Learning and Improvement Framework: Terms of reference

Introduction

The revised *Working Together to Safeguard children* [1]requires a change in emphasis in learning from Serious Case Reviews to broader learning and improvement. The Serious Case Review sub-group considered options available and propose use of the *Welsh model of child practice reviews (2013)*

Working Together (2013) offers guidance in principle however little prescription. However to ensure learning and improvement aligns with other frameworks any local guidance will need to be a dynamic document that responds to change in practice elsewhere in the system.

Attached to this document are appendices setting out:

1. The principles from (*Working Together 2013)*
2. Principles from *the Welsh model (2013) Guidance for arrangements for multi-agency child practice reviews*
3. A matrix to identify the degrees of concern in a case and the type of report required.

The guidance suggests a learning and improvement framework should have a practice paradigm[2] involving core principles suggested as:

- **Philosophy**: - openness, integrity, quality of inputs, systemic thinking, clarity of purpose
- **Principles:** - culture of learning, proportionality, independence, involvement of professionals, involvement of family, published report, sustained improvement in the system through monitoring and follows up
- **Process:** - a clear process that is systemic
- **Practice change:** - outcomes, action plans, learning and improvement

This document addresses the need to manage review reports for the Board for both statutory and learning purpose. However the principles involved are those to be adopted for the different levels of learning including single agency reports, critical learning incidents, audit and best practice

The *Welsh model*

The guidance asks that 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. These processes should be transparent and the new guidance suggests this learning should be linked to a Safeguarding Children Board maintaining a local learning and improvement framework shared across local organisations who work with children and families. This framework [3]should support the work of the Board and partners. The *Welsh model* offers this clarity. It is also clear on single agency responsibility to be taken in action where it finds unprofessional practice.

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[1] HM Government (2013) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children

[2] With reference to Jane Wonnacott & Fergus Smith presentation to LSCB 2013

[3] HM Government (2013) p65

The Welsh model gives a clear direction in the form of a framework. It has the flexibility to allow another methodology to be used alongside it eg SCIE. Therefore it has the ability to ensure the case leads the review and not the methodology.

Serious Case Review

Cases subject to a formal Serious Case Review have a clearly set out process in *Working Together* (*2013).* This new guidance has enabled how SCRs are conducted to allow for different methodologies to be used. There is also a set of principles that SCRs must adhere to, including recognising the complex circumstances in which professionals work, understanding the underlying reasons why people act as they did, avoiding hindsight bias, transparency about research methods and making use of research as well as case evidence to inform findings. Therefore a systems approach is recommended to identify the nuance impacting on the case within the family and professionals experience. The *Welsh model (2013)* has the potential to help us develop a window on the system in using the case to achieve broader learning.

The *Welsh model (2013)* consists of several interrelated parts with a process for the review as well as a methodology to cascade the learning arising. There is a structure with **extended reviews** (fulfilling criteria for SCR) and **concise reviews** for SCRs and other learning. The difference between the two reviews is in the scope of the review.

Other Reviews

The *Welsh model* and *Working Together (2013)* ask that 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. This guidance is relevant for reviews including management overview reports, single agency reports, critical learning incidents, audit and best practice

Working Together (2013) invites LSCBs to develop mechanisms to explore learning broadly and therefore to consider use of single and multi agency review process for both cases where there have been serious incidents as well as best practice.

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the child
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them.

This learning and improvement framework has indicated a proportionate approach to other reviews in order to learn from cases and is set out in a matrix (appendix 3) that indicates different levels of concern from **catastrophic** (SCR) to **low level** (minor injury due to failure to comply with policy) and includes **best practice.** This matrix is suggested as a framework to consider the level of review of a given case

Principles of Terms of Reference: Learning and improvement

Purpose:

1. Promote a positive culture of multi-agency child protection learning and reviewing in local areas,
2. Set in place a foundation for learning together by professionals from different agencies, including those circumstances where more formal review is required when there are serious incidents resulting from abuse or neglect
3. Outcomes of the review process are anticipated to generate new learning which can support continuous improvement in inter-agency child protection
4. To evaluate the child and their family life and the support s/he received from universal, targeted or specialist services
5. Provide an overview report to the Serious Case Review sub group (or other sub-group) summarising the key findings, lessons and any recommendations for the Board to consider for future practice.
6. Identify any areas of good practice or practice that may need development and support and to act as a window on the system.
7. To be transparent for family and staff or volunteers
8. Identify any lessons to be learned
9. Make recommendations about policy/procedure/protocol or learning and development within a multi agency context
10. To inform the Performance Management Framework
11. Confirm that the SCR panel as being responsible for agreeing the Terms of Reference for the review; as well as where possible including the overview author in finalising terms of reference.
12. To guide the different sub groups in their work programme eg audit and learning, practice training and development activity

The process of a learning and improvement review report to include:

