Suffolk Safeguarding Partnership

Practice Review Guidance

March 2021

Contents

Document Control

Review Date

Date	By Whom

Change History

Version	Date	Author	Notes/Summary of Changes
V0.1	Feb 2021	Howard Woldsmith	First draft for discussion with LIG
V0.2	11 March 2021	Howard Woldsmith	Draft for Board Approval

1. Scope

The Suffolk Safeguarding Partnership will undertake statutory reviews as set out in the Care Act 2014 and the Children and Social Work Act 2017. This guidance is designed to support the most effective response possible response to safeguarding referrals within Suffolk and to support the Partnership to discharge its statutory duties. It aims to outline when and how the Partnership will undertake a safeguarding practice review, the timescale needed, and the steps involved to ensure learning is identified, disseminated, and applied in practice. All processes are compliant with our statutory function and are designed to complement the safeguarding policies of the statutory partner agencies.

The purpose of any practice review is to identify improvements that can be embedded in practice to safeguard and promote the welfare of adults or children at risk of harm, abuse, or neglect. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to apportion blame or to hold individuals, organisations, or agencies to account unless such a holding to account has to be the focus due to the circumstances of the case or situation. Mostly, reviews are about learning lessons.

The multi-agency system in Suffolk has a culture of continuous improvement. Where appropriate, local practice review methodologies will be used rather than commissioning independent reviews so that the local statutory partners take ownership of what needs doing at the earliest possible opportunity.

Legislative Context

Adults

Section 44 of the Care Act[1] states that a Safeguarding Adults Board (SAB) should arrange for a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- there is reasonable cause for concern about how SAB members or other agencies providing services, worked together to safeguard an adult,

and

- the adult has died, and SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

or

- the adult is still alive, and SAB knows or suspects that the adult has experienced serious abuse or neglect.
- The SAB may arrange for there to be a review of any other case involving an adult with care and support needs. In this case the SAB would only consider a SAR if there were clearly identified areas of learning, practice improvement or service development that have the potential to significantly improve the provision of care and support and this cannot be achieved by other review procedures.

Any consideration or link with other review processes must be detailed in the recommendation to the SAB Chair including:

- Criminal investigation
- Learning Disabilities Mortality Review
- Outstanding complaints
- Section 42 safeguarding enquiry
- Coroner's Inquest

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

Children's

Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)[2] 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:

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

Purpose

Whatever the trigger for a referral, the purpose of all reviews is to:

- To establish whether there are lessons to be learned about the way in which professionals and agencies worked together to safeguard people at risk.
- To review the effectiveness of multi-agency procedures and those of individual organisations.
- To inform and improve local inter-agency practice.
- Implementing change from lessons learned.

2. Review Management

Governance Arrangements

The Executive Group has lead responsibility for all practice reviews and ensuring learning identified is embedded in practice. This function is delegated to the Safeguarding Adult Review Panel and Children's Case Review Panel accordingly. They are formal subgroups of the Board.

The Panels commission and oversee the completion of the review process, both statutory and discretionary reviews, working with involved professionals from start to finish, communicating with service users and families, and commissioning the independent author (where required). Once the review has been completed, the Case Review Panel (the Panel) will be responsible for developing an action plan based on the recommendations before this is transferred to the Learning and Improvement Group (LIG) for implementation and monitoring.

Learning from reviews in other local areas in England and Wales will also be trawled as much as possible and lessons applied to the local context in Suffolk. Full terms of reference for the Panels can be found on the Partnership's website[3].

Confidentiality

These cases can be subject to high levels of public interest and complex legal processes in the criminal and civil courts. Reviewers/Authors, case review members and any others involved with the case review process need to be clear that the information they learn about the case and agency involvement is confidential. This means it should not be discussed with anyone apart from key agency members within the agency who are responsible for either the current case management, where information is required to manage the case or the senior managers in the agency who need to be kept informed on a need-to-know basis.

To maintain the anonymity of individuals subject to review in they will be referred to as Baby (under 2), Young Person (3-17) or Adult (18+). Typically, these will be letters of the alphabet. Prior to publication a pseudonym will be chosen to humanise the review. Where possible, the family will be offered the opportunity to choose this name.

Further details on how the Partnership managers personal information can be found on the website[4].

