care inspectorate

TRIENNIAL REVIEW OF INITIAL CASE REVIEWS AND SIGNIFICANT CASE REVIEWS (2018-2021):

Impact on practice

CONTENTS

FOREWORD

'In the context of child protection, a Significant Case Review (SCR) is a multi-agency process for establishing the facts of, and learning lessons from, a situation where a child has died or been significantly harmed. SCRs should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate. An Initial Case Review (ICR) precedes a SCR and is the process through which child protection committees consider relevant information, determine the course of action and recommend whether a SCR or other response is required'. National Guidance for Child Protection Committees Conducting a Significant Case review (2015)

This report follows on from our two previous triennial reviews. In common with the findings from those and key messages from serious case review research and reports in England, the themes in this report will already be familiar to child protection and public protection committees. Understandably, committees feel frustrated that the themes are recurring. This has led to questions about the value of reviews and their contribution to learning and developing child protection practice. It is important however to continue to highlight the patterns of harm and create opportunities to share learning. This will help ensure that findings are able to influence wider policy and practice change where necessary, and not just in the area where harm occurred.

This is our final triennial SCR overview report. With the introduction of the new National Guidance for Child Protection Committees: Undertaking Learning Reviews (due to be published in 2021), all ICRs and SCRs will be replaced by Learning Reviews. From 2022, these will be the focus of our overview reports.

This report also seeks to provide some insight into what supports changes in practice and what the challenges are when review recommendations have been the catalyst for the change.

We hope that this and future reports, along with the introduction of more routine updates through Child Protection Committees Scotland (CPCScotland)[1], the Learning Review knowledge hub and the Learning Review Liaison Group[2] will be used to encourage further discussion and create more opportunities to disseminate and implement changes from learning.

[1] CPCSotland is a non-statutory group who work together to develop and drive forward national policies and best practice with the aim of protecting children and young people.
[2] The Learning Review Liaison Group (comprising Scottish Government, CPCScotland and Care Inspectorate) routinely meets to discuss thematic findings from learning reviews that have national implications for policy and practice development.

EXECUTIVE SUMMARY OF KEY FINDINGS

The process for undertaking significant case reviews (SCRs), the multi-agency process for learning lessons from a situation where a child has died or been significantly harmed, is changing with the introduction of the new Learning Review Guidance (2021). This is the time to pause and reflect on how the learning from Initial Case Reviews (ICRs) and SCRs has been implemented and the impact it has had on practice and policy.

This report presents the findings from review reports submitted to the Care Inspectorate between 1 April 2018 and 31 March 2021. It includes the key findings from our analysis of 50 ICRs that did not proceed to a full SCR, 23 SCRs and two thematic learning reviews. The reviews considered the circumstances of 96 children and young people. Sixty-four children and young people were the focus of ICRs and 32 were the focus of SCRs.

The report also includes the views and experiences from Child Protection Committee (CPC) members across Scotland. Surveys were sent to the 28 committees who had been actively involved with ICRs and SCRs during the timeframe of this report. All CPCs were invited to participate in the regional focus groups.

Almost 40% of reviews followed the death of a child or young person (28 of 75 reviews). The most common cause of death was suicide (eight young people), closely followed by drug-related deaths (seven young people).

Neglect was the main feature in non-fatal reviews, affecting 35 children. While the majority of children subject to reviews where neglect featured were under 11 years, a third of the children were aged 12-17 years. Neglect is an issue that can affect children of all ages.

Information sharing, the role of the person acting as the professional point of contact in universal services or 'named person' and lead professional, quality of assessment and analysis of risk remain areas identified in review reports for learning and development. These are familiar themes that have been highlighted in our previous SCR overview reports and inspections. These areas continue to be addressed through local CPC improvement plans.

Decision making is inconsistent across Scotland about when and why SCRs are carried out. We anticipate that the clarity of the new Learning Review Guidance (2021) will support greater consistency. It provides revised criteria for carrying out learning reviews and places an emphasis on the additional learning that will be gained from a review.

CPCs provided insight into the factors that have an impact on implementing change as a result of ICR and SCR findings.

The following points provide a summary:

- ICR and SCR recommendations and findings can be catalysts for changes in practice and organisational culture. CPCs provided helpful examples which are in **Appendix 4**.

- Recommendations directed at senior managers and CPCs create opportunities to influence, lead and implement change. Those which required a multi-agency solution make the biggest difference to practice.

- Recommendations related to training, closely followed by those relating to policies, procedures and protocols are considered by CPCs to have the biggest impact on practice. From a CPC perspective, reports with fewer and more specific recommendations make the biggest difference to achieving improvement.

- Further development of impact measures would provide an evidence base of the influence that review findings and recommendations have on practice and on improving outcomes for children and young people.

- Improvement actions from case reviews that are owned by chief officers and relevant strategic groups, children's services and adult services are more likely to achieve and sustain changes in practice and organisational culture.

- Assorted approaches to disseminating learning from reviews enables learning to be shared timeously and targeted appropriately at different staff groups across children and adult services. Effective, ongoing engagement with practitioners, managers and leaders is key in disseminating learning.

- ICRs and SCRs have played an important role in the development of learning cultures. Learning reviews will continue to be a significant tool for identifying learning and contributing to systems development and practice improvements.

- Across the child protection landscape there is a range of work being undertaken to strengthen and improve child protection practice. This includes the publication of new guidance, establishment of the learning review liaison group and the learning review knowledge hub. We anticipate that they will provide opportunities to better support local and national learning.

ACKNOWLEDGEMENTS

This report has been developed in collaboration with the Protecting Children Team from Centre for Excellence for Children's Care and Protection (CELCIS). The team was created in 2016 to support the delivery of the national Child Protection Improvement Programme and provide secretariat support to CPCScotland on continuous improvement.

We would like to thank the child protection and public protection committees across Scotland for their contributions to the report. They provided invaluable insights into their experiences of commissioning and conducting ICRs and SCRs, as well as an overview of the impact on practice in response to recommendations and findings, which acted as catalysts for change.

We recognise the complex and difficult circumstances that child protection and public protection committees have been working through during the Covid-19 pandemic and we are grateful for their support in the production of this report. We have included a section on the challenges and opportunities identified in relation to undertaking and completing ICRs and SCRs during the pandemic.

PURPOSE OF THE REPORT

As part of a commitment to further improvement, the Care Inspectorate is required to report publicly on thematic findings from SCRs to provide independent public assurance on the quality of care for children and young people, share any learning worthy of dissemination nationally, and support improvements to child protection practices and policy across Scotland. At a meeting of the National Child Protection Leadership Group in April 2019, it was acknowledged that there is inconclusive evidence that case reviews lead to the improvement of children's outcomes. The group agreed that further consideration should be given to how continuous improvement can be supported.

In previous Care Inspectorate national overview reports the focus has been on the themes emerging from findings as well as feedback on the consistency and quality of the review process. From our analysis of ICR and SCR reports that we received, we were not able to extract material that helped us to understand the impact of the recommendations on practice.

The process for undertaking and learning from reviews is changing as we move forward with the new Learning Review Guidance (2021). This is the time to pause and reflect on how the learning from ICRs and SCRs has been implemented and the impact it has had on practice and policy. To date, there has been no national overview of the impact of recommendations and findings from ICRs and SCRs.

The purpose of this report is to:

- provide commentary that can help inform practitioners and agencies in their work to keep children and young people safe from harm
- provide a national overview of the impact on practice and policy
- highlight the processes that support and challenge change
- consider the implications for practitioners, leaders and policy makers locally and nationally.

This report builds on the key messages from the Care Inspectorate's previous triennial report **Learning from Significant Case Reviews (March 2015 to April 2018)**. Throughout, we use the term Child Protection Committees (CPCs) for simplicity.

However, we acknowledge that in Scotland some areas have arrangements for a single public protection committee with a wider remit.

METHODOLOGY

The Care Inspectorate has been the central collation point for SCRs carried out by CPCs in Scotland since April 2012 and in June 2017 the role was extended to include ICRs.

The method we adopted for collating data to inform this report was different from the approach used in previous triennial reports. In addition to the analysis of the ICRs and SCRs that the Care Inspectorate received, we invited CPCs to contribute to the report by sharing their experiences of the ICR and SCR processes. Invitations to contribute were extended to all 30 child protection and public protection committees across Scotland.

Our approach involved:

- a desk-top review and analysis of the recommendations and themes emerging from ICRs and SCRs received by the Care Inspectorate between 1 April 2018 and 31 March 2021
- an analysis of survey responses from 25 CPCs which focused on review recommendations and findings, and the impact on practice
- five focus groups involving 28 CPCs to follow up points emerging from the survey
- an invitation to CPCs to provide case examples to illustrate the impact of ICR and SCR recommendations and findings on practice.

The surveys were sent to the 28 committees who had been actively involved with ICRs and SCRs during the timeframe of this report.

STRUCTURE OF THE REPORT

Throughout the report we refer to 'reviews and reports'. These terms relate to both the ICRs which did not proceed to a SCR as well as the completed SCR reports which CPCs sent to us. Where relevant, we comment on whether the findings are from the ICR or SCR.

Part 1: Overview of notifications, themes and decision-making processes

This provides an overview of the numbers of cases included in this report and the key learning points. We also include observations about the rationale for cases that that did not proceed to a SCR and how learning was disseminated. We draw from our analysis of the reports received.

Part 2: Recommendations and impact on practice

This section explores the impact ICRs and SCRs had on practice and policy. We highlight the number, type and quality of findings and recommendations, as well as what supported and challenged the implementation of recommendations and the impact on practice. We draw on the learning from ICRs and SCRs and the feedback from the survey and the focus groups. The survey question set mirrors those used in a recent study **Complexity and Challenge: A triennial analysis of SCRs (2014-2017)** which was published in 2020 and provides helpful comparisons.

Part 3: Impact of the Covid-19 pandemic

This presents information about the impact that the pandemic has had on undertaking and completing ICRs and SCRs. We summarise feedback through the survey and the focus groups on what CPCs identified as opportunities and challenges.

Part 4: Conclusions

This section considers the implications for policy and practice and future opportunities.

PART 1: OVERVIEW OF NOTIFICATIONS, THEMES AND DECISION-MAKING PROCESSES

Numbers of notifications

Between the 1 April 2018 and the 31 March 2021, the Care Inspectorate received 82 notifications that ICRs had been undertaken, of which 32 were proceeding to a SCR. Since 2015, the number of ICRs proceeding to SCR has averaged 11 each year. This means that approximately two thirds of the ICRs do not progress to a SCR.

While there was an increase in the number of notifications in 2018 and 2019, the proportion proceeding to SCR has remained constant. This reflects the pattern that was noted in the last triennial report and is consistent with the numbers over a six-year period.

Numbers of ICRs and SCRs

This report includes the key findings from our analysis of 50 ICRs that did not proceed to a full SCR, 23 SCRs and two thematic learning reviews. The reviews involved 96 children and young people — 64 children and young people were the focus of ICRs and 32 were the focus of SCRs.

Between 1 April 2018 and 31 March 2021, 28 CPCs were actively involved in undertaking ICRs and SCRs or submitting SCRs. A total of 11 SCRs we received and considered for this report were started before 2018.

Review themes

As in our previous overview reports, there was a number of familiar themes that remain areas for learning and development across a range of adult and children's strategic partnerships and services. We have drawn out some of the key points below.

While Getting it Right for Every Child (GIRFEC) principles have been embedded across partnerships, there continues to be some confusion about the roles of the named person service (or person acting as the professional point of contact in universal services) and the lead professional which is undermining practitioners' confidence. This is continuing to result in a lack of a coordinated approach to meeting children and young people's needs in some instances.

Appropriate, consistent information-sharing and effective inter-professional communication remains a challenge and featured in nine SCRs. There were examples in SCRs that despite local protocols and guidance being in place, professional cultures were

continuing to impact on information-sharing behaviour and attitudes within and across organisations. One of the impacts of this can be different thresholds for intervention or a delay in initiating action. For example, inconsistency in recording information from professional discussions such as Team Around the Child meetings could lead to a lack of clarity about what had been agreed, planned and progressed.

Neglect continues to be a prominent and contributory feature in a quarter of the ICRs and SCRs submitted which considered a total of 35 children and young people. As highlighted in our previous reports, review findings identified missed opportunities to intervene or to recognise signs or patterns early enough, leaving children unnoticed in neglectful or harmful situations until a threshold for child protection was reached. Reviews also identified that social and environmental factors could have implications on how and when professionals made decisions about when to intervene to protect the child from further harm.

