SCIE Learning Together: reflections from the South West project
This report will help readers to understand what the Learning Together methodology is and how it operates.

The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.
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Professionals are not clear or confident in how to handle retractions of allegations of sexual abuse by children, risking children being left in harm

The tendency locally to respond to a lack of parental change by adding on successive layers of service is ineffective and wasteful
Executive summary

The 2013 document *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* \(^1\) brings a new relevance to the South West pilots of the Social Care Institute for Excellence (SCIE) systems approach to case reviews and serious case reviews (SCRs) – Learning Together. Adapting to the new policy requirements means that Local Safeguarding Children Boards (LSCBs) and member agencies need to think about the relative strengths of different available systems approaches to organisational learning. This includes what options of scale they offer to allow for a proportionate response.

This report will help readers to:

- understand what the Learning Together methodology is and how it operates along a sliding scale of options
- see for themselves the kind of learning that is produced through this approach
- consider the potential benefits of using a common categorisation system for organising and presenting findings
- appraise the value of the consistent way that Learning Together findings are presented to create transparency and nuance about the strength of evidence behind each finding
- reflect on different ways in which a Learning Together case review can make a real difference, with concrete illustrations
- think about the need for an ‘impact model’ to underpin the evaluation of learning and improvement activities.

The report does not form a formal evaluation of the Learning Together methodology because the South West pilots were conducted by people being simultaneously trained in the approach and supported to try it out for the first time.
Introduction

A systems approach for a high-risk sector

SCIE has led in the development of a new ‘systems approach’ for conducting case reviews of multi-agency safeguarding and child protection work. This provides a theory and method for understanding why good and poor practice occurs, in order to identify effective supports and solutions. It has been adapted from methods developed in other high-risk areas of work, such as aviation, and subsequently has been taken up in health, for example via the National Patient Safety Agency.

In 2010, following the publication two years earlier of Learning together to safeguard children: developing a multi-agency systems approach to case reviews, [2] many Local Safeguarding Children Boards (LSCBs) expressed a strong interest in the systems approach and the potential it holds for improving learning through case reviews and serious case reviews (SCRs). In response, SCIE made an offer to work collaboratively with the child welfare sector on a regional basis to support regional pilots of case reviews and SCRs using the systems model. The approach was piloted in the North West of England and the West Midlands during 2010.

It was subsequently endorsed by Professor Eileen Munro, in her review of child protection. [3] Accepting Munro’s view of its potential, as the most developed systems model for the child welfare sector, the Department for Education then funded SCIE to carry out further capacity building through a training and accreditation programme. This included commissioning the Office for Public Management to evaluate the impact of the approach.

In its response to the Munro Review, the government stated its commitment to working out how to make such an approach feasible, and permitted Devon, Coventry and Lancashire LSCBs to carry out SCRs using the SCIE Learning Together approach (which required dispensation from certain aspects of the statutory guidance Working together to safeguard children 2010 [4]).

South West piloting and training project

The South West Association of Directors of Children’s Services sought funding from the Regional Improvement and Efficiency Partnership (RIEP) (South West Councils) to enable participation in the piloting of the Learning Together model, and four LSCBs within the region put themselves forward as pilot sites:

- Bristol
- Cornwall
- Devon
- Gloucestershire.

The piloting was run as a project from South West Councils, in partnership with SCIE, and was launched in May 2011. It was coordinated by Sally Halls.
SCIE Learning Together training comprised a 10-day training course as part of a supervised case review over a six-month period. This training was provided by Edi Carmi and Nick Lister, accredited Learning Together reviewers. In addition to the 10 days’ training, SCIE Learning Together programme lead, Dr Sheila Fish, provided quality assurance and feedback on the draft report from each LSCB. She attended the project management group meetings, and is lead author of this final evaluation report capturing learning gained about training people to use the model for the first time, and its use.

Table 1 lists the participants who were involved in the South West Learning Together project.

Table 1: Participants in the South West Learning Together project

<table>
<thead>
<tr>
<th>Chair of the project management group</th>
<th>Annie Hudson, Director of Children’s Services, Bristol</th>
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<tbody>
<tr>
<td>Project manager</td>
<td>Sally Halls</td>
</tr>
<tr>
<td>SCIE lead</td>
<td>Sheila Fish, Head of Learning Together, SCIE</td>
</tr>
<tr>
<td>SCIE trainers</td>
<td>Edi Carmi, independent consultant and accredited Learning Together reviewer</td>
</tr>
<tr>
<td></td>
<td>Nick Lister, Director of Tri.x and accredited Learning Together reviewer</td>
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<tr>
<td>Trainee lead reviewers</td>
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<tr>
<td>Champion</td>
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<tr>
<td>Bristol</td>
<td></td>
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<tr>
<td></td>
<td>Angela Clarke, Service Manager, Safeguarding and Quality Assurance, Children and Young People’s Service</td>
</tr>
<tr>
<td></td>
<td>Matthew Turner, Manager, Somerset LSCB</td>
</tr>
<tr>
<td></td>
<td>Catherine Boyce, Manager, Safeguarding Business Unit, Children and Young People’s Service, Bristol City Council</td>
</tr>
<tr>
<td>Cornwall</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deborah Jeremiah, independent consultant</td>
</tr>
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<td></td>
<td>Sue James, independent consultant</td>
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<tr>
<td></td>
<td>Karen Dale, Senior Manager Safeguarding Children Unit</td>
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<tr>
<td>Devon</td>
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<tr>
<td></td>
<td>Maria Kasprzyk, Professional Lead for Social Work, Devon County Council</td>
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<tr>
<td></td>
<td>Helen Hyland, Designated Nurse, NHS Devon</td>
</tr>
<tr>
<td></td>
<td>Chris Dimmelow, Head of Safeguarding, Devon Safeguarding Children Board</td>
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<tr>
<td>Gloucestershire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vickie Butler, Service Manager, Gloucester Locality, Gloucestershire Children Social Care Service</td>
</tr>
<tr>
<td></td>
<td>Joanna Nicolas, independent consultant</td>
</tr>
<tr>
<td></td>
<td>Cathy Griffiths, Head of Quality (Children and Young People), Gloucestershire County Council</td>
</tr>
</tbody>
</table>
Timescales and opportunities for reflection

The training programme and practice case reviews ran over a seven-month period from May to November 2011. Completion of the reports by trainee lead reviewers took significantly longer – a point we reflect on in the Impact section on page 37.

The project management group met approximately monthly over the lifetime of the project. Champions for each of the participating sites prepared and shared update reports for these meetings. The reports captured the experiences of the participating LSCBs over time.

Cross-site meeting

A full-day meeting for the four participating LSCB pilots was held on 30 January 2012. The aim of the day was to allow participants to reflect on, share and compare their experiences of using the systems approach in a case review. It also gave them an opportunity to reflect on how to develop expertise further in the future. Key benefits were identified for:

- participating staff involved with a case
- LSCB review teams
- lead reviewers
- pilot LSCBs
- the region.
An additional aim was to plan for a regional dissemination event.

There was good representation of review team and case group members from all four sites. Discussion was lively – see the following photographs.

Caption: Participants at the cross-site meeting, 30 January 2012

Participants’ reflections on the training process

Overall, participants were very positive about their experience of the SCIE Learning Together cohort training programme. One participant’s reflections are reproduced in Box 1.
Box 1: Training and supervision

I felt that some of the very early sessions I was involved with were slightly lacking in focus in terms of what I felt I would need as a lead reviewer. However, they were designed to be a briefing for all those involved in the pilots irrespective of role and so had to be broader in content. As the group narrowed down to those conducting the reviews, the content became much more appropriately focussed and felt increasingly relevant – an aspect that was supported as we actually began to plan and conduct reviews.

The training sessions were instructive and sufficiently flexible to allow room to cover other aspects of the review and respond to the need of those involved. At times it felt slightly frustrating that it appeared that SCIE were quite prescriptive about what had to be covered in each session whilst there were also ongoing ‘changes’ to the process – although this is clearly an indication of the learning taking place elsewhere, the ongoing evaluation by SCIE and the overall development of the model. We have to accept that the model is still not a finished product!

All group members were fully engaged with the process and were active in their accounts of their experiences. It was an extremely positive group in terms of the commitment to the pilot, to learning and to ensuring optimum impact from the reviews. Each meeting was, in effect, joint supervision and that maximised the learning experience available. The sessions were very well chaired/managed/facilitated by Nick and Edi who, because they had been directly involved in reviews elsewhere and the developments at SCIE, were very aware of how the model had evolved, the practical challenges that were to be encountered and the shift in thinking that is required to complete a review and draw out the salient learning points.

The reality of being involved in genuine innovation was also experienced first-hand by the trainees in the South West project. Various aspects of the model were still being finalised, some of the administrative support for the process was still in development and our knowledge of how best to train and support people to use the model for the first time was at a relatively early stage. Some of this created frustrations for the trainees, which generated very useful feedback and SCIE has since amended the training programme on the basis of this learning. The feedback included the following:

- Be more explicit that the heaviest workload comes at the end.
- Number the handouts.
- Improve accompanying project management.
- Warn participants that it is hard and to expect detailed critique of their written work.
• Input spread over time and opportunities to share between sites are a great benefit.