[2] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

[3] https://www.suffolksp.org.uk/about-us/governance-structure-and-subgroups/

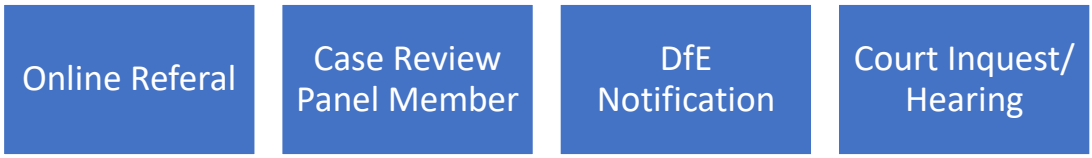
[4] link to privacy statement on website when available

3. Referrals

Making a Referral

When a serious incident becomes known to the Partnership, each case review panel (for adults and children's) will consider whether the case meets the criteria for a review. Decisions on whether to undertake reviews will be made transparently and the rationale communicated appropriately including, where appropriate, to families.

Referrals can be submitted in any of the following ways:



Upon receipt of a referral, the Partnership will trigger a rapid review of the case. The Rapid review will try to establish what happened and to apply any obvious and immediate learning to prevent a recurrence of what happened as far as possible. It may be that the rapid review is able to brigade all the essential facts and information, so that any actions which need to be taken can be put into a short action plan at an early stage.

Information Gathering (Rapid Review)

Before a review is commissioned, all referrals will be triaged using the Rapid Review process.

The aim of the Rapid Review is to:

- Gather and establish the facts about the case, as far as they can be known at the time.
- Discuss where there is any immediate action needed to ensure safety and share any learning appropriately.
- Consider the potential for identifying improvements which will safeguard and promote the welfare of adults or children at risk.
- Agree the next steps in the process: whether that be immediate application of learning or a review as described in Appendix 1.

When considering referrals, the Panel will bear in mind the following points:

- A case referred in order to secure a service will be passed to the agency concerned to make that decision – Partnership action should be restricted to multi-agency systemic learning.
- The urge to escalate a serious welfare concern into a safeguarding concern and service must be resisted. Safeguarding concerns only apply to a small minority of concerns and requests for service in respect of children in need – some 5% nationally. This boundary should be policed effectively by the Panel and by agencies with each other. This in turn means that agencies must listen to the concerns being expressed by their partner agencies about an individual rather than to pull the drawbridge up and quote rigid eligibility criteria as a reason not to accept the referral. This practice tends to push the referring agency into the safeguarding route, which is why so often professionals and referrals go round in circles. A conversation-based approach will be taken between agencies about what is best to do.
- All relevant information must be shared at the earliest point. This includes relevant material about the child in question as well as the outcomes of any internal reviews about an incident or a situation. If internal reviews are not shared, the Panel is at risk of setting up a new review or mechanism when in fact the learning has already been identified and some actions have already been taken.
- The paradigm shift from large-scale reviewing to effective early action requires a change in practice. The Panel will show leadership about this. It is a shift to earlier internal ownership of mistakes and what is needed to correct them, rather than waiting to be told this by an external reviewer in several months' time. There are exceptions where an external independent review is needed as set out in section 5. But the bias should be towards effective early internal action (internal within the Partnership).
- The Panel will promote professional curiosity, appreciative inquiries, restorative practice, problem-solving round tables, and dispute resolution between partners so that decisions and risks are genuinely shared. Using creative methodologies supports effective early action.

A request to undertake a Rapid Review will be sent to the following organisations: Safeguarding Leads from the Local Authority, CCG, Police and Mental Health Trust. Where appropriate, referrals will also be sent to Education Leads, Cafcass, probation, care homes and commissioning leads.

The CCG will take responsibility for collating and providing an initial analysis of all heath responses with exception of that from the Mental Health Trust.

The SSP Business Unit will be responsible for sending out requests to partners to undertake a Rapid Review and they will collate the responses. The referral will then be discussed at the next panel taking place 10 days after the referral was sent out. Assuming the panel took place on the twenty fifth of the month, any referrals received after the 15th of the month would be considered at the following months panel.

DfE Referrals

The Local Authority is responsible for notifying the national Children's Safeguarding Practice Review Panel Notifications within 5 days of becoming aware of a serious incident. These serious incidents are passed to the Partnership via the national panel with the expectation that the incident is reviewed and a response submitted to DfE within 15 days as per Working Together 2018.

