Salford Safeguarding Children Partnership

PRACTICE REVIEW POLICY AND TOOLKIT

FOR ALL TYPES OF REVIEWS,

INCLUDING RAPID REVIEWS AND AUDITS

JUNE 2019

FINAL

Contents

1 Introduction

In Salford, we want to understand the lived experiences of children and their families, and the part we play in ensuring this is the best that it can be, and children are safe. We recognise that this requires a whole partnership approach, including shining a spotlight together on the work that we do, to determine what we did well; what we could have done better; why; the impact on the lives of children and families; and how can we learn from this to continuously improve.

Our new multi-agency safeguarding arrangements from 1st April 2019 introduces a Safeguarding Effectiveness Framework whereby a range of evidence, including learning from practice, is brought together to identify knowledge and improvements. These feed into training, communications, and organisational change.

We want to not only understand and hold ourselves to account when we do not achieve the outcomes we should, but also to understand where there is outstanding practice to celebrate and replicate. This review of practice, whether through national or local reviews, needs to be as proportionate and transparent as possible.

We have taken the decision to operate a combined Practice Review Policy which covers different types of reviews of practice: local case reviews, rapid reviews, child safeguarding practice reviews and links to other quality assurance activity. This means that for all referrals for a review of practice, the same methodology will be followed, but timescales will be different (a rapid review needs to be completed in 15 days, a local case review can be longer). Chapter 4 provides a fuller description and definitions of the different types of practice reviews.

This policy and toolkit replace the 'draft arrangements for notifying serious incidents and information to the national child safeguarding practice review panel '(July 2018), 'case review policy' (last review Feb 2018) and related forms. The Audit Guide is also part of this suite of documents.

This document provides guidance on:

- the principles to be applied in any methodology used to carry out reviews;
- the principle outcomes any practice review should achieve;
- the framework (including thresholds and tools) for conducting reviews;
- how we will collate and share learning to ensure at the earliest opportunity, practice is fully informed by local, regional and national reviews.

Appendix A provides a range of tools (further guidance and forms) for each part of the system. These are highlighted throughout this policy for ease of reference.

The framework will apply to Salford Safeguarding Children Partnership and all partner agencies and be managed by the Practice Review sub-group (PRSG). It should inform single agency frameworks to ensure connectivity and compatibility.

It will be reviewed in November 2019 or earlier if legislation changes. Documents and tools that sit within the framework will be updated as and when changes are required.

2 Context

There are a number of national and local drivers, which have contributed to forming this policy and toolkit. It has been developed in light of The Children Act 2004, as amended by the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 (Chapters 3 and 4). The most significant changes are new processes for Child Safeguarding Practice Reviews, which replace the previous Serious Case Review.

An independent evaluation of Salford's Safeguarding Children Board existing multi-agency case reviews and rapid reviews has also informed changes. The review found that Salford's case review guidance and practice has many positive elements, underpinned by evidence of strong partnership working and a good culture whereby the value of case reviews, discussions and learning is understood, signed up to, and undertaken positively. Areas for improvement reflected here include a greater focus on the child and family and their lived experiences, and more timely reviews.

The revised Working Together guidance recognises that:

"When a child suffers a serious injury or death as a result of child abuse or neglect, understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of their family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgements about what might need to change at a local or national level"

Greater Manchester and other types of review need to be linked as part of the proportionate approach to learning from individual cases. How these processes link is provided more in section 4.3.

3 Principles, Values and Assumptions

Our new safeguarding children partnership arrangements outline how our vision, values and six principles drive our approach. Reviews should also reflect the following principles, values and assumptions:

3.1 Principles

- Child and family centred: The individual (where able) and their families 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
- The framework must result in providing learning back into the system – its core purpose is to improve service provision not simply describe or challenge it
- There should be a culture of continuous learning and improvement across agencies that work together to safeguard and promote the wellbeing of children, identifying opportunities to draw on what works and promote good practice
- We support the principle of identifying issues and addressing them early, and individual agencies should be pro-active and pre-emptive in analysing and learning from individual cases. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- The Safeguarding Children Partnership is responsible for the review and must assure themselves that it takes place in a timely manner and that appropriate action is taken to secure improvements in practice
- Any reviews should be led by individuals who are independent (i.e. no direct line management) of the case under review and of the organisations whose actions are being reviewed
- All types of practice reviews should be completed in a timely manner unless there is a reason for a longer period, e.g. on-going criminal proceedings.

