Slough LSCB

Learning and Improvement Framework

April 2014

Protecting children is everyone's business

Slough LSCB

Contents

1. Introduction

Working Together to Safeguard Children (2013) requires all LSCBs to maintain a local Learning and Improvement Framework. The framework should collate the findings and lessons from the full range of case reviews (from statutory Serious Case Reviews and child death reviews, to case reviews below the thresholds of a serious case review), audits, and practitioner forums.

Professionals and organisations responsible for protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

The framework should enable partner organisations to be clear about what needs to be learnt, where services and practice require improvement, and how any programme of action will lead to sustainable improvements.

Reviews of individual cases, or an audit on a number of cases, can also be selected for the 'good' outcomes, to help identify learning, disseminate the learning and embed into practice the characteristics of practice that lead to good outcomes for children and their families.

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

This document provides guidance on:

- the **principles** to be applied in any methodology used to identify learning and improvement;
- the **principal outcomes** any learning and improvement process should achieve;
- **the framework** which outlines the different types of case reviews;
- the **thresholds** for conducting the different types of reviews;
- the **methodology** recommended to conduct case reviews.

2. Principles for learning and improvement

- There should be a culture of **continuous learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process
- Final reports of SCRs must be **published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

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

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.
- Identifies clear findings from the review and recommend areas for improvement and learning

Working Together 2013 expects LSCBs to use a learning model which is consistent with the above principles.

A new national panel

From 2013 onwards there will be a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the panel will be to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports.

The panel will also report to the Government their views of how the SCR system is working.

The panel's remit will include advising LSCBs about:

- application of the SCR criteria;
- appointment of reviewers; and
- publication of SCR reports.

LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.

3. The Slough LSCB learning and improvement framework

The LSCB function in relation to serious case reviews (SCR) is set out in Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The function is to undertake reviews of serious cases and advise the local authority and their Board partners on lessons to be learned. In Slough, this function is discharged by the SCR Sub Group, and the Terms of Reference will be revised in accordance with the new guidance.

A 'Serious Case' is one where abuse or neglect of a child is known or suspected and either, the child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority and their Board partners or other relevant persons have worked together to safeguard the child.

The Serious Case Review Sub-Group will consider whether an incident notified to them meets the criteria for an SCR when the child is normally resident in Slough and make a recommendation to the independent chair of the LSCB.

Cases which meet one of these criteria must always trigger an SCR. In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5 also includes cases where a child died by suspected suicide.

Where a case is being considered under regulation 5, unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR.

The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5 are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.