These referrals will be triaged by a subgroup of the Case Review Panel consisting of the Partnerships Independent Chair and Business Manager and the Designated Safeguarding Leads from Police, Health & Social Care. Decisions made by this group will then be noted at the next meeting. The national panel may decide it is appropriate to commission a national review of a case. In these rare instances, the review process will be undertaken in collaboration with the Department for Education.

Court Referrals

Where practical, cases referred to the Partnership by the court will be dealt with using the rapid review process. In instances where this would not be practical or it would be an inefficient use of practitioner time, the Independent Chair will agree how to proceed.

Referral Decision

The Criteria for determining if a referral meets the criteria for a review will be based on if the case highlights or may highlight:

- improvements needed to safeguard and promote the welfare of the person(s) referred, including where those improvements have been previously identified.
- recurrent themes in the safeguarding and promotion of the welfare of the person(s) referred.
- concerns regarding two or more organisations or agencies working together effectively to safeguarding and promote the welfare of the person(s) referred.
- evidence of serious abuse, neglect, permanent harm, reduced capacity, or quality of life
- death of a person(s) referred which is/could be as a result of abuse or neglect.

Not all criteria need to be met for a review to be initiated. Depending on the identified concerns, this will inform the type of review undertaken, if any.

Case Review Panels will also give regard to the following circumstances where:

- there is cause for concern about the actions of a single agency.
- there has been no agency involvement, and this gives the Case Review Panel cause for concern.
- more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around.
- the case raises issues relating to the safeguarding or promoting the welfare of individuals in institutional settings.

Sometimes, the rapid review process will need to be paused before next steps can be established. This is usually where there is insufficient information on which to base a decision. The review can be put on hold for a specific period or an indeterminate length of time. Cases on hold will be reviewed at each Panel meeting to ensure the need continues or else to take a different decision.

Feedback

The Panel will feed back to the referrer the decision and next steps for the case whenever possible and appropriate to do so. This will typically be acknowledgement that their referral has been considered. Where a referral is made by a professional and it is decided it does not meet the criteria for a review, the rationale for this decision will be fed back.

4. Reviews

Types of Review

All reviews will identify improvements to be made to safeguard and promote the welfare of children and adults at risk. The types of reviews undertaken in Suffolk are summarised below. Full details of the key characteristics can be found in appendix 1.

Action Learning from the Rapid Review

An action plan will be developed by the key partners based on the findings from the Rapid Review process. A summary of the case and the learning will be produced to help practitioners understand the rationale behind the action plan.

Single Agency Review

Undertaken when a single agency only was involved in the case. The review will be undertaken by a local reviewer, a single agency report will be produced, and the review and report will be completed within three months.

Partnership Review

This type of review will be undertaken when the full criteria for an Independent Review is not quite met, but the Case Review Panel feels there is still considerable learning that the can be found across multi-agency partners. It will be led by a local reviewer. The review and report will be completed within three months. A summary of the case and the learning in a Signs of Safety format will be produced and published on the Partnership's website alongside the action plan.

Independent Review

When full criteria are met, a Safeguarding Adults Review, or a Local Child Safeguarding Practice Review (LCSPR) will be undertaken by an External Reviewer commissioned by the Panel. The timescales for completion are 6 months. A Findings Report will be produced with recommendations for the Boards to consider, and an Executive summary will be published on the SSP website.

Making Safeguarding Personal

Ensuring the individuals experiences and their story remain at the heart of all practice reviews is fundamental to the Suffolk model. Wherever practical and wherever possible service users and their families will be involved, and their views sought. Practitioners will also be invited to participate so their unique perspective can also be seen and heard.

Service User Involvement

An individual's experiences will be at the heart of any learning from reviews. Suffolk Safeguarding Partnership will always, where possible and appropriate, seek to ensure that carers and families (including surviving relatives) are invited to contribute to reviews. They will be supported to understand how they will be involved, and their expectations will be managed appropriately and sensitively.

Communication at an early stage is vital in gaining support and cooperation from family members during the review process. Before a review commences the level of family involvement will be agreed. It is the expectation that families are involved, unless there is a reason for them not to i.e., they are a suspect in the incident that triggered the review. A member of the review team will become the liaison officer and primary contact with the family.