3.2 Values and Behaviours

- Participative and collaborative – Staff from all levels should participate and feel they are making a difference and a consultative approach provides richer narrative, encourages awareness of quality issues and ownership of the findings. It encourages the view that measuring quality and impact is something done with and by staff rather than done to them. We include the voice and experience of families, children and young people wherever possible
- Transparent – delivering clear messages about the purpose of performance and quality assurance activity, with honest constructive feedback regarding how these benefit the organisation and individuals. The aim is to encourage openness and engagement with the process and achieving goals
- Strengths Based: High challenge, high support - we are committed to a culture of improvement and learning which is relationship based and focuses on strengths within agencies, individuals, families and communities. It is a culture which delivers high levels of challenge and high levels of support and we expect this to underpin our performance and quality assurance framework

- Outcome Focussed: consistently focussing on the lived experiences of children and the impact of what we do on outcomes for them
- Respectful: Each child and family's record belong to them. We must demonstrate our respect in the manner in which we share and record information and provide feedback to staff. We have a duty to report with accuracy, and inaccurate recording of information in any form is detrimental to outcomes for children and families.

3.3 Assumptions

- We can't always prevent children from being harmed, but we can always learn to increase our ability to achieve this. We will never be perfect and constant scrutiny is required to ensure the right standards are met and exceeded and continuous improvement is evident across the system
- Professionals generally act from good intentions and try to act in the best interests of their clients. Organisations' systems, process, culture and other factors can lead to poor decision making and practice and these elements should also be the focus for review and improvement. For example, out-dated or unclear procedures, resources not available where needed
- Where possible, information relating to children and families will be based on reports drawn from case management systems and we expect individual agencies to ensure this remains accurate and relevant, with appropriate controls.
- Every agency has a responsibility for identifying and implementing its own learning in addition to multi-agency learning.
- Measures of outcomes for children are clearly the most important ones to assess, measuring the effectiveness of the system also requires a focus on both what we do and the impact of what we do in improving outcomes

4 Types of Review

4.1 Purpose of reviews

The purpose of any review of practice is to identify improvements to be made to safeguard and promote the welfare of children. The purpose of a review is to:

- understand what happened or is happening, and why
- highlight any lessons that can be learned from the case and make a clear set of recommendations and ensure relevant action is taken
- learn lessons from the way professionals and agencies worked together and improve future practice by implementing the learning

- identify what the agencies and individuals might have done differently that could have prevented harm or death
- prevent similar harm occurring in the future
- review and improve relevant procedures
- identify good practice.

Reviews should focus more on understanding whether there are systemic issues and whether and how policy and practice need to change, than holding individuals, organisations or agencies to account. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy makers.

4.2 Different types of reviews

There are three main types of reviews, and consideration must be given to the type of review process or methodology that will best achieve effective learning and improvement:

- **Individual Agency Reviews:** where an agency identifies that a case raises issues for them, and from which there may be multi-agency learning, it may be appropriate to conduct a single agency review or a single agency audit.
- **Salford Case Reviews and Audits - Multi-agency, below national review criteria:** where safeguarding partners consider that a case raises issues of importance in relation to the local area.
- **National criteria (Working Together 2018) met - Rapid Reviews and Child Safeguarding Practice Reviews:** where the SSCP and Child Safeguarding Practice Review Panel considers that a case raises issues which are complex or of national importance. The Panel may also commission reviews on any incident(s) or theme they think relevant.

The diagram below summarises the types and stages of review depending on thresholds, all of which need to have any learning extracted and shared at the earliest opportunity.

THRESHOLDS OF HARM AND TO DETERMINE PROPORTIONALITY	AD HOC REVIEWS OF PRACTICE (AS A NEED IS IDENTIFIED)	ENSURE ALL LAERNING IS EXTRACTED AND COMMUNICATE KEY MESSAGES, ACTIONS ARE COMPLETED AND IMPACT
	Individual Agency reviews and audits	
	Pre-SSCP Referral: When a professional has identified a review may be required. To be agreed by the designated decision maker.	
	Referral: Receipt and decision making by SSCP	
	Rapid Review (where it meets Working Together threshold) or Case Review (where it does not meet threshold for Rapid Review): Collecting information and case discussions and decision-making whether a full review is required.	
	Further review required, either Child Safeguarding Practice Review or fuller case review using appropriate methodology.	
	SUDC: Undertaken by Senior Investigating Officer and SUDC paediatrician (not covered by this policy)	
	Child Death Review: Undertaken by CDOP (not covered by this policy)	
	PLANNED REVIEWS OF PRACTICE (LINKED TO SAFEGUARDING EFFECTIVENESS FRAMEWORK)	
	Audits	
	Other, e.g. Section 11 audit -(see Safeguarding Effectiveness Framework)	

The Practice Review sub group will always consider the most appropriate way forward, based on what is in the best interest of the child/ren being referred and wider systemic learning.

This policy and referral processes do not cover child death reviews, which are dealt with by the local Child Death Review panel; or Sudden Unexpected Death of Child, which are covered by Greater Manchester SUDC processes.

More details about these practice review of children, together with other types of reviews are provided below.

