North West Safeguarding Steering Group

North West Learning & Improvement Framework

V1.1, June 2013

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.

The framework should enable the LSCBs, their partner organisations and local partnership bodies 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.

It is expected that all LSCBs in the North West region will implement the framework to ensure consistency in the region. Whilst accountability for learning and resulting action will remain locally, a consistent framework will help partner agencies and lead reviewers across the region be more familiar with learning processes, case review thresholds, methodologies and learning dissemination/action programmes. Over time, a consistent approach should lead to both professional and public confidence in the rigour of the learning.

This document provides LSCBs with guidance on:

- the principles to be applied in any methodology used to identify learning and improvement;
- the principle 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 by the North West Safeguarding Steering Group to conduct case reviews[1]; and
- how LSCBs will share and collate learning to ensure practice locally is fully informed by experience regionally.

[1] In line with paragraph 11, Chapter 4 of Working Together to Safeguard Children (2013), LSCBs retain their right to choose any learning methodology to conduct case reviews

Principles for Learning and Improvement

The following principles have been adapted from the English[2] and Welsh[3] statutory guidance. Statutory guidance documents outline both methodological and outcome principles in one set, but for ease of use and clarity the principles below are separated.

Principles in the Methodology

The following principles outline the statutory requirements that LSCBs should adhere to in methodology and processes used to conduct the different case reviews, practitioner forums and audits. They should play a vital part in shaping the design and development of arrangements.

- There should be a culture of continuous learning and improvement across organisations, identifying opportunities to draw on what works and promote good and effective multi-agency practice;
- Case reviews, practitioner forums and audits should provide regular opportunities to address multi-agency collaboration and practice through learning, reflection and development;
- Learning and reviewing methods recognise the complex circumstances in which professionals work together to safeguard children – as much effort in the process of reviewing should go into identifying and analysing areas of good practice as well as practice that requires improvement;
- Learning and reviewing methods are transparent in the way they collate and analyse data and make use of research and evidence to inform findings;
- Case reviews, practitioner forums and audits must seek to understand precisely who did what and the underlying reasons that led individuals, teams and organisations to act as they did/do;
- The approach taken on learning and reviewing should be proportionate to the scale and complexity of the issues being examined;
- Professionals must be involved in learning and reviewing opportunities; contributing their perspectives without a fear of being blamed for actions taken in good faith;
- Families, including children (where possible) should be invited to contribute in learning and reviewing opportunities; there should be clarity of how they will be involved and their expectations should be managed appropriately and sensitively;
- Serious Case Reviews should be led by one or more persons who are independent of the case being reviewed and the organisations whose actions are being reviewed;
- There is transparency with professionals, family and the public in disseminating the learning; final serious case review reports will be

[2] Working Together to Safeguard Children, DfE (2013)
[3] Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government (2012)

published[4] and findings from all other reviews, practitioner forums and audits will be summarised in LSCB annual reports.

Outcome Principles

The following principles outline the outcomes LSCBs and their partner agencies should achieve through the process of conducting case reviews, practitioner forums and audits. These outcomes should always be placed in the context that any system, including safeguarding systems can only manage and reduce risk, not eliminate it and that systems are made up of numerous variables that constantly change and fully appraising and managing risks of each variable is a complex task.

- Learning and reviewing opportunities should be transparent so that they identify promptly the need for systemic or organisational changes and ensures timely action is taken;
- Professionals in all services working with children and families are given the assistance they need so that they can undertake the complex and difficult work of protecting children with confidence and competence;
- Organisational and multi-agency cultures, and the processes that underpin the cultures, are experienced as fair and just by professionals, and promote supportive work and management environments for them;
- Through regular monitoring and follow up, improvements recommended and actioned from findings must be sustained;
- Transparency is created that shares and disseminates lessons learnt on a multi-agency basis locally, regionally and nationally;
- The processes used for learning, the findings from reviews and action taken should provide accountability and reassurance to children, families, the public and government/inspectorates;
- The impact of case reviews, practitioner forums and audits should be to improve services for children and families and on reducing the incidence of harm; the impact of Serious Case Reviews should be to reduce the incidence of serious harm and death in children.

Initiation of Case Reviews

Each LSCB will determine the most suitable process to use in deciding if a case meets the criteria for a case review, or nominating areas/safeguarding themes for practitioner forums/case file audits. Some LSCBs will use formal mechanisms requiring referral forms to be completed and scheduled panel meetings that regularly meet to decide on all types of case reviews; other LSCBs may only use a formal panel process for serious case reviews and decide on other types of case reviews, practitioner forums or audits through a quality assurance sub-group.