All reviews should feel like a collaborative process. The individual and/or family should be provided with opportunities to shape the areas of learning being explored and ensure the story of the person subject to the review is heard through the reports and its findings.

The expectation is that as a minimum family will be:

- Informed that a review is going to take place and invited for their views on any elements they feel should be covered as part of the review.
- Given the opportunity to provide a 'pen picture' of their family member subject to the review.
- Offered a meeting with the liaison officer to go through the initial findings of the report and an opportunity to comments/share their views.
- Asked if they would like a particular name for their relative to be referred to in the report prior to publication.
- consulted on any media releases that are produced when the report is published.
- Given advance notification of the publication date of the review.

The use of interpreters or translation services will be used where English is not the first language of the family members. The timings of notifications and correspondence with families is crucial, in particular, where there are current Police investigations and any pending criminal proceedings involving the individual and or family will be discussed with the Police safeguarding lead.

Practitioner Involvement

Practitioners who have had direct involvement in the case should have the opportunity to be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for their actions. Consideration should be given to the support practitioners may need at what may be a traumatic or difficult time for them as well.

Parallel Criminal Investigations

When a case review is undertaken whilst there is an ongoing police investigation, it is important that the two processes link with attention to disclosure requirements.

There is a presumption that even when criminal proceedings are ongoing, the work of the review will go ahead in accordance with statutory timescales unless there are special circumstances which would require some compromise. If there are clear reasons put forward by the Police or CPS in discussion with the Reviewer/Independent Reviewer it may be possible to negotiate a delay in final completion of the case review, or some restriction of its scope such as consideration being given to not interviewing or involving specific people who may be key witnesses or defendants in criminal proceedings.

Statutory Reporting

When a Local Child Safeguarding Practice Review or Safeguarding Adult Review is undertaken, the report should include a summary of any recommended improvements and any analysis of any systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report.

The report must be published unless the case review panel considers it inappropriate to do so. They should be made publicly available for at least a year. Consideration must be given to how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case.

Distribution lists for the final report will vary depending on whether it is an adult or children's review.

Adults

Although there is no comprehensive national repository for adult reviews the Care Act states that all reviews should be published unless it would be inappropriate to do so. This will be done on the Partnerships website and a copy will be sent to the Social Care Institute for Excellence to add to their bank of Safeguarding Adult Reviews.

Children's

A copy of all children's Local Children's Safeguarding Practice Reviews must be sent to the National Panel, Ofsted, and the Secretary of State for Education no later than seven working days before the date of publication. In cases where other proceedings such as an ongoing criminal investigation, inquest or future prosecution may have an impact or delay publication, the Partnership should inform the National Panel and the Secretary of State giving the reasons for the delay.

Third Party Investigations

Where other investigations take place alongside the Practice Review, e.g., CQC inspection, coroner's inquest, the findings from these investigations should always be considered as part of the safeguarding practice review.

Where a review has already been published and subsequent investigation takes place/report is published the case review panel will be expected to review the findings and where appropriate amend the action plans to ensure all learning is obtained.

5. Reviewers

Wherever possible, local reviewers will be used. Local Reviewers are members of staff employed by one of the Partner organisations who will be afforded time away from their substantive role to undertake a review. This could be a personal development opportunity for the individual concerned along with providing them with experience of working in the wider safeguarding arena. Full support will be provided to all local reviewers through the Case Review Panel and the Partnerships business unit. Guidance and template documents are also available for use. The Partnership is always keen to grow the pool of local reviewers and information for prospective local reviews can be found on the Partnership's website[5].

There are some circumstances when an Independent Reviewer will be appointed to undertake a review. These include, but are not limited to:

- recurrent themes
- issues of national significance
- heightened media or political attention
- where there are particular sensitivities around interagency working that would be best investigated by someone with no knowledge of the local system

The decision as to who will undertake a review will always be agreed when the referral is first considered. Should a dispute arise between the use of an internal or external reviewer the final decision will sit with the Independent Chair.