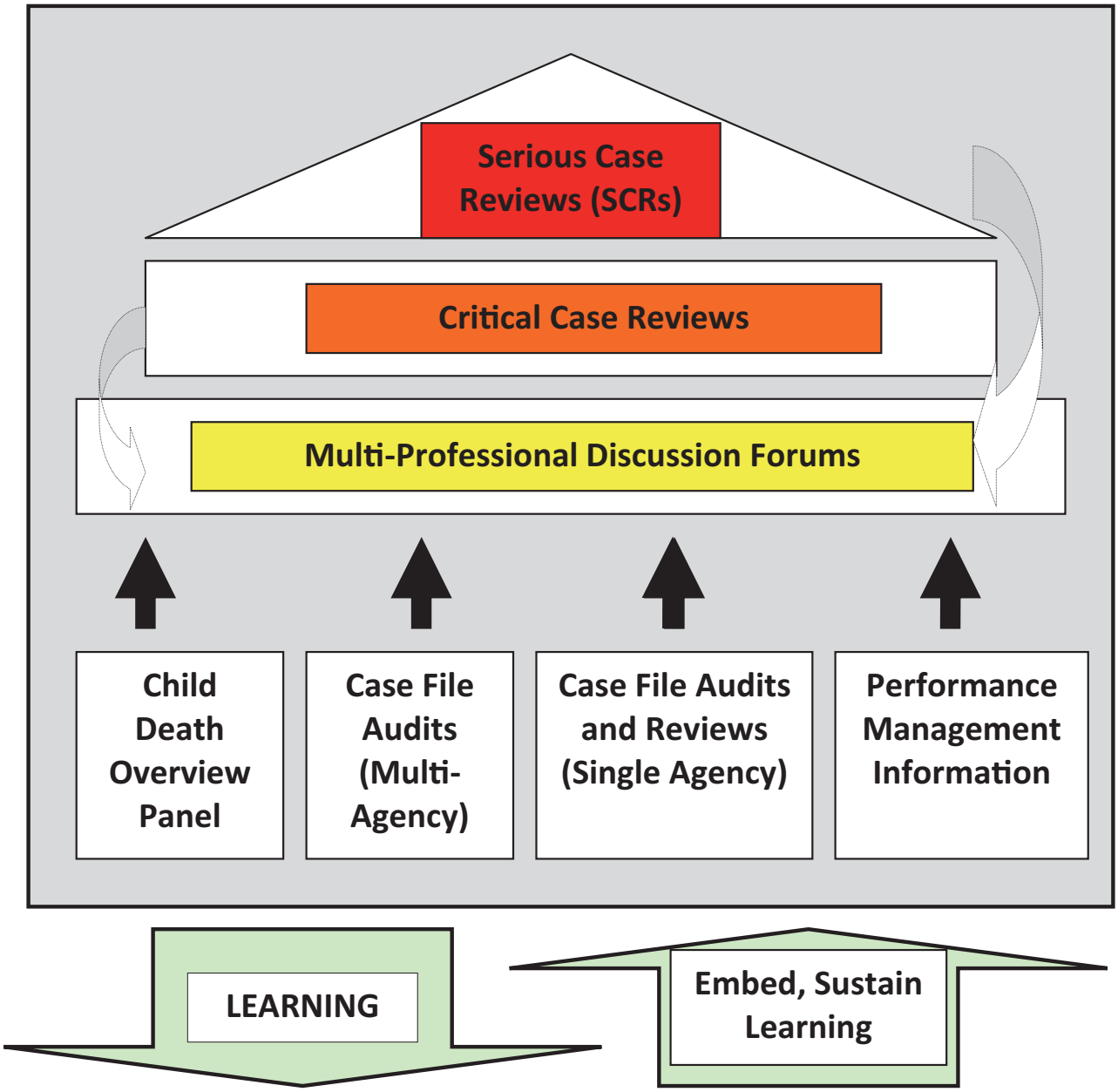
The SCR Sub Group will consider conducting reviews on cases which do not meet the SCR criteria. They will also review instances of good practice and consider how these can be shared and embedded.

This decision should normally be made within one month of notification of the incident, and each partner agency is invited to submit a notification form to the chair of the SCR Sub Group and to the LSCB Chair. The chair of the SCR Sub Group and the group's members will discuss the notification and make recommendations to the LSCB Chair. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB Chair must let Ofsted and the national panel of independent experts know their decision.

If the LSCB Chair decides not to initiate an SCR, their decision may be subject to scrutiny by the national panel. The LSCB should provide information to the panel on request to inform its deliberations and the LSCB Chair should be prepared to attend in person to give evidence to the panel.

The following diagram represents the components and their interrelationships of the framework we will use in Slough to conduct the different types of multi-agency case reviews, practitioner forums and audits:



- Single and Multi-Agency Recommendations for Action
- Training for improvements
- Priorities for Strategic Plans and Business Plans
- Impact assessment on how action taken has Improved Services

4. Serious case reviews

Serious Case Reviews (SCR) must be undertaken for every case where abuse or neglect is known or suspected and either:

- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;

Appointing reviewers

The LSCB SCR Sub group must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The Sub Group will always consider appointing an independent author and an independent chair of the SCR Panel. The reviewers should be independent of the LSCB and the organisations involved in the case.

The LSCB Chair should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

Engagement of organisations

The SCR Sub Group must ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family.

The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements.

The SCR Sub Group will (as part of the SCR) ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review. This is to ensure that the background information is received from each single agency perspective and for the LSCB to satisfy itself that any immediate action required has been taken.

Timescale for SCR completion

The SCR Sub Group should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action

The SCR Sub Group will oversee the process of agreeing with partners what action they need to take in light of the SCR findings.

The SCR Sub Group will monitor and oversee implementation of actions resulting from all reviews

The LSCB full Board will receive and discuss regular reports from the Sub Group and reflect on progress in its annual report.

Publication of reports

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published

should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

Final SCR reports should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

When compiling and preparing to publish reports, the SCR Sub Group will consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders.

LSCBs should send copies of all SCR reports to the national panel of independent experts at least one week before publication. If an LSCB considers that an SCR report should not be published, it should inform the panel which will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations.

5. Critical case reviews

Critical Case Reviews are reviews of cases falling below the SCR threshold but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. These Reviews can be important for highlighting good practice as well as identifying improvements which need to be made to local practice.