INDIVIDUAL AGENCIES	**Individual Agency Reviews or audit**	**Purpose:** Where a case is referred but does not meet the criteria for a multi-agency review, the sub group may recommend an individual agency review. The lessons will be disseminated using a range of methods as other reviews, with scrutiny that learning has been effectively addressed.
SALFORD SAFEGUARDING CHILDREN	**Salford Case Review**	**Purpose:** Does not meet threshold for a child safeguarding practice review or rapid review but there is clear multi agency learning that would benefit from an independent report being completed. There are terms of reference, practitioner learning event, and a written report with learning recommendations agreed. Different methodologies for doing this are included in the methodologies document. **Timescale:** There is no statutory timescale and 45 working days has been set by Salford Practice Review Group.

	Rapid Review	**Purpose:** Following guidance within Working Together to Safeguard Children 2018 (Chapter 4), the aim of the Rapid Review is to: • Gather the facts about the case, as far as they can be readily established at the time; • Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately; • Consider the potential for identifying improvements to safeguard and promote the welfare of children; • Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review. **Timescale:** Notification from Local Authority to The National Panel by online system and to the Safeguarding Children Partnership (SSCP@salford.gov.uk) within 5 working days of the local authority becoming aware of the incident. Local Safeguarding Partners are required to conduct the Rapid Review and forward the results to the National Panel within 15 days of receipt of a referral.
	Child Safeguarding Practice Review (CSPR)	**Purpose:** Replaces Serious Case Reviews (SCRs) from when new local area safeguarding arrangements commence, as detailed in Working Together to Safeguarding Children 2018 (Chapter 4). In Salford, this applies from 1st April 2019. Child Safeguarding Practice Reviews will be initiated once the National Panel and Local Area agree that a fuller review is required following a Rapid Review. They will include an Independent Author and Chair, terms of reference for identification of issues, published report, and learning recommendations. The National Panel may also undertake CSPRs. **Timescale:** There is no set timescale for conducting a CSPR, it should be aimed to complete within six months.
GREATER MANCHESTER / JOINT	**Child Death Review (CDOP)**	**Purpose:** Covering Wigan, Bolton and Salford. The Child Death Review Statutory Guidance (October 2018) applies to all organisations involved with the process of child death reviews. The purpose is to identify, through specific steps outlined in Working Together Chapter 5, any matters relating to the death that is relevant to the welfare of children in the area or to public health and safety, and consider whether action should be taken. The CDOP panel and processes are currently (2019) tri-area.
	Sudden Unexplained Death in Childhood (SUDC)	**Purpose:** A SUDC review is a multi-agency rapid response held under the remit of the H.M. Coroner, which occurs when a child (0-18 years) dies suddenly and unexpectedly. Further information: greatermanchesterscb.proceduresonline
SAFEGUARDING ADULTS BOARD	**Safeguarding Adults Review (SAR)**	**Purpose:** The Care Act 2014 introduces statutory Safeguarding Adults Reviews mandates when they must be arranged and gives Safeguarding Adults Boards flexibility to choose a proportionate methodology. SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; or an adult in its area has not died, but the SAB know or suspects that the adult has experienced serious abuse or neglect.
COMMUNITY SAFETY PARTNERSHIP	**Domestic Homicide Review (DHR)**	**Purpose:** A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. There is a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.
HEALTH	**LeDeR review process (learning disabilities)**	**Purpose:** The LeDeR mortality review process for people with learning disabilities. It is expected that the child death review process will be the primary review process for children with learning disabilities and that it will not be necessary for the LeDeR programme to review each case separately. More Information: http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/

4.3 Links between reviews

A child or their family may be subject of more than one review at a time and we want to prevent duplication and enhance the impact of learning into practice, so that good practice can be shared across all types of reviews. In these cases, a proportionate approach where agreement about the appropriate lead, and sharing information to save repetition is encouraged.

Where a case meets the criteria for more than one review process, such as a Domestic Homicide Review or SUDC, or crosses geographic boundaries, a referral should be made to both review processes so that the relevant organisations can work in partnership to identify the most appropriate method to conduct the review, and the possibility of commissioning a review jointly. This will ensure that all aspects of the review are addressed and that the identified process dovetails with any other investigations that are on-going.

For Salford reviews, the Inter-Board protocol will provide a whole system approach whereby communication between the relevant Boards will be through agreed and most appropriate person(s) for that case.

SSCP will share best practice in conducting reviews with other Boards and fora who may undertake thematic reviews but not normally undertake case reviews themselves.

4.4 Methodologies for undertaking reviews

Consideration must be given to the most appropriate type of review process and methodology to promote effective learning and improvement. Methods that will be used by the SSCP include a case discussion tool, Appreciate Inquiry, and Root Cause Analysis (see ***Review Methodology Options (Document 1)*** for more details).