Regional dissemination event

A regional dissemination event was held on 9 March 2012. Each LSCB was allocated up to 10 places. The purpose of the event was to enable participants to:

• hear about the experiences and outcomes of the four South West pilot case reviews using the SCIE Learning Together systems model, from a range of different perspectives (lead reviewers, review group, case group, LSCB)
• share key reflections and learning from those pilots
• be briefed about the national context and research base for the methodology from Dr Sheila Fish (SCIE), as well as findings from pilots in London and elsewhere
• hear from Colin Green, then Director of Children’s Services (and former LSCB chair) about Coventry’s experience of conducting an SCR using the methodology
• consider implications of the review experiences for LSCB practice in the South West.

Members of the review teams and staff who had been involved as ‘case group’ members formed respective panels and responded to questions about their experiences of being involved.

The event was very well attended with over a hundred participants. Feedback was extremely positive (see Box 2).

<table>
<thead>
<tr>
<th>Box 2: Selection of feedback comments from participants at the regional Dissemination event</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good range &amp; quality of information &amp; input. Felt real sense of how the SCIE model is different.</td>
</tr>
<tr>
<td>• It was helpful to have the different levels of the new process being given a chance to express their experiences honestly.</td>
</tr>
<tr>
<td>• Event was successful – very positive – feel optimistic &amp; enthused</td>
</tr>
<tr>
<td>• The passion of the principles &amp; processes shone through &amp; has really captured my interest to learn more – thank you.</td>
</tr>
<tr>
<td>• Very well organised – no mean feat with the number of people involved.</td>
</tr>
<tr>
<td>• Brilliant day. Came away very enthused.</td>
</tr>
<tr>
<td>• Hearing how it worked in practice &amp; the change in practice &amp; improved outcomes for young people.</td>
</tr>
<tr>
<td>• Thank you for a thoughtful &amp; informative day and a (big!) glimmer of hope for a different future for the SCR process.</td>
</tr>
</tbody>
</table>
Updated context and this report

Revised statutory guidance came into effect on 15 April 2013: *Working together to safeguard children*. [1] For the first time, systems principles for learning and improvement activities are written in statute.

LSCBs are now required to maintain a local learning and improvement framework that supports the regular conduct of reviews and audits beyond those meeting the statutory SCR criteria.

The *Working together* guidance requires case reviews and SCRs to be conducted according to five principles (see Box 3). These are drawn from the essential ingredients that Munro explained must be present in an investigation for it to justify the label ‘a systems approach’. [5] They are central to the core of Learning Together, which we refer to as the ‘methodological heart’. Avoiding the bias of hindsight and using robust research methods, a systems approach facilitates analysis of why professionals acted in the way they did and what this reveals about strengths in the system and problems that need to be addressed.

**Box 3: Principles for learning and improvement**

SCRs and other case reviews should be conducted in a way that:

- recognises the complex circumstances in which professionals work
- seeks to understand the underlying reasons why people acted as they did
- seeks to avoid hindsight bias
- is transparent about research methods
- makes use of research as well as case evidence to inform findings. [1, page 67]

This context brings renewed relevance to the South West project. The content of this report is informed by the sources of data described earlier: sites’ reports for the project group meetings, the cross-site meeting and input from participants at the regional dissemination event.

It is not a formal evaluation as this was not part of the funded project. Moreover, formally evaluating the model itself when it is being conducted by people in a training context, using it for the first time, is so challenging to be of questionable value. The Office for Public Management experience of attempting to do this for Learning Together raised important learning points about when certain types of evaluation are feasible, even useful, in a context of capacity building. At the regional dissemination event, Annie Hudson, chair of the project management group, noted: ‘We’re delighted to be at the forefront of understanding and applying this approach – a great opportunity for the SW [South West] to influence its development.’ She also noted that the multi-agency project management group had been ‘struck by the range of views about the approach – ranging from enormous enthusiasm by participants to deep scepticism’. The aim of this report is to speak to some of the questions held by those in the more sceptical camp. Some detail about questions raised and responses is included as part of the report.
Given the changed policy context, the responses to the questions raised by the South West LSCB chairs presented reporting Chapter 5 have been updated in light of the 2013 Working together guidance. [1]

Chapter 6 captures subsequent developments that individuals and boards have been involved in. It is hoped that this will be helpful for readers interested in flexible ways in which the model can be used on a smaller scale, how capacity can be increased and so on.
Overview of the Learning Together model

Introduction

Learning Together is a methodology for conducting case reviews of multi-agency child protection practice. It is underpinned by a systems approach to understanding and investigating practice, commonly used in sectors such as aviation. The model and its evidence base are described in more detail in the following SCIE publications:

- Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews [6].

Learning Together reviews use a single case to provide a ‘window on the system’, [7] acting like a lens to gain insights into underlying patterns that either support good practice or make poor practice more likely. The reviews therefore aim to result in generic or generalisable findings, rather than providing explanations of issues specific only to the case of the particular child or family.

The Learning Together case review process

Participants in the process

A Learning Together case review is designed to be a collaborative, multi-agency process, including both managers and frontline practitioners. The participants in the process are shown in Figure 1.
The review is commissioned by, and reports back to, the LSCB and its member agencies (purple box). The review is then led by two ‘lead reviewers’. The lead reviewers can but do not have to be independent of the LSCB. They work with a local multi-agency team of managers/senior managers known as the ‘review team’ (blue boxes). The review team has a key role in conducting the review, including talking to staff, reviewing documentation and analysing the data, including identifying and prioritising underlying patterns revealed by the case.

The review team works with a ‘case group’ (orange boxes) comprising the key frontline practitioners from across agencies who worked on the case being reviewed. The case group members play two key roles:

- sharing knowledge about the thinking and context of their work at the time, sometimes referred to as ‘the view from inside the tunnel’ [8]
- sharing their broader practice experience beyond the particular case to help the review team identify which are general issues.

The family are also involved in the review, in particular to get their perspective of how things were at the time for them. While they are represented in Figure 1 as part of the case group, on the basis that they are part of the group with close day-to-day involvement, they are usually engaged with through separate conversations and meetings, to ensure that they are well supported.
The process

The case review has three principal stages, summarised in Figure 2:

1. **Introduction and preparation** – including selecting the case, the review team and case group, choosing the time period to review and assembling a very brief ‘skeleton chronology’ or timeline of professional involvement.

2. **Data collection** – collecting data through ‘individual conversations’ with members of the case group, during which they give a detailed account of their perspective of the case at the time, and through written records of the case.

3. **Analysis and reporting** – an iterative process of analysis carried out by the review team, with opportunities at two ‘follow-on’ meetings for the case group to challenge, correct and amplify the review team’s analysis. The lead reviewers then lead on writing up the findings along with considerations for the LSCB.
Figure 2: How the SCIE Learning Together model works

HOW THE SCIE MODEL WORKS

PREPARATION

Identify a case for review
A review should be initiated to answer particular questions. These should not be restricted to understanding why harm has been caused to a child and how it could be avoided.

Select a review team
The team should reflect the key professions involved in the case being reviewed. Outsider status can help workers engage in the process more openly.

Identify who should be involved
This selection of people to talk to about the case should include both workers and family members to achieve a holistic perspective.

Brief participants
Participants need a detailed introduction to the approach and must understand confidentiality requirements.

DATA COLLECTION

FORMAL RECORDS AND CASE FILES

ONE-TO-ONE CONVERSATIONS

ORGANISNG AND ANALYSING DATA

PRODUCE A REPORT

1. Produce a narrative of multi-agency perspectives: This novel-like interpretation of data should include people’s opinions on their motivations for actions, what things went well and ideas for useful change.

2. Identify key practice episodes. The review team uses its discretion to determine the defining factors of the case.

3. Review the data and analysis. The review team now presents its interpretation of the case to participants to check the accuracy of facts and for group discussions.

4. Identify patterns: The review team now categorises types of systems issues. Not all patterns can be covered so selection is necessary.

ASK FOR FEEDBACK

RECOMMENDATIONS

1. Issues with clear-cut solutions that can be addressed locally and by the agencies involved.

2. Issues where solutions cannot be so precise because of competing priorities and inevitable resource constraints.

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.

Source: www.communitycare.co.uk/Articles/27/03/2012/118106/case-review-model-aims-to-end-social-work-blame-culture.htm
How the model provides a ‘window on the system’

The aim of a Learning Together review is to move beyond the specifics of the particular case to generalisable learning about the reliability of the multi-agency child protection system. This is termed ‘underlying patterns of systemic interaction’. SCIE has developed a six-part typology for grouping these patterns:

- management systems
- family–professional interactions
- tools
- communication and collaboration in response to incidents
- longer-term communication and collaboration
- cognitive and emotional crises.

Each stage of the review is designed to contribute to building up an understanding of these patterns, as illustrated in Figure 3. The process moves from building up an understanding of the issues in the case; exploring whether the issues were particular to the individuals involved in the case or whether they are underlying issues; seeking to identify whether the issues in the case are widespread or prevalent; through to what the implications are for the reliability of the multi-agency child protection system.

Figure 3: ‘Anatomy’ of a Learning Together finding
By following this analytical process, the review should be able to move from the specifics of the individual case, to an understanding of the broader systems issues.