1. Decision to undertake either a SCR, management overview report or a Critical Learning or other review is endorsed by the independent chair of the SSCB
2. The decision making process for a SCR to be informed by the national panel of independent experts on SCRs where appropriate to do so
3. Guidance to be followed as set out in *Working Together (2013)* and to use a systemic model. The *Welsh model (2013)* systems framework is proposed.
4. Family to be involved in the review and any decision and the reasons to not include them to be included in the report
5. The review to plan at the outset how the report will be published

In other types of review,

1. The key principles for SCR to be followed proportionately to the issue. This to also include any other methodology alongside the *Welsh model*, presentation/publication, transparency and inclusion of family members.
2. Consideration as to the writing of the report and how best this can present challenge to the process and independence. This may be served with a professional, independent of the case but with interest and skills in the subject area of the case eg a designated lead professional. However the report may require independence demonstrated through an author commissioned for the specific case.
3. The SCR panel to advise on the relevant agencies to be involved and whether an individual Agency review report is required. This view may differ to the requirements of single agency governance and accountability eg health have their own standards and root cause analysis system

6. Any further methodology to be agreed between the author of the report and the panel. Any other methodology other than the *Welsh model* to follow the key principles of *Working Together (2013)* and be a systems methodology. Systems methodology can be briefly described as providing a nuanced understanding of frontline practice by getting behind *what* professionals do and illuminating *why* they do what they do (SCIE 2008)
7. The SCR panel to advise in other reports on the involvement, if any of the child and their family in this review. Where appropriate the child and family to be informed of the review. If the family are not to be informed/involved then this to be clearly recorded as a decision.
8. The SCR panel to advise as to involvement of front line staff and volunteers in the review process. If staff and volunteers are not to be informed/involved then this to be clearly recorded as a decision. At minimum staff/volunteers will be involved in direct discussion of their involvement in the case. Further involvement may include meeting(s) of these staff by report author to identify issues to be considered by the report and for consideration of the draft report for comment and accuracy.
9. The SCR panel to consider at the point of commissioning a review how this report will be presented and what readership it will have. In particular whether the report will be available to staff in whole or shortened format or as a management letter from the independent chair of the SSCB
10. The timeline for the individual agency reviews, completed report and publication to be set out at the start of the process
11. Individual Agency reviews setting out chronology of significant key milestones and events in the child and family life, alongside agency contact and genogram
12. A time frame agreed by the commissioning group to reflect a proportionate period of time to inform the review including the key areas of concern
13. A summary analysis of agency and inter agency work from the single agency perspective. This analysis to conclude with identification of lessons learned and action points
14. An annual update on progress and themes emerging of management reviews undertaken in the course of the year to be shared with the SSCB
15. The purpose of the review is to identify improvements and to consolidate good practice.
16. Issues arising where a professional or author feels urgent action should be taken to protect the chid then this matter should be escalated using usual agency procedures and informed by the London Safeguarding Children Board Child Protection procedures

Learning and improvement cycle

The *Welsh model* gives direction and practical guidance in how the Board will cascade learning from cases, audits or other method of review. It also offers different levels of learning including:

- **Multi agency professional forums**: as a foundation for producing organisational learning, improving the quality of work with children and families and strengthen the ability of services to keep children safe. It is anticipated this forum is arranged and facilitated by the Board with the purpose of learning from cases, audits, inspections and reviews in order to improve future child protection practice and
- **Learning events:** The Welsh model intends to provide an environment whereby practitioners and their agencies can learn from their case work. To achieve this effectively individuals in the group need to feel safe in order they can open up and connect with other members and with the

information shared. These events are linked to the extended and concise reviews and require the reviewer to not only have professional, analytical and report writing skills but also an understanding of how adults learn, group dynamics and skills in managing group process

The accompanying Child Practice reviews: guide for organising and facilitating learning events provides practical tools to assist this process. As such enables a complete cycle of identifying a serious incident/ concern to review method as to how to review and then to share learning as part of the review process and for wider learning on completion of the review

References

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HM Government (2013) *Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*

Fisher S, Munro E & Bairstow S (2008) *Learning together to safeguard children: Developing a multi agency systems approach to case reviews* London Social Care Institute for Excellence

London Safeguarding Children Board (2010) *Child protection procedures* www.londonscb.gov.uk

London Safeguarding Children Board (2010) *Serious Case Review Toolkit* www.londonscb.gov.uk

Munro R & Lushey C (2013) *Undertaking Serious Case reviews using the Social Care Institute for Excellence: Learning together systems model: Lessons from the pilots* SCIE

Root cause analysis
www.npsa.nhs.uk/patientsafety/improvingpatientsafety/rootcauseanalysis

Rzepnicki T 7 Johnson R (2004) *Examining decision errors in child protection: a new application of Root Cause Analysis*

Tudor P & Ohdedar D (2012) *Significant Incident Learning Process*

Welsh Government (2013) *Guidance for arrangements for multi-agency child practice reviews*

Welsh Government (2013) *Child Practice Reviews: Guide for organising and facilitating learning events*

Appendix 1: Working Together to Safeguard Children: Principles for learning and improvement

The following principles (p68) should be applied by LSCBs and their partner organisations to all reviews:

1. 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;
2. the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
3. 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;
4. 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;
5. 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;
6. 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
7. 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.

