic factors that either support good practice or create unsafe conditions in which poor practice is more likely. Trying to cover everything runs the risk of losing the most important in the blizzard. Judgement is therefore required to prioritise the most important. Reviewers should take into account:

- how widespread the issues are beyond the particular case under review
- their contemporary relevance, i.e. their importance for the future safety in providing children's services.

Far from being a neutral and objective enterprise, different issues are likely to stand out to differing extents for different members of the review team and for different participants. For example, Woodcock and Smiley's (1998) study found that the more senior the position of the safety specialist, the more likely they were to focus on front-line issues as opposed to systems issues emanating from further up the hierarchy. This variation between participants underlines the fact that this stage is (a) creative and (b) dependent on good background knowledge of the area.

There can be no mechanical process for formulating deep causes or prioritising them. Therefore, it is crucial to ensure both sufficient methodological consistency and transparency at this stage. A key element of this, we suggest, is recording sufficient detail of the analysis of the whole case in order that the basis from which patterns have been selected is accessible and, in principle, alternative selections can be made.

3.4.6 Making recommendations

- Not all recommendations can be immediately 'SMART' (Specific, Measurable, Achievable, Realistic and Timely).
- Our pilots suggest that three different kinds of recommendations are usefully distinguished: clear cut; requires judgement and compromise; needs further research.

Identifying the underlying patterns shows what issues need further exploration. It starts to shape ideas about ways of maximising the factors that contribute to good performance and minimising the factors that contribute to poor quality work.

A key lesson from the pilot sites has been appreciating the importance of recognising the difference between the overt and the covert organisational messages. Workers tend to be strongly influenced by the covert messages and, unless these change, efforts to alter practice are unlikely to be successful. One example was the perceived priority given to through-put over the quality of work, with staff reporting strong covert messages about the importance of meeting performance indicators relative to doing what was necessary to meet a specific child's needs. Allowing assessment forms to be classed as 'completed' when they had serious deficiencies was one example of how such pressure was acted out.

Our pilots also suggest that it helps to distinguish three types of recommendations. First, there are those patterns for which there are clear cut solutions that can be addressed at a local level and are, therefore, feasible for LSCB member agencies to implement. An example is creating a consistent rule across agencies of when and why to copy in someone to a letter rather than addressing the letter to them directly. In this instance it matters less what the rule is and more that there is one and that it is adhered to consistently.

Secondly, there are recommendations that cannot be so precise because they will highlight weaknesses in practice that need to be considered in the light of other demands on and priorities of the different agencies. This is a task more properly done by the senior management than the review team. An example would be when greater attention in supervision to detecting errors in reasoning requires more time allocated to the critical review aspects of the supervisory role. Can that be obtained by cutting back on some other tasks? How will the agency manage time differently?

The third category of recommendations relates to practice issues that need detailed development research in order to find solutions, although those solutions might then have wide relevance to children's services. For example, difficulties in capturing risk well when completing core assessments indicates a need to research how widespread this problem is and, if necessary, experimentation with alternative theoretical frameworks, structuring and formatting of forms and possibly software.

Summary of three different kinds of recommendation

1 Issues with clear cut solutions that can be addressed locally and by all relevant agencies.
2 Issues where solutions can not be so precise because competing priorities and inevitable resource constraints mean there are no easy answers.
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.

Section 4: Next steps

- There seems to be a high level of interest in the systems approach.
- SCIE can offer:
  1 to meet with LSCBs individually or at regional meetings to present and discuss the model and its implementation
  2 to put people in touch with the consultants who were involved in piloting and developing the model
  3 to facilitate the creation of a community of practice network to enable people to sharing their experiences of using of the approach and build up the knowledge base.
- We encourage people to get in touch

SCIE has received a high level of interest in the systems approach. Some LSCBs have already used the method of their own accord. Others have been in touch because they are interested in using the approach, but need further information and help with putting it into practice.