More than just a process

A Learning Together case review consists of four main stages:

- preparation
- data collection
- organising and analysing the data
- reporting.

In the following sections of this chapter on the process, we consider each of these stages and outline:

- the intended process
- the methodological purpose of the stage
- the intended experience of the stage.
Preparation

Case selection

**Box 4: The Learning Together model: how case selection should work**

**Process**

The case should be selected by the LSCB, often via its SCR and/or Quality Assurance Subcommittee and/or the review team. The case can be chosen on a number of different grounds: it may be a serious incident or ‘near miss’, or it may be representative of an area of practice that is known to be problematic.

**Methodological purpose**

For the purposes of a Learning Together case review, the case selected will act as a ‘window on the system’. Therefore, the rationale for the selection needs to be transparent: in what ways is it assumed at the beginning of the process to have the potential for wider learning?

**Experience**

SCIE’s experience of reviews to date indicates the benefits to the review team and case group where members are clearly aware of the rationale for the selection of the case. It can avoid mistaken assumptions about why the review is taking place.
Selection and preparation of the case group

Box 5: The Learning Together model: how selection and preparation of the case group should work

Process

The case group should comprise the key practitioners involved in the case – these are usually identified from ‘skeleton chronologies’ submitted by relevant agencies at the beginning of the review process. Practitioners are then notified by letter that their case has been selected for review, given written information about the Learning Together methodology and invited to attend an introductory meeting for further clarification.

Methodological purpose

Case group membership should enable as accurate a picture to be developed as possible of how and why the case developed in the way it did and why it was handled in the way it was. Methodologically, it is vital that people who were ‘key’ are openly and actively involved.

Experience

The letter to practitioners should inform them clearly about why their case has been chosen for review. The introductory meeting should provide an opportunity for them to:

- learn about the review process and their role in it
- meet the review team members
- hear of the organisational backing for the focus on learning
- respond to any queries and anxieties they may have about the process.

Data collection

The data collection process under the Learning Together model includes the collection of documentary evidence from formal case records and files, and obtaining information from the practitioners involved through a series of individual conversations.
Individual conversations

Box 6: The Learning Together model: how individual conversations should work

The aim of this stage of the data collection is to get detailed input from practitioners who were involved in the case. The aim is to get their view of what was going on in and around the case, their perspective on the role they played, and their views on how the system works in relation to both the case and in general.

Key features of the individual conversations should be as follows.

Process

Conversations should be conducted by the lead reviewers and review team. Each conversation is led by two review team members – one who leads on asking questions, and the other who takes notes, which are later written up and circulated. It is guided by a semi-structured interview schedule and the majority of questions are open-ended.

Methodological purpose

Conversations should focus on practitioners’ perspectives on the case and their own and others’ roles, as the case unfolded over time. The practitioners should endeavour to take themselves back in time and remember what they knew, their comprehension and the thinking behind their actions and decisions, as they saw things at the time, not how they see things now with hindsight. This is sometimes referred to as ‘the view in the tunnel’. They should also endeavour to remember how different elements of the work environment influenced their practice (contributory factors). It is not designed with pedagogic intent and differs in this way from usual supervision.

Experience

The way the conversations are structured within the model should enable genuine dialogue between the review team and case group members. People should feel that their perspective is heard and valued and that they are enabled to ‘tell their story’.

Organising and analysing the data

The process of organising and analysing the data obtained through individual conversations and documentation is specifically collaborative under the Learning Together model. It involves working with the multi-agency case group to make sense of the data, establishing an understanding of the key practice episodes and developing the findings of the review.
Box 7: The Learning Together model: how organising and analysing the data should work

Process

The review team should work collaboratively to bring together the data gathered from the individual conversations and formal records so that the interpretations can then be checked, challenged and amplified again by the staff directly involved (see the next subsection on follow-on meetings). There are three elements of the analytic framework and accompanying tools that should be carried out:

- reconstructing how practitioners saw the case at the time, drawing on information from the conversations and documentation
- identification and analysis of a number of key practice episodes, including identification of contributory factors
- consideration of the broader significance in terms of underlying patterns identified.

Methodological purpose

The aim of the different elements of the analysis is to move from an understanding of the specifics of the case to the identification of underlying patterns of systemic influence on practice.

Experience

Organising and analysing the data is an iterative process that can feel messy, and it can be disconcerting for review team members not knowing where things will end up. The process should be lively as review team members all help to ensure that use is made of all available data. Judgement is involved, so discussion and debate are necessary and a consensus as to the significance or priority of issues may not always be reached. The lead reviewers lead the process, often doing the writing, but the review team should feel actively involved and have joint ownership of the final report.
Multi-agency ‘follow-on’ meetings

**Box 8: The Learning Together model: how the follow-on meetings should work**

Each case review includes two opportunities for the review team and case group to meet together. These provide an opportunity for the review team to share their emerging analysis with the case group so that they can check accuracy, answer further questions and challenge and/or amplify interpretation.

Key features of the follow-on meetings in terms of process, purpose and experience are detailed below.

**Process**

The follow-on meetings should be attended by all members of the review team and case group.

**Methodological purpose**

This differs across the two meetings. The aim of the first meeting is to check the accuracy and interpretation of the review team’s analysis of the reconstruction of how different professionals were viewing the case over time, and to provide a first draft of the key practice episodes for further exploration. The aim of the second follow-on meeting is particularly focused on moving from the findings of the specific case to the ‘underlying patterns’ present in the case and gathering participants’ experiences of the findings more broadly.

**Experience**

The meetings should be facilitated in such a way as to enable contributions from all case group members and to emphasise that all perspectives are valued. They are often not comfortable for participants but should be experienced as constructive. They need to be planned sensitively with the individual participants and the judgement that has been made of their practice in mind.
Box 9: The Learning Together model: how producing the report should work

**Process**

The lead reviewers undertake most of the report writing, capturing and taking forward the thinking that has been done collaboratively with the review team in analysis meetings, and taking into account clarifications and amplifications from the two follow-on meetings. Where necessary, differences of opinion should be recorded in the report.

**Methodological purpose**

The focus of the report should be on the underlying patterns that have been identified through the analysis of the particular case. These then give rise to issues for the LSCB and member agencies to consider. Rather than containing recommendations, the findings present the issues and problems identified and endeavour to help the board in its considerations about an appropriate response.

**Experience**

If the process is followed, the review team should own the findings that are put forward for the board and the case group should feel that the report accurately represents their views and experiences, shedding light on what helps and what gets in the way of them doing a good job.

Learning Together's core principles and developing flexibility in their application

In response to demand from LSCBs for more flexibility to the potential use of Learning Together, SCIE has worked with the pool of accredited reviewers and commissioning boards to test out a whole range of possible applications of the model. The sliding scale of options now includes ‘reflective audits’, ‘focused’ and ‘speed’ reviews as well as the standard full version described above. A core set of principles and analytic tools unifies this whole range of learning activity.

This is referred to as the ‘methodological heart’ of the Learning Together model. The three key principles are as follows (see also Figure 4):

- **Avoid hindsight bias** – reconstruct how things were seen and experienced at the time.

- **Appraise and explain** – stand up for good practice and articulate clearly where decision making and actions were poor or problematic, but never judge without also explaining why people did what they did.
• **Move from the individual instance to the general significance** – seek to generate data to distinguish issues unique to the case from underlying systemic weaknesses.

These three essential aspects are not negotiable.

**Figure 4: The key principles of the Learning Together model**

<table>
<thead>
<tr>
<th>Reconstructing</th>
<th><strong>“What happened?”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reconstructing the case and surrounding context as experienced by the professionals involved</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appraising and explaining</th>
<th><strong>“Why did it happen?”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analysing episodes of practice in detail, appraising individual practice and looking at individual, local and national influences on practice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessing relevance</th>
<th><strong>“What are the implications for wider practice?”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exploring whether issues identified in the case apply more widely, in consultation with staff and managers, and their relevance to achieving better safeguarding</td>
<td></td>
</tr>
</tbody>
</table>

However, other aspects of the model are flexible according to local needs. These include:

• Which part of the case timeline to review in detail and how long/short this needs to be

• how many individual conversations to conduct with the staff involved and if so, with whom

• whether to hold a facilitated group conversation instead of meeting with individual practitioners

• how hands-on a role senior managers from involved agencies play, so how many meetings they require

• how much cross-referencing with documentary sources of data is done.

With this flexibility of application, the model lends itself to case reviews, SCRs and other quality assurance work such as routine case audits.
Potential benefits

Chapter 4 introduces the impact model that SCIE has developed to underpin evaluation activities of Learning Together. Simultaneously a rigorous analytic process and an intensively collaborative one, the key features of success are captured in Box 10.