No one model will be applicable for all cases and the Practice Review Virtual Panel or case review group will determine the most appropriate methodology and tools to use that is proportionate to the case. However, for rapid review meetings and reflective sessions, it is recommended that ***Case Discussion Tool (Document 11)*** developed by Salford specifically for this purpose is applied.

5 Thresholds

Thresholds and Definitions Quick Guide (Document 2) provides a reference guide to definitions and thresholds to assist decision-making re: threshold for different types of review.

5.1 Purpose of a practice review

All types of practice reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. We also want to learn from good practice, and have introduced ***good outcome reviews*** where we seek to identify cases where relevant agencies and individuals involved I the case have worked outstandingly together and there are positive outcomes for the child.

5.2 When should the SSCP undertake a Rapid Review or Child Safeguarding Practice Review?

16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) and Working Together 2018 states that where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

(a) the child dies or is seriously harmed in the local authority's area, or

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development, or impairment of physical health. This is not an exhaustive list – judgment should be exercised in cases where impairment is likely to be long term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred".

Local child safeguarding practice reviews should seek to understand why mistakes were made and, critically, comprehend whether mistakes made on one case frequently happen elsewhere and understand why.

The National Panel is clear that many of the cases are complex and, in some cases, there is no definitive 'right' answer to the debates about whether or not a local child safeguarding practice review should be undertaken, or the circumstances in which it is not appropriate to publish a final review. In all instances, the decision as to whether to undertake a learning review should be informed by whether a review would be able to identify improvements to practice.

Whilst the National Panel will provide its decision, ultimately, the decision to proceed to a local child safeguarding practice review is always a local decision, for which local safeguarding partners are responsible. Where the National Panel feel strongly that a particular case requires scrutiny, they may commission the review themselves.

Thresholds and Definitions Quick Guide provides further detail about the thresholds and criteria for each type of review.

5.3 Good Outcome Review

Referrals for a 'Good Outcome Review' ***(Good Outcome Review Referral (Document 6))*** could be made in instances where there has been exceptionally positive impact on the lived experiences of the child, and good (better than normal) outcomes achieved, and a significant factor that has contributed to this success. It is important to note that a 'Good Outcome Review' only looks at exceptional practice and its impact on the lives of children. Good Outcome Reviews will examine multi agency success, how it was achieved and what we can learn to disseminate the success further.

Referrals should be very clear about what was done, and how this made a difference, and include the following features:

- The lived experience of the child and family- how we know we made a positive difference to their lived experience (outcomes).
- Present the steps you took to improve care in a practical and accessible way
- Give others the knowledge they need to improve care in their areas
- Provide an opportunity to reflect on your successes and challenges
- Help to identify learning and further areas for improvement
- Highlight learning that could be useful to others
- Be written in easy to understand English, free from jargon
- Have clear objectives, including an explanation of what was happening before the project, why it was needed and how it was implemented
- Outline any barriers the organisation faced when implementing the project and the methods used to overcome these
- Outline the effect the change had on service performance and outcomes through an evaluation process.

6 Involving children and families

The lived experience of children and families plays a crucial role in understanding how we can help improve the safeguarding system. Working Together 2018 states that "*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*". (HM Government, 2018: p90).

In addition, research into family involvement in Serious Case Reviews identified four reasons for family involvement: human rights; a child-centred perspective; a primary source of knowledge and information; altruistic and cathartic motives (Morris et al 2013).

In Salford, we consider it good practice to involve parents and children (subject to age and understanding) in a meaningful way, and reviews should, where appropriate be informed by family members' knowledge and experiences relevant to the period under review. There should be a common understanding amongst the professionals on how children and their families should be involved, and who should be responsible for facilitating their involvement, recognising that not all information should be shared with the child or family.

The overarching principle should always be to act in the best interests of the child. If it is decided that such involvement is not in the best interests of the child then the reasons for the decision should be clearly stated in the meeting notes.

Children and Families in Practice Reviews Guidance (Document 3) provides further good practice guidance adapted from SCIE Family Involvement: Serious Case Review Quality Markers (2016). A leaflet for families is also provided and included as part of the guidance.

7 Processes for Reviews (Including Rapid Reviews)

7.1 Assurance questions throughout the process

At key stages in the process, those involved should use ***Practice Review Assurance Questions and Checklist (Document 4)*** to ensure that the review is undertaken to the highest possible standards.

7.2 Flowchart

The flowchart overleaf summarises the steps and timescale for rapid reviews and child safeguarding reviews specified in Working Together 2018.