SCIE is happy to offer advice where possible by meeting with LSCBs individually or in regional groupings to present and discuss the model and its implementation. We can, where appropriate, also put people in touch with the consultants who have been centrally involved in this work.

We stress again that what we have presented are important first steps in the development of a systems model for child welfare. There is an urgent need for a shared mechanism for learning from each other in the use of this model in order that it can be further developed. Consequently, SCIE is keen to identify interested parties both nationally and internationally and broker a simple community of practice network. We therefore encourage people to get in touch.

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Appendix 1 Introductory letter for participants

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Dear colleague,

Someone from your team or organisation may have spoken to you about the plan to conduct a case review of [*fill in relevant details*]. With this letter, we would like to take the opportunity to give you a brief summary of the approach that is going to be taken and the role that we would like you to play.

The approach

In this case review we are going to use a new method called 'systems analysis'.

This sort of review process will be familiar to Health colleagues but applying a systems approach to safeguarding work is still a relatively new endeavour. Up till now, any review of cases had tended to take the 'bad apple' approach, which focuses on blaming the 'bad apple' individual for mistakes and failures.

A systems approach concentrates *not* on judging people's work. Instead, by taking account of the situation they were in, the tasks they were performing, and the tools they were using etc, it focuses on understanding *why* someone acted in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. Importantly, it also highlights what is working well and patterns of good practice.

Traditional 'bad apple' approach	Systems approach
Human error is the cause of accidents	Human error is a symptom of trouble deeper inside the system
To explain failure, you must seek failure	To explain failure, do not try to find where people went wrong
You must find people's inaccurate assessments, wrong decision, bad judgements	Instead, find how people's assessments and actions made sense at the time, given the circumstances that surrounded them

Your role

The experiences and perspectives of people like yourself, who were directly involved in this case, are central to a systems review. The review is, therefore, very much a joint venture which we hope you will take an active part in.

We would, therefore, like to invite you to talk with us about the case on a number of different occasions. Details of the most immediate meetings are given below.

INTRODUCTION TO SYSTEMS ANALYSIS

On [*fill in relevant details: date; place*], [*fill in relevant details: name]* will be giving an introduction to systems analysis. We then hope to discuss plans for using this method in relation to the case we are reviewing. This will include one-to-one conversations with everyone involved in the case, as detailed below.

ONE-TO-ONE CONVERSATIONS

The purpose of this conversation is to ascertain how you understood the situation at the time, how you understood your role or the part you were playing in the case and your perspective on what aspects of the whole system influenced you as a worker. We hope to be able to arrange a time to have this one-to-one talk some time in [*fill in relevant details: month*], during the initial meeting. Conversations will take up to one hour and a half. FEEDBACK MEETINGS

A joint meeting of the review team and all the people involved in the case after individual conversations have taken place will be arranged at a later date.

Organisational backing

The use of the systems approach has the full backing of the local safeguarding children board and the agencies to which they are accountable. The LSCB has agreed that this process is NOT about blame and disciplinary action, but about an open and transparent learning from practice, in order to improve inter-agency working. The board has actively promoted the 'no blame' premise of this work. Chief officers of all agencies have been informed and are in agreement.

Staff can, therefore, be confident they will not be penalised for taking part in this project. In formal terms, the thresholds for disciplinary action have been raised for the sake of learning. If serious malpractice were to emerge in the course of the review, then disciplinary procedures would, of course, come into play.

We very much look forward to working with you in this exciting project. If you have any queries then please do not hesitate to contact one of us.

All the best,

[*fill in relevant details: names of review team*]

Appendix 2 Communication with participants re one-to-one conversations

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ONE-TO-ONE CONVERSATIONS

We will be contacting you shortly to try and arrange a time to talk with you one-to-one about the case. The main purpose of this conversation is to get your view of what was going on in and around this case, how you understood your role or the part you were playing and your perspective on what aspects of the whole system influenced you as a worker.