**Box 10: What does success look like in a Learning Together review?**

- Frontline staff and managers are directly involved and have a constructive experience.
- Children, young people and family members have their say and are kept in the picture.
- Change starts to occur early on in the review, with participants altering their practice.
- Analysis unpicks problems to reveal the norms and drivers behind them, presenting a nuanced picture reflecting the strength of current evidence.
- The findings are owned at a senior level, across agencies.
- The report enables LSCBs to take action appropriate to the local context and to hold member agencies to account.
- Transparency allows public accountability without jeopardising the anonymity of family members or professionals.
- The changes in practice generated provide better support to frontline workers in their work to improve outcomes for children.
Findings from the pilot-training South West case reviews

Case selection choices

Using the Learning Together model requires explicitly setting out to use a single case to create generalisable learning. We use the phrase coined by health academic Charles Vincent to capture this; we want the case review to provide a ‘window on the system’. [7] Trainee lead reviewers in the South West project therefore worked with the participating boards to think about aspects of the multi-agency system functioning their choice of case would allow a window to open onto. Summaries of the cases and the rationale for why they were chosen to be reviewed are presented in Boxes 11 to 14.

Box 11: Site 1

Case summary

A family of two children was subject to child protection plans for neglect for over two years and, following a brief period where the family was supported under a children in need plan, the children became subject to child protection plans for the second time. The children remained on a child protection plan until they were removed from the family home in September 2010.

Rationale for selection; window on the system

The LSCB was focusing on the need to ‘get it right first time’ for children. This meant that children who were re-refferred to social care or who had been subject to child protection plans for the second or subsequent times were of particular interest. Previous reviews of safeguarding services had also highlighted the high level of cases within the county where the main concern was neglect.

The LSCB chose this particular case due to the fact that it raised issues seen in many SCRs and was typical of a neglect case, which typically improves over time, then dips again but then improves.

This case also consisted of a mother with a level of learning need and two children with a level of disability – both factors often seen in child protection work.

Timeline

June 2007 to September 2010.
Box 12: Site 2

Case summary

The child under consideration came to the attention of professionals on making a disclosure of sexual abuse by her stepfather in 2009, although she retracted the allegations before the investigation was complete. Prior to this, there had been concern about the stepfather’s violence towards the mother, and this continued after her disclosure. When the child started to run away from home in the summer of 2010, her family and the professionals involved thought that her running behaviour reflected problems in her relationship with her family members, although there were also concerns about the impact of physical and emotional abuse as a result of her experience of the adult relationships at home. The child repeated her sexual abuse disclosure in January 2011 and her running behaviour escalated before a decision was made for her to live with a foster carer in February 2011.

Rationale for selection; window on the system

The LSCB decided that it wanted the opportunity to review the inter-agency practice in relation to a child who had run away from home, as this was an area of development for the board. This case was thought to provide a good opportunity to review the services and systems in place.

The board wanted a ‘window on the system’ in relation to the inter-agency response to a child who had run away from home.

Timeline

June 2009 to February 2010 (nine months).
Box 13: Site 3

Case summary

This case review involved a vulnerable teenager who became estranged from her family after an alleged assault on her by her father. The police attended and took her to her friend’s mother’s home. The father has never allowed any agency into the family home. The teenager maintained that it was not safe for her to return home. After a short stay with her sister, and a failed placement at the YMCA, she has returned to her friend’s mother’s home where she remains. She has presented with risky behaviours throughout, with deterioration in her physical and mental health. She has taken an overdose of tablets in the past and has medical problems that cause her pain.

Rationale for selection; window on the system

This case was chosen as it involved many agencies and presented some challenging issues around the management of a homeless vulnerable teenager.

Timeline

November 2010 to June 2011 (eight months).

Box 14: Site 4

Case summary

A teenage boy and his sister were living with their father. The boy had been known to health and social work professionals throughout his childhood, who worked with him as a child in need case. There were ongoing disagreements between agencies about whether his presenting issues had medical or social causes and therefore the need for child protection intervention. He was made the subject of a child protection plan in May 2011.

Rationale for selection; window on the system

This case was raised with senior managers by a practice manager as a ‘near miss’1 following transfer from children’s social work to the integrated children’s service. The practice manager felt that there had been numerous opportunities to intervene that had

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1 ‘Near miss’ cases are cases that do not meet the criteria for an SCR but the outcomes for the child/young person have been impaired due to the response and approach of the children’s workforce.
been missed. She wished to raise it as a learning opportunity for staff. At the same time, the consultant paediatrician had written to children’s services expressing her concern that she had made numerous child protection referrals to children’s services that had not been acted upon.

The case was deemed to hold promise to illuminate four key questions, the fourth being raised by the case group:

- How are the history of the child’s experiences and the knowledge of the wider family considered in assessing significant harm?
- How effective is child in need planning in managing cases of chronic neglect?
- What are the determining factors (and multi-agency contribution to these) to moving from a threshold for managing a case under children in need to one for child protection.
- How do you capture the issues surrounding children and young people with multiple and complex needs who do not present as meeting the child protection threshold?

**Timeline**

August 2010 to 16 June 2011

**Collation of South West findings by category**

The goal of a systems case review; looking back in order to look forwards

Using a systems approach helps to be clear as to the purpose of a case review or SCR. It is not simply a retrospective activity whereby we try to find out what happened and why. It is instead better thought of as a future-oriented search for current weaknesses in the way our systems are functioning, and therefore future potential problems; we look back in order to look forwards. [7] The case/incident acts as a ‘window’ on the system to reveal present gaps and inadequacies that might impact in the future. While this has been implicit in approaches to SCRs to date, it has not commonly been an explicit goal.

**Learning Together findings; genotypes of failure**

The end-products of Learning Together reviews are ‘findings’ and a series of associated questions for the LSCB. These findings specify generic or underlying patterns of how the system is functioning: ‘The surface characteristics of a near miss or adverse event are unique to a particular setting and people. Generic patterns re-appear in many specific situations’. [9, page 0000] They are the genotypes, if you like, of failures. The term is taken from biology, meaning to distinguish the internal blueprint or set of instructions for building a living organism (the genotype) from the outward, surface manifestation (the phenotype).

They are used to differentiate:

- the surface description (phenotype of failure) and
- underlying patterns of systemic factors (generic or genotypical patterns).
So, good or problematic practice may look different in different cases but the sets of possible underlying causes can be the same and it is these that need to be identified.

Learning Together findings therefore articulate the cause, not the consequence. For example, if it is discovered that professionals are not speaking to children on a routine basis, the finding needs to lead to an identification of the underlying pattern that leads to them not speaking to children. The finding headline needs to capture why the practice problem is happening, not simply that it is happening.

This is a novel development. To date, findings from SCRs have tended to name what should have happened but did not happen in the particular case. There has not been a consistent focus on clarifying the underlying causes of practice problems.

The ‘headlines’ of individual Learning Together findings seek to describe the pattern and why it matters.

Use and benefits of a common categorisation scheme for findings

SCIE has pioneered a common categorisation scheme for ordering the findings from case reviews and SCRs. As stated in Chapter 2, this distinguishes six types of underlying patterns to do with:

- management systems
- family–professional interactions
- tools
- communication and collaboration in response to incidents
- longer-term communication and collaboration
- emotional and cognitive biases.

More background to this scheme can be found in the original Learning together report. [6]

Learning Together reviewers use this categorisation scheme as lines of enquiry at the end-stage of the case review process. This helps them to stand back from the detailed analysis of how professionals handled the case, to think about what has been learnt from the particular case that is relevant more broadly.

Deciding which category a finding belongs to is part of the analytic process. In many ways, therefore, the hardest part of the analytic thinking comes towards the end of the case review process, when lead reviewers have to work with review team members to refine exactly what their findings are.

A practice problem can be the result of findings across a number of different categories of the typology. For example, not routinely speaking to children can be linked to a management system finding concerning what is prioritised, noticed and praised, and/or it can be an issue of norms of multi-agency working such as a lack of professional confidence in speaking to certain age groups. Those involved in the review process
have to be very precise in how they formulate what exactly the underlying pattern is because it will affect the kind of action that the board will think about taking in response. Is it an issue about professional knowledge or cultural norms, how systems and processes are designed and controlled managerially, or something to do with the tools that people have to use?

This too is a novel development. To date, there has not been any consistency in how learning from case reviews and SCRs is organised and presented. SCIE’s six-part typology is, therefore, a high-order scheme that holds potential for making comparisons across cases easier and quicker to conduct. It also provides greater opportunity for cumulative learning from the series of SCRs. Findings can be collated in real time as they are pre-ordered in such a way as to make it straightforward, reducing the delay that has been a standard part of biennial reviews of SCRs.

**Illustration of what Learning Together findings look like and how they can be collated**

Given how novel a development it is to use a common categorisation scheme for findings, this subsection presents the ‘headlines’ of findings from the four South West case reviews. They are collated by type or category of the six-part typology of underlying patterns (see Boxes 15 to 19).

The lists in the boxes are not comprehensive. Not all of the trainees successfully completed the move to this new way of presenting findings. The project was not set up with adequate time or support for this difficult end-part – which became an important learning point for future development of the training programme.

For the purposes of this report, we hope that it is adequate to give people who were not directly involved a sense of the kinds of learning that are produced through this systems approach and how that learning is presented. We also hope that the potential of the common categorisation scheme is evident enough for readers to appraise.
**Box 15: Management systems**
- A routine lack of social work engagement in Achieving Best Evidence (ABE) interviews may mean that children are less likely to be able to tell their story and provide evidence.
- A set-up whereby only student social workers, with their reduced workloads, have time to engage with children and families, leaves the most inexperienced potentially doing the most difficult work, albeit with support.
- A routine lack of meetings of professionals outside the Child Protection Core Group structure affords no opportunity for exchange of vital ‘soft’ information and reflection about a case as it progresses.
- There is currently no vehicle locally for providing supervision to multi-agency groups, leaving them without opportunity for reflection.
- There is a tendency to respond to a lack of parental change by adding on successive layers of service, which is an ineffective and wasteful use of limited resources.
- There is a pattern locally in which placements of 16- to 17-year-olds are determined by age rather than need, leaving some vulnerable.