Good mental health and wellbeing and access to trauma-informed treatment and prevention services are important for all children and young people. However, our reviews of ICRs and SCRs identified that the mental health and wellbeing of older children and young people whose circumstances were subject to review is not addressed appropriately. For example, young people repeatedly present at emergency departments with self-harming or possible suicidal behaviour and with no follow-up referral to the Child and Adolescent Mental Health Service (CAMHS), or to social work prior to discharge.

Themes in relation to assessment and decision making were identified in a number of the SCRs that we reviewed. These included the quality of assessments, lack of adequate analysis of the impact of cumulative adverse events on the risk of harm, and the use and effectiveness of tools and frameworks in the assessment process. These were similar to the themes and findings we have described in our previous reports.

There were particular examples concerning a lack of coordinated approaches to pre- and post-birth planning and assessment of babies, and lack of clear communications and processes for discharge of new-born infants, which were not integrated into child protection processes. In one example, a vulnerable expectant mother was referred to midwifery by the professional who identified the pregnancy. However, information contained in the mother's record was not shared with midwifery as the professional had no direct knowledge of the mother's circumstances. This resulted in a delay in identifying and assessing the needs of the mother and unborn baby until just before birth. This adversely impacted upon the child's plan.

Other recurring examples related to the lack of a holistic assessment when considering risks across family groups. The focus tended to be on the behaviours of the adult where there was parental substance use, domestic abuse, parental mental health concerns or where there was criminality. There were examples of no joint assessment of the impact on the child or children in the household being carried out.

Types of significant harm or nature of death

We categorised significant harm or death using the language that was used in the review reports. Where there was more than one type of harm, we used the primary cause of harm that initiated the review process. (Please see **Appendix 1**)

Of the 96 children and young people subject to review processes over the three-year period, 28 had died. The most common categories of death were suicide (eight young people) and drug-related incidents (seven young people). We identified variability in the decision-making about the types of reviews for children and young people who died. For example, the deaths of four children were attributed to sudden unexpected death in infancy (SUDI). Only one of these children was subject of a SCR, and the three other children were subject to a SUDI review instead. Some of the older young people who died were subject of an ICR only, while others proceeded to a SCR.

One CPC appropriately decided not to progress to a SCR because the young person was the subject of a death of a looked after child review, a drug related death review in line with national and local guidance and a police independent review commissioner report. The new Learning Review guidance (2021) and the **National Hub for Reviewing and Learning from the Deaths of Children and Young People - National Guidance (2021)** promote collaboration between agencies and organisations to reach a decision about the most suitable review process.

The establishment of the National Hub for reviewing and learning from the deaths of children and young people will ensure that the death of every child in Scotland will be subject to a quality review. The National Hub has been tasked with ensuring reviews are conducted on all deaths of live-born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death. Local governance arrangements will be in place which will determine the type of review required to be carried out. Learning reviews coordinated through CPCs will be one of the review mechanisms considered when the learning review criteria have been met.

As in our previous reports, neglect recurs as the main non-fatal category of significant harm. Neglect was prevalent in 18 of the reviews and related to 35 children. Five of the reviews related to family groups. There were 11 ICRs which did not proceed to a SCR

where neglect was identified. While most of the children experiencing neglect were under 11 years, a third of the children were between 12-17 years of age.

Adolescents

Typically, in our previous overview reports of SCRs the majority of children whose circumstances led to a review were pre-school age. We found a similar pattern within this three-year period. In our previous reports, we did not include a full analysis of the ICRs that did not proceed to a SCR, therefore we are unable to make direct comparisons with regards to the numbers and age ranges. However, when we reviewed the age range of the young people who were subject of an ICR that did not proceed to a SCR for this report, we found that more than a third were aged 12 years and older. We found that CPCs were less likely to proceed to a SCR for this age group of young people. Later in the report there is a section that explores the decisions that CPCs made and reasons for not proceeding to a SCR. Within the total number of ICRs and SCRs, 30 involved young people aged 12 years and over. In total, 15 of the reviews related to death of a young person and 15 were related to non-fatal significant harm.

The table below highlights the themes that emerged in relation to adolescents, for example chronic neglect, mental health, self-harm and suicide, risk of sexual exploitation and drug-related deaths.

Category of harm: Number of young people aged 12-18 years

Type of harm (non-fatal)	ICR only	SCR	Total
Neglect	9	1	10
Murder/assault on others/risk of harm to others	4	0	4
Sexual abuse/(risk of) CSE	3	0	3
Type of harm (fatal)			
Suicide	5	3	8
Drugs related	7	0	7
Accidental	0	1	1

Our recent joint inspections of children in need of care and protection highlighted that most children and young people were being kept safe as a result of coordinated responses to risk of significant harm. However, there remains room for improvement, particularly in addressing the impact of cumulative harm, including domestic abuse, child sexual exploitation or neglect, and the identification of risk to older young people.

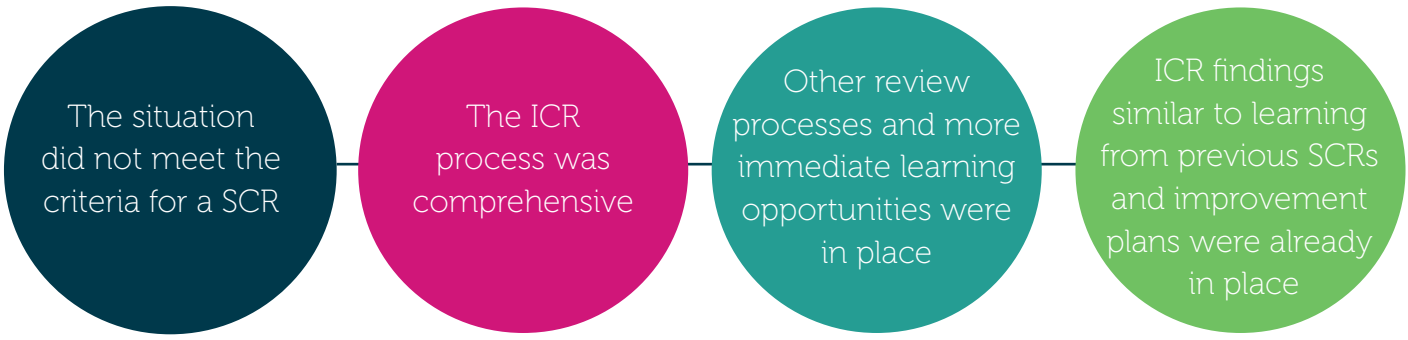
ICRs that did not proceed to SCRs

> **"An Initial Case Review is an opportunity for the child protection committee to consider relevant information, determine the course of action and recommend whether a Significant Case review or other response is required"**
>
> National Guidance for Child Protection Committees Conducting a Significant Case review (2015)

The report of the Systems Review Group, **Protecting Scotland's children and young people: it is still everyone's job (2017)**, commented that there were limited learning opportunities arising from ICRs at a national level. The report considered this to be a missed opportunity and that learning from ICRs and SCRs should not be considered in isolation. As a result, since June 2017 CPCs have routinely submitted their ICRs to the Care Inspectorate. This has provided insight into CPC decision-making processes when considering whether to progress to a SCR. It has also enabled us to build a picture nationally about how CPCs are disseminating learning from ICRs that do not proceed to a SCR at a local level.

CPCs referenced the criteria from the **National Guidance for Child Protection Committees for Conducting a Significant Case Review (2015)** when making the decision on whether or not to proceed to a SCR. The level of detail about the rationale for the decision was variable across Scotland. However, we have been able to identify four general overlapping themes.

Rationale for not proceeding to a SCR



Just over half of the ICRs that did not proceed to a SCR were on the grounds that the circumstances did not meet the criteria. Although the criteria were met in the other ICRs, other factors contributed to the decision not to proceed to a SCR. It was not always clear how a decision was reached, particularly when there was disagreement or when many of the criteria were met and particular weighting had been put on some of the criteria over others. For example, in a few ICRs while most of the criteria were met, the CPC decided that it was not in the public interest to proceed to SCR.

Although it was acknowledged that there had been significant harm or that a child had died, in all of the ICRs not proceeding to SCR, the main reason for not proceeding was because there were no concerns about the professional and or service involvement or lack of involvement.

Some ICR reports were comprehensive, and the findings were extensive. In these circumstances, the decision not to proceed to a SCR was on the basis that learning had been identified and it was felt that no additional learning would be gained through a SCR. This approach enabled some areas to quickly gather information, identify learning and feed it back quickly across the workforce. CPCs considered this helpful because it meant that the learning was current and had a greater impact. This was particularly prevalent in relation to reviews that involved adolescents.

The capacity to identify and disseminate learning quickly was important to all CPCs. This was reflected in the decision-making in a few of the ICRs. While the SCR criteria may have been met, CPCs sometimes made the decision not to proceed because the findings were similar to those in previous SCRs, improvement plans were already in place and changes in policy and practice were under way. In light of the number of recurring review themes and recommendations, it is not surprising that such decisions were taken. In several ICRs the reason for not proceeding further included other review processes being in place, for example a SUDI review, or because the ICR identified single service recommendations and single agency reviews were deemed the most appropriate response. However, sometimes the reasons for undertaking alternative reviews, such as multi-agency learning reviews, independent learning reviews or learning events instead of a SCR, particularly when the criteria were met, were less clear.

The National Guidance for Child Protection Committees Undertaking Learning Reviews (due to be published in 2021) which replaces the 2015 national guidance, outlines the key features, principles and values of learning reviews. These include supportive and collective learning, proportionality and flexibility with the goal of achieving optimum learning opportunities from a process that is not overly lengthy. In future national overview reports, it will be interesting to explore the impact of these on learning processes, practice change and on outcomes for children and young people.

PART 2: RECOMMENDATIONS AND IMPACT ON PRACTICE

The main focus of this section is on how the learning from reviews has influenced practice. We considered the findings from the survey that CPCs completed, our discussions with focus groups and have also incorporated aspects our analysis of the ICRs and SCRs that were sent to us, where appropriate.

Scotland is not in a unique position. Our survey responses were similar to those in the **Complexity and Challenge study**, which asked the same questions of Local Safeguarding Children's Boards (LSCB) in England.

In this report we focus on learning at a local level and across Scotland, however CPCs may wish to consider exploring cross-border opportunities to share learning and experiences in the future.

Our survey responses can be found in **Appendix 2** and practice change examples are in **Appendix 4**.

Between 1 April 2018 and 31 March 2021, CPCs submitted 23 SCRs and two reports referred to as 'learning reviews' to the Care Inspectorate. Three of the reviews took a thematic approach rather than on an individual incident or case basis. A total of 15 reviews used the Social Care Institute for Excellence (SCIE) Learning Together model. This is twice the number using the SCIE approach than was the case in our previous triennial report. The methodology of the review and how findings were presented did not appear to have an impact upon how a CPC considered its response to a review and next steps.

Number of SCR recommendations

There were 180 recommendations and findings in the SCRs that we reviewed. Most reports had between three and 10 recommendations or findings. Three SCRs contained between 13 and 28 recommendations. In general, however, the numbers of recommendations and findings in reports have reduced since our previous triennial report. In response to our survey and focus groups, CPCs told us that reports which produced fewer and more specific recommendations were most helpful.

> 'The extent to which a recommendation/finding can make a difference to practice will depend on how specific it is... If the recommendation/finding is too broad ranging, then it may be difficult to determine the extent to which practice has changed as a result of it. As such, findings/recommendations need to be SMART'.
>
> (survey reponse)

Type of recommendations and findings

To undertake our analysis and description of SCR recommendations and findings, we used the **six broad categories of underlying patterns** that were developed by the Social Care Institute for Excellence (SCIE).

The majority of recommendations focused on management systems closely followed by professional norms and cultures. A few recommendations related to cognitive and emotional biases such as lack of professional challenges and insufficient professional curiosity. Some focused on interactions with families, for example, working with non-engaging families and professionals' over optimism about parents' capacity to change. We were interested to hear CPC members' opinions about what type of recommendations were more likely to influence changes in practice and whether the recommendation target made any difference. We extracted the types of SCR recommendations from the reports we had received and included them in the survey question set. While we separated the types of recommendations to provide illustrations on the potential to influence change, we acknowledge that it is far more complex and that change most often happens as a result of a number of contributory actions.