In all cases, the case review panel must ensure that the reviewer has the following:

- Relevant professional knowledge, understanding and practice.
- The ability to engage both with practitioners and children and families.
- The ability to tell the story of the person subject to the review.
- Knowledge and understanding of research relevant to the safeguarding issues of the case.
- Ability to recognise the complex circumstances in which practitioners work together to safeguard children, families, and adults at risk.
- Ability to understand practice from the viewpoint of the individuals, organisations, or agencies at the time rather than using hindsight.
- Ability to communicate findings effectively.
- Whether the reviewer has any real or perceived conflict of interest.

[5] add page on local reviews and link in here.

6. Findings, Recommendations & Action Planning

Information gathering (learning) events will be held with practitioners from key agencies to explore the key themes identified by the review group in a three-stage manor: what went well, what could have been done better and what would we do differently if this happened again (learning for the future).

The Partnership provides report templates for the author(s) to complete. All reports will cover:

- A summary of the case and circumstances leading to the review.
- The voice and/or story of the person(s) subject to the review.
- Exploration of the key themes and lessons to be learnt.
- Recommendations or questions about the system for the board to answer.

The findings of the report should be written up with sufficient details that 'the story' with consideration given that these will be publicly available reports that any member of the public could have access to.

Where questions are presented (as with the reviews in rapid time methodology, it will be the responsibility of the review group to explore these questions and devise recommendation that will answer and resolve the question posed.

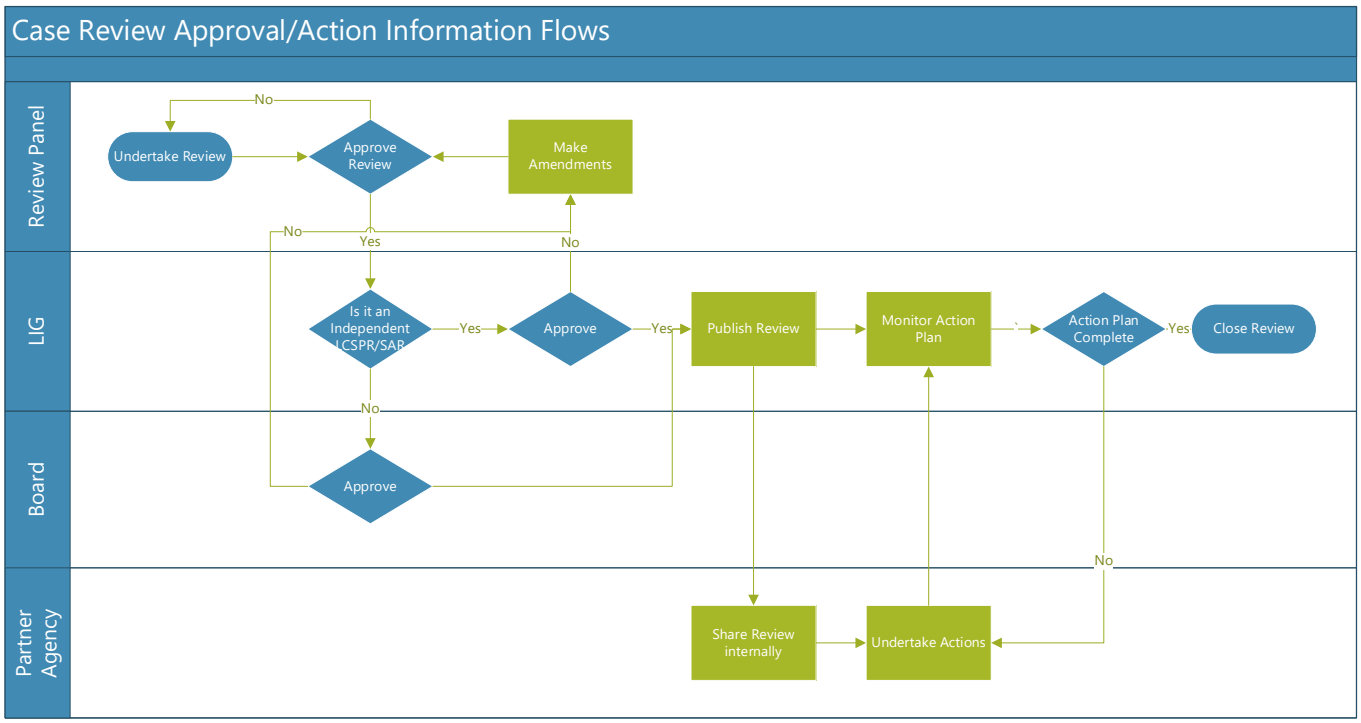
Once the report is signed off, action planning will commence by the review group. Action plans are usually best if they are short, realistic and if they contain clear milestones and dates for delivery or implementation. As much attention must be paid to implementation and applying learning as it is to the investigation or diagnostic stage.