**Box 16: Family-professionals interactions**
- Professional naivety regarding the conflicted loyalties of mothers in cases involving domestic abuse, violence and child sexual abuse, and the complicated relationship dynamics with their partners, risks and oversimplified understanding of the situation and ineffective planning.
- The good pattern of the engaging directly and incisively with children in times of crisis locally does not continue regularly post-crisis, reducing the child-centredness of that work.
- Insufficient acknowledgement of the emotional toil of working with chaotic families with an extraordinary amount of competing needs leaves professionals vulnerable to being collectively overwhelmed.

**Box 17: Tools**
- Schools’ School Information Management System (SIMS) does not allow for the logging of ‘soft’ information, making it harder for school-based professionals to know all the relevant information about children in need of protection.
- Integrated chronologies are not routinely used by professionals when working with families with long-term support needs, making it more difficult to assess risk to children and parental capacity to change.
- The requirement to select a single category of abuse for the registration of children subject to a child protection plan creates a tendency to overlook other types of abuse the child is suffering from or is at risk of suffering from at the same time.
- There is no system for collating non-attendance at appointments DNAs across health services, making it difficult to spot patterns.
**Box 18: Communication and collaboration in response to incidents**

- Professionals locally are not clear or confident in how to handle retractions of allegations of sexual abuse by children, risking children being left at risk of further harm.
- A dominant ethos locally that professionals should not talk to children about their experience of sexual abuse before they are in a ‘safe place’ leaves them dealing with their own distress alone and unsupported.
- Lack of recognition locally of sexual abuse means that even blatant indicators are misinterpreted.
- An over-emphasis on the medical opinion of how an injury to a child has been sustained hinders appropriate responses.
- It is usual among professionals for a police decision to take no action for alleged assault against a child to be mistaken as discrediting the allegation, risking flawed assessments and decision making about the safety of the child concerned.

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**Box 19: Longer-term communication and collaboration**

- A false assumption locally that social workers working in a statutory capacity with children running away from home provide the same kind of help as services commissioned specifically for that purpose, leaves children the most at risk with the least appropriate support.
- There is an assumption that the emphasis of partnership working with the parent/carer means that meetings of professionals are not allowed, and this jeopardises opportunities for thinking together across agencies.
- A child becoming subject to a child protection plan creates a distorted sense of security, reducing individual feelings of responsibility for case management decisions and cross-agency challenge.
- No shared culture of openly questioning and exploring disagreements makes effective challenge precarious.
- Perceptions of social care gatekeeping and a lack of effective escalation by other agencies potentially leave children at risk.

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**Illustration of findings in the full**

The Learning Together model produces systemic rather than case-specific findings as the headlines presented in Boxes 15 to 19 demonstrate. The substance and formatting of Learning Together findings are distinctive. The formulation of headlines follows a particular template and they are organised using a common six-part categorisation scheme or typology, as discussed in the previous section.

The evidence for each finding is also distinctive. It is laid out using a specific structure, referred to as the ‘anatomy’ of a Learning Together finding – illustrated in Chapter 2.
This creates a consistency to the presentation of findings that is unusual. This section of the report therefore presents some findings in the full to serve as illustrations.

Benefits of the ‘anatomy’ of a Learning Together finding

Structuring each finding according to the different segments of the anatomy creates a consistency to the presentation of findings across all Learning Together case reviews. This is important for:

- supporting analytic rigour on the part of lead reviewers, so that they generate the right kind of data and make the most of them in their reporting
- enabling transparency for the reader about the strength of the data underpinning the findings
- cultivating familiarity among those receiving Learning Together reports about what a finding looks like and ‘fluency’ in ability to read them critically.

Breakdown of the structure of Learning Together findings

Presenting a Learning Together finding involves laying out the relevant data, using the anatomy, that justify the claim to have identified an underlying pattern about the routine functioning of the child protection system.

Lead reviewers need to answer the following four questions in sequence:

- **How did the issue manifest in the case?** A single powerful example from the case is used as an illustration.
- **What data have you generated that suggest it is not unique to these people in this case but an underlying pattern?** What did case group and review team members say about how this issue plays out in other similar cases/scenarios? How embedded is it in usual practice and by what means?
- **Do you have any information on how common the issue is or how widespread the pattern?**
- **So what? What are the implications for the reliability with which the multi-agency system functions?** What would a safe system look like and what kind of risk does this pattern introduce to the safe and reliable functioning of the system?

Lead reviewers need to find a way to make the most of the data they have, while not over-claiming the certainty of what has been learnt through the case review.

Questions for the board to consider

Learning Together findings are accompanied by questions for the commissioning board and member agencies to consider. These questions replace recommendations. Rather than telling the board what to do, the aim is to enable those in the most appropriate positions to decide the response to be taken. The questions aim to help them think about their response. This allows more ownership to be felt for the actions that result
because they are generated locally rather than imposed by outsider authors. They hold the promise of being more realistic too because they are made with full cognisance of the local situation.

**Puzzles and problems**

The recent imperative to end case reviews with recommendations that are SMART (specific, measurable, achievable, realistic and timely) has had unintended consequences. [10] By presenting findings in the Learning Together model, the hope is that talking about and grappling with the ‘wicked issues’ will be re-legitimised.

**Two illustrative findings**

In this subsection, two findings from different reviews are reproduced in full. As with the presentation of findings headlines in the preceding section, these are intended to allow readers to see what the end-product looks like. They are not presented as exemplars. Readers can appraise the extent to which all four aspects of the anatomy are present. This is something that tends to improve as reviewers do more Learning Together reviews. Since the South West pilots were completed, lead reviewers have begun to use the four headings of the anatomy as subheadings to structure their findings more explicitly. This has had positive feedback from LSCBs.

*Illustrative finding number 1: professionals are not clear or confident in how to handle retractions of allegations of sexual abuse by children, risking children being left at risk of further harm (communication and collaboration in response to incidents)*

Professional involvement with the child in question (D) and her family began with a significant, very concerning, disclosure of sexual abuse by the child. This was clearly a crisis for D, the family and the professionals who were assessing the situation. This disclosure initially triggered an appropriate child protection process and information-sharing between professionals. In contrast, the D’s subsequent retraction of her sexual abuse allegations had the effect of immobilising the professionals and sexual abuse not being considered as an ongoing risk. It also effectively ended the Children Act 1989, Section 47 enquiries and process with immediate effect. A key part of the joint Section 47 investigation had been the search for evidence, and yet once D began to retract, practitioners stopped looking for evidence of sexual abuse and shifted their focus. In their ‘revision’ of what was going on, they failed to include the possibility that the abuse did happen. So the head teacher of D’s school was led to believe that sexual abuse was not an ongoing risk, with the consequence that when the child moved schools, she did not include this information in what she transferred to the receiving head teacher. **The reasons for this are explored in more detail in Finding 8.**

In appraising this disjuncture, the review team judged this about-face as very problematic. They would have expected that when D started to withdraw her allegations, professionals would have considered in greater depth why she may have been doing this, and they should have seen sexual abuse as an ongoing risk to the child within the context of a family where domestic violence was a dominant theme. A strategy meeting should have been called to consider the actual meaning of the retraction and what
investigation should be done, whether or not a criminal prosecution was likely to be sought. Instead, the focus of the work shifted and became more about supporting the mother to manage the stepfather’s violent behaviour.

Input from D herself as part of this case review process reinforced that appraisal. When the child first spoke about being sexually abused she expected that her mother would make her abuser leave the house because she thought her mother would believe her and know that what he had done was very wrong. She was surprised that he was still in the house the following day and therefore she thought that her mother must have decided that it wasn’t true. She was sure that her grandfather would believe that it had happened but she soon was led to believe that he didn’t think she was telling the truth either, particularly when she found that her stepfather was staying with her grandfather after being told to leave her mother’s home. The child’s recollection of this time was that she thought that no one believed her. She found it difficult to deal with her family being upset and angry so she decided it was better to tell them that it didn’t really happen.

With hindsight, D’s experience is deeply troubling. So why did professionals not pick up on it at the time? Exploring this issue in more detail with the review team and case group revealed a striking discrepancy in professional confidence in handling sexual abuse and handling the retraction of sexual abuse allegations both in this case and more generally. No one that the review team spoke to thought that they lacked understanding about sexual abuse, or would have been too wary of talking about it if a child had disclosed to them. However, they were unsure about how to deal with the child’s retraction. So in this case, the police officer and the social worker involved at the time described feeling ‘torn’ around this time. They did start to question whether D really had been sexually abused by her step-father and they did not know what to believe. The review team were struck by the fact that they did not seem to interpret D’s behaviour sufficiently in light of her age and development – she was nine years old so the likelihood of her allegation being malicious was significantly less than if she had been a teenager. Instead, they took the retraction at face value. This was bolstered by their impression that D’s mother had separated from the stepfather – this is explored in more detail in Finding 3. And the police officer thought that there was no point in pursuing the criminal case against the stepfather given D’s retraction.