CPCs highlighted that each recommendation, irrespective of who it is targeted at, has the capacity to deliver substantial changes to practice. One CPC commented that how learning is shared and how change is managed and implemented should be dependent on where the change is targeted:

> "[at an] individual practitioner level, practitioners can connect with findings in a review, especially if they are/ have been involved, recognise the practice and/or are impacted by the findings... They can affect important changes themselves... [At a] service/agency level ... connection, discussion and exploration of the issues can

> make a difference... Change will only come with breaking this down to manageable levels and supporting the whole service/agency to believe and plan how they will influence a change."

Nevertheless, change to practice is not without challenge and this is covered later in the report.

Survey results indicated that multi-agency recommendations made the most difference to practice followed closely by single-agency recommendations. Our examination of SCR recommendations showed that the majority were multi-agency in nature. Many of the reviews noted the key role of health within child protection and we identified that the majority of single-agency recommendations related to NHS management systems and cultural practices. Examples included the need to ensure appropriate information-sharing across primary and acute health services, between health boards and with other professionals.

Many of the CPCs commented on the importance of leadership and ownership of the review findings. They felt that when chief officers had oversight of, and monitored improvement activities, changes in practice were encouraged more effectively and likely to be more sustainable. Recommendations targeting CPCs and senior managers were considered as opportunities to influence, lead and implement change.

> "Having collective senior management buy-in and the ability to monitor and see through action plans while providing the right supportive learning framework for staff is vital."
>
> (survey response)

Survey responses indicated that national recommendations had the least impact in influencing local practice change compared to other targets of recommendations. While national recommendations had only been made in two reviews, we identified themes that were common in many reviews across different areas of Scotland. Many of the local recommendations were related to wider societal issues that we are familiar with, such as neglect, poverty, mental ill-health and drug use. Change in local practice is more challenging in the context of these national concerns.

We asked CPCs to identify the type of recommendations that led to changes in practice. Survey results suggested that the most impact on practice comes from recommendations related to training, closely followed by recommendations relating to policies, procedures and protocols. Staff supervision, audits, new approaches to working with families and achieving culture change were examples highlighted as having some impact on practice.

The least substantial impact was felt to come from recommendations to improve staffing levels and improvements to IT to support service delivery.

There were a number of recommendations in the reviews we read that related to training. Survey responses commented on the importance of training as a mechanism for changing practice. However, CPCs noted challenges in developing consistent approaches to evaluate the impact that training was having on practice.

> "Training tends to improve knowledge but [there is] no evidence that practice changes significantly as a result."
>
> (survey response)

> "Training is often seen as the solution to many findings but without support and supervision to follow this up, it is difficult to see the impact of training on practice."
>
> (survey response)

The importance placed on training and its benefits are also reflected in the **Joint inspections of services for children and young people in need of care and protection overview report (2018-2020)**.

The report highlighted:

> "Overall, two thirds of staff surveyed believed their participation in regular multi-agency training had strengthened their contribution to joint working."

We were told by CPCs that changing culture and practice is complex and the ever-changing landscapes of children's services and child protection means that improvements and better outcomes for children and young people do not always happen quickly or in a linear fashion.

> "In some areas, we learn very quickly, make quick wins to make a substantial difference. In other areas it takes longer to deliver on the identified priorities and the recommendations make some difference."
>
> (survey response)

> "Achieving cultural change may take long term investment and relies on good respectful professional relationships."
>
> (survey response)

Summary points – types of recommendations

- Recommendations targeting senior managers and CPCs were considered as opportunities to influence, lead and implement change.
- Recommendations which required a multi-agency solution were thought to make the biggest difference to practice.
- Recommendations related to training, closely followed by recommendations relating to policies, procedures and protocols were considered by CPCs to have the biggest impact on practice.
- Reports with fewer and more specific recommendations make the biggest difference to managing and implementing changes in practice.

Monitoring implementation and quality assurance

CPCs told us that they have a range of monitoring and quality assurance systems in place that help to provide oversight on the implementation of recommendations.

Progress reporting arrangements and red, amber, green (RAG) traffic light systems were the most popular approaches to monitoring how well change was being implemented, with CPCs' annual reporting providing accountability. Most areas mentioned the importance of quality assurance and SCR sub-groups as a driving force for producing improvement plans, reports and disseminating learning. Other approaches highlighted by respondents included:

- practice review oversight sub-groups
- feedback from practitioners
- risk register
- supervision processes
- feedback from children, young people and their families.

In response to a case review consultation exercise undertaken by CELCIS in 2020, a CPC commented:

> "SCRs tend to generate actions and action plans, these can result in changes to training, policy and process. However, this does not necessarily lead to improvement. Where change has been implemented, this needs to be followed up by qualitative analysis of impact."

This issue was also highlighted in our focus groups. While monitoring and quality assurance systems were in place, some CPCs acknowledged that they did not always provide a qualitative analysis of impact, providing instead quantitative information about

activity being undertaken. CPCs told us that it could sometimes be difficult to monitor the implementation of practice change from ICR and SCR recommendations and improvement actions. When recommendations were broken down into manageable parts, CPCs had more confidence that change would be possible.

We were told that when the monitoring and evaluation of practice improvement was overseen by the Chief Officers' Group, services at individual practice and systems level were held accountable and encouraged to work together to make a difference.

This mirrors the findings of the CELCIS case review consultation, referenced above, regarding the importance of "**ensuring buy in from all parties; creating local ownership of the change and involving all levels of the system in the change process".**

Summary points – monitoring implementation and quality assurance

- CPCs use a variety of monitoring and quality assurance approaches. However, further analysis and evaluation is required to understand the impact of training and other improvement activity on practice and culture change.
- The role of chief officers in the monitoring and evaluation of practice improvement is critical to supporting and sustaining transformational change.

Dissemination of learning

CPCs used a wide range of approaches to share learning from ICRs and SCRs. The majority highlighted training being delivered to disseminate learning and some shared examples of their experience of using seven-minute briefings, bulletins, action learning sets, conferences or events based on specific themes. CPCs told us that these approaches were helpful in sharing learning quickly, developing better understanding of the learning points, and contributing to attitudinal, culture and practice change at both an individual practitioner level and at a systems level.

In addition to training, we were told that case management oversight and supervision to support practitioners to implement required changes in practice that had been identified from reviews was important. One area told us that multi-agency group supervision had been used successfully to disseminate learning from reviews.

> "One-to-one supervision is limited to individual learning and response. Group supervision is seen to be helpful, with a focus on collective responsibility. Multi-agency group supervision has been very well received and a collective approach has continued. The NHS have started multi-disciplinary group supervision, but it is in its early stages."
>
> (focus group participant)

Another area shared an example of supervision and case management as systems for supporting learning.

> "Inter-agency reflective supervision and case management at senior level is a significant factor within our learning locally, and work is being done to develop protocols and guidance to promote and embed this as a shared framework across the region."
>
> (focus group participant)

The benefits of using a variety of approaches as per these examples is consistent with the findings from the CELCIS case review consultation with CPCs. CPCs were not relying on only one approach for the wider local dissemination of learning but were using a variety of formats and types of dissemination that supported the various needs of practitioners and services.

Our analysis of SCR recommendations highlighted that the majority were multi-agency and focused on the need to have coordinated and informed approaches across services to impact on a child's safety, health and wellbeing. Recommendations had implications for a wide range of different partners and services including adult services, housing services, mental health and wellbeing services, drugs and alcohol services as well as children's services.

Our survey responses suggested that in most areas, messages about learning and improvement were disseminated appropriately to staff and agencies that make up the community planning partnership. Supported by CPCs, learning and improvement actions were shared, for example, across a range of public protection committees, children's services strategic groups, health and social care partnerships and corporate parenting strategic groups.

CPCs were keen to emphasise that learning did not just occur once the review was over and that the involvement of practitioners throughout the process was a meaningful approach that ensured that learning happened right from the outset.

> **"Bringing practitioners together to share an experience and a story [means] the learning happens right from the beginning."**
>
> (survey response)

All of the SCRs we read indicated that practitioners were involved in the process in terms of gathering information and many of them involved professionals in group discussions to reflect on practice. The new learning review guidance promotes the engagement with staff throughout the process and the importance of creating and sustaining a "positive shared learning culture". This is "an essential requirement for achieving effective multi-agency practice".

We were told that learning was disseminated mainly within the local authority area and that discussion in CPC regional meetings, national lead officer meetings and CPCScotland meetings provided opportunities to reflect on the learning from elsewhere and explore how it might be applied within their own partnership area. In the case review consultation exercise that CELCIS undertook, CPCs expressed dissatisfaction with the inefficiency of the limited channels to disseminate learning nationally. They suggested that a more consistent and nationally coordinated approach would be helpful.

From the focus groups and survey responses, there was some optimism that learning from reviews was being more widely shared at a national level. The publication of the Care Inspectorate overview reports, the development of the Learning Review Knowledge Hub and the recently created learning review liaison group were considered helpful approaches that facilitated improved communication and dissemination of learning from reviews. CPCs highlighted that they were uncertain about how national recommendations and emerging themes from reviews were influencing national policy development, but they were hopeful that the new structures in place would assist this.

There was confidence in the variety of approaches being used to share learning. However, CPCs acknowledged that there were challenges and further areas for improvement. These included routine evaluation of the impact of the dissemination of learning approaches in supporting, implementing and embedding change.

While it is important to disseminate learning across all partners and at all levels from front-line staff to senior leaders, we were told that this could be challenging. Reliable organisational collaboration and cooperation, and good communication providing consistent and clear messages were reported to support learning and practice change.

> "Where we have seen most success and embedding of learning in practice changes resulting from SCRs, were in situations where people are freed up to creatively respond to challenges in a joined-up, partnership way. This has the effect, over time, of changing cultures."
>
> (survey response)

Summary points – dissemination of learning

- Ownership of and commitment to the review process and subsequent improvement planning by senior leaders reinforced the key learning points and supported dissemination of learning.
- Learning happens during and after a review. Engagement with practitioners, managers and leaders is key in disseminating learning.
- Assorted approaches to disseminating learning from reviews enables learning to be shared in a timely manner and targeted appropriately at different staff groups across children and adult services.
- While there was some evaluation of the effectiveness of the way in which learning was being disseminated, further exploration and evaluation of the impact of the approaches was identified.
- National recommendations and emerging themes from reviews have the potential to influence national policy development. The establishment of the learning review liaison group and the learning review knowledge hub aim to assist how the learning from local reviews is disseminated nationally.

Impact on practice

Our analysis of review reports did not extend to gathering information about the impact of the recommendations and findings on practice or systems development. However, we recognised that key stakeholders were interested in finding out more about the difference that reviews were making and sharing this information at a national level. In order to gather information in relation to this, we used the survey and focus groups where CPCs shared their knowledge and experiences with us.

We were told that review recommendations and findings were acting as catalysts for change. The survey responses suggested that CPCs were gathering evidence of change from a variety of sources. Audits, self-evaluation, collation of action plan responses, consultation with practitioners and making use of performance indicators were among the most frequently highlighted. However, despite these efforts to evidence the impact from SCR findings on practice, we were told that this was challenging and required further consideration.

We asked CPCs to tell us about what supported change and what were the barriers to it. Commonly reported enablers and barriers are outlined below and in **Appendix 3** we have listed common enablers identified by CPCs.

As highlighted earlier, improvement planning and changes in practice and policy were more likely to be achieved by supportive and effective leadership from chief officers and the CPC. The role of the chair of the CPC, lead officer and CPC subgroups were also viewed as key to ensuring that any findings identified by reviews were considered and actions or changes to practice were implemented.

> "The role of lead officer is pivotal in driving forward change and improving communication with staff (for example) setting up better means of communication such as a staff message board on website and the introduction of informal chat sessions for all agency staff on CP issues."
>
> The role of the (independent) chair is vital in progressing change with senior partners in COGPP."
>
> (survey responses)

Several factors relating to review processes were seen to support change. These included the appointment of a skilled reviewer, timely completion of reviews, engagement of staff throughout the process and clear recommendations.

> "A really participative process where practitioners feel part of the review at all stages including sharing findings."
>
> (survey response)

This practice was also a finding from the case review consultation exercise undertaken by CELCIS noting it "creates local ownership of change".

Delays in the review process were a challenge to implementing learning from SCRs and developing practice. Delays may occur, for example, where the circumstances resulting in a review are subject to criminal proceedings. However, a new protocol has been agreed with the Crown Office and Procurator Fiscal Service (COPFS) which is included in the new learning review guidance. This highlights that criminal proceedings should not inappropriately adversely affect the progress of a learning review.