The following criteria to follow in selecting cases for a multi-agency critical case review:

- *a child is harmed through abuse/neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the child that could lead to significant and new learning that improves multi-agency communication, procedures, policy and/or practice.*

Where a case gives rise to concern about learning already identified in previous case reviews, practitioner forums or case audits, the LSCB sub group should review, outside of the multi-agency critical case review process, how that learning is being embedded and query why the learning has not been sustained.

6. Individual agency reviews

Where a case is considered for a serious case review or management review but does not meet the criteria because practice requiring further analysis and learning is limited to a single agency, the SCR Sub Group may recommend an Individual Agency Review. The methodology used to undertake this review and how the lessons will be disseminated will be decided by the sub group.

7. Multi-professional discussion forums

The SCR Sub Group will convene a regular number of forums for practitioners to discuss practice so that they can safely and openly consider, challenge and change multi-agency practice.

The SCR Sub Group or the Quality and Performance Sub Group or any individual professional, can identify themes through a variety of methods, including as outlined in the diagram above where findings from different review processes identify the need to change practice. Equally, changes in national guidance, identification of best practice principles, concerns with the effectiveness of a policy or procedure (or a timetabled review of a policy procedure), could also be reasons for convening a forum.

8. Case review methodologies

Whilst Working Together stops short of advocating any specific method the systems methodology as recommended by Professor Munro (**The Munro Review of Child Protection: Final Report: A Child Centred System**) is cited as an example of a model that is consistent with these principles.

Some Examples of Models which may be considered

- **SCIE Learning Together* (LT)** has been piloted and evaluated during the Working Together consultation period** and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved.
- **Root Cause Analysis (RCA)** has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.***
- **Child Practice Reviews** **** replaced the Serious Case Review system as the statutory guidance in Wales on 01.01.13, This process consists of several inter-related parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an Extended review which involves an additional level of scrutiny of the work of the statutory agencies.
- **Significant Incident Learning Process (SILP)** was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.
- **Appreciative Inquiry (AI)**, rooted in action research and organisational development, is a strengths-based, collaborative approach for creating learning change. SCR's conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective Serious Case Reviews hindsight wisdom to design practice improvements.

Serious case Reviews are not limited to systems methodology; there may be cases which require the inclusion of issues from outside a strictly defined systems model.

* Fish, S., E. Munro, and S. Bairstow, Learning together to safeguard children: developing a multi-agency systems approach for case reviews. 2008, Social Care Institute for Excellence: London)

** Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together systems model: lessons from the pilots. March 2013

*** **Root Cause Analysis (RCA) Investigation website**

**** Protecting Children in Wales. Guidance for Arrangements for Multi-Agency Child Practice Reviews. 2013

Irrespective of the methodology the emphasis must be on the establishment of a local framework for learning and improvement which will achieve the outcomes set out in **Section 1.2, Purpose of Local Framework**, and undertaking a review which is proportionate to the scale and level of complexity of the issues being examined.

9. Sharing learning

Integral to the success of this framework will be the sharing of learning on a wide area basis to ensure transparency, accountability and consistent improvement to practice. As such, in addition to the statutory requirements on publication, we will seek to develop mechanisms to share, where practicable, the outcomes of case reviews and multi-professional discussion forums which do not meet Serious Case Review thresholds. In addition, there will be an expectation placed upon Lead Reviewers, via commissioning arrangements or other means, that concise Learning Summary documentation will form part of all review reports. A template for this is proposed as the final section of this document..

The LSCB SCR Sub Group will collate the learning summaries on a periodic basis to analyse and disseminate the learning from across partner agencies. Periodically the group will also evaluate how this framework is working and advise the LSCB Board members of any changes required to this framework.

10. Implementation

A 12 months period of consultation and reflection will be undertaken in order to ensure the Framework is implemented successfully. To be reviewed and revised in January 2015.

Appendix 1

Learning summary template

Date Form Completed	
Type of Review conducted	(Please include details of methodology, chairing/authoring, how case was selected)
Month/year of incident	
Review reference code	
What you learnt about the case: Key themes/ early learning.	(Specific issues or general areas of concern or good practice)
What you learnt about the review/ methodology:	(What worked / didn't?; Who was involved, how long did it take, chairs, authors etc)
Key recommendations - single agency	(Indicate transferrable learning, not necessarily all recommendations)
Key recommendations - Multi-agency	(As above, focus on transferrable learning)
How do you intend to make changes? Who's doing what?	
How will you audit the impact? I.e. how will you know anything has changed?	
Any other comments, advice, suggestions - about the case, the method, embedding change or evidencing impact/change