7. Sign-off & Publication

Sign-off

The Partnership will publish all Independent Reviews unless in collaboration with the Case Review Panel, there is a reason why it would be considered inappropriate to do so. This could be the full report, an executive summary, or a quick-read case study.

The table below illustrates the sign-off process for review prior to publication.



Publication

Publication and media planning will start once the final report and recommendations have been formally endorsed by the Partnership. Consideration will be given as to how best to manage the impact of the publication on the person in the review, their family members, practitioners, and others closely affected by the case. The wishes of the family will be considered as part of the publication and media planning. The arrangements will be discussed with the family and appropriate steps taken to minimise the disruption and distress. Arrangements to inform practitioners will also be considered. As part of this work, consideration will be given to what name the report will be published under, and how anonymity will be ensured.

For LSCPR's, the Partnership must send a copy of the full report to the National Panel, Ofsted and to the Secretary of State no later than seven working days before the date of publication. Published reports will also be submitted for inclusion in the NSPCC National Repository of safeguarding case reviews.

All review reports and learning summaries will be published on the Partnerships website and notifications will be sent to representatives on the Executive Group, Board and Learning and Improvement Group. It will be the responsibility of partner agencies to ensure learning is cascaded and embedded within their own organisation.

8. Application of Learning

Partners are responsible for ensuring that learning from reviews is embedded into their individual organisations. The Partnership will look to produce resources in support of this and evaluate their effectiveness via monitoring at the Learning & Improvement Group (LIG)

Since COVID-19 and the move away from face-to-face meetings and towards digital responses, the Partnership has reviewed its approach to implementing learning from reviews across adults and children to ensure it is delivering the right information, to the right people, in a timely way.

Where the Partnership is responsible for dissemination of an element of learning it will look to harnesses the use of digital technology and this should also have a wider reach than traditional face to face events.

Alongside this, the Partnerships business unit takes a wider view of thematic learning to spot trends. These will be shared with the Learning & Improvement Group who will agree how best to address them in a timely way, considering learning and issues more broadly across the region and nationally. Learning from reviews will be one way in which audit topics are identified.

This section sets out how learning will be embedded across multi-agency partners, and the approach to disseminating and sharing information from reviews.

Share learning with professionals	• Weave or adapt learning in to existing relevant safeguarding training to meet a need • Creation of new training courses (Workforce Development) • Virtual sessions offered by the Partnership discussing a theme or case • Cascade via Strategic manager's meetings • Enlist the support of the Quality Assurance Teams to support the dissemination of learning • Publication of case studies on the Partnerships website
Embrace new approaches	• SSP to host webinars on targetted themes evident from reviews • 7 minute briefings (developed in collaboration with Workforce Development) • Better link up and promotion of online events from other orgs on SSP socials • Preparation of 'packs' from the Partnership which can be given to lead agencies to deliver learning within their orgs • Create areas on the website for key learning events to be advertised
Proactive in spotting trends in Suffolk	• QA and autit activity undertaken by individual Parnters • Partners sharing their own learning with the Partnership • QA and audit processes completed by the Business Unite within the Partnership to routinely look at thematic trends in reviews
Wider view around the country	• Professional Advisors to proactivley look at what reviews have concluded nationally, identifying relevant learning for the Suffolk • Business Manager to filter through info from the Regional Board Managers Meetings • Independent Chair brings a national perspective on safeguarding issues and how they apply to Suffolk

In the first instance, application for learning will be monitored through the Learning & Improvement Group and escalated to Board and/or Exec as appropriate.