> "The amount of time from initiation of ICR/SCR to completion and recommendations [and] the time taken to complete the learning process [means that] staff may have moved on from their post or it may have been some time from the incident resulting in some detail about events being lost."
>
> (survey response)

Improvement plans with specific actions, timescales and clearly identified leads with responsibilities for progressing specific recommendations or findings were considered by CPCs to be key to driving change. Some CPCs described specific action plans informed by a single SCR or ICR while in other areas the learning was collated into an overall development plan for the CPC. However, the improvement plans were structured and effective monitoring was seen as crucial in supporting improvement.

Many survey respondents did not feel that SCR conclusions or findings without recommendations were helpful. It could delay the implementation of improvements if the CPC had to undertake further internal analysis to agree and plan actions to address findings.

The importance of improving staff supervision across all disciplines to support and promote learning and change was noted in ICR and SCR recommendations. Survey respondents told us that reflective and supportive supervision structures were in use in some areas, but this practice was not consistent across all disciplines. Some agencies had a more formalised and robust supervision process for practitioners involved in child protection work.

We noted a challenge for leaders in smaller local authority areas in which individuals hold strategic and operational roles. This could mean that prioritising improvement work and effecting strategic change was challenging, as individuals were faced with balancing that and the day-to-day operational demands of service delivery.

Working across local authority, health board and police divisional areas which are not co-terminus was seen as a challenge by some CPCs.

> "Multi-agency and cross authority working are both an enabler and a barrier. For example, in [our area] we have one health board, one police division and three local authorities and navigating a consensus to change across these bodies is not without its challenges."
>
> (survey response)

Many areas recognised the need to ensure that adult protection, child protection and other public protection activity were intrinsically linked and some areas had established joint committees under the umbrella of public protection to enhance communication and achieve a more joined up approach. Other areas had put systems in place to make sure that routine communication between the various public protection committees in the area was robust and that cross-cutting issues were acted upon using a joint approach.

Influencing change

Our survey asked if some situations or types of case were harder to learn from than others. On this question, 63% of respondents agreed, highlighting that some complex and multi-faceted cases were most difficult to use learning from to influence change. Respondents mostly referred to cases that involved national and wider societal issues such as neglect, mental health and transitions from children's services into adult services.

Survey respondents noted:

> "Complex cases where there are a multitude of services involved with the family and where there has been cross-authority involvement in the family are potentially more challenging."

> "Cases involving a young person in transition between children and adult services are challenging."

> "Buy-in from strategic managers is necessary to influence change. There may be resistance to change across the workforce. Commitment and agreement are needed across the workforce that change is required."

> "It can be difficult to influence change when an organisational culture shift is required - a move away from the way things have always been done."

Implementing change – some examples

Although CPCs expressed frustration that the same learning points and themes recur, our survey findings and focus group conversations indicated there had been local change of practice as a result of reviews. CPCs provided examples of changes in practice but were less confident about their measurements of the impact of these changes on outcomes for children and young people.

"We are good at taking action in relation to specific process changes. We need to do more to reflect on the impact of our practice."

(survey response)

Listed below are a few examples of local changes in practice that were shared with us where recommendations from reviews acted as catalysts. Other more detailed examples can be found in **Appendix 4**.

"Following extensive work by health, a Distressed Children and Young People pathway, covering refinements to CAMHS/Emergency Department/General Practitioner systems and processes in relation to the journey of a distressed young person through NHS services, [a new agreed pathway] is in place and has been tested for young people under the age of 16 years who attend the emergency department."

(survey response)

"Following from a SCR in the area, there has been an increased focus on bringing GIRFEC practice and principles into [our] pre-birth planning and approach. There are good relationships between social work and health and more proportionate referrals are being made".

(survey response)

"Findings of the SCR have been [a] catalyst/lever to initiate change at a systems level. Realigning of resources to adopt [a] public protection team is bringing together CPC and Violence Against Women Partnership agendas, as well as significant investment in new models of practice, such as Safe and Together, and relational approaches. Inter-agency reflective supervision and case management at senior level is a significant factor within our learning locally, and work is being done to develop protocols and guidance to promote and embed this as a shared framework across (the region)."

(survey response)

"In (area) SCRs have led to an operational instruction to review 16-18 year olds under child protection procedures if they are not open to adult services. This has seen an increase in referrals, conferences and appropriate response to young people in transition."

(focus group participant)

Summary points – impact on practice

- Improvement planning and changes in practice and policy are more likely to be achieved with supportive and effective leadership from chief officers and the CPC.
- Improvement actions from case reviews that are owned by chief officers and relevant strategic groups, children's services and adult services are more likely to achieve and sustain changes in practice and organisational culture.
- Further development of quality and performance indicators, and evaluation of learning from recommendations, will provide an evidence base about the impact the learning has on practice.
- Reviews of complex and multi-faceted cases, and reviews which identify recurring themes such as neglect, mental health, transitions from children's services into adult services are less likely to influence significant change in the short term. In these circumstances, change is more likely to happen over a longer period.

PART 3: IMPACT OF THE COVID-19 PANDEMIC

At the start of the pandemic, we recognised that services, local authorities and strategic partnerships would be faced with challenges in their work to meet the needs of the most vulnerable people in our communities during this global health emergency. The Care Inspectorate issued a statement that CPCs should continue as normal to notify us of any ICRs and forward completed SCRs. However, we acknowledged that some SCRs may take longer than usual to complete and that there would be challenges to undertaking ICRs.

Between 23 March 2020 and 23 March 2021, we received a total of 16 ICR notifications, of which seven were proceeding to SCR. This was 50% fewer compared to the same period the previous year and likely reflected some of the challenges stemming from the pandemic.

CPCs told us that at the start of the pandemic, there was uncertainty on how to undertake an ICR/SCR while the 'stay at home' guidance from Scottish Government was in place and that initially there was some delay while operational recovery plans were put in place. As a result, some activity was temporarily paused but reinitiated as quickly as possible when digital solutions were identified.

The use of virtual or ICT platforms to undertake ICRs and SCRs has had success, although some challenges have been identified. While it requires a range of partners adopting similar platforms, the introduction of virtual meetings had created more flexibility and opportunities for a greater contribution from key professionals. For those professionals who were located some distance from the CPC area or had changed jobs and relocated away from where a review was being undertaken, the use of virtual platforms enabled them to contribute.

On the impact of Covid survey respondents noted:

> "ICRs and SCRs are continuing virtually. Workforces are under increased pressures though."
>
> (survey response)

> "We are currently in the process of drawing up action plans in relation to one ICR and one SCR and as online virtual processes are now well established no significant difficulties are anticipated."
>
> (survey response)

While CPCs shared their experiences of the benefits of virtual meetings to support the continuation of carrying out review processes, they also acknowledged some of the limitations. Remote working had created difficulties in accessing files and information. CPCs also noted that while virtual meetings had enabled the process to continue, the richness of discussion and interaction was impacted by the artificial face-to-face connection between the contributors during the online meetings.

The Systems Review Report (2017) acknowledged the personal and professional anxiety for staff involved in ICRs and SCRs as well as the importance of the way in which staff are engaged, consulted and supported throughout the process. During the pandemic, this has been even more relevant. CPCs commented that remote working had left some staff feeling disconnected from colleagues and that the limitations of virtual contact between colleagues had added to the challenges in accessing or providing support to staff during a review process. However, we noted that review teams had remained committed to supporting staff through the processes.

Some CPCs had found it difficult to identify appropriate people to carry out SCRs and ICRs during the pandemic. Finding reviewers who had the capacity, availability and who were appropriately skilled to undertake 'virtual' reviews could be challenging.

While CPCs continued to undertake ICRs and complete SCRs, the priority and the immediate response during the pandemic was to ensure that families continued to receive support. Many of the CPCs commented that quality assurance and improvement work from review recommendations and findings had stalled because of pressures on services to prioritise service delivery. This resulted in more fragmented and limited dissemination of learning and learning opportunities in some partnership areas.

Survey responses indicated that with face-to-face training stopped, colleagues missed the informal opportunities to share ideas and ask questions that are possible when people are in a shared physical space. Nevertheless, e-learning opportunities for staff had been provided and tailored training, informed by review findings, had been developed. While this was considered positive during the pandemic, the longitudinal impact of this approach had not been evaluated at the time of this report.

Summary points — impact of the pandemic on review processes

- CPCs had mixed experiences on progressing ICRs and SCRs during the pandemic.
- Creative solutions were used to enable review processes to carry on during challenging circumstances.
- Virtual meetings might continue to be used as part of the approach to engaging with staff through the review process.
- More use of online learning may be one of the approaches to disseminating findings/recommendations from reviews to wider groups of staff.

PART 4: CONCLUSIONS

The work for this report has sought to provide a national overview of the experiences of and views from CPCs across Scotland in relation to ICRs and SCRs. It has highlighted the necessity for strong and effective leadership in driving change and supporting staff. It has reinforced the value of efficient systems to identify learning and appropriate performance measures to evaluate the impact of learning on practice and on improved outcomes for children and young people.

The Child Protection Systems review identified three overarching and cross cutting themes: leadership, accountability and governance; developing a learning culture and shared values. When considered together, these three themes are vital to continuing to improve processes and structures to protect children and young people. ICRs and SCRs play an important contributory part in the development of learning cultures along with the development of the child protection minimum data set developed by CELCIS, in consultation with key stakeholders.

Working with children and young people who are at risk of significant harm and their families is complex and demanding. This was clearly reflected in our focus group discussions and in our analysis of reviews. We know from other reports such as the child neglect in Scotland series of reviews including the rapid reviews of literature on intervention and on legislation and policy **(Daniel and Scott)** and the Care Inspectorate's triennial reviews that some children and young people living with parental substance misuse, domestic abuse, parental learning disabilities and poor parental mental health can face greater difficulties than their peers. Wider societal issues such as poverty, ill-health, discrimination, unemployment, poor housing and disability also adversely impact on children and young people.

> "Services are delivered to children and their families in a complex environment where there is national change to legislation, guidance, responding to the pandemic as well as local challenges delivering services in this context... shrinking resources, increased demand due to impact of poverty on children and their families... ensuring workforce is skilled to work with families and learning from reviews is implemented despite turnover."
>
> (survey response)

CPCs expressed their frustration that, despite much improvement activity taking place to support practitioners work in these complex environments, the themes and learning points arising from reviews consistently remain the same. We know that acting on learning and implementing change is demanding and not always easily

achieved. Despite the level of local activity and commitment to disseminate learning and implement improvements in practice and culture change, the pace of change has been disappointingly slow for CPCs.

Responses by CPCs to previous recommendations arising from reviews demonstrate that CPCs use the same methods on each occasion to disseminate learning and undertake improvement in practice. Perhaps as a consequence, the scale of change remains constrained and there remains limited evidence of the effectiveness of these approaches, as highlighted through the three Care Inspectorate SCR national overview reports which span nine years.

This study has shown that a better understanding of the effectiveness of the approaches that are being used to respond to the learning and improvement activity identified in reviews would be beneficial. This could lead to more selective evidence-informed interventions and approaches. The success of the intervention however is based not only on what works, but also the capacity of the partnership to deploy resources and sustain them within the wider context of strategic improvement planning and activity.

CPCs provided examples of changes to practice and organisational culture. However, they were less able to provide tangible evidence of how impact is measured, or how this translated into positive outcomes for children, young people and families. We were told that there were systems and checks in place which oversee improvement work undertaken by CPCs, yet efficacy was not always measured. Performance measures focused on process and activity-based data more than qualitative, outcome data. They were, therefore, constrained in their ability to show the differences that changes to practice and organisational culture made to outcomes for children and young people.

Findings from this study reflect our own findings from the overview report on joint inspections 2018-2020:

> **"Partnerships had worked hard to develop systems for collating, analysing and reporting on performance data. However, we saw an over emphasis on quantitative data and information on outputs or actions, rather than a balance between quantitative data and qualitative data which could inform services about the differences these outputs and actions were making to the lives of children and young people."**

CPCs recognised the importance of strong and effective local leadership and the significance of their role in driving forward improvements, implementing and sustaining systems and practice change, as well as providing the resources and support to the multi-agency workforce. Survey and focus group responses indicated that practice change was

more likely to be implemented and sustained when there was strong forward-thinking leadership across the partnership, good governance arrangements and effective quality assurance systems.