Salford Practice Review Activities and Timescale Flowchart (Including Rapid Reviews)

Acronyms used	
CSPR	Child Safeguarding Practice Review
IA	Independent Advisor
LA	Local Authority
PR	Practice Review Sub Group
RR	Rapid Review
SSCP	Salford Safeguarding Children Partnership

Working Days from Referral

Rapid Review	**Other Review**	
-5 aware of the incident		**Pre-referral actions** undertaken including discussion with agency representative on PRSG, key worker and family where appropriate. Focus on lived experiences of child.
0	**0**	Agency submits ***Practice Review Referral Form*** via email to sscp@salford.gov.uk using guidance to ensure sufficient information provided
1	**1**	Referral checked and emailed to the Practice Review Virtual Panel for comments/decision. Panel outcome (*referral form- section 2*) emailed to sscp@salford.gov.uk *a) MEETS threshold for Rapid Review* / *b) MEETS threshold for case review* / *c) Does NOT MEET threshold* / *d) Queries back to referrer*
2	**7**	LA notify national panel and sscp@salford.gov.uk SSCP Business Unit send ***agency summary and chronology template*** to those involved to complete and immediately inform SSCP of other professionals involved. Date set for RR meeting and Chair assigned. Consider alternative process: • Single agency audit/actions • Multi-agency audit/actions • Use Escalation Policy • Themed Assurance report Action as appropriate with feedback to referrer
2-9	**36**	Completed ***Agency Summary Template*** returned by agencies to sscp@salford.gov.uk. Collated by Business Unit including combined chronology.
10	**42**	SSCP Business Unit collate agency information and circulate to those attending the Rapid Review or Case Review meeting along with the Referral Form and LA notification
12	**45**	***Rapid*** **or** **Case** **Review meeting held:** Review the facts and learning. For Rapid Review consider against the criteria for CSPR. Agree any immediate action and decide outcome of rapid review, inc legal advice. Complete ***Report/notes,*** recording all challenge, strengths and decisions
13-15 *(noon)*		***Rapid Review*****:** Chair and Independent Advisor sign off RR Report and decision. SSCP Business Unit follow up agency queries. *a) MEETS threshold for CSPR* / *b) DOES NOT MEET threshold for CSPR*
15 *By 4:30pm*		*SSCP Business Unit sends endorsed* ***Rapid Review Report*** to National Panel, RR, PRSG, SSCP members. Referrer informed
		Rapid Review: Response from National Panel Received: *a) National Panel and SSCP agree MEETS threshold for CSPR* / *b) National Panel and SSCP agree DOES NOT MEET threshold for CSPR* / *c) National Panel and SSCP are not in agreement re: threshold*
		Commence CSPR (National Panel or Locally) / Other type of review/method if further learning to be extracted / No further action: all learning and actions already in place / Action depends on individual cases. Consult with the IA as required.

7.3 Before making a referral

Any agency can refer a case to the Practice Review Sub Group, requesting that consideration be given to holding a practice review if they identify a case where they believe that the criteria for a review are met (see section 5). Cases can also be referred by the Rapid Response Team, Coroner, or Child Death Overview Panel.

Where an agency has identified a possible practice review referral, the case should first be considered internally within the organisation at the appropriate level, but with due consideration to timescales. Each organisation needs to decide how a referral will be verified internally before the referral is made to SSCP. This process should be clearly communicated and noted in the child record within that agency.

The Referral Form ***(Practice Review Referral Form, Document 7)*** includes guidance and assurance questions for the referrer and their agency to consider prior to submitting a referral, and to ensure the referral contains the right information to inform decision-making.

7.4 Making a referral

The referral must be made on the ***Practice Review Referral Form*** and emailed to sscp@salford.gov.uk.

Local authorities have a separate duty to:

- notify the national Child Safeguarding Practice Review Panel if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area)

- notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

Where a local authority makes a formal notification to the national Panel or Ofsted, it must always share this with the relevant local safeguarding partners and also complete the formal referral form for a child safeguarding practice review.

7.5 Receipt of Referral and Decision Making

The SSCP Business Unit should aim to forward the referral to the Salford Practice Review Virtual Panel (see section 10) for consideration and decision within 24 hours of receipt of a referral. They will decide virtually by email or telephone within 48 hours whether the referral contains sufficient information to progress and whether the thresholds are met. Two of the panel only are needed to be quorate. Where there is not agreement, the decision will be based on the majority. Where the review is obviously a rapid review, an immediate decision is taken by the Business Manager and panel are informed.

Decisions could be:

- **Commence rapid review:** Where thresholds for Rapid Review have been met the safeguarding partners are required to promptly undertake a Rapid Review of the case in line with current national guidance within the timescales outlined in guidance from the National Panel.
- **Does not meet threshold for rapid review:** If thresholds for a rapid review have not been met, the virtual panel will decide if a case review should progress within the 45 day timescale.
- **Incomplete Referral:** Where the referral does not include sufficient information, a member of the Review Panel or the relevant agency representative of the PRSG will be assigned to liaise with the Referrer to gather further information and re-submit the updated referral within five working days of return.
- **Does not meet threshold hold for a Rapid Review or Case Review:** Where the virtual panel agree that the referral does not lead to the need for a rapid review or case review, clear feedback with the rationale for decision making will be given to the referring agency. If the referring agency is not in agreement, the SSCP should seek the view of the independent advisor to inform the final decision.