Appendix 2: *the Welsh model (2013) Guidance for arrangements for multi-agency child practice reviews*

- professionals in all services working with children and families in the local area are given the assistance they need so they can undertake the complex and difficult work of protecting children with confidence and competence;
- organisational cultures, and the processes that underpin the culture, are experienced as fair and just, and promote supportive management and work environments for professional;.
- a positive shared learning culture is an essential requirement for achieving effective multi-agency practice;
- a culture of transparency is created that
    - Provides regular opportunities to address multi agency collaboration and practice, and multi-agency learning, reflection and development;
    - Has processes for learning and reviewing that are flexible and proportionate and are open to professional and public challenge;
    - Engages with children and families in individual cases and takes account of their wishes and views;
    - Provides accountability and reassurance to children, families and the wider public;
    - Identifies promptly the need for systemic or professional changes and ensures timely action is taken;
    - Shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally and nationally;
- The work of learning, reviewing and improving local multi-agency child protection policy and practice is audited and evaluated for its effectiveness

Appendix 3: SSCB - Terms of reference: Reports for Learning and Improvement

Grade	Outcome			
Category	**Incident**	**Statutory compliance**	**Type of review**	**Reputation**
Catastrophic	-where abuse or neglect of a child is known or suspected & - 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[4]	-Cases which meet one of these criteria regulation 5(2)(a)&(b)(i)or 5 (2)(a) and (b)(ii) above **must always** trigger a SCR [5] -A SCR **should always** be carried out if a child dies in custody, police custody, on remand or following sentencing, in a Youth Offender Institution, secure training centre or a secure children's home, or where the child was detained under the Mental Capacity Act 2005. Regulation 5(2)(b)(i) includes where a child dies by suspected suicide -Under r5(2)(b)(ii), unless clear there are no concerns about interagency working, the LSCB **must** commission a SCR - Use guidance from independent panels on SCR	Serious Case Review/CDOP Approach to consider possible use of: -Welsh Government[6] (2013) -SCIE[7]	-Publication -Media coverage -Political questions local/national -Annual Safeguarding Report -Single agency governance structure

[4] HM Government (2013) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children

[5] Regulation 5 (1) 1 and (2) Local Safeguarding Children Boards Regulations 2006

[7] Fisher S, Munro E & Bairstow S (2008) Learning together to safeguard children: Developing a multi agency systems approach to case reviews London Social Care Institute for Excellence

Severe	-where abuse or neglect of a child is known or suspected & - either (i) the child has died; or (ii) the child has been seriously harmed and there is *curiosity* or *concern* as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child -Injury requiring immediate hospital admission for more than 24 hours (RIDDOR reportable), -Permanent disability/disease -a child has been seriously harmed as a result of being subjected to sexual abuse/child sexual exploitation or the parent has been murdered due to domestic homicide	-Failure to meet professional standards and/or statutory requirements	Multi agency management overview Report/ Critical Incident Report/ CDOP Approach to consider possible use of: -Welsh Government (2013) -SCIE	-Media coverage -Political questions local/ national -Annual Safeguarding Children Board Report -Single agency governance report

Significant	-Injury requiring transportation to hospital for treatment - Death of a child - Significant episode of self harm by child -a child has been seriously harmed as a result of being subjected to sexual abuse/child sexual exploitation or the parent has been murdered due to domestic homicide/neglect	Failure to meet professional standards and/or statutory requirements	Critical Incident Report/Child Death Overview Panel/Serious Incident Report or review Approach to consider: -Welsh Government (2013) -SCIE	-Media coverage -Political questions local/national -Annual Safeguarding Children Board Report -Single agency governance structure report
Moderate	Injury requiring transportation to hospital for treatment -Significant episode of self harm by child -Parents charged with neglect/child missing education and child on a child protection plan, child in need and/or receiving significant services	Failure to meet internal standards and policy, procedure	Front line learning (SCIE) report/ Multi agency Audit Single agency review	-Media coverage -Political questions local/national -Annual Safeguarding Children Board Report -Single agency governance structure report
Low	-Abrasions/bruises -Minor injuries to a child who is missing education/ child on a	-Failure to meet internal standards and policy, procedure -Minor non compliance	Practice manager audit or review	-Media coverage -Political questions local/national -Annual Safeguarding Report

	child protection plan/ child in need and/or receiving significant services			-Single agency governance structure report
Best Practice	Examples of good practice in work with vulnerable children and their families that can be cascaded to the multi agency partnership	Good practice examples that can illustrate good outcomes for children	Audit/ Case scenarios & studies that are appropriate to share in newsletter or cascaded in training or Board events	-Media coverage -Political questions local/national -Annual Safeguarding Children Board Report -Single agency governance structure

This matrix allows for movement between the grades of concern and any situation can be escalated to a higher criteria as the case is assessed