9. Appendices

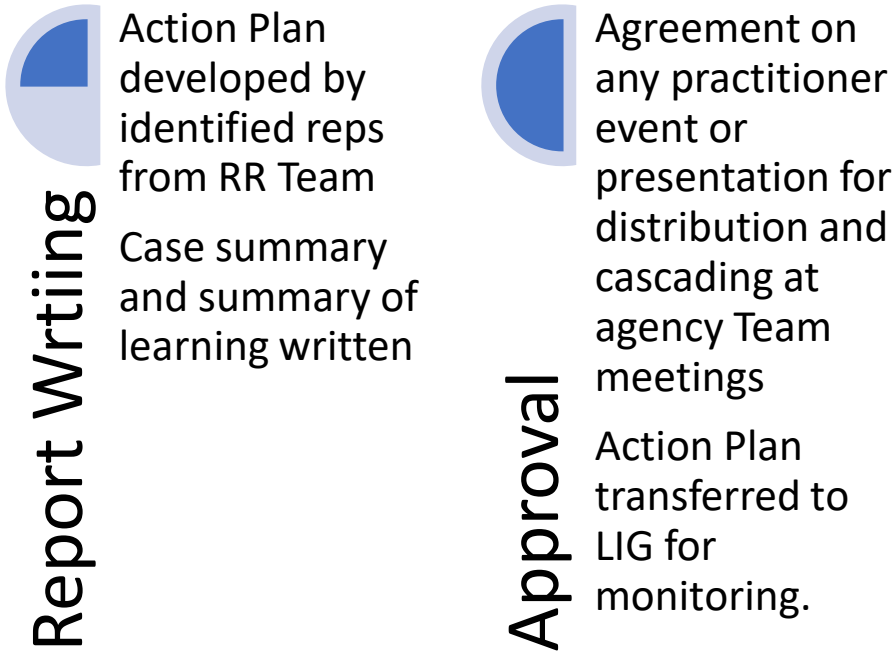
Appendix 1: Overview of Core Features and Process for Review Types

	Action Learning from Rapid Review	Single Agency Review	Partnership Review	Independent Review/SAR
Purpose: To identify changes that could save the lives of children and adults at risk				
Lead/Facilitator	• SSP Professional Advisor/Business Manager	• SSP Professional Advisor/Business Manager	• SSP Professional Advisor/Business Manager	• SSP Professional Advisor/Business Manager
Author	• SSP Professional Advisor/Business Manager	• Local Reviewer Pool	• Local Reviewer Pool • SSP Professional Advisor/Business Manager	• Independent Consultant
Review Team	• Rapid Review Team or their delegates • Additional members as agreed during Rapid Review	• Key Representatives from Agency • Third party members as agreed in the Terms of Reference	• The review team will be a representative from each of the agencies involved. • Additional members as appropriate will be invited by agreement of the review team	• The review team will be a representative from each of the agencies involved. • Additional members as agreed by statutory partners via the chair of the Review Panel (CRP/SARP)
Terms of Reference	• Agreed Actions from Rapid Review	• Agreed by Case Review Panel (or a subgroup thereof)	• Agreed by Review Team	• Drafted and commissioned by Review Team and using a standardised template. • Agreed by CRP/SARP
Timescales	• 1 month	• Up to 3 months (unless there is an unavoidable delay by exception)	• Up to 3 months (unless there is an unavoidable delay by exception)	• Up to 6 months (unless there is an unavoidable delay by exception)
Expected Outcomes	• Evidence-based Action Plan and case summary briefing document plus power point presentation to take out to teams and agencies to discuss.	• Evidence-based Action Plan • Single Agency Report (Template used).	• Evidence- based Action Plan • Partnership Report (template used). • Easy Read case study • Media Response drafted • Engagement with family	• Evidence- based Action Plan • Full LCSRP/SAR Report (Template used). • Executive Summary • Easy Read case study/case summary briefing document. • Pro-active Media Release • Engagement with family
Sign-off Process	• Approved by LIG	• Consent from family on learning • Approved by LIG	• Consent from family on learning • Approved by LIG	• Consent from family on learning • Approved by LIG. • Approved by Board
Publication	• Key findings incorporated into training programmes or modules as appropriate.	• Key findings incorporated into training programmes or modules as appropriate.	• Key findings incorporated into training programmes or modules as appropriate.	• Key findings incorporated into training programmes or modules as appropriate.