> **"A strong coherent vision at a local level is essential to ensure that children are protected now and in the future. Clear leadership from Chief Officers (across community planning partnerships and integration boards) plays a vital role in ensuring high standards of child protection and support in their areas."**
>
> (Child Protection Systems Review Report 2017)

Across Scotland significant progress has been made in recognising that everyone has a responsibility for protecting children and young people. National leadership plays an essential role in driving improvement nation-wide. Political engagement and the development of national frameworks, national guidance, the changes to Scotland's legislative framework, and research have been influential contributory factors.
In a dynamic system, it is important therefore to create pathways between local and national learning to ensure that national policy makers and local frontline workers and managers have opportunities and methods for communicating and learning from each other.

Learning reviews will continue to be an important approach to identifying learning and contributing to systems development and improvements in practice.

> **"The overall purpose of a Learning Review is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children and young people. The process is underpinned by the rights of children and young people as set out in the United Nations Convention on the Rights of the Child (UNCRC)."**
>
> (Learning Review Guidance 2021)

The learning review knowledge hub and the learning review liaison group provide methods to share learning and resources more widely and have the potential to create opportunities to influence national policy development through learning and insights from reviews.

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APPENDIX 1: NOTIFICATIONS AND CHILD AND FAMILY CHARACTERISTICS

Table 1: Total number of notifications received between 1 April 2018-31 March 2021

Year of notification	Total number of notifications	ICRs – not proceeding to SCR	ICRs proceeding to SCR or learning review
1 April 2018-31 March 2019	27	17	10
1 April 2019-31 March 2020	33	21	12
1 April 2020-31 March 2021	22	12	10
Total	**82**	**50**	**32**

The figures in this report are drawn from the 50 ICRs that did not proceed to a SCR and the 23 SCRs that were submitted between 1 April 2018 and 31 March 2021. The two thematic learning reviews are not included as they were not case specific. Some of the information below relates only to young people who were subject of a SCR as the data was not always available in the ICR reports.

Characteristics of the children and young people and their families

Of the 96 children and young people who were the subject of a ICR or a SCR, 43 (44%) were male and 35 (36%) were female. Gender was not recorded for 18 children. Their ages ranged from three weeks to 18 years. The table below provides a breakdown of ages at the time of the incident that led to a review being carried out.

Table 2: Breakdown of age ranges

Age range	Number of children/young people subject of SCR	Number of children/young people subject of an ICR
< 1 year	11	13
1-2 years	4	5
3-4 years	3	9
5-10 years	8	7
11-17 years	6	27
Age not specified	0	3
Total	**32 children and young people from 23 SCRs**	**64 children and young people from 50 ICRS**

Table 3: Breakdown of non-fatal cases

Type of harm *	Number of children/young people subject of SCR	Number of children/young people subject of ICR
Neglect	13	22
Risks to self and others	0	4
Physical and/or emotional abuse (incl. 1 case of FII)	6	15
Sexual abuse/child sexual exploitation	1	3
Accident	0	1
Emotional harm	0	3
Lack of parental care	1	0
Attempted murder		1
Total	**21**	**49**

Table 4: Breakdown of deaths

Of the 96 children and young people subject to a ICR or SCR 28 had died. The eight young people whose deaths were as a result of suicide and the seven young people whose deaths were drug related, were known to specialist services such as Child and Adolescent Mental Health Services (CAMHS), addiction services, housing services and social work services. While two of the children and young people died from medical complications, the SCRs were conducted due to wider concerns regarding the circumstance of their deaths.

The table below provides a fuller breakdown of the details.

Type of harm	Number of children / young people subject to SCR	Number of children / young people subject to ICR
Sudden unexpected death in infancy or childhood (SUDI/SUDIC)	1	3
Suicide	3	5
Culpable homicide/murdered	1	1
Neglect – child died	3	1
Drug related death	0	7
Physical injury	1	0
Accidental/misadventure	1	0
Health-related condition	0	1
Total	**10**	**18**

Table 5: Living circumstances of child or young person at time of harm or death

Of the children and young people subject of a SCR, 29 (91%) were living at home at the time of the incident. Three (9%) young people subject to a SCR who died were looked after and accommodated in residential care.

Of the children and young people subject of an ICR, 54 (80%) were living at home at the time of the incident and 25% were looked after and accommodated including placements with relatives, in foster care, residential care and a supported tenancy.

Living circumstances at the point of harm or death	Number of children/young people subject to SCR (% in brackets to nearest whole number)	Number of children/ young people subject to ICR (% in brackets to nearest whole number)
Living at home	29 (91%)	51 (80%)
Living with relatives or friends	0	1 (1%)
Looked after and accommodated	3 (9%)	8 (13%)
Throughcare/aftercare	0	4 (6%)
Total	**32**	**64**

Ethnicity

Ethnicity was described as white Scottish for nine children and 19 of the submitted SCRs did not record ethnicity. One person subject to SCR is recorded as white Scottish/ American and one child's ethnicity was described as white. The information about ethnicity was not included in ICR reports.

Child health and disability

The submitted SCRs confirmed that there was no childhood disability in seven cases. Disability status was not provided for 18 children. Possible disability was noted in one case (autism). The remaining six children and young people were recorded as having some form of disability, which included spina bifida, Down's syndrome, developmental delay and autistic spectrum disorder (ASD).

The submitted ICRs confirmed that there was no childhood disability in eight cases. Disability status was not provided for 50 children. The remaining seven children and young people were recorded as having some form of disability, including mental health difficulties, ADHD, ASD, learning difficulty and intensive health needs which were not specified.

Family size and circumstances

In one case three children in a sibling group were all subject of the SCR, while one other SCR included a sibling group of six children. In four cases, the subject of SCR was the only child. In 15 cases, the subject of the SCR was the youngest of a sibling group (two of whom had at least one sibling from a multiple birth). In one case, siblings were not recorded. In one case, the subject of the SCR was the oldest of a sibling group.

Theme	Number of SCRs with theme recorded (% in brackets to nearest whole number)			
	2007-2012 from 56 SCRs	2012-2015 from 20 SCRs	2015-2018 from 25 SCRs	2018-2021 from 23 SCRs
Mental health problems	24 (43%)	13 (65%)	9 (36%)	12 (52%)
Domestic abuse	30 (54%)	13 (65%)	10 (40%)	11 (48%)
Parental substance misuse	36 (64%)	11 (55%)	10 (40%)	9 (39%)
Criminality	31 (55%)	7 (35%)	7 (28%)	12 (52%)
Parents' own childhood issues	22 (39%)	4 (20%)	14 (56%)	14 (61%)
Learning disability	4 (7%)	0	5 (20%)	0

Characteristics of child or young person's parents or guardians

The following table provides an overview of particular aspects in relation to parents, identified in the audit of SCRs carried out in 2012 **(Vincent & Petch)**, and in the reviews of SCRs in 2015 and 2018 by the Care Inspectorate, with a comparison of these key themes with this more recent review. There were no parents identified as affected by learning disability. It should be noted that some comorbidity exists in the figures noted.

Not all SCRs reflect the history of the parents, in particular their own childhood experiences, which includes their experience of being looked after, parental drug use, parental alcohol use, parental mental illness, experience of harm and abuse and other childhood trauma.

Parental criminality was noted in 12 (52%) of SCRs. This included theft, drug-related offences, assault and domestic abuse.

It was not possible to accurately extract information about the history of the parents, from the ICRs that did not proceed to SCR. The amount of detail was variable. However, from the information that was included in ICRs, it was clear that many of the parents' experiences were similar.

APPENDIX 2: SURVEY RESULTS

Listed below are the responses from the survey. The tables show aggregated results from the 25 survey responses.

Types of recommendations/findings

To what extent do you feel the following recommendation targets make a difference to practice?

	Substantial		Some		Don't know		None		Total	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Single-agency recommendations/ findings	12	48%	11	44%	2	8%	0	0%	25	100%
Multi-agency recommendations/ findings	12	48%	12	48%	1	4%	0	0%	25	100%
Recommendations/ findings for the CPC	11	44%	13	52%	1	4%	0	0%	25	100%
Recommendations/ findings for senior managers	10	40%	13	52%	2	8%	0	0%	25	100%
National recommendations/ findings	5	20%	12	48%	4	16%	4	16%	25	100%

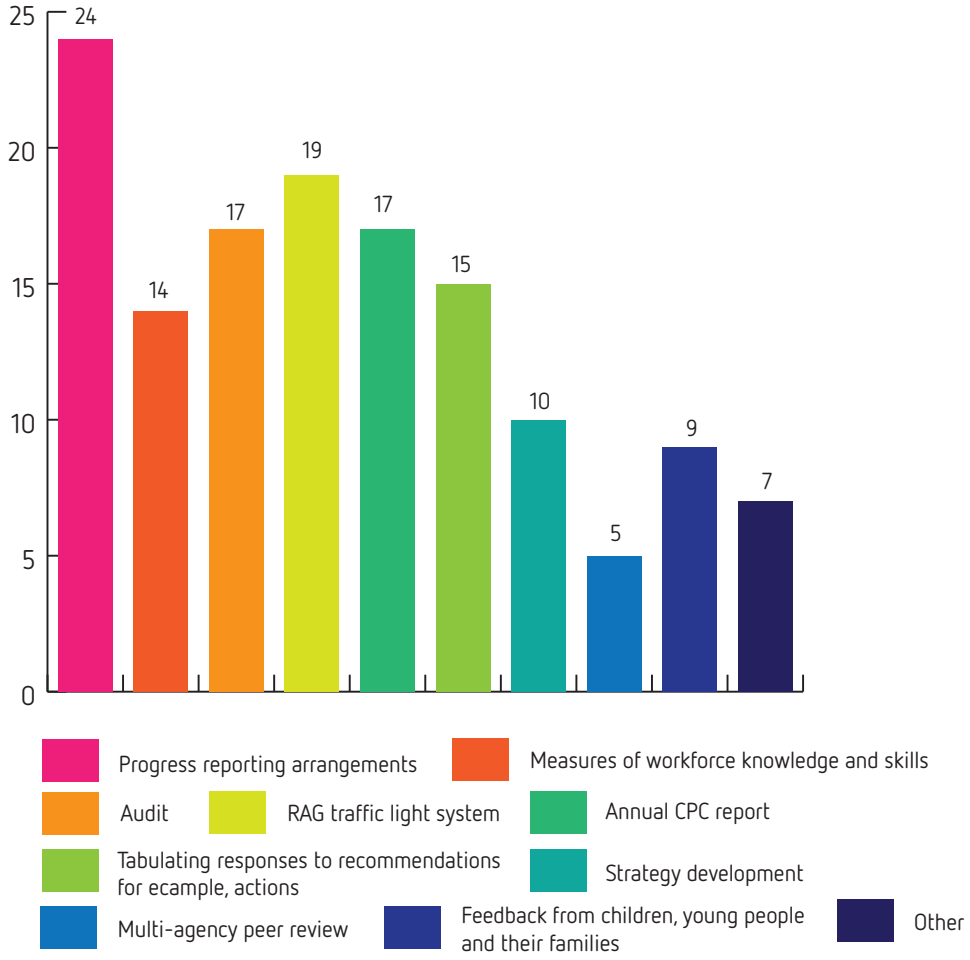
To what extent do you feel the following type of recommendations/findings make a difference to practice?