Where the decision is to undertake a review, the panel will consider who should chair it and also check whether Ofsted notification has been completed if required.

7.6 Leading reviews

The Chair of PRSG will decide, in consultation as appropriate with members, who should chair the review. In deciding who this should be, the PRSG chair should consider the degree of independence required from the main agencies involved in the case. Required skills for review chairs (including Rapid Reviews) is provided in **Chair and Lead Reviewer Specification (Document 5).**

7.7 Information sharing

There are two stages of information sharing (gathering information about the child and others who may be relevant to the referral).

1. Agency summaries and chronology for case review or Rapid Review
2. Fuller agency involvement and report if the threshold met for full CSPR met after rapid review held.

Agency summaries: Gather information from professionals about involvement with the child and family. This will include a time bound chronology. There needs to be sufficient detail to inform whether a Child Safeguarding Practice Review is required.

Full Review: If a further review is required, whether a child safeguarding practice review, agencies will be expected to provide much greater detail and contribute to review meetings and interviews.

In all cases, the ***Agency Summary Report Template (Document 8)*** and blank ***Chronology Form (Document 9*****)** should be sent out to all relevant agencies within two working days of receiving the referral, along with an accompanying ***Request for information letter or email (Document 10)*** that briefly outlines the referral and explains the purpose of the review**.**

All agencies who have had involvement with the subject child or family will be required to contribute to the review. Agencies will need to prioritise information sharing for Rapid Reviews, and provide completed initial information within five working days of request.

7.8 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 and the impact on the child's lived experience. 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
- Impact- How did the agency response impact on the presenting risk and lived experience of the child?
- 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.

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 Child Safeguarding Practice Review criteria have been 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?

7.9 Securing files

Where the severity of a case demands it, all agencies should also secure all records/files in relation to the case, ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative. (This request is included in the template letter). Where access to the records is required for on-going case work, a copy should be made and secured.

7.10 Setting the date of the review meeting

At the same time as requests for information are sent, the Business Unit should set the date for the review meeting at the appropriate timescale. At this time, it is good practice to also ensure there is a time in the Decision Makers (the three statutory partners and independent advisor) diary after the case discussion meeting to sign off the report and documents to the National Panel.

Other types of review meetings are subject to different time limitations, but should be scheduled days of receiving the referral as good practice and to ensure attendance by key people.

7.11 Documentation for the review meeting

The documentation will be shared with participants at least 24 hours in advance of the meeting wherever possible. However, it is recognised that it may on occasion be necessary to share documentation at the meeting, and in these instances sufficient reading time should be allocated at the beginning of the meeting. Documents to be shared are:

- the completed Referral Form that initiated the process;
- copies of the completed **Agency Summary Form** from relevant agencies.
- Individual agency chronologies will be amalgamated into a composite chronology by the SSCP business unit. It is therefore critical that chronologies are provided in the correct format.

7.12 The review meeting and decision making

The meeting should include representatives from each of the three safeguarding partners and any other relevant individuals. A Rapid Review meeting will only be quorate if at least one representative is present from each of the three safeguarding partners (the CCG, Police and Local Authority).

The Rapid Review meeting should:

- review the facts about the case as presented in the documentation
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide whether or not to undertake a child safeguarding practice review. If the decision is not to proceed with a formal child safeguarding practice review, the Group will consider whether an alternative form of learning review is appropriate. In some cases, the rapid review process may identify key local learning that can be quickly acted upon, removing the need for further review
- consider the impact of any significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances a rapid review can still be completed, not least because it is the multi-agency working which is the key focus (i.e. what happened between agencies *before* the incident.

There are three likely outcomes from the rapid review:

1) Recommendation for a child safeguarding practice review (replacing serious case reviews)
2) Other type of local review or learning event
3) No further action

In all outcomes, any immediate actions and learning should be discussed by the PRSG, acted on and followed up.

The ***Rapid Review Meeting Report (Document 12)*** should be completed by the Chair by the deadline (see flowchart). The report should state clearly whether the recommendation is that a Child Safeguarding Practice Review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a National Review may be appropriate.

The Independent Adviser and the three statutory partners endorse the outcome of the Rapid Review. Where there is disagreement about the outcome, the decision will be escalated to the next level within the three partners up to the Safeguarding Executive if necessary for decision. There may be instances where they will need to draw on their own agency legal advisors.