It is also a chance for us to share with you something of our emerging overview of the case so that together we can begin explore any differences between your own view and other accounts that we have been told. Sharing the wider picture of the case as a whole also gives us the opportunity to explore together the merits and limitations of your judgements and actions. As we explained previously, discussing differences of opinion and judging the adequacy of people's judgements and actions is not about criticising or blaming anyone. Instead it is a necessary step in order that we can better understand what factors in the work environment support or hinder you in doing a good job.

CONFIDENTIALITY

What you and others tell us during this conversation is vital data. So we will refer to it in our interim and final report, as well as various draft versions of the final report. Other participants will have the chance to read and discuss these reports. So we are asking everyone to keep them confidential *within* the group and *not* to share them with colleagues or managers who are not directly involved.

We will not be using your name in either of the reports. We will need to identify you but only by your position and in the public report there will not be any mention of geographic location, so no one should be able to identify you. The family will be referred to by pseudonyms.

We are going to be recording our discussion in order to take data from it for analysis but once that is done the recording will be destroyed.

Appendix 3
Conversation structure summary

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1.	Introduction	– Purpose of the conversation – Confidentiality and ethics – Outline of the structure
2	Overview	– a brief description of what happened in this case and the part you played
3a	'Turning points' or 'key practice episodes'	– What do you think were crucial moments in this sequence, when key decisions or actions were taken that you think determined the direction the case took or the way the case was handled?
3b	'Mindset' and 'local rationality'	– What did you think was going on here? – What was behind your thinking (reasons but also emotions) and actions at the time? – What information was at the front of your mind? What was most significant to you at this point? What was catching your attention? – What other things were occupying you at the time? – What were your main concerns? What were you tossing up at the time? Did these concerns clash at all? Were there any conflicts? Were some dismissed, others prioritised? – What were you hoping to achieve? – What options did you think you had to influence the course of events?
4	Contributory factors	What were the key factors that influenced how you interpreted the situation and how you acted at the time? In what ways? Prioritise aspects that were most significant. – Aspects of the family – Aspects of your role – Conditions of work/work environment – Personal aspects – Your own team factors – Inter-agency/inter-professional team factors – Organisational culture and management – Wider political context – Other

5	Things that went well	– What things relating to the case went well? – What do you think you or others did that was helpful/useful? And what factors supported/enabled it?
6	Queries from the overview perspective	
7	Suggested changes	Off the top of your head, having thought back on this case and your role, are there are any small, practical changes that you can think of, that would help you/ staff do a better job?
8	Summing up	– Have we got your view of the case?
9	Reflections	– How have you found this session? Do you have any comments or questions? – How do you feel now, about yourself and your role, after this discussion?

Appendix 4
Table of key practice episodes

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Suggested layout for table of key practice episodes and contributory factors		
Description of key practice episode and significance with hindsight	Breakdown and reviewers' judgement of adequacy of practice	Contributory factors (why did actions/decisions make sense at the time?)

Appendix 5
Framework for contributory factors

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Factor group according to level/location	**Factor types**	**Contributory influencing factor**
FRONT-LINE FACTORS	aspects of the family that influenced a worker's thinking about a case and action	• Nature of the problem(s) – complexity and/or seriousness and availability of suitable services; strength of knowledge base/level of professional consensus on diagnostic categories and possibilities • Duration of problems; well known to services or not • Problems as self-identified and/or designated a problem by others • Manner of problem presentation – help seeking help or hostile • Willingness to engage • Nature of relationship between professional and family member(s) • Availability for meeting • Number of children • Size of family; no. of significant adults involved • Complexity of family dynamics • Communication issues and language • Personality • Social factors, history • Gender • Age • Sexuality • Ethnicity
	personal (staff) aspects	• Knowledge, skills and expertise • Mindset • Human reasoning • Attentional factors (what were they doing when they weren't doing something else) • Illness, tiredness, burnout etc,. leading to their not being able to work to optimal standards • Motivation • Personality • Social factors – history • Interactional style