	Substantial		Some		Don't know		None		Total	
	Frequency	%		%	Frequency	%		%		%
Deliver training to improve knowledge and more effective working	16	64%	8	32%	1	4%	0	0%	25	100%
Develop new or implement existing policies, procedures or protocols	13	52%	11	44%	1	4%	0	0%	25	100%
Raise awareness about an issue from the SCR	9	36%	12	48%	3	12%	1	4%	25	100%
Initiate audits of practice	8	32%	14	56%	1	4%	2	8%	25	
Improve supervision to improve knowledge, reflection and effective working	9	36%	12	48%	3	12%	1	4%	25	100%
Improve management of cases at systems level	8	32%	13	52%	4	16%	0	0%	25	100%
Achieve cultural change	6	24%	15	60%	3	12%	1	4%	25	100%
Improve documentation	5	20%	15	60%	2	8%	3	12%	25	100%
Improve staffing levels	2	8%	10	40%	8	32%	5	20%	25	100%
Develop new services/ resources	5	20%	14	56%	3	12%	3	12%	25	100%

Apply new models or approaches to working with children young, people and their families	5	20%	15	60%	4	16%	1	4%	25	100%
Improvements to the collation and management of performance information and how it is used to inform	8	32%	12	48%	4	16%	1	4%	25	100%
Improvements to IT to support service delivery	3	12%	10	40%	6	24%	6	24%	25	100%

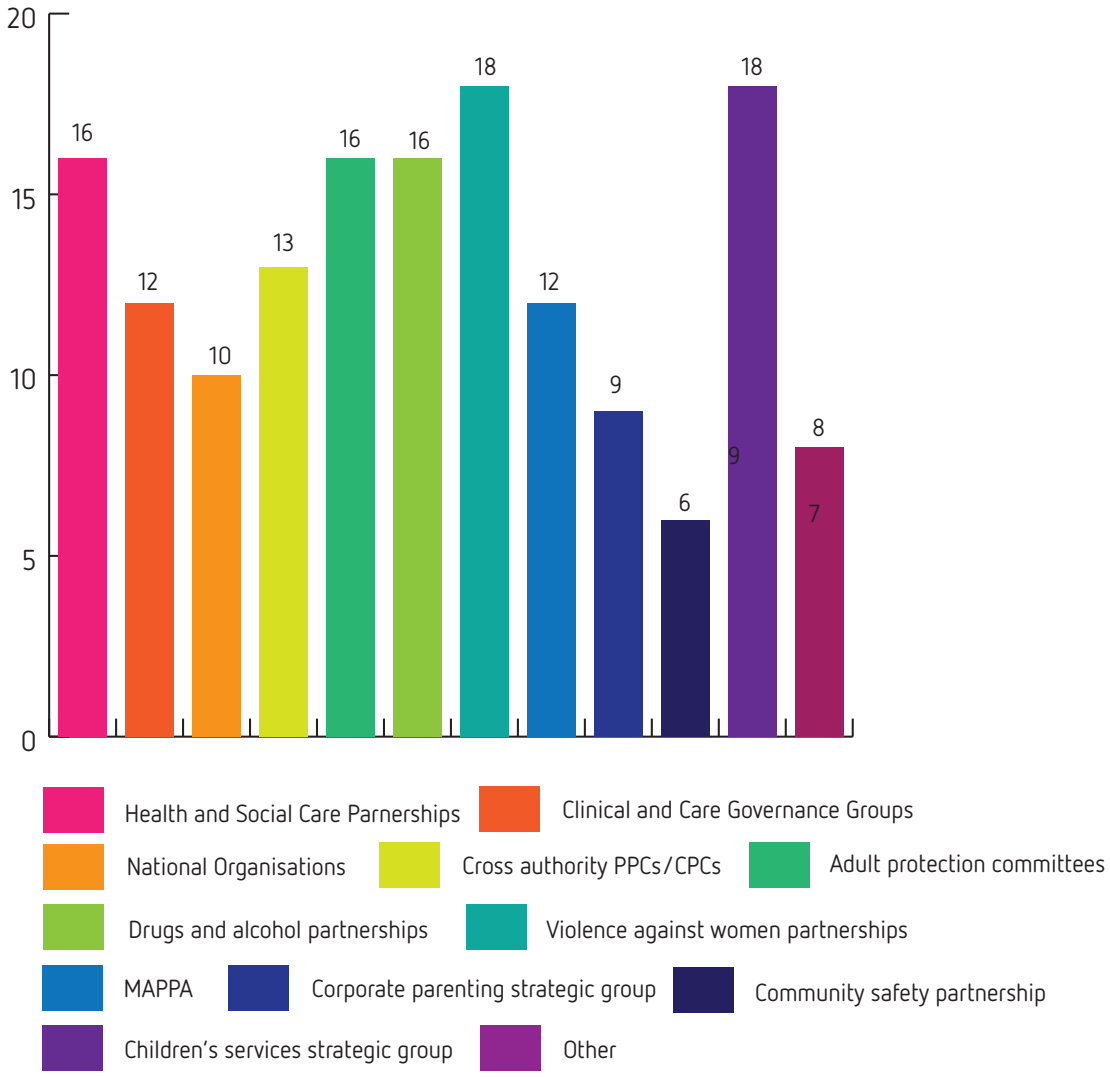
Monitoring implementation and quality assurances

How do you monitor the implementation of your action plan or its equivalent?

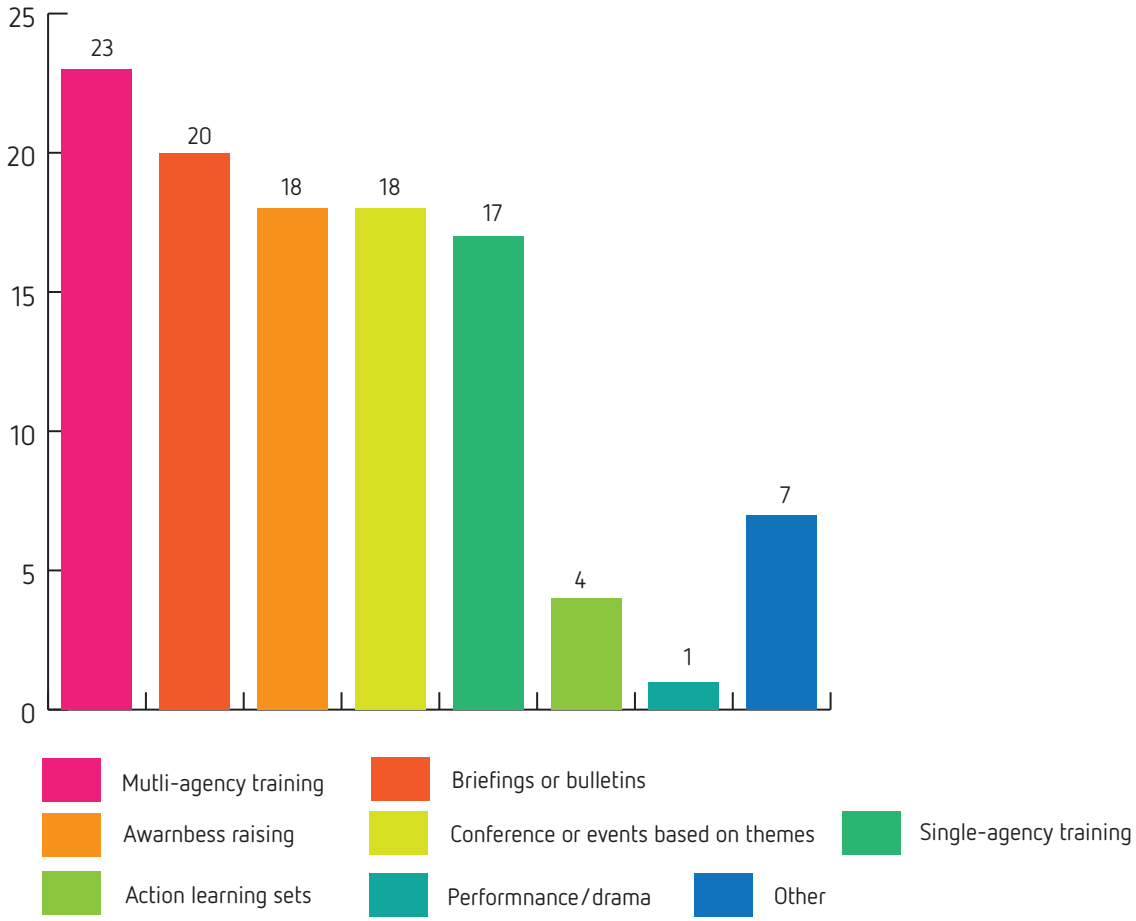


Dissemination of learning

Is learning shared across the wider community/planning partnership/strategic group?

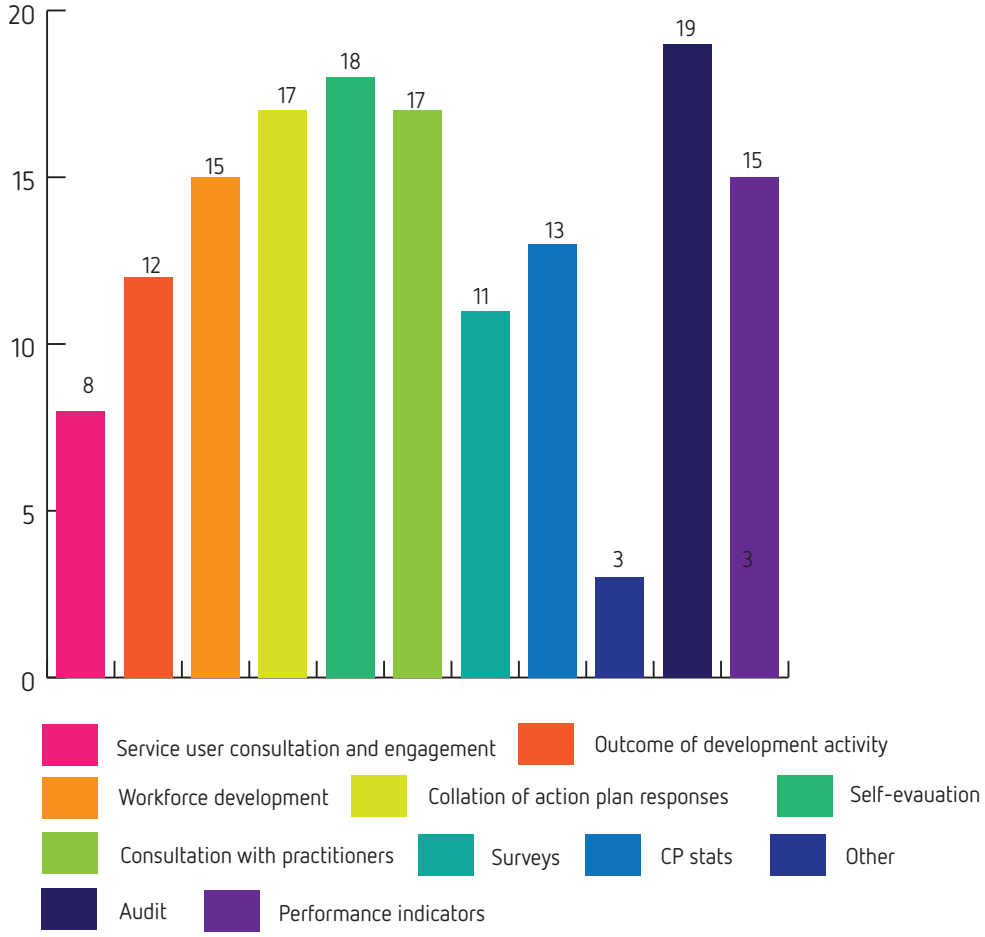


What are the ways in which you disseminate learning from ICRs and SCRs to the workforce?



Impact

Source of evidence for local practice change as a result of ICR and SCR recommendations/learning