7.13 Sharing the outcome of the rapid review

Within two working days of the Rapid Review meeting, the Business Manager should, on behalf of the safeguarding partners, send the completed ***Rapid Review Meeting Report*** to the National Panel: (Mailbox.NationalReviewPanel@education.gov.uk).

Other agencies (including the agency who made the referral) should also be informed of the outcome of the Review and individual agencies should notify their own inspectorate bodies as required.

8 Conducting a Local Child Safeguarding Practice Review

8.1 Commencing a review, terms of reference and appointing a lead reviewer

As soon as it has been agreed that a further review is required following the rapid review, the Business Manager will inform the National Panel including details of any reviewer they have commissioned, if known.

The safeguarding partners are responsible for commissioning and supervising reviewers. The Practice Review Virtual Panel will appoint a lead reviewer within 10 working days of decision to commence a fuller review. The lead reviewer does not need to be external to the local area, but should meet the minimum criteria in the **Review Chair and Lead Reviewer Specification (Document 5)** and confirm they have read and will adhere to this practice review policy, and have a signed contract in place.

Terms of reference will be drafted at the rapid review meeting stage and be agreed by the review group, for sign off at the next Practice Review Sub Group.

8.2 Conducting the review

The review will be conducted in compliance with Working Together to Safeguard Children Chapter 4 paragraphs 34 to 35.

A **Review Group and Chair** will be established for each Child Safeguarding Practice Review, to oversee the governance of the specific review. The group should be made up of senior managers from relevant agencies and qualified lead reviewers who are independent of the case. They will:

- Agree Terms of Reference which will include timescales for completion
- Determine how the child or family will be involved and informed throughout the review
- Establish what evidence is required from each agency or person and how it will be collected
- Identify relevant policy, practice or procedures that may be relevant to the conduct of the review
- Take into account the nature and extent of any legal advice required, including Data Protection, Freedom of Information and Human Rights Act.
- Analyse the evidence to understand why the incident took place. In particular, the Review Group will consider any wider systemic issues.
- Agree key points to be included in the report and action plans, and agree the final version of the review report.

The Chairperson will set meeting dates and agendas, ensure relevant representatives are involved and liaise with statutory agencies such as the police and/or coroner's office. They will be supported by the business unit in these tasks.

A **case group** will consist of frontline practitioners and managers who were involved with the case, especially those involved in the significant practice events. Case group members can individually contribute to the case review. The aim is to understand the practitioners' view of events and assist in analysing 'contributory factors' and how the safeguarding system can be improved.

8.3 Practice review reports – completing and publishing

All reviews of cases meeting the criteria for a Child Safeguarding Practice Review under the Working Together 2018 criteria will result in a review report. Review reports will vary according to the lead reviewer's style. However, lead reviewers and the SSCP will ensure that all review reports include:

- have clearly framed questions that the review seeks to answer;
- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances;
- what needs to happen to ensure that agencies learn from this case.
- have an executive summary of no more than 2 A4 pages;
- state clearly the learning points and the steps for professional learning;
- be written such that the review report can be published nationally with minimal redaction.

Salford's Practice Review Assurance Questions and Checklist (Document 4) provides headings and good practice guidance for writing an analytical practice review report with SMART recommendations.

The draft report should be sent to contributing agencies inviting comments on the factual accuracy. It is important to note that agencies are not being asked to agree with the report or findings, but to ensure the report is factually accurate, understood and recommendations are clear. Agencies have 10 working days to respond. The Review Group will consider all comments and agree the final version for sign off by the three statutory partners.

The National Panel recommends that all child safeguarding practice reviews and legacy Serious Case Reviews should be published, but there is no statutory requirement to do so. We aim to publish all reports, but they will be considered on a case by case basis, and a community impact assessment may be undertaken to assist in this decision.

The SSCP will send copies of all reports to the National Panel at least one week before publication. If the SSCP considers that a review report should not be published, it should inform the Panel which will provide advice to the SSCP.

Publication of review reports will be accessible on the SSCP website for a minimum of 12 months, thereafter the report will be available on request. From the very start of the review, the fact that the report will be published should be taken into consideration, and 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.

The findings from any Practice Review will be published in the SSCP Annual Report along with the actions taken in relation to those findings.

9 Learning and Improvement

The multi-agency action plan for reviews should be agreed by the review group and 'handed over' to the business unit to monitor progress, ensuring no unnecessary delay in implementation. The impact of the action plans will be owned and scrutinised by the Practice Sub group and Safeguarding Effectiveness sub group. Plans should be outcome focussed and include actions that are needed, responsibilities for completion, timescales and intended outcomes: what will change as a result?

The SSCP will oversee implementation of actions resulting from all reviews, and the Independent Adviser will undertake an annual scrutiny of action plans to review, challenge and support and test impact and learning.