For cases that are considered for serious case reviews, the final decision if a case meets the serious case review criteria will rest with the LSCB's Independent Chair.

[4] In line with the directions from the Minister for Children and Families, 24.06.2013

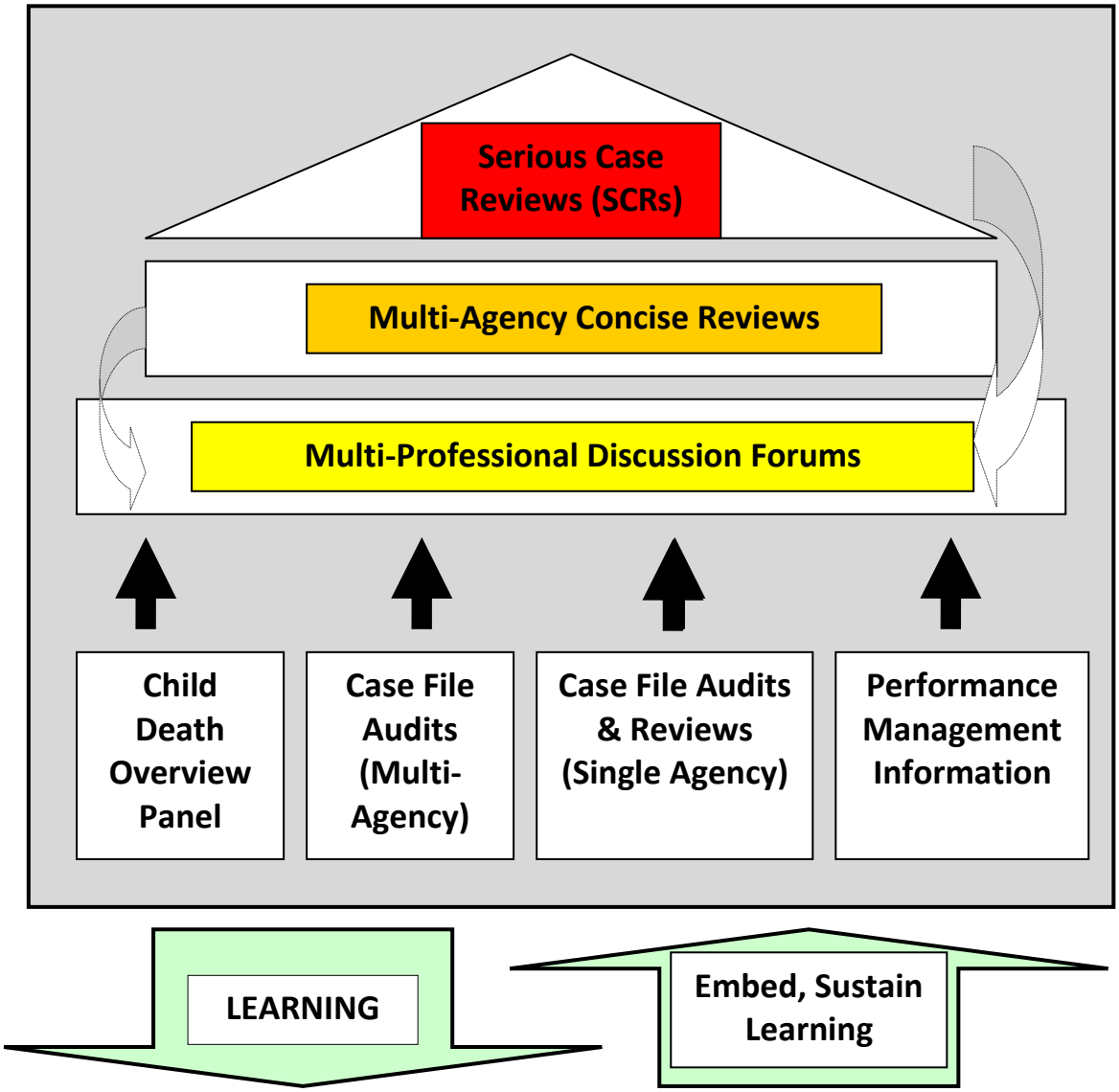
Decisions on whether to initiate a serious case review should be normally made within one month of the LSCB being notified of the incident triggering the threshold.