This pattern whereby professionals are not clear or confident in how to handle retractions of allegations of sexual abuse by children, risks necessary investigations not taking place and necessary protective measures not being put in place, with the predictable result that children are left to be further abused and successful prosecutions of perpetrators are less likely.
Box 20: Professionals are not clear or confident in how to handle retractions of allegations of sexual abuse by children, risking children being left in harm

Supporting children to be able to tell (disclose) if someone has or is sexually abusing them, and giving them the necessary protection, are pivotal to a functioning child protection system. By the nature of sexual abuse, professionals need to be as expert in dealing with the retraction of an allegation of sexual abuse by a child, as in dealing with a child’s disclosing sexual abuse in the first place. But the prime finding of this case review is that professionals, particularly social workers and the police, are in fact much more confident and capable of dealing with the latter than the former. This makes errors in the handling of disclosures more likely, risking children being left without protection and the successful prosecution of perpetrators less likely.

Issues for the board and member agencies to consider are:

- Does the board have access to data about retractions of allegations of sexual abuse by children?
- Is there consensus across member agencies about the status of an allegation following a retraction? Is there agreement that this does not automatically discredit the allegation?
- Are materials readily available that capture the evidence base about interpreting allegations and retractions of sexual abuse by children in light of their age and stage of development?
- Do staff, particularly the police and social care professionals, have an adequate understanding of the need for investigative work whether or not a criminal prosecution is likely?

Illustrative finding number 2: the tendency in Midshire to respond to a lack of parental change by adding on successive layers of service is ineffective and wasteful (management systems)

The review team was struck by the high number of professionals – 20 at most – working with the family in question, including eight professionals undertaking direct family support work with the mother, at the same time.

Exploring this issue in more detail with the review team and case group revealed an unexpected pattern. What became clear is that Midshire’s systems are set up in such a way that there are a high number of public sector services and voluntary services that all offer support to families. When those already working with the family are unable to effect change in the family, additional agencies/professionals are automatically brought on board. As Munro talks about adding another layer of bureaucracy in response to a high-profile child death, [3] in neglect cases there is a tendency to add another layer of ‘help’ in response to a crisis. In families with complex needs this creates something like a ‘spiralling’ effect, with ever-increasing numbers of professionals and agencies working with the family, as if the quantity of the work will somehow compensate for the quality and/or appropriateness of it.
The result is that there is often duplication of work being done. While this may not be a significant resource burden on any of the particular agencies, when the total cost is tallied, it can be significant although this is not reflected in the effectiveness of the interventions or outcomes achieved. Furthermore, a high number of professionals involved can end up creating unnecessary imposition on families, and extra challenges for professionals to coordinate services and communication within the large group. In cases of chronic neglect, the very fact that it is ‘chronic’ means the systems in place are not effective. More worryingly perhaps, this case review has shown a total lack of organisational safeguards that would allow such ‘spiralling’ to be picked up and rectified. As such, it represents a significant weakness in the reliability of the systems to safeguard and protect children and support families well, and a wasteful one.

Box 21: The tendency locally to respond to a lack of parental change by adding on successive layers of service is ineffective and wasteful

It was the review team’s view that this is a particularly significant finding and one that has come about as a result of using this system’s approach. In straightened economic times, the need for services to be organised and delivered in ways that can demonstrate value for money is ever-more pressing. This is particularly pertinent to support services. Yet the current system is constituted on a pattern whereby layer, after layer, after layer of service is added to the help given to families where no improvement is manifest, without any standard regard to whether the new layer will add anything different, or indeed make any difference. This creates extra work for professionals, added impositions on families, and as this case has illustrated, can lead to real risks to the children involved being overlooked and inappropriate delay to their being removed from their parents’ care.

It is for the board to consider and be satisfied that the current delivery and structure of services is the most cost-effective and efficient way of working with families with complex needs.

Issues for the board and member agencies to consider are:

- Are there ways that professional networks can ascertain the total cost of the care package being provided to a particular family? If not, should these be developed?
- What are the barriers to pooling costing data to form a family budget? What can the board and member agencies do to address these?
- Does the board have access to type of information on performance of the system to assess quality and improvement in terms of multi-agency cost-effectiveness of interventions? Is a change needed to the information collected and analysed?
Impact

Rethinking how change occurs

Taking a systems approach to learning and improvement helps us to think carefully about how we imagine that change might be brought about through case review and SCR activities.

In thinking about the potential impact of Learning Together and ways of evaluating it, SCIE has drawn heavily on the work of Jeanne Mengis, Davide Nicolini (University of Warwick) and Justin Waring (University of Nottingham) in a research project to evaluate Root Cause Analysis in the NHS, based at IKON (Innovation, Knowledge & Organizational Networks), Warwick Business School. [11]

SCIE has distinguished three different potential routes to impact, captured in Figure 5.

**Figure 5: Triple-track routes to impact**

![Triple track routes to impact](image)

**Route 1** is the one we have considered most to date – the formal findings and responses to them. Research in the health field directs us to pay attention to the political and organisational obstacles that make effective actions far from straightforward. This
has the potential to allow more constructive solutions than admonishing boards more and more frequently to monitor their action plans.

The active involvement of staff in the Learning Together process has long received positive comment. **Route 3** captures the ‘training effect’ that taking part in a Learning Together review can have for professionals and others directly involved in it. Participating boards have suggested that it would be useful to consider how such participation could count towards continuing professional development (CPD) points.

**Route 2** is the least familiar. With this route, we endeavour to capture the less planned and less intentional ‘ripples’ that get created by carrying out Learning Together reviews or indeed resistance to them.

This triple-track route model allows us to move away from an over-simplistic view of organisational learning and improvement that assumes a single, linear path from identifying systemic causes to responding with counter-measures, resulting in improved safety. It also allows for a more developmental approach that will allow us to understand not only whether improvement has occurred, but also how and what helped and hindered so we might better support change over time.

**Case study illustrations from the South West pilots – different sites of learning and change**

**Route 1: Board and member agencies’ responses to the findings**

**What factors are boards’ effective responses contingent upon? What are the political and organisational challenges that prevent organisational learning from being a simple linear path from incident to action, and from learning to change?**

Gathering systemic feedback about the responses of the four participating LSCBs to the Learning Together reports they received is part of a larger evaluation proposal. Here we capture commentary by participants about the challenges they anticipated would be created for boards by the form and content of Learning Together findings, and why. We also include descriptions from participants at the regional dissemination event.

During the course of the training and in discussions at the cross-site meeting, participants were themselves questioning about how their boards would respond to the findings of their Learning Together reviews. Some were notably sceptical, expecting ‘supportive words, less action’. Others were genuinely curious to see how their boards did respond.

Where there was agreement was in the nature of the challenges that Learning Together findings would create for boards:

‘These will not be SMART recommendations.’
‘Some of the findings are quite big, cultural issues – how will they respond?’
‘The findings are likely to generate more work. They’ll need a “task and finish group” to take them in hand and implement.’
‘How to take the recommendations forward in a multi-agency way – it would be valuable to maintain the multi-agency approach taken to the review.’
‘Who is accountable for taking action? Getting sign-up from key strategic people is critical.’

Participants highlighted how different the end-product of a Learning Together review is, compared with what boards are used to. They were wary of boards too readily falling back into the status quo:

‘How thorough and effective is the current process? Currently SMART recommendations are very ‘packaged’ for the LSCB. At the moment, we desperately try and pull down the (perceived) level of risk and harm. Using this approach we want to raise it and say if we tackled it in a different way ...’

Trainee lead reviewers talked about the ‘cultural shift’ that was involved for boards in receiving Learning Together review findings:

‘We need to think about how we support a cultural shift, address cultural issues such as this. For the board this is the beginning of their journey. They need to own the issue as a board. That’s why it is important to hear the “structural” message and not blame individuals. It is about change. This approach is much better at looking at why we do things and what might assist change.’

They compared the ‘journeys’ they had been on through the training programme, and how the lack of equivalent support to boards exacerbated the challenge of responding effectively:

‘The board has not yet been on the journey so there’s quite a lot of educating to do through the process. The process is part learning, part peer supervision.’

This commentary mirrored closely the description of the experience of Coventry LSCB’s, given by Colin Green at the regional dissemination event:

‘When you remove the comfort zone of a SMART recommendation and ask the board “what are your recommendations?”, it actually transfers responsibility to board and we found that very difficult. Because then it means that recommendations need to deal with the wicked issues – the puzzles – including relationships between agencies, worker behaviour, people’s understanding of their role, resources – which are at the heart of why our services have not got better. It’s much more of a challenge to the board because this process highlights the stuff that we know is a problem. It’s much tougher than the traditional bunch of recommendations that the board can sign off and then hand on to a subcommittee. This is much harder. And that’s good because it should be harder.’
As with South West participants, the difficulty and challenge involved in responding constructively was by no means seen as discrediting the form and content of Learning Together findings. It was seen as necessarily difficult if effective responses were to result.