Factor group according to level/location	**Factor types**	**Contributory influencing factor**
	aspects of their role	• Frequency of contact with the family • Location of contacts – e.g. going into family home or not • Focus of their concerns
	conditions of work	• The general atmosphere surrounding the case • Staffing levels and skill mix • Workload • The timing e.g. shift patterns or busy time of year • Admin support • Managerial support • IT/computers
	own team factors	• Issues related to getting help, advice or support • Supervision • Communication both written and oral • Differences of opinion within the team • Issues around team operations e.g. mixed messages • Team culture • Accepted/usual/routine practices • Capacity/workload • Skills/experience mix • Strength of knowledgebase/level of professional consensus on diagnostic categories and possibilities
	Inter-agency/inter-professional team factors	as above and also • Relative hierarchies; status and hierarchy • Language • Clarity of relative roles • Information sharing • Personal relationships and history (knowing each other or not) • Nature of working relationships (good–hostile) • Group dynamics • Cultures of communication across boundaries • Inter-agency culture and accepted practices • Culture of dealing with conflict – covert or overt

Factor group according to level/location	**Factor types**	**Contributory influencing factor**
LOCAL STRATEGIC-LEVEL FACTORS	Organisational culture and management (of individual agencies and multi-agency system as a whole)	• Financial resources and constraints • Resource allocation • Organisational priorities • Organisational structure • Organisational culture • Thresholds • Local policy • Local procedures • Standards and goals • Safety culture and priorities • Mixed messages • Availability of services; gaps in service provision • Clarity and adequacy of commissioning arrangements • Staffing decisions/allocation
NATIONAL / GOVERNMENT-LEVEL FACTORS	Political context and priorities	• Government policy • Government guidance • Management system and regulation; performance indicators • Tools: assessment framework and associated forms; ICT systems

Appendix 6
Typology of underlying patterns

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Patterns of systemic factors that contribute to good practice or make problematic practice more likely
1 Patterns in human–tool operation • The influence of assessment forms – No detail on the quality or depth of assessments, or difficulties faced in completing them – Discourages documentation of the rationale or complexity behind conclusions drawn – Encourages factual statements and assertions and discourages the recording of a healthy unease or gaps in understanding • The influence of the assessment framework – Focus on the assessment of need discourages articulation of risk factors • The influence of case management framework e.g. assessment, planning, implementation and review (APIR) – Revision becomes an interruption in the flow of practice
2 Patterns in human–management system operation • Resource-demand mismatch – Difficulties accessing expert assessments – Gaps in service provision – Funding disputes and practitioners creating safety • Performance indicators and borrowing from safety – Trade-offs between competing priorities; overt and covert messages – Conceptual blurring • Supervision
3 Patterns in communication and collaboration in multi-agency working in response to incidents/crises • Organisational culture around priority setting • Understanding the nature of the task; overlooking the wider needs of the children in child protection response • Reserve capacity • The importance of knowing each other • Referral procedures and cultures of feedback

4. Patterns in communication and collaboration in multi-agency working in assessment and longer-term work

- Understanding the nature of the task; assessment and planning as one off event or on-going process?
- Clarity of roles and responsibilities
  - How much shared responsibility is there?
  - Who is responsible for thinking?
  - What and how much should be shared?
- What barriers and facilities exist contribute to good team work in longer-term case work?
  - Are conflicts of opinion repressed or is there a shared culture in which it is acceptable and even desirable to query each other's assessments?
  - Group think
  - Ascribed and perceived occupational status
  - Overestimating the remit of service provision of different agencies

5. Patterns in family–professional interactions

- Salience of the mother in social services involvement
- Classic gendered presentation of problems by family members

6. Patterns in human judgement (thinking, reasoning)

- Failure to review judgements and plans
- Drift into failure
- Attribution error
- Tunnel vision

Learning together to safeguard children: developing a multi-agency systems approach for case reviews

This SCIE guide presents an innovative multi-agency 'systems' model for organisational learning. *Learning together* is an introduction both to a way of thinking and its application in practice. It sets out the actions needed for a structured and systematic process of learning from practice via case reviews.

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