In line with the directions issued by the Children and Families Minister[5], the National Panel of Independent Experts on serious case reviews will be notified within 14 days of the LSCB Chair's decision on whether a serious case review is to be initiated. Where a case is considered for a serious case review and the LSCB Chair decides the threshold is not met, additional information to justify the decision will be required to be provided to the National Panel of Independent Experts on serious case reviews. Where the notification to the National Panel of Independent Experts on serious case reviews is to initiate a serious case review, the notification information should also contain the name(s) of the independent Lead Reviewer(s) appointed by the LSCB Chair.

[5] Letter from the Children and Families Minister, Edward Timpson to LSCB Chairs, Directors of Children's Services, Local Authority Chief Executives and Lead Member, DfE, 24.06.2013

Learning and Improvement Framework

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



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

Serious Case Reviews (SCRs)

All LSCBs must conduct SCRs in line with requirements in paragraphs 12 to 18 and the checklist on pages 70 to 72 of Chapter 4, Working Together to Safeguard Children (2013). In the next section, the methodology recommended by the North West Safeguarding Steering Group is outlined and to ensure consistency for all stakeholders in the process, it is proposed that LSCBs use the methodology[6] including the use of proportionate methodologies between complex and less complex cases.

Multi-Agency Concise Reviews

Multi-agency concise reviews are reviews of all cases falling below the SCR threshold. Cases can involve incidents where a child has been *harmed* and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice.

The North West Safeguarding Steering Group recommends the following criteria to follow in select cases for a multi-agency concise 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 should review, outside of the multi-agency concise review process, how that learning is being embedded and query why the learning has not been sustained.

Individual Agency Reviews

Where a case is considered for a serious case review or multi-agency concise review but does not meet the criteria, as practice requiring further analysis and learning is limited to a single agency, the SCR Panel (or relevant Quality Assurance Group) may recommend an Individual Agency Review. The methodology used to undertake a review and how the lessons will be disseminated will be decided locally by each LSCB.

[6] LSCBs are requested that any departure from the methodology, where new methodologies are trialled, is brought to the attention of the North West Safeguarding Steering Group to consider if revision to this framework is required

Multi-Professional Discussion Forums

LSCBs should hold a regular number of forums for practitioners to discuss practice so that they can safely and openly consider, challenge and change multi-agency practice. LSCB Quality and Improvement/Quality Assurance groups, or any professional, can identify themes through a variety of methods, including as outlined in the diagram above where findings from different review processes identifies the need to change practice. Equally, changes in national guidance, identification of best practice principles, concerns with the effectiveness of a policy/procedure, or a timetabled review of a policy/procedure could also be reasons for convening a forum.

LSCBs should select methods of undertaking practitioner forums that suit their local practitioners and the theme being discussed. Guidance from the Welsh Government is available to help LSCBs organise and facilitate these events[7].

[7] Protecting Children in Wales, Child Practice Reviews: Guide for Organising and Facilitating Learning Events, Welsh Government (2012)

Case Review Methodologies

Consistent with recommendations of Professor Eileen Munro, this framework outlines a systems approach to case review. A proportionate approach of *Intensive* and *Targeted* reviews is proposed. A flowchart to support decision making is at Appendix A. These methodologies are based on practical experience of a range of systems approaches to case reviews within the North West across children's and adult services. They focus on the discharge of Local Safeguarding Children Boards' responsibilities to undertake reviews of serious cases as confirmed below.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

> 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
> (2) For the purposes of paragraph (1) (e) a serious case is one where:
> (a) abuse or neglect of a child is known or suspected; and
> (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Significant Practice Events Chronologies

There is a strong commitment that robust and proportionate chronologies inform decisions to initiate case reviews and determine the scope and methodology for review. Each relevant agency will provide 'Significant Practice Event' chronologies to detail its involvement with the child who is the subject of the review. Whilst this framework embraces the value of local approaches to chronologies, a robust and consistent approach focussed on the following principles should be considered:

- Risk – each Significant Practice Event (SPE) details the presentation of risk
- Response – agency response is clear
- Partnership – understanding of multi-agency considerations is apparent
- Learning – the core of the methodology and chronologies should identify learning opportunities, in particular those which are significant or new.