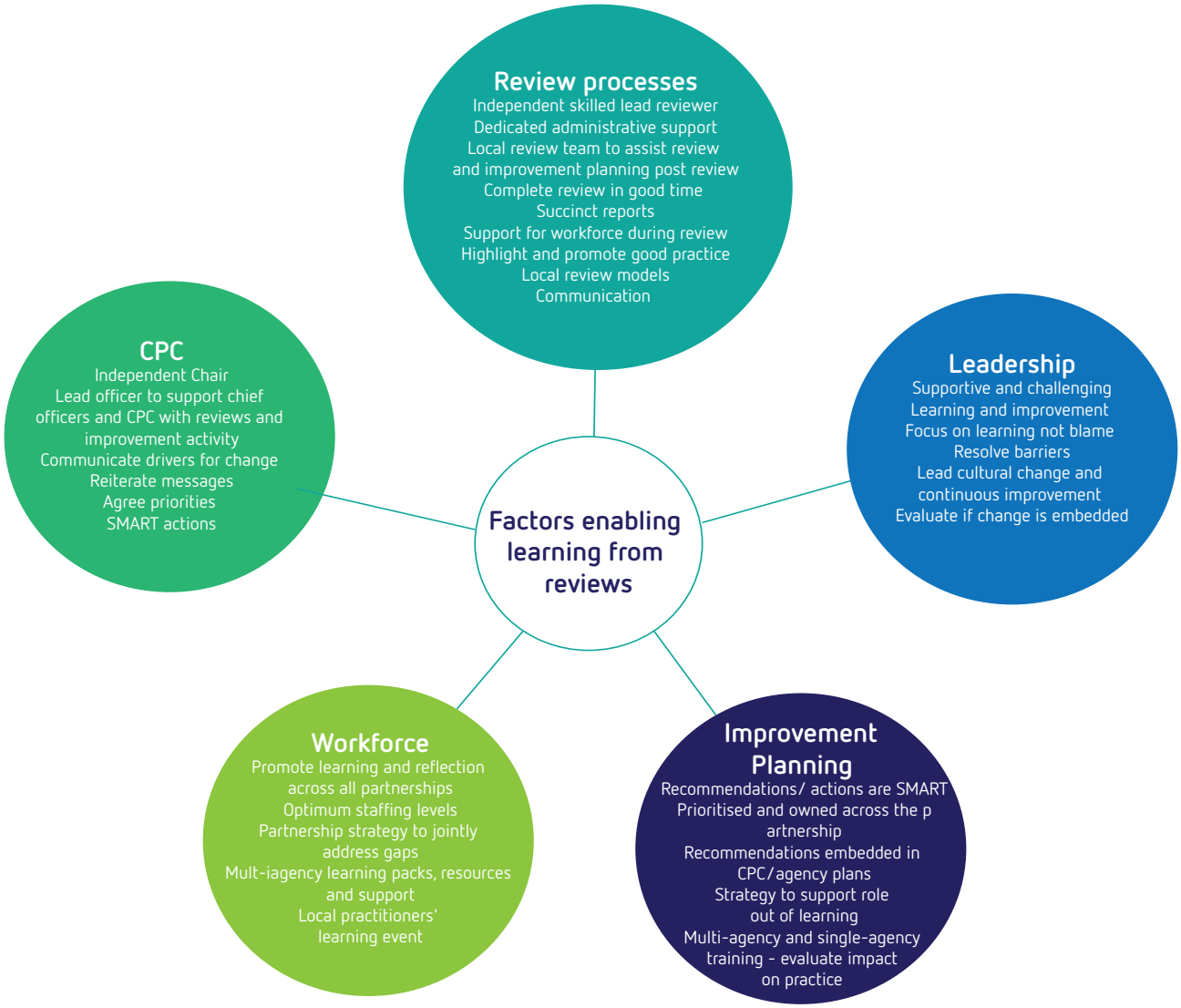
Types of cases, themes and learning

Some types of cases are harder to influence/change than others.

	Frequency	Percentage
Agree	16	64%
Disagree	0	0%
Don't know	9	36%
Total	25	100%

APPENDIX 3: FACTORS THAT SUPPORT LEARNING AND CHANGES IN PRACTICE

CPCs gave us examples of the types of factors that support practice change as a result of learning from ICR and SCR recommendations. We have listed them below.



APPENDIX 4: EXAMPLES OF PRACTICE CHANGE

Following from the focus groups and survey responses, Child Protection Committees (CPCs) and Public Protection Committees (PPCs) were invited to provide examples of change(s) in practice, where ICR or SCR findings or recommendations were the catalysts. In total, 10 CPCs or PPCs provided examples, which are outlined below, along with one example provided by an NHS Board.

Most committees acknowledged that further work is required to be able to evidence the difference these changes and innovations are making to the lives of children, young people and their families. However, we can see from the examples below that a range of system, process and service improvements have been implemented to help reduce the likelihood of serious harm recurring. Each area has voiced a commitment to continued self-evaluation and quality assurance, to measure the impact of these changes on the outcomes experienced by children, young people and their families.

Angus Child Protection Committee

The change in practice

Following two SCRs for older young people in the adult and child protection processes, a comprehensive improvement plan was developed. A participatory approach to the dissemination of learning from ICRs and SCRs was undertaken.

The approach to learning was reviewed and a SCR learning resource pack was developed to maximise learning. This can be used in single- or multi-agency settings to facilitate discussion and reflection on learning and improvement. The learning resource pack includes a learning brief and SCR links, a presentation and seven-minute briefings on the two SCRs, including a summary of the findings.

The focus of the learning resource pack and events is about implementing change. Participants are asked to consider what they can do in their own practice to influence the change that is required; how they can influence the change in their team or service area; what needs to be changed in the organisation and how they can influence larger changes if required.

A dissemination plan has been developed, with aims to host the pack on the NHS Education for Scotland's TURAS system (a single, unified platform for health and social care professionals). A launch event is also planned.

The findings and recommendations which influenced change

The Angus CPC and Adult Protection Committee SCRs were published together in August 2020. Similar themes were identified in both reviews. The connection between the improvements identified in reviews and practice needed strengthening.

How partners worked together to achieve change

The Protecting People workforce learning and development subgroup comprises of multi-agency membership representing the six thematic Protecting People partnerships in Angus. This group has provided oversight of the development of the learning review pack and are working together to develop the dissemination plan. Sessions that are offered will be multi-agency and single-agency where appropriate.

The process of developing the seven-minute briefing sessions and the resource pack has been participatory. A video is planned to use the information from the young person involved. This will highlight children's voices and what the young person identified as important.

East Ayrshire Child Protection Committee

The change in practice

A young person's pathway was developed for children and young people attending hospital emergency departments in Ayrshire in relation to mental health concerns. This helped ensure that important information flows appropriately and timeously and that relevant supports are put in place promptly to safeguard their welling.

A multi-agency group including various services within NHS Ayrshire & Arran, including Child and Adolescent Mental Health Service (CAMHS), child protection, paediatrics and emergency department contributed to the process.

A standard operating procedure (SOP) to look at any young person who may present at an emergency department on a frequent basis is in development. The SOP requires to be ratified within Health and then it will be disseminated. The senior nurse manager for children services in East Ayrshire, GPs and school nursing are now routinely made aware of any such attendances at an emergency department.

The aim is for the pathway to be used across Ayrshire to ensure that all relevant services have a clear pathway to follow, ensuring that everyone receives the most appropriate care at any given time.

The findings and recommendations which influenced change

The findings of an ICR identified the need for emergency department staff to be more aware of the processes and procedures to be adopted when young people present, including on multiple occasions, with issues of attempted suicide and self-harm.

How partners worked together to achieve change

Contributions were made from various services within NHS Ayrshire & Arran, including CAMHS, child protection, paediatrics and emergency department. Early indications are that children and young people are spending reduced time in the emergency department and their mental health assessment is being carried out in paediatrics, which is more age appropriate. This will have a positive outcome for the young people concerned.

Falkirk Child Protection Committee

The change in practice

There has been increased focus on bringing GIRFEC practice and principles into pre-birth planning and intervening earlier. Good relationships between social work and Health exist and more proportionate referrals are being made.

The findings and recommendations which influenced change

SCR findings referred to the need for practitioners to consistently recognise the impact of all risk factors which adversely affect a parent's ability to safely look after their children, so that actions to support and protect children can be appropriately targeted to their needs.

The CPC was asked to consider how to support the development of a clear pathway for pre-birth planning and assessment for those considered to be in need of protection. It was recognised that this was not solely an issue for Falkirk. The Care Inspectorate's second triennial review found improvements could be made in the rigour and effectiveness of assessment and decision-making processes.

How partners worked together to achieve change

The CPC worked collaboratively across Forth Valley, updating the pre-birth pathway to embed the GIRFEC approach. The CPC ensured that the Inter-agency Referral Discussion (IRD) is a key part of all child protection assessments for unborn babies, and they implemented a dedicated pre-birth assessment tool.

It took time to formulate and finalise the new guidance and the latest child protection minimum dataset report evidenced 100% use of the pathway and lead professional tool. One critical element has been bringing in IRDs as standard. Positive feedback about the impact has been received. Information is being shared earlier and parents have a better understanding of the written assessment and the plan. Managerial oversight of assessments has been built in and the IRD steering group provide ongoing quality assurance.

Falkirk Child Protection Committee

The change in practice

Falkirk have developed a self-evaluation champion's group to build engagement with operational staff in peer and themed audits to help embed learning.

The findings and recommendations which influenced change

Inter-agency assessment and planning for children who are not within the child protection system: better outcomes for children are more likely when all agencies are fully engaged with the risk and need assessment process, working in partnership and effectively sharing information. Without these processes being embedded in practice, children and young people would be at additional risk of their needs not being met. The SCR contained questions about the use of audit practices and how best practice and learning could be shared widely. This was an opportunity for staff to become more directly involved in audits.

How partners worked together to achieve change

The partnership aimed to support staff to share learning and inform daily practice. They decided to take forward peer audits and an approach using champions. It attracted staff from social work, health and the third sector. Those who took part in the first audit activity proposed developing a checklist for practitioners to be clearer about the quality of work expected. As staff are based in different teams and disciplines, there has been an exchange of ideas and practice methods and a willingness to be involved in learning. Audits and champions meetings are scheduled throughout 2021. This is showing willingness during a health pandemic to work together and get creative about learning together. Ideas are taken back to teams for discussion.

Fife Child Protection Committee

The change in practice

Realising that over 140 actions had to be brought together in a coherent way, Dr Sharon Vincent, from Northumbria University, was commissioned to support a revised approach. Six for Safety promotes best practice when working with children and families. The CPC continues to focus on these six key actions and uses the findings from this analysis to inform the development of their new improvement plan. More information on Six for Safety can be accessed at: https://girfec.fife.scot/home/girfec-pages/child-protection

The findings and recommendations which influenced change

Decision making in child protection is complex and challenging with many different influences. Numerous recommendations and emerging themes from ICRs and SCRs identified the need to take learning, findings and recommendations forward in a different way.

How partners worked together to achieve change

Six for Safety was rolled out through an internal strategy, which included a multi-agency communications strategy, benchmarking and evaluation. An evaluation of the initial phases of activity was undertaken.

The CPC commissioned Dr Vincent to evaluate a further 10 ICRs. The findings validated the Six for Safety approach. The CPC has continued to focus on this approach and have used the findings from the research and analysis to inform their improvement plan.

A number of improvements have been introduced which link to the six themes. Child wellbeing liaison nurses advise and enquire about wellbeing issues in the acute service, escalating as necessary when they recognise an issue as child protection. All wellbeing referrals are now signed off by the emergency department consultant and referral criteria has been refreshed.

There has been a review and refresh of guidance relating to the child wellbeing pathway, in particular the continuum between child wellbeing meetings and child protection case conferences. Multi-agency practice development sessions have been held throughout the authority, providing an opportunity to embed guidance for the child wellbeing pathway into practice for practitioners.

The self-evaluation and audit working group of the CPC completed a multi- agency audit in 2018, focusing on the child wellbeing pathway. A framework is now in place to undertake more in-depth evaluation, informed by qualitative feedback.

A minimum visiting schedule has been agreed, which includes seeing children on their own with the key principle of keeping children at the centre.

Glasgow Child Protection Committee

The change in practice

There were three significant strands of activity initiated relating to the assessment and response to neglect. Learning events were organised where the SCR could be presented and the implications for individual practice and agency systems and processes could be discussed.

Two neglect summits were attended by almost 500 professionals from a range of agencies and roles across the city. These included input on the impact on psychological functioning and behaviours, initiatives to reduce the risk of neglect, the influence of poverty and deprivation on neglect, and Glasgow's strategic response to need and risk.

Several smaller events were also held, including the child protection local management reviews and a development session with the third sector city-wide forum.

The second strand was the review and relaunch of a standardised assessment tool for use where neglect is a concern. This had existed for a considerable period, but an audit had shown that it was not being used as anticipated. A learning network was established of associate trainers to deliver the training on a locality basis, with training for trainers being provided. In total, 300 people attended the training over a six-month period. The locality child protection forums were delegated the task of leadership and raising the profile of the toolkit and its implementation.

The CPC learning and development programme was reviewed with all courses being updated to incorporate the key themes from the SCR. Two new courses: Good Practice in Chronologies and Multi-agency Risk Assessment and Decision-Making were added.

Chronology materials were made available to partners and an audit tool was devised, which was also shared.

The findings and recommendations which influenced change

There was insufficient use of assessment tools, including chronologies, leading to a lack of basic information around family composition, family routines, living conditions, and the involvement of extended family. There were indications of a culture and mindset in relation to poverty and deprivation, and the levels of care which were appropriate or not.

Indicators of neglect and disguised compliance were not recognised, and incidents were dealt with in isolation. There was insufficient interagency communication, effective joint decision-making, and a lack of liaison with possible sources of information.

How partners worked together to achieve change

The CPC sought to improve the existing communication channels and establish new ones to increase the reach of CPC information. This range and number of professionals attending summits and training than normal increased. The CPC listened to what the learning and development needs of the workforce were.

Membership of the CPC and its subgroups was revised to include a range of different partners.

Early indicators are that the evaluations of learning events and toolkit training are consistently positive. There is a reported increase in knowledge and understanding of neglect. There is increased confidence in identifying neglect and professional challenge.