Learning from all types of practice review is imperative. Identifying the correct methods, time that is most effective will be important, and PRSG will work with the Strategic Workforce Development sub group and Communications and Engagement sub group to both arrange learning opportunities as well as be assured that individual agencies have implemented and sustained any learning and actions. This may include following up changes to policies and procedures, learning events, using the Practitioner Forum as determining success, views of professionals may need to be gathered.

10 Governance

10.1 Roles and Responsibilities

The Practice Review Sub -group includes representatives of the three statutory partners as well as a full range of other agencies and members of the group should be of sufficient seniority of a range of key agencies. The sub group is responsible for implementation of this policy and the system of conducting reviews, as well as analysis of key themes, learning of individual and multi-agency reviews and audits, ensuring actions are undertaken and impact realised.

The Practice Review Virtual Panel, reporting into the Practice Review sub-group is a small subgroup who will operate virtually, and is responsible for making decisions on referral, appointing lead reviewers. It will consist of SSCP Independent Adviser, the Chair and Deputy Chair of the Practice Review Group, Business Manager.

Scrutineers, who will normally, but not exclusively, be members of the Practice Review sub-group will be assigned on a rota basis to verify action plans.

10.2 Cross Boundary Issues

There will be cases where children have moved from their 'home' area and may be living outside the area. If this is the case, the review should be carried out by the local safeguarding arrangements that is responsible for the location where the serious incident took place. Multi-agency safeguarding arrangements and agencies should co-operate across boundaries and requests for the provision of information should be responded to as a priority. If agreement cannot be reached on the requirement for the review, the ultimate decision making will be delegated to the Executive Group.

10.3 Measuring Performance

We will collect and use the following data to help us monitor and improve the system and impact it has. This will be provided to the Safeguarding Executive on an annual basis:

How much have we done? a) Number of referrals by type, outcome, referrer and theme b) Number of reviews by type and outcome c) Number of reviews where there is disagreement between SSCP and National Panel
How well have we done it? d) Timeliness of reviews e) Quality of agency summaries f) Quality and timeliness of action plans
Have we made a difference? g) Action plans completed and follow up evidences impact h) Reflective sessions report greater understanding of the issues i) No repeat incidence in same circumstances following implementation of actions. j) Family members involved report that the review has been conducted in a sensitive way.

11 References

HM Government (2018) Working Together to Safeguard Children 2018

HM Government (2015) Working Together to Safeguard Children 2015

HM Government (2018) Working Together: Transitional Guidance

HM Government (2019) Child Safeguarding Practice Review Panel: Practice Guidance

Research in Practice (2018) Building a quality culture in child and family services

Sidebotham et al (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report (HM Government)

NSPCC library of published case reviews: https://learning.nspcc.org.uk/case-reviews/recently-published-case-reviews/

Internal Review: Independent evaluation of Salford case review report (January 2019)

West Midlands Regional Rapid Review Pilot: Evaluation Findings 2018

SCIE (2019): Serious Case Review Quality Markers

Buckley H, Carr N and Whelen S (2011) 'Like walking on eggshells': service user views and expectations of child protection. Child and Family Social Work, 16, 1, 101-110

Bunn A (2013) Signs of Safety Model in child protection in England, NSPCC

Dumbrill GC (2006) Child parental experience of child protection intervention: a qualitative study. Child Abuse & Neglect 30, 27-37

Family Rights Group (n.d.) Charter of mutual expectations.

Appendix A: TOOLKIT

Document	Type	Purpose
1. Review Methodology Options	Guidance	Lists different methods for undertaking reviews, such as Appreciative Inquiry, Root Cause Analysis, Learning Event, Salford case discussion tool.
2. Thresholds and Definitions Quick Guide	Guidance	To assist decision making about most the most appropriate type of review to conduct.
3. Children and Families in Practice Reviews Guidance	Guidance	Guidance about involving children and families in reviews.
4. Practice Review Assurance Questions and Checklist	Guidance	Checklist for Chairs, lead reviewer and those involved in reviews including what makes a good review report.
5. Chair and Lead Reviewer Specification	Guidance	Provides standards and behaviours expected from a lead reviewer
6. Seriously good outcome review guidance and referral form	Guidance Template	Encourages professionals to put forward cases where there has been good practice and good outcomes for the child, and learning that can be applied.
7. Referral Form (including pre-referral guidance)	Template	Form to make a referral for practice review
8. Agency Summary Form	Template	Gather initial information from agencies involved in the case
9. Chronology template	Template	
10. Request for information letter	Template	
11. Case discussion tool	Form	Provides a format for structuring case review discussions.
12. Rapid Review Meeting Report	Template	Summarise discussion and findings from the rapid review.
13. Review Action Plan	Template	Action plan format for all practice reviews
14. Review Action Plan Verification	Template	Quality Assurance form to assist in ensuring all recommendations have been addressed and learning embedded into practice. This could be used on a case basis, or an agency basis.