Defining Significant Practice Events

The use of Significant Practice Events (SPE) chronologies is integral to ensure clear parameters of any review are agreed based upon the circumstances of the case. They will be used to support decision making on whether Serious Case Review criteria have satisfied; how case reviews can be discharged in a proportionate way;

and how engagement with Case Groups should be configured. Agencies should consider the following when preparing SPE chronologies:

- Is this event one that changed/could have changed your assessment of the situation for the child?
- Is this event symbolic or indicative of a pattern of events that individually would not otherwise be considered significant?
- Is this a 'statutory' event e.g. child protection conference, court hearing or similar?
- Would this have been an event that the child perceived as significant in their life?
- Would this have been an event that a significant adult would perceive as significant in their life or the life of the child?
- Has this event got significance as a learning point for agencies?

Intensive Serious Case Review

Where cases are of a very serious and/or very complex nature, LSCB should consider undertaking an Intensive Serious Case Review. On an exceptional basis, or where LSCBs have not previously used a systems approach to case review, there may be learning benefits from adopting the Intensive Serious Case Review approach in less complex cases.

Targeted Serious Case Review

This methodology seeks to target review activity in a proportionate way based on the specific circumstances of the case. A Targeted Case Review should be considered in the following circumstances

i. Serious Case Reviews where 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 and the LSCB considers that criteria under Regulation 5(2)(a) have not been met.
ii. Serious Case Reviews where the LSCB considers it is proportionate to use the Targeted Case Review methodology. This may include cases where:
    a. chronologies reveal SPEs are limited in scope and it would not be compatible with the principles of Working Together in respect of proportionality to undertake an Intensive Case Review;
    b. the scope for learning is focussed on an area of practice, or issues which have already been recently identified and agencies are in the process of, or recently implemented a programme of action;
    c. in exceptional circumstances, if the case is largely historical in nature and it is not practicable or desirable to undertake an Intensive Case Review; or
    d. the LSCB Chair does not consider the Serious Case Review threshold to have been met, but peer challenge or consultation with the National

Panel of independent experts on Serious Case Reviews would suggest that initiation of a Serious Case Review may be prudent.

Multi-Agency Concise Reviews

Where the LSCB considers the criteria for a multi-agency concise review is met (page 6), the LSCB will decide the most appropriate methodology for conducting the review, ensuring all the appropriate methodological and outcome principles (pages 3-4) are met.

Review Group

The Review Group should be made up of senior managers from relevant agencies and qualified Lead Reviewers who are independent of the case. In Intensive Serious Case Reviews and Targeted Serious Case Reviews where the statutory threshold for initiation of an SCR has been satisfied, Lead Reviewer(s) should be fully independent of all the agencies of the LSCB.

Where LSCBs choose to conduct other types of reviews like Multi-Agency Concise Reviews, internal Lead Reviewers may be appointed as appropriate.

Case Group

The Case Group will be made up of the frontline practitioners and managers who were involved in the case, especially those involved in the Significant Practice Events. Case Group members can individually contribute to the case review, or different agency practitioners brought together in forums. The aim is to understand the practitioner's view of the practice events (source of data) and assist in analysing 'contributory factors' and how the safeguarding system can be improved.

The involvement of practitioners in the case review must be a safe way for them to contribute to identify the learning, and empower them to share and disseminate the learning. Case Group members must be informed and consulted on the findings from the case review and provided the opportunity to help the Review Group in correcting and enhancing the findings and learning.

Proportionate approach to Serious Case Review

The following table outlines the staged approached to Intensive and Targeted Serious Case Reviews[8]. Specific attention is drawn to emphasis upon the process of analysis at the heart of the review.

Stage	**Activity**	
Review Group Initial Meeting	Review Group meets to identify agencies involved with child and initiate pre-review processes following notification of an incident. This meeting may be of a Serious Case Review sub group or similar, depending on local arrangements. Any parallel or overlapping review processes by other partnerships (eg Domestic Homicide Reviews, MAPPA SCRs, Youth Justice Serious Incidents or Health Serious Incidents) should be carefully considered, including any impact on criminal investigations processes.	
Significant Practice Events (SPEs) Chronologies	All agencies involved prepare SPEs chronologies identifying risk, response, partnership and learning issues underpinning each episode.	
Review Group Planning Meeting	Review Group convenes to consider SPE chronologies and confirm whether it is considered that Serious Case Review criteria have been satisfied. Based on SPE chronologies, Review Group advise on scope and type of review and consider appointment of independent or internal Lead Reviewer. Initial parameters of SPE Forums with Case Group are set. **½ day**	
Engagement with National Panel of Independent Experts/ Peer challenge	LSCB Chair seeks peer challenge where appropriate. LSCB Chair consults with National Panel regarding application of SCR criteria and inform of the appointment of Lead Reviewer(s).	
	Intensive	**Targeted**
Case Group Significant Practice Event Forums	Review Group lead information gathering process via Forums with groups of case workers on an 'episodic' basis which assembles appropriate groups of case workers as defined at the Review Group Planning Meeting. This approach should create conditions for inter-agency learning including	As Intensive approach. The number of Case Group SPE Forums should be proportionate to the complexity of the case and senior management resources from agencies within the Review Group should be reflective of this. **Up to 1 day**