Education services have collated information giving specific examples where children had received additional support and protection. A number of staff and teams, including the health visiting service, reviewed the circumstances of the children they worked with and amended care plans and escalated concerns accordingly.

Partnership feedback demonstrates that the approach to neglect feels more co-ordinated with a greater sense of shared responsibility at all stages.

Highland Child Protection Committee

The change in practice

Previously, harmful sexual behaviour was not always considered as a child protection issue. Using a trauma-informed approach to the review considered the needs of young people displaying harmful sexual behaviour to ensure a child-centred focus.

A joint subgroup was formed to take forward recommendations of the thematic review. This group developed care and risk management procedures which were agreed by all partners. Care and risk management meetings became formally chaired and minuted, with action plans being distributed to all partners. Discussions involved the young person and their carers.

The CPC formally adopted these procedures which led to clearer pathways and referral processes. Meeting procedures were established with clearer roles and responsibilities. Monitoring and reporting arrangements were put in place. There was a decision taken to change the language from 'perpetrator' to 'young person'. Children's rights became embedded with a focus on the management of risk and harm.

The findings and recommendations which influenced change

A thematic learning review was undertaken in relation to a young person with numerous allegations of sexual assault against other young people. The learning review highlighted the absence of operational care and risk management procedures. This meant a potential lack of clarity around the actions, responsibilities or contingency plans agreed at meetings.

The learning review also identified a need to consider the use of Risk of Sexual Harm Orders in relation to young people and the impact this may have upon them in the future.

How partners worked together to achieve change

The subgroup developed care and risk management procedures, which were agreed by all partners at the CPC. The inclusion of Education in the sub-group meant that the education issues highlighted in the report can be progressed. Partners will participate in multiagency training to develop a shared language and understanding of the needs of young people and their carers across Highland.

Considering harmful sexual behaviour as a child protection issue has facilitated a shift in thinking in relation to the need for care and support for young people. Data about the care and risk management process is now part of the minimum dataset for child protection considered by the CPC and chief officers.

It is anticipated that this will lead to improved outcomes for young people, their carers and any victims. Staff should be better able to consider the provision of education and availability of therapeutic interventions for young people who display harmful sexual behaviours. Risk of sexual harm orders are now considered through care and risk management meetings. This ensures all partners contribute to discussions about orders and any conditions, which may apply prior to the application being lodged in court.

North Ayrshire Child Protection Committee

The change in practice

The CPC sought to ensure that children's experiences are listened and responded to, and that adult's voices do not preside over the voices of children. This is seen as fundamental to safe child protection practice. How children are experiencing their lives is key to the assessment of their care and safety.

Multi-agency Practice Reflective Improvement Short Modules (PRISM) are providing staff with an opportunity to reflect and learn from case reviews, and how this is having an impact on their practice. Several PRISMs of the SCR have been delivered and evaluations indicate that this is positive in terms of the insight and knowledge gained for professional practice.

North Ayrshire is launching a child sexual abuse strategy. It supports training for all practitioners, helping them to be responsive to concerns in relation to sexual abuse and supporting them to protect children and young people when there are no disclosures or criminal proceedings. This work will follow on from the Stop to Listen pathfinder project in 2015/2016.

An increase in staff's recording of children's experiences in quarterly audits suggests that practitioners are adopting an individualised approach, putting children at the heart of decision making. Previously, practitioners would often record that the child was too young to express a view or would copy and paste the viewpoint of a sibling rather than the individual child. Audits are indicating that this is changing. Senior managers are ensuring that staff are aware of good practice and the importance of this.

The findings and recommendations which influenced change

A SCR finding highlighted that professionals across all agencies tend to restrict the evidence of children's experiences to what they say, resulting in missed cues and prioritising the voices of adults.

This finding was further validated by another ICR and through multi-agency self-evaluation, which examined child protection case conference, child's plans and core groups.

How partners worked together to achieve change

Using quarterly CPC data has been beneficial in developing a shared understanding of what needs to change. This is supported by a recognition of actions taken in response to data analysis. The dataset was previously not used in the same way.

Senior managers work with staff to share examples of good practice as well as what needs to be improved. Some recent data has indicated improvements in how social workers record children's experiences in records. This is audited quarterly by the CPC. There have been significant increases in the proportion of children's views recorded, with an increasing emphasis on the children's experience.

The CPC is in the process of expanding the PRISM model, it can be applied to specific cases. Practitioners are given more opportunities to reflect and learn in a multi-agency forum. A pilot project, practice reflective improvement dialogue, is in the process of being launched. It is anticipated that this will support practitioners to reflect and learn from cases in a way which ensures that the child's experience is at the heart of all planning and decision making.

North Lanarkshire Child Protection Committee

The change in practice

The CPC is in the early stages of introducing the contextual safeguarding approach and have developed a strategic group to plan implementation of the approach with support from the contextual safeguarding network. Contextual safeguarding is an approach to reducing the risks and harms that young people experience in contexts and relationships beyond their families. This includes risks associated with child sexual and criminal exploitation, online abuse, peer on peer sexual abuse and bullying. The approach provides a framework for practitioners to recognise that assessment of, and intervention with, these social networks and spaces are a critical part of child protection practice.

Work is at an early stage. It is an approach which fits well with wider system change in North Lanarkshire through empowering clusters and child protection systems aimed at improving planning for young people. The tools and frameworks are free to access and available online. They are designed to complement and enhance existing processes. It is multiagency and supports an integrated approach to making places, including schools, safer.

The findings and recommendations which influenced change

A review of ICR and SCR findings has informed the contextual safeguarding approach in North Lanarkshire. It is now implemented in 19 test sites across England.

How partners worked together to achieve change

There is a partnership approach to training in relation to child sexual exploitation. Practitioners are more able to recognise signs of child sexual exploitation and there is effective partnership working to protect young people in these circumstances. This year, the CPC developed care and risk management procedures to support effective multiagency working where a young person is presenting harmful behaviours to others. There is a recognition that some young people are still drawn to places or to people in North Lanarkshire where they experience harm.

South Lanarkshire Child Protection Committee

The change in practice

A strategic SCR subgroup for adult and child protection has been established. This group has oversight of all case review activity and reports directly to the Chief Officers' Group to avoid delays, embed any recommendations and put learning into practice. An increase in the number of case reviews identified a range of improvement actions across all disciplines and included several challenges.

There was some difficulty monitoring the progress of case reviews, ensuring identified improvement was being delivered. The evaluation of the evidence of improvement was not consistent. There was an identified need to provide a standard approach for all staff taking part, from referral to conclusion.

The lead officer and chair of the CPC developed new guidance, A Practical Approach to Conducting Case Reviews in South Lanarkshire. It fits around the lead reviewer model and is embedded in the terms of reference at the start of any case review.

The process includes a partnership tracking system where the lead officer for child protection acts as second reviewer. A multi-agency case review team is established to include a support system for staff involved. Every published finding or recommendation delivers a SMART action plan. Monitoring and concluding improvement actions includes measuring impact and outcomes, using the new Case Reviews Annual Impact Assessment Tool.

A revised self-evaluation toolkit for partners has been developed and implemented to encourage routine reporting back to the CPC on audit activity in key areas of concern. Multi-agency audits are linked to highlighted key themes from previous case reviews, to monitor evidence of improvement over time.

A learning session is provided to any manager who will be part of a case review team (four to six staff). Staff involved in case reviews are offered regular updates throughout process, help shape the outcome of the case review and attend briefings at the start and on completion prior to publication.

The findings and recommendations which influenced change

A review of the SCR process recognised a need to improve oversight of how case reviews are undertaken and how recommendations were progressed. The varied approaches were difficult for staff and had in some cases led to unnecessary

delays. Staff did not always know the outcome of reviews as quickly as they should. The implementation of a practice standard for staff from the outset, alongside a system to prevent drift in implementing recommendations was seen as an important change as part of improvement methodology.

How partners worked together to achieve change

All current and new managers across multi-agency disciplines are provided with training on SCRs and receive an overview the process as part of their induction to their new role; meaning they can offer reassurance and support to staff should a review be convened.

The learning model has improved a joint understanding of and contribution to learning from significant events. This includes early notifications, regular briefings and updates, applying a practical approach throughout. The importance of regular communication and consultation until publication is a key feature.

Innovative practice is encouraged and invited in improving outcomes based upon the case review experience. Only in exceptional circumstances are families not invited to take part and the inclusion of siblings is considered. Family plays an integral part in the lead reviewer's understanding of family dynamics during the child's life and at the time of the event.

Staff across the partnership report that the process has promoted confidence and a sense of safety and wellbeing during the case review process. Staff have fed back that a consistent approach is key, as is regular communication and a strongly promoted learning culture.

West Lothian Child Protection Committee

The change in practice

A themed review looking at neglect identified that the lack of multi-agency chronologies affects practitioners' ability to identify patterns of concerns, the accumulation of neglect and to respond appropriately. This means that children may be living in circumstances detrimental to their health, wellbeing and development. This had also been identified in audit activity, previous ICRs and in national reports.

In order to address this prior to a Lothian-wide technical solution being found, a decision was taken to pilot a core group report for six-month review child protection case conferences, which started in 2018. The aim of the pilot was to reduce the duplication of information; produce a multi-agency chronology to be used as a tool by the core group; and for the core group to reach an agreed understanding of risk and how risk should be addressed.

The pilot also provides the opportunity for the core group to meet as professionals with an independent person to reflect on progress, lack of progress and the analysis of risk.

The findings and recommendations which influenced change

Child neglect was recognised within West Lothian as an issue that has emerged from ICRs and multi-agency audit activity. Recognising and responding to neglect provided challenges for professionals across agencies. The decision was taken by the Chief Officers' Group to undertake a learning together themed review.

The absence of a multi-agency chronology hindered the ability of professionals to identify the re-emergence of historical behaviours, relating to avoidance and non-compliance. It is crucial in situations where children are living with neglect that patterns are identified, and their significance recognised. Chronologies have to be regularly updated, reviewed and inform planning for children at risk.

How partners worked together to achieve change

The findings were shared with partners in West Lothian. There was consensus among partners that local action was required prior to a Lothian-wide solution being found.

An audit of core group reports and child protection plans in 2020 showed improvement in risk assessment and planning for children on the child protection register. A survey of multi-agency practitioners involved in core groups indicated that there was almost unanimous agreement the multi-agency chronology had been a useful tool, enabling better identification of patterns, analysis of risk and planning.

NHS Grampian

The change in practice

NHS Grampian have made a commitment to mandatory case supervision for all health visitors, family nurses, school nurses and community midwives in recognition that supervision makes a difference to outcomes for unborn babies, children, young people and families.

This approach recognises that supervision has a fundamental impact on the way staff feel about their work, their behaviour towards service users and colleagues and their knowledge and skills. As a result, supervision has a fundamental impact on the experience of service users and ultimately outcomes for adults, children and their families.

NHS Grampian has introduced a case supervision policy that provides a case supervision model, based on work developed by Tony Morrison (2005), as well as more recent developments of the model (Wonnacott, 2012 & Wonnacott, 2013). This approach has been used by numerous social care and health organisations in the UK and has been positively evaluated and found to increase job satisfaction, worker retention and worker effectiveness (Carpenter et al, 2012).

The findings and recommendations which influenced change

Several ICRs and SCRs conducted in Grampian recommend that frontline staff should have access to regular case supervision with particular emphasis placed on health visiting. NHS Grampian recognise that school nurses and community midwives would also benefit from regular case supervision.

Caseloads over time reflect an increasing number of vulnerable children and parents. The family nurse partnerships already have a supervision framework that is part of a licensed requirement and their child protection supervision is provided by NHS Grampian.

How partners worked together to achieve change

This is a single agency process introduced in discussion with partners. The model is colloquially known as the 4x4x4 model, as it recognises the interrelationship between the four key functions of supervision, the impact of the quality of supervision on four key stakeholders and the use of the four stages of the supervision cycle to deliver reflective supervision.

The policy includes a quality improvement framework that ensures that there is continuous evaluation of the quality of supervision that is offered to the workforce. This includes the requirement for annual tri-supervision for every supervisor with constructive feedback on the skills observed and survey of supervisee satisfaction with the supervision that they are receiving.

Supervisors are given continual support in their role by specialist nurses for child protection and the lead nurse for child protection in regular forums to share relevant issues that arise from practice. The commitment to this process has seen more than 60 case supervisors being trained in the model of supervision over the past two years. This has continued throughout the Covid-19 pandemic.

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