In her closing comments at the regional event, Annie Hudson also emphasised the same point:

‘We need to think about how we mainstream the learning and embed it in practice. I think in particular there’s going to be some real challenges for LSCBs. None of the LSCBs have had the reports yet. For at least 50 per cent of us in this room we will be on LSCB boards, and have the challenge of working out how to respond to the review reports. I’m struck by your phrase Sheila – their brains need to hurt! And if this doesn’t happen we’re not achieving what we need to achieve.

I think there’s a real sense of excitement that actually maybe this is going to help us do reviewing of tragic circumstance of when children die in a different way. But we’re also going away with a sense that this will be very challenging and taxing.’

This captures a consensus view that it will be because of, not in spite of, the challenging nature of the task set for boards, that possibilities for effective change will be created.

Route 2: Learning at the fringes

Does Learning Together have the capacity to produce learning and change through less formalised mechanisms than board responses to the formal findings? What are the ‘organisational ripples’ that the introduction of, and resistance to, Learning Together produces? Are changes to existing practices brought about? Are any new practices created as a result?

The work of Jeanne Mengis, Davide Nicolini and Justin Waring encourages us to be alert to the organisational ripples that may be created through the introduction of a new practice of reviewing, such as in our case Learning Together. When you introduce a new practice into a network of existing practices, it potentially changes some of those existing practice and creates new ones.

As with Route 1 discussed above, gathering systematic feedback about changes that have taken place at the fringes of the Learning Together case review itself, across the four participating LSCBs, is part of a larger evaluation proposal. Here we capture just some illustrations as had been shared by the end of the project.
Changes to existing practices

All participating LSCBs had an established practice of audit and review prior to taking part in the pilot of the Learning Together model. By the end of the project, one board in particular had already clarified ways in which it was changing the processes involved:

- Devon Safeguarding Children Board agreed for revised and shortened SCIE methodology to be applied to multi-agency case audits commencing 30 January 2012
- Devon County Council Children’s Social Work would use ‘conversations’ as part of its peer review activity commencing 3 February 2012.

Detail of this shortened methodology is discussed further in the context of subsequent regional developments in Chapter 6. It provides a strong example of the kinds of unplanned and unintended ‘ripples’ that can be produced. This is a very different form of organisational learning that was initiated by the lead reviewers in the pilot case review process.

New forms of thinking and talking

During the cross-site meeting, some lead reviewers described how the theoretical framing and language of the systems approach used in Learning Together had begun to ‘seep’ out of case review-specific activity:

‘People are talking about systems more now, rather than people. And are challenging senior managers about systems, in terms of their impact and why. I presented at LSCB subgroup recently and I was doing it almost subconsciously.’

Creating new practices

At the cross-site meeting, participants gave a clear picture that overall one of the main benefits of the case review for staff had been to provide a good example of a multi-agency critical reflection process. The experience had led people to question whether opportunities for multi-agency critical reflection could be embedded in practice more. People across all the sites reflected that the current case group/child protection conference structures are not very conducive to supporting a multi-agency group to ‘think’ together, particularly if the parents are present. Participants highlighted the absence of spaces to do the ‘working-out’ process together, including putting ‘hunches’ or ‘gut feelings’ into the mix, not as evidenced facts but as potential issues to explore further and follow up on. The Learning Together case review had provided an opportunity to do this and therefore highlighted the lack of similar forums in day-to-day work, in contrast with forums for sharing individual agency conclusions in the form of reports.

Some sites have since formalised the possibility of these multi-agency reflection meetings as a routine part of practice, describing them as a ‘bottom-up’ initiative
stemming from the Learning Together case review process, but not originally within the ‘scope’ of that process.

**Route 3: Impact on people from taking part**

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<tr>
<th>What kind of change occurs, if any, through participation in the process, for case group and/or review team members? What factors is this contingent upon?</th>
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At both the cross-site meeting and the regional dissemination event, one of the points most powerfully made about the use of the Learning Together model, from the perspective of participants, was the immediacy of the learning and change that happened for those taking part.

*Contingent factors; active participation; open, critical reflection*

Case group members gave illuminating descriptions of how the immediate learning happened, explaining what it was about the process that caused it:

‘You evolve with it and learn to dissect your practice. We get very driven by thresholds and timescales, and this has shown me that if it didn’t work, why and don’t do it again – I am more confident in my practice and moving this forward.’

‘I got a lot from the experience. The main experience for me was taking a step back and thinking freely – not just what you did but why you did it. I liked the tunnel idea because it felt like we were learning within the process, not just from the process. I've been involved in a SCR before I just didn't get the sense you learned as much.’

These two quotations highlight the part played by the guided, critical reflection not only on the appropriateness and effectiveness of their own practice, but also going further and answering the ‘why’ questions. This allowed them to understand what lay behind the appraisal of certain practice as inappropriate, as well as what influenced their own decision making at the time. Being actively involved in this analytic ‘dissection’ process is, in these descriptions, a prerequisite to learning and associated change for participants involved in a Learning Together case review process.

*New ways of doing*

Two of the examples of change brought about by participation in the case group process, which were described by case group members at the regional dissemination event, related to the development of child protection plans. One participant described it as follows:

‘I’ve been able to forge ahead in my own work as part of the pilot project. Given me more confidence to be able to challenge other professionals in a
good way as to whether the work they’re doing is for that child. I think we identified in the last “follow-on” meeting, that at one point there were eight agencies working with a family trying to do the same thing – in a case that I’m involved with that’ll never happen again.

I’ve now looked at every case I’m dealing with on a CPP [child protection plan] plan and making sure that the right people are around the table and making sure we’re working to the plan and the plan is relevant to the child.” This captures a ‘new way of doing’ core aspects of child protection work with more confidence and expertise.

The second example of doing things differently in the development of a child protection plan related to the same case that had been the subject of the Learning Together review and included a powerful example of how this had led to greatly improved outcomes for the child concerned:

‘We went on to the follow-on meeting and that was the eureka moment. Always in SCRs is the issue of communication but when you have everyone in the room then the communication really happens, you can talk around the words in the report. We could hear the school perspective and the health perspective at the time.

And subsequently we built up a real picture of the support that was necessary. And what it’s resulted in is a child protection plan that I think is one of the best that I’ve ever been involved. Because of the talk that has happened in this case we’ve been able to develop the plan so that it really puts together the agencies in the interests of the young person.’

New ways of relating

Another illustration of the type of learning and change that happened by way of route 3 concerns the way professionals related to each other across professional divides. Here too, the group meetings of the staff directly involved in the case were described as critical in the learning and change on the part of participants:

‘One other thing I got from the experience was how we interpret differently what we say to each other. At the group discussion we discovered that there was a conversation that me and another professional had had and we’d both had a completely different interpretation. And I was really shocked when I saw that. And that group discussion was really helpful and I’ll try to encourage that with other colleagues to have open and honest discussions with colleagues.’

This highlights a new awareness of the need to be much more skilful and courageous of being challenging of one another and critical of ourselves in regular communications, which participation in the process allows.

A second example of learning and change described at the regional event concerned awareness of different professional skills and tolerances for challenging parents:
'As social workers we’re expected to challenge parents very confidently and easily and we do, but as part of this case review process I’ve realised how difficult it is for other professionals to do the same, and particularly within a core group setting. As a SW [social worker] there are some things that I would be comfortable saying but other people wouldn’t.

At every third core group meeting, I’ve started asking who is comfortable with doing what, and getting people to pair up if they’re not comfortable making those kinds of challenges, as a way of making sure that challenges are actually made. We’re a group and we’re all in it together. ... I’ve learned I won’t ever expect someone to do the same job as someone else within a core group. It’s helped me be more confident in my practice in moving things on.'

This captures a relatively simple, cost-free practice improvement measure that was generated by this participant as a result of the case review process.

**Contingent factors; creating the conditions for honesty and openness**

At the cross-site meeting and the regional event, staff involved as case group members gave moving descriptions of how difficult the process can be. This was described as relating on the one hand to fear about being blamed:

‘I won’t say I didn’t feel threatened to begin with because we’re all in this culture of blame and when I went to the first meeting and I thought someone’s going to have the finger pointed at them in a minute. It soon became apparent this wasn’t the case.’

For some this related to previous experience of being involved in a traditional serious case review process:

‘The first thing when I first found out I was going to be involved I was quite worried – I got a letter that was very official and about four sides. I was involved in an SCR before of a YP [young person’s] suicide. In that case someone came in and interviewed me and then they went away and I never heard from them again – I didn’t know if I’d done anything wrong or anything right.’

As well as fear of blame, people also described the difficulty as relating to ‘baring all’ and the courage required to open up their own practice to such detailed and public scrutiny:

‘The beginning of [the Learning Together] process is very difficult to be involved in. We do this work because we’re very passionate about the children we work with so to go to a meeting and bare all and be challenged about it is very difficult.
It really helped me to see the role of other professionals in that group, and to sit in a group talking about the insecurities and the decisions that we did or didn't make, but it took time.

You learn to really dissect your practice and I've learned I won't ever expect someone to do the same job as someone else within a core group. It's helped me be more confident in my practice in moving things on. But it's by no means easy and takes time.’