[8] Adapted from the Social Care Institute of Excellence (SCIE) Systems Methodology

	introducing the approach to case workers. The outcome from these concurrent Forums will be to build a co-ordinated picture of the case from the perspective of professionals. **1 day**	
Review Group Information Audit	Review Group considers relevant documentation and outcome of any interviews with families/surviving children and triangulates these findings with those of the Case Group SPE Forums.	There should be a strong emphasis on ensuring the timely completion of this phase in Targeted reviews. Proportionate use of independent or internal Lead Reviewers should be given particular regard.
Significant Practice Event Analysis Meetings	Review Group convenes to evaluate emerging individual and systemic practice issues arising from review activity. Transferrable learning is identified and typologies proposed. **2 or more ½ day sessions.**	Methodology as Intensive approach. **1 or 2 ½ day sessions**
Family and Child(ren) Involvement[9]	Lead reviewers to meet with family and child(ren) – the session should capture: • the lived experience of the child(ren) • understanding the SPEs and the professional and family responses • capturing the voice of the family and child(ren), including issues of justice • reflecting on how resolution, repair and	As Intensive approach

[9] Family and child (surviving subject child(ren) and/or siblings) involvement at this stage in the process will require careful planning and where criminal proceedings are ongoing may require moving to a later stage in the process; for SCRs involvement should be complete prior to publication of the final report

	change can be brought about in the future[10] **½ day session**	
LSCB Progress Report	Review Group updates wider LSCB membership on progress to date and confirm planning for Learning Workshop.	As Intensive approach
Learning Workshop	Review Group presents emerging transferrable learning to Case Group. Consistent with the systems approach this workshop should identify opportunities to improve multi-agency communication, procedures, policy and/or practice. This consultation should confirm both the typology of learning and that it is transferrable beyond the individual case. **1 day**	As Intensive approach. **1 day**
Initial report to LSCB	Lead Reviewers present initial findings to the wider LSCB. This session should provide opportunity to address any areas of conflict and confirm plans to share learning on a wider area basis.	As Intensive approach
Programmes of Action	Translation of findings into programmes of action that lead to sustainable improvements in practice and the prevention of future death/serious harm to children. Family Involvement - feedback, fulfilling any commitments like reporting action taken for	As Intensive approach

[10] Objectives adapted from *A Study of Family Involvement in Case Reviews: Messages for Policy and Practice,* Morris et al, BASPCAN (2012)

	change and evaluation of the process.[11]	

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, North West LSCBs 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 at Appendix B.

The North West LSCB Business Manager's Group will collate the learning summaries on a periodic basis to analyse and disseminate the learning from across the region. Periodically the group will also evaluate how this framework is working and advise the North West Safeguarding Steering Group of any changes required to this framework.