	Action Learning from Rapid Review	Single Agency Review	Partnership Review	Independent Review/SAR
	• Condensed into Annual Summary of Reviews for CRP/SARP	• Condensed into Annual Summary of Reviews for CRP/SARP	• Summary of case and learning in a Signs of Safety format	• Redacted Exec Summary on Website • Full report to DfE (Children's)
Information				
Gathering	• Rapid Review responses • Specific trails identified in the Rapid Review	• Chronologies • Document Trawl • National Benchmarking	• Chronologies • Document Trawl • National Benchmarking • Practitioner Event • Family Consultation	• Chronologies • Document Trawl • National Benchmarking • Practitioner Event • Interview with key practitioners • Family Consultation
Storage	• All documents retained by SSP			
Learning				
Identification	• Identified as part of the Rapid Review Process and through final action plan created.	• Key Themes identified through initial review team meetings	• Key Themes identified through initial review team meetings. • Key Themes explored at Practitioner Event	• Key Themes identified through initial review team meetings. • Key Themes explored at Practitioner Event. • Detailed analysis of Evidence by Author • Engagement with Board • Engagement with SUC's
Dissemination and implementation of actions	• Managers Meetings • Targeted Training, workshops & learning symposiums. • Webinar • Management action in one or more agencies e.g., via managers or leadership team meetings • Revised Guidance, Policies & Procedures • Media Campaigns			
Embedding	• Action plan monitored by LIG. • Revised Training, Policies & Procedures • Quality Assurance & Audit measures • Review as part of Thematic Process			
Involvement				
Level of Service User engagement	Discretionary but should always be considered	Invitation to be included extended. Consent sought where applicable		

Appendix 2: Process Flows

Application of Rapid Review Learning



Single Agency and Partnership Reviews

First Review Meeting

- Involves key partners identified as part of rapid review
- Agree family contact/involvement
- Identify further information required
- Organise sourcing chrnoologies
- Agree key themes of ReviewSourcing of chronologies.
- Choose/identify report author.

Second Review Meeting

- review chronologies
- review family responce
- plan practitioner event
- challenge agencies on practice
- Chronologies reviewed.
- Review family response.
- Plan practitioner event.
- Discuss and challenge the practice with the agency.

Practitioner Event

- Invite to all invovled/with an interest in the case
- Follow Signs of Safety Exercise on Key Themes
- Identffy Key Leanring & Actions
- Agree Next Steps

Report Writing

- Drafted by SPP team
- Action Plan incorpoated
- Consultation with Family
- Review Panel Sign Off

Approval

- Learning and report discussed with the family.
- Refinement of Action Plan
- Action plan passed to LIG for monitoring
- Review Closed

Independent Review/SAR

First Review Meeting

- Rapid Review Team and any additional members as agreed by RR.
- Sourcing of chronologies.
- Agree family contact/involvement.
- Identify if any further information is required.
- Themes identified.
- Choose/identify independent consultant to write the report.

Second Review Meeting

- Chronologies reviewed.
- Review family response.
- Plan practitioner event.

Practitioner Event

- Invite all practitioners and managers who have been involved in the case.
- Signs of Safety process to be used to identify the key themes in the case.
- Key learning and possible actions identified.
- Next steps agreed.

Report Writing

- Written by the Independent Consultant.
- Recommendations and actions identified as part of the report.
- Consultation with the family undertaken as part of the report writing process.

Approval

- Learning and report discussed with the family.
- Action plan developed by the SSP and key partners.
- Action plan monitored at LIG.
- Learning event delivered by the Independent Consultant.
- Report published on SSP website.

Appendix 3: Pre-Publication Checklist

	Application of Learning	Single Agency	Partnership Review	Independent
Summary learning PowerPoint, Easy Read Case study developed				
Report & PowerPoint independently proofread				
Notification to comms & press teams statement/strategy drafted to share with Partnership Group for final sign off prior to publication				
Final QA of report: check watermarks & formatting				
SSP Chair to brief partners re publication date & draft press statement shared with: • SSP Executive Group • Heads of Other Agencies involved • Lead member				
Press statement shared with comms partners from all agencies involved in the case				
Advise family of report publication date – if applicable, share press statement				
Send report only to National Panel/SCIE with proposed publication date allowing at least five working days before publication				
Forward final report and PowerPoint to: • Case Review Panel, Board & LIG members Advise that the report is embargoed until publication date and to let professionals involved in review know publication date				
Write to family and send them a copy of the published report/case study				
Post report and summary PowerPoint on website to meet publication date				
Send link to report and notice of publication to: • Exec, Board • Lead Members				

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