These descriptions indicate how much their ability to get and stay engaged in the process, and so gain the learning and initiate the change, was dependent on the skills of the lead reviewers and review team in setting the tone and cultivating trust in both the people and the process.
Wider discussion

During the course of the project, the independent LSCB chairs within the South West region identified a number of areas for exploration. These can be grouped broadly into:

- areas for policy development (including accountability, the role of the regulator, the introduction of the new methodology, system capacity)
- areas of particular concern to LSCBs (including LSCBs’ role, comparison with the SCR process, alternative models, availability of expertise, success criteria, how to respond)
- questions for SCIE (cost, training, applicability of the model across different scenarios)
- questions that could be addressed to the pilot sites (concerning aspects of the process, perceived benefits).

‘New statutory guidance came into effect on 15 April 2013 – the 2013 version of Working together to safeguard children. [1] Responses to the questions raised by the South West LSCB chairs have been updated in light of this document.’

Policy development questions

1. Is the ‘holding to account’ element part of the SCR remit and if so how will the model address it?

The 2013 Working together guidance stresses public, organisational accountability fostered by the requirement to publish final SCR reports in full, rather than blame individuals.

In the Learning Together model, concerns about individual disciplinary or capability issues raised in the course of the review are passed on via the review team member of the relevant agency, to that agency. These concerns can then be dealt with using the normal disciplinary processes as appropriate.

2. What will Ofsted’s role in this be, if it starts to grade or comment on the process in inspections, which will significantly alter behaviour and could take us back to a process-orientated system rather than a focus on outcome?

Ofsted no longer has a role in quality-assuring individual SCRs. Instead, the way that SCRs inform organisational learning and improvement will form one of the criteria in future inspections. The new Ofsted Single Inspection Framework [12] includes a review of the LSCB in each local authority area. The framework suggests a focus on learning outcomes of SCRs, rather than process. It states that for LSCBs achieving a ‘good’ rating:
‘Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. Serious case reviews are published.’ [10, p 33]

3. What are the arrangements for parallel criminal and/or care proceedings running with the current system?

The new requirement to involve staff in SCRs can raise challenges when there are criminal proceedings and staff are witnesses. This is particularly so for models, such as Learning Together, which involve bringing the multi-agency staff group together as standard. Devon LSCB’s experience demonstrates that this is possible nonetheless. However, decisions about necessary adaptations will need to be made on a case-by-case basis.

4. The training needed would mean a lengthy phasing-in period: how would this be managed?

The government has funded the NSPCC consortium to provide training to support writing for publication. This complements its funding of SCIE to develop a pool of accredited Learning Together reviewers. There are no indications that there will be more central government support for training to comply with the new requirements.

Some boards are prioritising the cultivation of internal capacity and using SCIE’s Foundation Course as the basis, with the number of individuals qualified to lead reviews increased gradually through a mentoring scheme.

Questions for LSCBs

5. Will it work in the face of a hard-edged SCR where agencies are critical of each other and defensive?

This can be a challenge regardless of what methodology you use. There have now been three successful SCRs using the Learning Together model, and there are numerous ongoing SCRs using the model. Instances where it does not work is likely to indicate the state of relations and learning culture in the locality and the need to address that.

6. How does the LSCB fit into the process rather than the outcome?

Very important learning points from the test SCRs were the importance of agreeing at the start how to keep the board abreast of progress as the Learning Together review continues and agreeing governance arrangements, including the role of the SCR subcommittee or equivalent.

7. Do we have sufficient skilled (as opposed to trained) facilitators? A badly handled facilitation could cause serious damage.

We are in a critical capacity-building phase. See Q4 for how some Boards are responding to this skills deficit.
8. There are other models out there. Are we being rushed into thinking that the SCIE model is the only way to go?

The 2013 *Working together* guidance makes clear that boards are free to choose what learning model they use to comply with the statutory criteria for how case reviews and SCRs are conducted.

SCIE’s Learning Together model is the most developed and tested systems approach specifically for safeguarding available, having benefited from the investment of various regions as well as central government.

9. What are the success criteria for a systems approach (i.e. compliance with a process/learning/practice change etc.) and how will these be measured?

It is useful to distinguish success of the process and fidelity to systems principles from successful impact. Attempts formally to evaluate impact during the capacity-building phase have proved difficult. But see Box 10: What does success look like in a Learning Together review?, in Chapter 2.

10. How will this system change the way recommendations are made and implemented?

See Chapter 3.

11. How does this process create solutions/outcomes that are tangible?

See Chapter 3.

12. How will we cope with training degradation, given that SCRs are still relatively few in number?

The 2013 *Working together* guidance requires LSCBs to routinely conduct case reviews rather than only requiring SCRs on cases that meet the statutory criteria.

Questions for SCIE and ongoing development of the model

13. Cost is critical, and possibly a show-stopper – it includes cash, training and opportunity cost. Costs are currently unclear or in excess of current SCR costs.

Learning Together is a flexible model; SCIE is offering a ‘sliding scale’ of application to meet the learning needs and budget in any particular instance. SCIE is also offering a mentoring scheme to support the cultivation of internal expertise and decrease the reliance on consultants.

The 2013 *Working Together* guidance gives freedom to boards to decide a ‘proportionate’ response to any case review or SCR.
Colin Green: ‘It is costly but I’m not sure that it is more so than other systems. Same in cash terms but more staff time, but they get more out of it, and we get more out of it as well because their learning is more powerful.’

14. **An LSCB within the region currently has an SCR with seven local authorities and 26 health agencies. How will the system cope with this?**

The model has not yet been applied in cases with more than two local authorities. This will be important development work. There is doubtless much transferable learning from usual SCR practice to date. Having core principles will inform pragmatic decisions.

**Questions for the South West pilots/case studies**

15. **Benefit – what exactly are we getting for the investment in terms of learning and how will we measure it?**

See Chapter 4.

16. **Everyone acknowledged that the staff like the process but that is not the remit of an SCR.**

See Chapter 4 for indications of the benefits of active engagement of staff.

17. **How does the family become involved?**

The South West pilot case reviews all involved family members through conversations. These have yet to be written up in more detail.

18. **How much bureaucracy is involved?**

Facilitating a collaborative approach requires good project management and organisation, much of which is ‘front-loaded’ in the process. Administrators have commented that this process is less intensive for them than Chapter 8 SCRs.

19. **How does the process work if there is a serious failure in professional practice that is glaringly obvious to everyone?**

Maltreatment, capability or disciplinary issues are dealt with in the same way that they are in any other context.

20. **How will this system change the way recommendations are made and implemented?**

See Chapter 3.
Subsequent regional developments – foundation courses, internal mentoring, test SCRs, ‘speed’ models and themed case reviews

It would be standard to keep the boundaries of this report only to the funded project time span. However, regional interest is not in a one-off training programme to produce accredited lead reviewers but instead in the question of the potential ways in which this model could support local and regional learning and improvement activities more broadly, and the benefits and drawbacks of it. So the subsequent, linked activities of the participating boards become of interest.

Again, detail on these has not been gathered systematically so what follows gives an indication of the kind of next steps that are possible and have been deemed worth it for the respective sites. For at least three of the four sites, they indicate an ongoing commitment to the use and development of Learning Together and its applications.

Doing subsequent reviews and cultivating internal capacity

Devon Safeguarding Children Board volunteered to be one of the three LSCBs given dispensation from the statutory guidance to conduct an SCR using Learning Together. It was the only one to have parallel criminal proceedings. Learning from that experience is being written up separately by SCIE.

The board has commissioned the Learning Together Foundation course for 12 members of the Quality Assurance, Audit and Complaints subgroup of the board. The aim is for these members first to support the board’s local forums to undertake multi-agency audits using the adapted ‘speed’ model of the SCIE ‘systems methodology’ in local areas and promote local learning. This adds a significant increase to local capacity from the original two lead reviewers.

A new case review has also been started, and will be led by two participants of the Foundation Course, mentored by the two internal leads who became accredited via the pilot project.

In Gloucestershire, the two accredited reviewers have mentored two internal trainees in the conduct of a second case review, as a means developing internal capacity. These two internal trainees have also attended an open Foundation Course run by SCIE.

Other LSCBs in the region have also commissioned the Foundation Course with a view to going on to run a mentored case review to allow two internal individuals to apply to be accredited.
New models of application

Devon ‘speed’ model

Following the multi-agency case audits that have taken place over recent years, the Devon Safeguarding Children Board has updated the process to reflect the SCIE Learning Together systems methodology recognised in the Munro Review. [3] Referred to by SCIE as the Devon ‘speed’ model, it maintains all the core elements of the full Learning Together review process, but conducts them in an intensive fashion, over a one-week period.

Themed audit of multiple cases

Somerset, in the SW region although not part of this pilot, has led on the innovation of an adaptation of the Learning Together model to support a themed review of multiple cases.
References


SCIE Learning Together: reflections from the South West project

This report will help readers to:

- understand what the Learning Together methodology is and how it operates along a sliding scale of options
- see for themselves the kind of learning that is produced through this approach
- consider the potential benefits of using a common categorisation system for organising and presenting findings
- appraise the value of the consistent way that Learning Together findings are presented to create transparency and nuance about the strength of evidence behind each finding
- reflect on different ways in which a Learning Together case review can make a real difference, with concrete illustrations
- think about the need for an ‘impact model’ to underpin the evaluation of learning and improvement activities.