Implementation

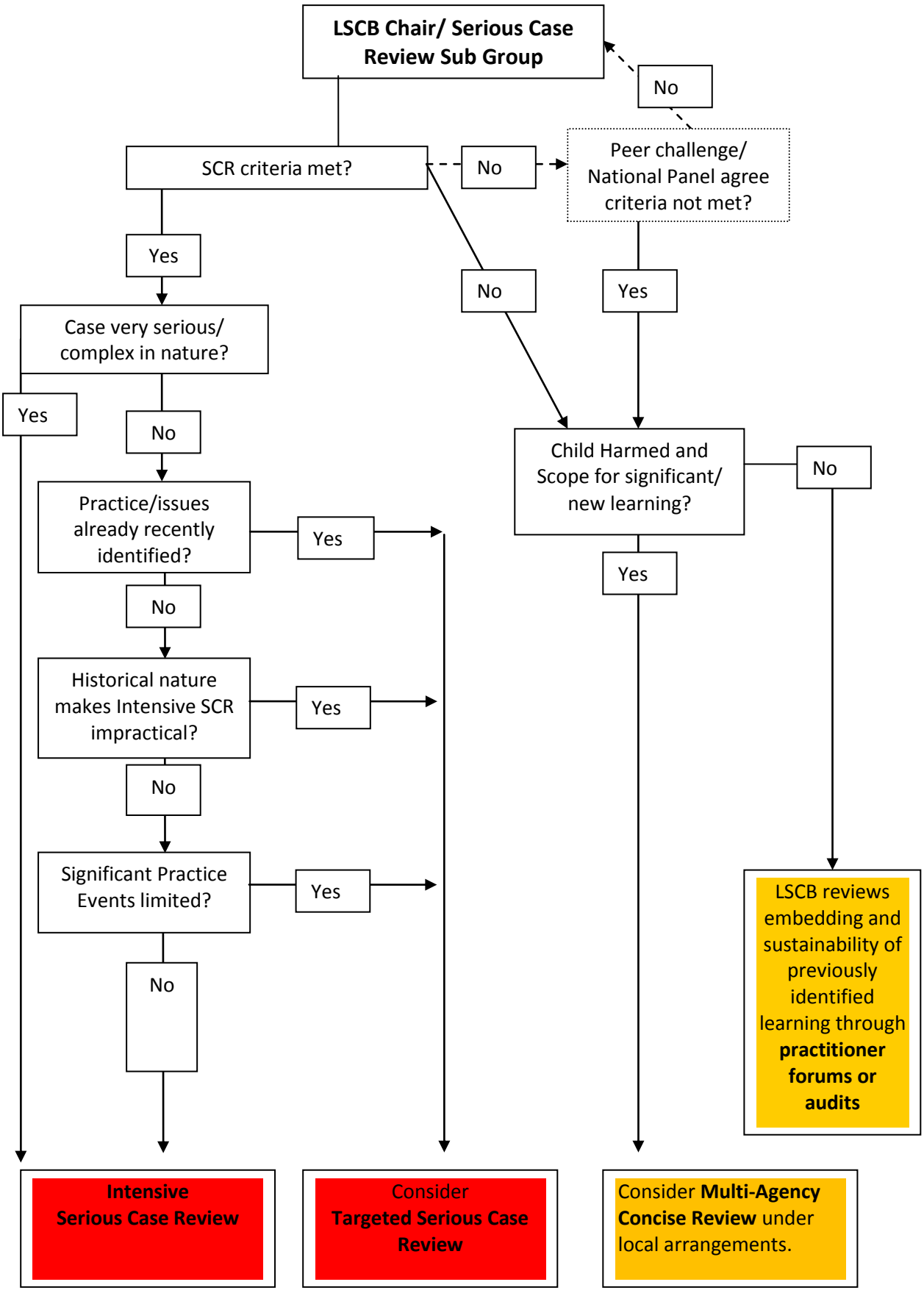
This framework is intended as a first stage of development of a North West approach to learning and improvement. A period of consultation and reflection should be undertaken in order to ensure the Framework is implemented successfully, with consideration of the following issues of particular importance:

- Developing a systems approach – it is acknowledged that the systems approach to case review is underdeveloped in many areas. Some LSCB partners have experiences of methodologies such as Root Cause Analysis (RCA) they may wish to test against these methodologies.
- Training – in addition to identification of a series of training needs and appropriate provision to meet those needs, the early implementation of any systems approach will need to create conditions for learning of itself. Accessing Department for Education funded training delivered via the NSPCC, in partnership with Action for Children and Sequeli Ltd on 'Improving the Quality of Children's Serious Case Reviews' will form a constituent element of this[12].
- Typology of learning characteristics – in order to facilitate consistent sharing of learning on a local, regional and national basis, implementation will need to fully consider the agreement of a shared typology of learning characteristics.

[11] Adapted from *A Study of Family Involvement in Case Reviews: Messages for Policy and Practice,* Morris et al, BASPCAN (2012)

[12] Funding and commissioning of national training by the DfE may alter; LSCBs are advised to contact the DfE to ascertain most up to date accredited training

Case Review Threshold Flowchart **Appendix A**



Appendix B

Learning Summary Template

LSCB Area	
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? Ie. how will you know anything has changed?	
Any other comments, advice, suggestions – about the case, the method, embedding change or evidencing impact/ change	

You may wish to consult NSPCC's 'Safeguarding Through Audit – A guide to auditing case review recommendations' – see: https://www.nspcc.org.uk/Inform/trainingandconsultancy/consultancy/supportingproductsandresources/safeguardingthroughaudit_wda47786.html