

**PRACTICE REVIEW POLICY AND TOOLKIT**



# Practice Review Assurance Questions and Checklist

These assurance questions may be useful as a checklist of required standards for lead reviewers, chairs and practice review sub-group members.

## Strategic approach and culture

1. Strengths-based approach and positive learning culture – avoid looking for ‘blame’
2. Clear processes, thresholds and expectations are in place and understood by partners as ‘business as usual’ so that any type of review is consistently meets requirements.
3. Commitment in individual organisations and the partnership to take on board learning and make changes. This may include a commitment of resources or facilitating professionals to attend learning events or opportunities to discuss briefings.
4. Transparency and honesty throughout the system.
5. Sufficient quality and quantity of administrative support and organisation for reviews.
6. Non-compliance or no activity should be escalated to avoid drift

## Process:

1. All families and professionals who should be engaged, are notified of reviews, prepared and given the opportunity to contribute at the earliest opportunity.
2. Clear scope, understanding of the purpose, criteria and general process of the review, with set up meetings with the reviewer at the start.
3. Deadlines clearly set out and met throughout the process, including action plans and expectations, and those involved understand the impact on the Review by failing to meet deadlines.
4. Clarity regarding standard of information required / expected to inform the review, to include chronologies, and analysis.
5. Strong chair and/or reviewer who is experienced, knowledgeable and reliable. Independent reviewers have a clear contract and understanding of local needs and objectives.
6. SSCP appropriately updated regularly through quarterly reports.
7. Media strategies in place and Local Authority communications team involved at an appropriate stage.
8. Clear monitoring of action plans and learning on an ongoing basis to ensure that this is embedded within agencies to impact future practice and ensure actions are undertaken in a timely manner. Where there are case reviews or audits with similar actions/learning, it may be more efficient to have as an action on one action plan, or the work plan for the most appropriate sub-group.
9. Clear plans for dissemination of learning.
10. Effective dissemination throughout the workforce
11. Evaluate the effectiveness and impact
12. Keep the National Panel updated regarding progress

## Content

1. There is a clear sense of the experience and feelings of the child and family at that time, and clear view as to what was happening for the workers at the time of the ‘incident’.
2. Evidence of analysis, effective triangulation and testing of emerging themes and learning. This includes checking out draft learning with practitioners involved and the family where possible.
3. The report is concise (it should be able to be completed in 20 pages maximum) and written in such a way that the learning can be clearly evidenced throughout and summarised at the end with SMART recommendations.
4. All risks to surviving children and families have been assessed, and family and practitioner consulted and support needs identified prior to any decisions re publication
5. The most effective reviews are those that remain much focused on the learning and limit recommendations to focused change rather than broad themes. The actions do not always respond to the root cause and the evidence for sustained change takes time to capture. Learning from cases that went well is just as important.

## Descriptive to Critical Writing

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| **Descriptive writing** |  | **Critical/analytical writing** |
| States what happened |  | Identifies the significance |
| States what something is like |  | Evaluates (judges the value of) strengths and weaknesses |
| Gives the story so far |  | Weighs one piece of information against another |
| States the order in which things happened |  | Makes reasoned judgements |
| Says how to do something |  | Argues a case according to evidence |
| Explains what a theory says |  | Shows why something is relevant or suitable |
| Explains how something works |  | Indicates why something will work (best) |
| Notes the method used |  | Indicates whether something is appropriate or suitable |
| Says when something occurred |  | Identifies why the timing is important |
| States the different components |  | Weighs up the importance of component parts |
| States options |  | Gives reason for the selection of each option |
| Lists details |  | Evaluates the relative significance of details |
| Lists in any order |  | Structures information in order (e.g. of importance) |
| States links between items |  | Shows the relevance of links between pieces of information |
| Gives information |  | Draws conclusions |

**(Cottrell, 2003)**

## Reporting:

1. Relevant family members are informed of and supported in respect of publication of report
2. All SCR/Child Safeguarding Practice Review reports presented to SSCP once complete and published on the SSCP website along with learning briefs
3. Local Authority communications team manage any media enquiries on behalf of the partnership to ensure consistent responses
4. Brief panels prior to publication on any potential media interest and provide contact details for communications team and ensure all issues have been considered including IOPC, Coronial Process, Care Proceedings

## Learning:

1. Check out draft learning with professionals involved to see if this feels right to them.
2. Where there is repeat learning (i.e. same issues and learning arising), consider why the actions were not effective last time and what would be done differently this time. This may include consideration of whether whole system change is needed.
3. Events that make the learning relevant for frontline staff and managers and how this will be supported.
4. Ensure that ‘systems’, including policy/procedures are considered in terms of changes required as a result of the learning as well as workforce.
5. Specific training courses arranged by SSCP and learning incorporated into existing courses
6. 7-minute briefings created
7. Newsletters and other publications include lessons learned
8. Action plans reviewed regularly